

# **Literature Survey on the ICDS**

*Antara Haldar*

May, 2004

**Title: Reaching Out to the Child: An Integrated Approach to Child Development (Draft Report)**

**Author:** Human Development Sector, South Asia Region

**Year:** 2004

**Source:** World Bank

**Type of data:** Primary and Secondary

**Abstract**

Universalisation has not been possible due to a shortage of funds. Implementation is also plagued by the problem of lack of co-ordination (esp. between the AWW of the ICDS and the ANM of the RCH)

**Overview**

- Rapid expansion of delivery network
- Shortfall of funds affecting coverage, expansion, quality improvements
- Holistic perspective of program undermined: over-standardisation of design and lack of contextual relevance; inadequate targeting of the most needy; inadequate convergence with other sectors and departments
- Underutilization: poor quality of service delivery and lack of accountability; impact level linked with governance environment.
- Unclear task definitions and too much workload on the AWW.
- NHE sorely neglected.

**Mid-term evaluation of the ICDS in AP and Orissa (1996)**

- IMR down from 93.6 to 62
- Proportion of LBW babies down from 23 to 20%
- Expansion in delivery network
- Nutri, health status continues to be alarmingly poor
- ANMs visits typically restricted to specific areas in the village often missing out on the more distant settlements.

**Major Themes**

- Dire need for attention to under 3s (often perceived to be too young too be left alone; left with older siblings; AWCs operational for only half the day): provision for crèches/daycare providing a conducive learning environment.
- 3-6 yr. olds: Less than 20% of the target group covered by PSE (contrasts findings of NCAER etc.); one of the weakest features of the ICDS; most AWCs operating as nutrition centers with the SNP acting as a major attendance incentive (esp. in the Northern States)
- The location of the AWC and community/caste of the AWW characteristically makes it inaccessible.
- Quantity of supplements, regularity of supply problem areas (esp. in UP, AP, Karnataka)
- Large nos. of children turned away because they cannot be accommodated by the AWC.

- Enrollment does not necessarily guarantee access to services promised.
- The AWC does not provide a very inviting atmosphere: poor quality of services; discrimination against lower caste children.

### **Recommendations**

- Responsibility for ECCE should be shared with the DoE rather than the sole responsibility of the DWCD with a separate budget. Question of feasibility of the ICDS program delivering high quality ECCE with its limited resources (single AWW) and multiple responsibilities.
- While there is a need for an integrated approach to child development, the attempt of the ICDS to multitask give the constraints of resources seem overambitious

### **Trends in ICDS expenditure**

- There has been an increase over time both in absolute expenditure and spending per child (between 1992/3-2001/2, both outlays and expenditure on nutrition have increased four-fold)
- Operation expenses have increased faster than outlays on SNP, thus the increase has been considerably less in real terms.
- Exp. On SNP (borne by the States) is an avg. of Rs. 0.51 (2001-2) per day per child < 6.
- Wide inter-state variations: Ranging from Rs. 3-5 per day to < Re. 1
- States such as AP, WB, UP, Orissa, Karnataka, Gujarat, Punjab have devoted significant amounts of revenue expenditure but only a few have delivered results in terms of, say, nutrition.
- Thus, it is difficult to infer that expenditure necessarily results in a superior outcome: program management and larger issues of government are important factors.
- Until 1992-3, actual expenditures exceeded available funds but there was a reversal of this situation subsequently. The reason why many States are unable to utilise funds or utilise them in time may range from delays in release of funds to the States to lack of administrative capacity of the States to utilize these funds.
- Adequacy of resource allocations: Consistent gap evident between estimated requirements of funds for a particular state as per population BPL and corresponding departmental estimations and allocations (analysis of data from the annual report of the planning commission). An analysis of this gap across States categorized on the basis of performance on CDI shows this gap to be substantially higher in the low CDI states. The lower departmental estimations are perhaps an outcome of the low absorptive capacity of the states. This is likely to result in a vicious cycle of poor endowments and slow development. Thus institutional reform must be undertaken concurrently to ensure both adequacy of financial resources and their efficient use.

**Title: Synthesis reports on factors facilitating/impeding successful primary school completion**

**Year:** 2003

**Place of study:** A.P., Karnataka and U.P.

**Author:** Educational Resource Unit

**Type of data:** Primary

**Source:** World Bank

### **Objectives**

- Identification of factors influencing a child's completion of primary school (special emphasis on children living in poverty)
- Obtaining feedback on government programs in operation

### **Abstract**

Stratified random sampling technique used to select samples from the three States. Analysis carried out in terms of a range of factors that can influence completion of schooling such as nutrition, poverty, class, gender, ethnicity, transport facilities, health (of both mother and child).

- Performance superior in A.P and Karnataka compared to U.P. Even in these States the status is far from satisfactory.
- Gender bias: Burden of work typically heavier for the girl child (especially first born).
- Dry rations and scholarships were found to act as incentives

### **Recommendations**

- Improvement of infrastructure, teaching material
- De-linking PSE from the ICDS and making it an integral part of primary school.
- Bolstering NHE
- Monitoring of ICDS has to involve community participation

**Title: Analysis of positive deviance in the ICDS programme in Rajasthan and UP**

**Author:** World Bank

**Year:** 2004

**Type of data:** Primary

**Source:** World Bank

**Place of Study:** Rajasthan and UP

### **Objective**

Identification of factors that contribute to positive deviance in the ICDS programme

### **Methodology:**

Based on baseline study information and ICDS data to identify blocks characterized by high participation among poor groups and low prevalence of malnutrition among regular attendants

In-depth interviews with staff, administrators and beneficiaries, to identify information gaps and implementation bottlenecks.

See pg. 6 for criteria

Qualitative study conducted in 1 block in each of the 2 States, 8 AWCs

### **Abstract**

Factors that contribute to positive deviance:

#### **State level-**

- Political and administrative commitment
- Consistency of guidelines, prompt implementation of directives
- Imputation of local factors and careful selection of AWWs
- Regularity and close monitoring of supplies
- Training that is motivational
- Focused targets for AWW minimizing extraneous responsibilities
- Inclusion of lower ranking staff in feedback structures, regular meetings of functionaries and administrators

#### **District level-**

- Existing work ethos
- Individual commitment of local administrators
- Close integration with other programs

#### **Block level-**

- Role of supervisor

#### **AWC level-**

Educational level of AWW, grasp of concept (esp. an understanding of the holistic approach), belonging to the local community and being from the appropriate social group, burden of additional responsibilities that may detract from primary tasks, rapport with women in the community, access to resources and infrastructure, distance of AWC from main road and center of village, accessing younger children.

#### **Panchayat/Community level-**

Presence of strong women's groups, supportive Panchayats crucial.

**Title: Public Spending on Child Development****Author:** Gupta Devendra B**Place of study:** India**Type of data:** Secondary**Source:** World Bank**Year:** 2003**Objective**

To assess the coverage, expenditure and allocation of funds of the ICDS program.

**Abstract****Methodology:**

Overview of government expenditure on child development including ICDS

Based on data from government sources like annual reports and yearbooks. Information also collected directly.

**Observations:**

- Increasing contribution of Union government funds towards administrative costs of ICDS
- In the decade from 1992-3 to 2002-3, spending has gone up four-fold from Rs. 329.8 cr. To 1333.2 cr.
- The increase is not uniform has been greater for TN, Harayana, Orissa as compared to Bihar, U.P.
- Actual expenditure < available funds esp. in WB, UP, Maharashtra, Gujarat, Karnataka.
- 2/3 of the cost of ICDS borne by the States and other international organization (e.g. WFP/CARE- financed nutrition requirement of ¼ ICDS beneficiaries in 2001-2)
- Coverage of all components of ICDS have increased with time: 31.5 mn children (<6) under the SNP, 6 mn mothers under SNP, 16.66 mn children attending PSE
- Coverage large in absolute terms but proportionate coverage still very small.

**Title: Report by the Commissioner to the Supreme Court (Third Report)**

**Author:** Dr. N.C. Saxena, S.R. Sankaran

**Year:** 2003

**Type of data:** Primary and Secondary

**Place of Study:** All-India

**Abstract**

The Report stresses that the provision of Integrated Child Development Scheme (ICDS) in every habitation, as directed by the Court, is not being properly observed and taken seriously. There seems to have been little action on this front. This scheme is essential to protect small children from undernutrition. The Government of India has been more interested in expanding the ICDS programme than in ensuring that it achieves results. In this context, the increase in the coverage of ICDS is recommended, taking into account that this scheme is not reaching enough children. Furthermore, ICDS should aim to give particular attention to children in the poorest families and to reach children aged under three.

**Title: Report by the Commissioner to the Supreme Court (Fourth Report)**

**Author:** Dr. N.C. Saxena, S.R. Sankaran

**Year:** 2003

**Type of data:** Primary and Secondary

**Place of Study:** All-India

**Abstract**

Taking up the issue of ICDS or Anganwadis, the Report points out to the lack of attention given by most States to the plight of pre-school children from 6-months to 2 years. There are no satisfactory arrangements to feed this extremely vulnerable group. The Commissioners stress that the Court order directing state governments to universalize the coverage of ICDS has to be taken seriously. Specifically, state governments should be directed to comply with the direction calling for an Anganwadi to be available in each habitation, and for the extension of the programme to all adolescent girls as well as pregnant and lactating women. Moreover, there is a need to direct states to ensure that all slums are within convenient reach of an Anganwadi and that urban homeless children are also covered.

**Title: Report by the Commissioner to the Supreme Court (Special Report)**

**Author:** Dr. N.C. Saxena, S.R. Sankaran

**Year:** 2003

**Type of data:** Primary and Secondary

**Place of Study:** All-India

**Abstract**

- DWCD has not issued orders to comply with order of November 28, 2001 for 1 AWC in every settlement. It claims that due to inadequate finances it is unable to universalize the scheme to cover each child, pregnant and nursing mother and adolescent girl. Requests for increased financial allocations turned down.
- Universalisation is not intended to mean coverage of blocks (as interpreted by the DWCD) but of habitations.
- Scheme covers 3.4 crores children under SNP out of a total child population of over 15 crores, 8.5 crores malnourished children, and 6 crores children BPL in the relevant age group.
- % of adolescent girls covered even less since the scheme has not been widely operationalised.
- Out of 14 lakhs habitations, there are only 6.05 reporting AWCs.
- Of the 3.4 crores enrolled actual coverage is much less due to parsimonious spending on food by the States.

**Recommendations**

- Clarify that the term “settlement” (as in the Nov.2003 order) mean ‘cluster of villages. (i.e. order not merely mean operational sing presently sanctioned projects)
- Universalize the program so that it is not restricted to the disadvantaged or a predetermined no.

**Title: Concurrent Evaluation of the ICDS (Vol. 1)**

**Year:** 2001

**Place of Study:** All-India

**Author:** National Council of Applied Economic Research

**Type of Data:** Primary

**Source:** NCAER

### **Abstract**

#### **Results:**

- Success in creation of awareness amongst target populations on a. nutrition b. women's health c. overall child development
- Success in demonstrating the importance of PSE, helping to bridge gap between PSE and formal education
- Inter-state and intra-state variation in delivery of services
- Overall assessment- **objectives of improving nutritional and health status of child achieved.**
- States: Top 5: Mizoram, Meghalaya, Orissa, Gujarat, Goa; Bottom 5: Arunachal Pradesh, Bihar, J&K, Nagaland, UP.
- Survey findings corroborated by perception of households (except in Arunachal Pradesh, Assam, Goa, Gujarat, Himachal Pradesh, Punjab, Tamil Nadu, UP)

#### **Methodology:**

- Covers **all** (4000 out of 4300) ICDS blocks in the country as on March 31, 1996.
- Coverage: 15 AWCs from each operational block, selected at random from one supervisor circle; 3 beneficiary households (a) with child up to 1 yr. (b) with child between 1-3 yrs. (c) with child between 3-6 yrs from each beneficiary AW area.
- Questionnaires: (a) AWCs (b) Hh (c) CDPO (d) Mukhya Sevika; content of questionnaire based on feedback from DWCD, NIPCCD, networking institutions, nodal agencies. formatting using OMR and ISSA; different questionnaires for rural and urban centers.
- Criteria: Identification, Demographic profile of settlement, profile of AWC profile of AWW and AWH, demographic profile of beneficiaries, functioning of AWC, weighing scales and other inventories at AWC, convergence with CDPOs/Supervisors and other departments\*, community participation and inter-departmental linkages\*, observation of investigator regarding records, cleanliness\*, skill of AWW, opinion of community leader about functioning of AWC\*.
- Sample size: 60,000 AWCs, 1.8 lakh beneficiary households, 4,000 CDPOs and 4,000 circle supervisors.

- Phases- four-phase survey planned (region wise) – intro mentions that the results are based on the 1<sup>st</sup> phase but results give for all regions.
- Conducted in **close co-operation** with the Department of Women and Child Development: selection of networking institutions (NWI) that carried out the fieldwork through interviewing teams, involvement in training through lectures, pyramidal structure.
- Safeguards: checks for consistency, spot checks, intervention. (see pg. 54)
- State-level data: Organized into State-level reports- analysis of performance at district level (national level data derived from these reports) - rural focus, factor analysis for ranking of states taking into account both rural and urban performance.
- Intangible index

### **Major Findings:**

**Infrastructure Facilities and Inventories:** (table on pg. 11)

#### **Village Amenities:**

- **Satisfactory availability** of safe drinking water, proximity of bus stops, primary education. (See pg. 58)

**Infrastructure** (details pg. 60, 61)

+ves:

- Physical proximity/ accessibility satisfactory- located within 100-200 meters away from beneficiary households, avg. travel time of 5-10 mins.
- States: Karnataka, TN, Assam > 200 m, Kerela, Andhra Pradesh, Bihar, Punjab < 100 m.

-ves:

- Only 30% functioned in their own buildings (higher for TN, Kerela, Karnataka, Orissa)
- Only 40% housed in pucca structures.
- Only 17% had toilet facilities.

#### **Inventories**

- 75% possessed weighing scales. (Significant inter-state variations)- inconsistent with poor growth monitoring
- Only 1/3 reported **adequacy** (? Not defined) of learning kits (variations 12% - 70%)
- Only 30% reported adequacy of NHE messages. (8% UP- 58% Goa)

**Profile of AW Functionaries** (table pg. 12, details pgs. 63)

- > 90% in position
- 70% residing within the vicinity
- Almost 50% are matriculate and above. (34.6% illiterate)

- 85% report that they have received some training (except the Northern States- Arunachal Pradesh, Uttar Pradesh, Rajasthan, not much intra-state variation) have some sort of training (**in stark contrast with findings of pilot survey**); < 30% have received in-service training i.e. largely pre-service training.
- Largely Hindu, married (80% approx)

### **Functioning of AWCs:**

#### **Duration:**

- Avg. no. Of days functional: **24 out of 30** p.m. [range: 21 (Nagaland) – 30 (Goa)]
- Avg. no. Of hours: 4.
- No significant seasonal variation, substantial inters-state variation (higher for TN, Kerela, lower for north-east, Gujarat: 3-4 hrs, TN: 6 hrs, Bihar- 4 hrs)

#### **Coverage**

- 65% of eligible children (72/110) and 75% of eligible women (15/20) registered (does this assume that all those registered are availing of the facilities?)
- 62% of woman availed of SNP and 60% of ANS/PNS. (for data for the States- Para 2, pg. 81)
- PSE- 54 eligible, 33 enrolled (. 60%) – pg. 13, 50% enrolled – pg. 81
- > 50% of eligible children provided with nutrition supplements
- **Male bias more evident in PSE than SNP.**

#### **Record Maintenance**

- Orissa, Andhra Pradesh, Punjab- better records maintained
- Growth monitoring, referral poor overall

#### **Utilization of services**

#### **Supplementary Nutrition**

- Provided for more than 21c days in > than 67% of ACws
- Significant inter and intra state variations

#### **Health Services**

- Only 26% usage on an average
- Inter-state variation (5-90%)
- Health check, referral problematic

#### **Nutrition and Health Education**

- 10% viewer ship of audio-visual cassettes

#### **Nutritional status**

- < 3% of children severely malnourished (except Bihar)

- 11.3% of children moderately malnourished (higher for 37-72 months)
- PSE- 605 of those eligible enrolled

### **Community Participation**

- Poor overall except for a few states
- Support from Panchayats very limited
- Support from mothers whose children are enrolled

**Title: Improving Household Food and Nutrition Security- Achievements and Challenges Ahead (Vol. 1: Main Report)**

**Year:** 2001

**Author:** Rural Development Sector Unit, South Asia Region

**Source:** World Bank

**Place of Study:** All-India

**Type of data:** Secondary

**Abstract**

- **The no. of ICDS beneficiaries increased rapidly over the last decade, although official estimates are likely to overestimate this.** A recent (1996) study conducted by the Foundation for Research in Health Systems of the ICDS in 7 States found a widespread tendency on the part of AWWs to over-report the no. of beneficiaries as well as rates of provision of food and other services. The over-reporting of receipt of food by children ranged from 21% in Bihar to 44% in Orissa. This is largely a function of pressure on staff to reach designated targets and weak monitoring based on MPRs with no formal confirmation on the part of beneficiaries.
- **ICDS only weakly meeting its program targets.** *Children* under 2 not being reached by the SNP. In AP, Bihar and Orissa, the FRHS study found that about 69% of the children were eligible for supplementary feeding but only 38% received it in Orissa, 50% in Bihar and 57% in AP. In MP, 52% were eligible while < half (24%) received SN. Even fewer children were receiving food for more than 3 days a week. The study also finds that SN is not reaching *pregnant and lactating women*- in MP, Rajasthan and UP, less than a third. *In general*, the food ration was shared with other family members, reducing impact on target group. Similar insignificant progress found by the FRHS and WB evaluations in distribution of *iron and folic* tablets, reaching less than 20% of target group relative to the 70% goal. Poor growth monitoring by the AWW limits the program's effectiveness in targeting *moiré* nutritionally vulnerable children, those < 2.
- **A number of critical problems that undermine program effectiveness have been identified in various reviews.** The bias towards rapid expansion of the program contributed to a diversion of attention away from ensuring the delivery of high quality services. Frontline AWWs are unable to effectively deliver key ICDS services because of inadequate training. The FRHS study found that from 10% (AP, Bihar) to 70% in WB could not record the height and weight of the child correctly. Even if the child is weighed, an avg. of about 60% were able to assign nutritional grade correctly- in Rajasthan, UP and WB this was as low as 1/3. The preoccupation with food distribution reduces AWW's attention and priority attached to interpersonal communications and counseling, which are vital to care-related determinants of child nutrition. This is also in part due to the large number of activities that the AWW has to perform: run the center, feed and weigh the children, carry out preschool activities, maintain records and growth charts carry out surveys and visit homes. Caste and other social related factors further

impede AWW interactions with beneficiaries. Problems of inadequate equipment, supporting infrastructure, and poor supply management further circumscribe what AWWs could do. Unavailability of weighing scales, storage facilities, and irregular delivery of food and other supplies (IFA and oral rehydration solution packets, and medicines) are reported as problems that hinder AWW activities. Weak monitoring and evaluation hampers correction of operational problem and opens opportunities for misappropriation of resources (e.g. the diversion and sale of food). The centralized nature of management and monitoring further impede quick feedback. The DWCD at the Central level is responsible for overall management, monitoring, collection and analysis of periodic reports. Moreover, weak supervision at the project level, and the lack of a mechanism to confirm data on reports prepared, permit inaccuracies to pass through the system. The recently approved WCDP (ICDS) takes some steps in addressing poor quality ICDS services in 5 States- Kerala, Maharashtra, Rajasthan, TN and UOP. The project focuses on improved worker training and fostering greater community participation in program implementation to improve its effectiveness.

- **Recent evaluations indicate that the ICDS contributed only to slight improvements in nutritional status.** Recent evaluation studies of Bank-assisted ICDS projects in AP and Orissa and the Integrated Nutrition Program in Tamil Nadu suggests improving trends in child nutritional status in project areas. The study found a reduction in severe, but minimal impact in reducing moderate, malnutrition. The project also contributed to a reduction in the infant mortality rate and the incidence of low birth weights. The study, however, noted that the “overall paucity of relevant, reliable, and timely data” made it difficult to draw “a definitive judgment on project outcomes.”

**Title: ICDS**

**Year: 2000**

**Author: CAG Report**

**Place of study: India**

**Type of data: Secondary**

## **Abstract**

### **Results:**

(1) Overall evaluation: The **scheme has done little to improve the health status of children, child development or maternal care** (attributed to complexity of prog.)

(2) The Ministry universalized the scheme in 1997 to cover the entire country without taking into account the financial and infrastructure requirements leading to a failure in implementation.

(i) Only 4200 projects are operational as opposed to the 5618 that would be required to cover the entire country.

(ii) 25% of the target group remains to be covered

(iii) No. of projects sanctioned and operational at variance with state reports.

(3) TE of Central Govt., St. Govts. And int'l agencies Rs. 8534 crores.

(4) Financial Control: Allocation of resources done arithmetically on the basis of no. of projects rather than on performance.

(i) An estimated 121 crore of scheme funds diverted.

(ii) Non-reconciliation of figures of grants released by the Ministry and those received by the states was one of the major flaws in the financial administration of the scheme, which rendered the reliability of the financial figures maintained by the Ministry questionable.

(5) Co-ordination problematic: Only 41% of projects submitted monthly reports (often inaccurate, incomplete); Ministry-State co-ordination based on these unreliable reports; field visits by CDPOs/ACPDOs inadequate.

### **Methodology:**

(1) Objectives: Status of- availability, utilization and flow of funds; ascertain credibility of reporting standards; utilization and deficiencies in manpower/infrastructure; assessment of delivery of package of services; quality of training; utilization of external assistance.

(2) Period: 1992-9

(3) Data and information examined in the Ministry and States through test check (I have NO CLUE what this means)

(4) Sample units of the states were operational projects (No diff of indices acc. To R/U/T since univ.)

(5) Availability of info. Not uniform, satisfactory- poor (irregular, unreliable) monitoring.

### **Major Findings:**

(i) Failure of **SNP**- non-identification of beneficiaries, insufficient coverage of beneficiaries, significant interruptions in feeding, deficiencies in the nutritive value of food, sub-standard food, etc. Many state governments did not provide adequate budget for supplementary nutrition. Therapeutic/weaning food for severely malnourished children had not been provided in 9 states. In four states cases of sub-standard and adulterated food were noticed.

(ii) **Multilateral and Bilateral Assistance:** Underutilization of WB (39% till March, 1999), CARE, UNICEF, SIDA sponsored/assisted projects; diversion of resources (to personal/non-ICDS uses); ineffective (e.g. Orissa- increasing malnutrition); mismanagement at State level

(iii) **Health check/ Referral services:** unavailability of baseline surveys for identification, poor maintenance of records, improper co-ordination with State Health Department.

(iv) **Immunization:** targets not fixed, incomplete coverage of monitoring mechanisms, improper maintenance of records.

(v) **Provision of medicine kits:** effects of purchase and delivery; shortfalls in 16 States.

(vi) **NHE:** no film/slide shows in 91% of projects; 27% shortfall in home visits by AWWs in 11 States (out of 5.16 cr. Women in the 15-45 age group only 3.74 cr. Were covered) underutilization of allocated resources/ no clear norms (details pg. 2)

(vii) **Functionaries:** Shortfall of 13-38% of persons in position; diversion to non-ICDS; variance between Ministry and State records.

(viii) **Training:** largely ineffective

(ix) **Adolescent girls scheme:** grant @ 1.10 lakhs/ block released records on the no. of beneficiaries covered not maintained; In **eight states, not a single beneficiary was covered since 1991-92 resulting in fructuous release of Rs 9 crores.**

(x) **Supply of vitamin A solution and iron & folic acid tablets:** records of receipt and distribution of vitamin A were not maintained while in majority of the states there was no supply of the vitamin A solution during 1992-99.

(xi) **PSE:** 66% of eligible children enrolled; 54% actually attending classes; basic records not maintained.

(xii) **Training:** sub-optimal training targets; targets not achieved in several states. (Table on pg. 47)

(xiii) **Performance of NIPCCD:** Against grant of 7.36 cr., 5.94 cr. actually utilized. (refresher training emphasized, job training suffered)

(xiv) **Performance of CTC:** Against 6.52 cr. Released, 6.96 cr. Incurred

(xv) **Miscellaneous Observations:**

(a) Large amounts of material and equipment lying idle or out of order

(b) 229 vehicles of the scheme used for non-scheme purposes in 14 States

© Advances of 12. 19 cr. lying unadjusted.

(xvi) **Monitoring and Evaluation:**

(a) Co-ordination committees not formed/meetings not held in several States

(b) Monthly monitoring reports received from 1720 out of 4178 operational projects.

© Monthly Progress Reports: Records either not maintained or incomplete/inaccurate in 13 States; CDPOs/ ACDPOs did not undertake prescribed no. of visits to AWCs (largely due to shortage of staff), night halts (as prescribed) were not made;

(xvii) **Impact:**

(a) The scheme has not had the desired impact on IMR/CMR

(b) The Ministry's 'India Nutrition Profile' reports that malnutrition in Arunachal Pradesh and Bihar were as high as 89 and 90 % respectively; in a number of States malnutrition among children in the 1-5 age group was 50%

**Title: ICDS – A Pilot Survey**

**Year:** 1998

**Place of study:** Karnataka, West Bengal, Gujarat, Uttar Pradesh, Himachal Pradesh

**Author:** National Council of Applied Economic Research

**Typr of data:** primary

**Source:** NCAER

**Methodology:**

- Commenced July, 1996
- 10 blocks over 5 districts
- 1362 AWCs, 2700 beneficiary households, 10 CDPOs and no supervisors
- Questionnaires: (a) AW Functionaries  
(b) Households  
© CDPO/ ACDPO? Supervisor

**Criteria:**

- AWCs
- Functioning of AWCs
- AWC functionaries
- Utilization of ICDS programs
- Community participation

**FINDINGS:**

- **AWCs-** in terms of physical enrollment, basic amenities
  - o Avg. population served: 700
  - o Hindu dominated (56%)
  - o SC/ST (30%)
  - o Karnataka- most developed in terms of drinking water, proximity of bus stop, primary school within village premises.
  - o West Bengal- lagging behind: wells main source of drinking water, transport, and education not easily available.
  - o Infrastructure: inadequate: ½ operate in open spaces, 1/3-pucca buildings, 1/5 have toilet facilities. (Gujarat, Karnataka in a better position than West Bengal, UP)
- **AW Functionaries**
- 38% lived outside village (esp. in West Bengal) – contrary to all-India trend

- AWWs relatively young, usually a member of the community, caste that the AWC serves
- All AWWs literate (all-India 38.4 % illiterate ??), 1/3 AWHs illiterate
- ½ AWWs matriculates, majority of AWHs have attended primary schools
- WB, HP higher levels of education
- Largely married or widowed
- Large proportions of AWWs have not attended ICDS training: 40% never trained, 39% trained once, only 1/5 has adequate training.
- 91% of Wash never trained
  
- **Functioning of AWCs**
- On an avg. operational for 24 out of 30 days per month, for 4 hours per day.
- ½ maintain 7-9 registers (indeterminate measure) (Up and Karnataka maintains the maximum number); growth monitoring poor.
- Attendance of children inadequate (esp. in Karnataka, HP, Gujarat), food is an important incentive.
- PSE successful
- Home visits satisfactory
- Enrollment: < ¾ eligible children, < 2/3 eligible women. (Contradicts all-India finding)
- Only 2/3 children normal, 3/5 malnourished.
  
- **Utilization of ICDS:**
- Greatest success of SNP, followed by immunization, followed by PSE (contrary to all-India trend)
- Growth monitoring, referral services, health checks, NHE problematic.
- **62% of beneficiary household received food supplements for 264 days < 300-day guideline. 38% for even less.**
- Only 1/ 5 of the household received Vitamin A supplements regularly, 1/10 received iron, folic acid.
- Only 2/3 of households aware of immunization services
  
- **Community Participation**
- Low levels apart from family members of AWW sans AWHs
- Community participation through: provision of firewood etc. spread of awareness regarding immunization, NHE, delivery and preparation of SNP, identification and registration of pregnancy and birth.

**Title: Wasting Away: The Crisis of Malnutrition in India**

**Author:** Anthony Measham, Meera Chatterjee

**Year:** 1998

**Source:** World Bank

**Type of data:** Secondary

**Abstract**

**Objectives:**

- To review effectiveness, efficiency and impact of public spending on nutrition in India
- To suggest how this may be enhanced.

**Background**

- More than half on India's children under four are moderately or severely malnourished, 30% of newborns are significantly underweight, 60% of Indian women are anemic.
- Despite a changing scenario where famine and epidemics are no longer chronic, marked by vast improvements in food production, disease control and economic and social development, India's children, less than 20% of the global child population, account for 40% of the world's malnourished children.
- Malnutrition varies widely across regions, status, age gender and social groups, being worst in children under 2, in the large northern states and among women, tribal populations and SCs.
- Malnutrition among young children and pregnant women has three main causes: inadequate food intake; disease- some as common as diarrhea; and deleterious caring practices such as complementary feeding.
- Poverty and gender inequity can be identified as the two most important of these causes.
- The cost of malnutrition to India's GDP was estimated to be at least \$ 10 billion in 1996.

**The ICDS Program**

- 0-6 yr. old population of areas covered by the ICDS already 63 mn, population of pregnant and lactating women 13.6 mn, only 30 mn children and 45.2 mn. Mother actually covered by SNP and 15 mn 3-6 yr olds by PSE.
- Coverage figures unavailable for other services.
- In fewer than 10% of the 4200 program blocks are schemes for adolescent girls' nutrition, health, awareness and skill development.
- Impact on nutritional status limited ( based on NFI-88 and NIPCCD-92)
- inadequate coverage of children < 3 (those at greatest risk of malnutrition) and women and children living in hamlets
- irregular food supply, irregular feeding and inadequate rations
- poor nutrition education of mothers to encourage improved feeding practices at home and other relevant behavioral changes

- inadequate training of AWWs particularly in nutritional and growth monitoring, and communication
- AWW overburdened, and weak unsupportive supervision of AWWs, resulting in neglect of nutrition related tasks
- Poor linkages between the ICDS and the health system

## **Overall**

“The quality of ICDS services is low. Although the services are much in demand, they are generally poorly delivered and uncoordinated. Worker training, in-service supervision, community support- indeed, community involvement in any sense- remain major gaps. Although there are exceptions, AW facilities and environments are sorely inadequate and the program does not inspire the good health, hygiene and nutrition-related behaviors that are so essential to changing the status of children and women in poor households.”

## **Recommendations:**

- Outreach programs to 5-24 month old children and pregnant mothers, either by hiring a second worker or by separating the PSE component from the rest of the program (I don't quite understand this- is it because this is eclipsing the rest of the program?)
- Quality improvements through better training, supervision and community ownership
- Establishing a reliable monitoring and evaluation system
- Freezing further expansion till quality and impact are measurably improved and meet substantially higher standards in current program areas (a time frame of 3-5 years seems reasonable)
- As against the enormous cost of malnutrition, the cost of an improved quality ICDS must be financed by re-allocating 10% of the PDS budget to it after 2002.

**Title: Supplementary Nutrition Delivery System Strategies in India**

**Year:** 1998

**Place of Study:** All-India

**Author:** Gopalan Sarala

**Type of data:** Secondary

**Source:** DWCD

**Objectives:**

- To assess the performance of the SNP
- Evaluation of the agencies involved in the program

**Abstract**

Methodology: Information compiled through discussion with government personnel, experts and researchers on health and nutrition, managers of companies involved in delivery of SNPs, NGOs, women's groups and CARE field offers. In addition to a review of ICDS literature and field visits.

Critical evaluation of systems in Tamil Nadu, Kerala and Delhi

Study of role of NGOs: ADITHI in Bihar, Tribhuvandas Foundation in Gujarat, and the functioning of the Women's Grain Bank.

National; evaluation conducted in 100 ICDS project areas

Overall results: ICDS areas had a higher coverage of Vitamin A and Iron Prophylaxis, a lower proportion of underweight babies at birth, a better nutrition status on average vis-à-vis non-ICDS areas.

**SNP in Delhi**

Both rural and slum areas- 28 projects, 3, 872 centers, 6, 88, 000 beneficiaries (5, 72, 500 children)

Menu: 2 slices of fruit bread o a packet of 6 biscuits

No special food for infants

Dissatisfaction with regularity of supply, punctuality of delivery and quality.

Very unhygienic operations. Space severely limited in slum areas.

**SNP in Kerala**

120 ICDS projects with a sanctioned strength of 18, 756 AWWs covering 7, 49, 733 beneficiaries.

It receives WFP support (since 1976). It supplies 10.23 lakhs beneficiaries through the ICDS and non-ICDS blocks (reduced to 8. 56 lakhs in 1994, mostly in the northern districts). The Stats Warehousing Corporation handles transport of WFP food.

Monitoring is done through the Dept. of Social Welfare.

Cost of SNP is fixed by the Govt. of Kerala at Rs. 0.60 for children and pregnant and lactating women.

While the WFP areas have an element of variety, the standard fare in other areas is rice and greengram.

The operation of the program is regular, closely monitored and involves local communities.

### **SNP in TN**

As per the WB, TNIP is one of the most successful nutrition interventions in the World. The scheme provides specially processed food that has been formulated by CFTRI and created by the Avinashalingam Institute of Home Science and Higher Education for Women.

In 1996-7, 7, 828 metric tones of weaning food were supplied.

A child is given 80 g of weaning food, in the form of 2 laddus at the center everyday except for Sundays.

Growth monitoring has been more rigorous in TNIP areas with an AWC.

Children in the 3-5 age groups covered under Rd. MGR's Nutritious Noon Meal Programme and given hot meals six days a week (with special food- sweet pongal- on festival days)

Pregnant and lactating women provided SN for six days @ 120 g per day.

The Civil Supplies Corporation Supplies raw ingredients to the center.

### **Recommendations**

- Nutrition awareness needs to be introduced
- Community participation for effective monitoring
- Formation of Women's groups
- Workshops for NGOs

**Title: ICDS: A critique of evaluation technique**

**Author:** Khullar Vandana

**Place of Study:** Maharashtra

**Type of data:** Primary and secondary

**Source:** EPW

**Year:** 1998

**Objectives:**

- Assessment of the loopholes in the evaluation and monitoring of the ICDS
- Exploration of alternative methods of evaluation

**Abstract**

- (1) Very limited theoretical literature on mechanisms of evaluation
- (2) Assessment of the existing monitoring and evaluation system (i.e. the monthly progress reports): lack of timely and effective feedback from higher to lower levels; inordinately voluminous amounts of paperwork; irrelevant reporting by field functionaries; failure to establish a link between cost and benefit; impossibility of distinguishing between actual and targeted achievement in the MPR format.
- (3) Analysis of methodological flaws in the NIPCCD evaluation compared with assessment of impact in case studies in Maharashtra (Pune urban project, sample evaluation exercise carries out by the divisional commissioner of Pune (1994), experimental exercise in comparing some crucial indicators between ICDS and non-ICDS areas in Pune city): **The NIPCCID evaluation was found to overstate the utilization and impact of the ICDS and the differences between ICDS and non-ICDS areas.**

**Recommendations:**

- Dire need for revision of evaluation techniques adopted by the government. Greater reliability if conducted by private agencies.
- CDPOs should be given specific target indicators e.g. IMR of 60 and 90% coverage of children in the 0-3 age group.
- Focus needs to be shifted to ends rather than means. More ambitious results need to be targeted.
- NGO involvement in education, health and family planning welcome.

**Title: Follow-up Review of Budgetary Support to the ICDS**

**Author:** Krishnamurthy K. G.

**Place of Study:** All-India

**Type of data:** Secondary

**Year:** 1998 (January)

**Source:** WFP, Project 2206.06 (Support to the ICDS Scheme)

**Objectives:**

- To discuss the budgeting situation of the ICDS in different States
- To evaluate progress and coverage of the ICDS
- To gauge the external support to ICDS and implementation issues

**Abstract**

The DWCD has approved the sanctioning of 5614 projects to cover the entire country, but due to resource constraints, all projects in 1995-6 could not be implemented. Programme operational in 4200 projects, covering most tribal blocks and remote rural areas. A large backlog is found in the recruitment, training and posting of personnel at all levels especially AWW and CDPOs. Micro studies reveal a great variation in training standards across different regions largely as a function of infrastructural and managerial variation. **High turnover of staff due to inadequate remuneration and limited upward mobility is a recurring problem.**

**Nutrition Programme**

- Implementation superior in WFP/CARE supported areas as opposed to State-funded projects.
- External assistance in order since States unable to revise budgetary allocations to keep up with the present pace of expansion.
- Despite significant increases (esp. in MP and Kerela), allocations for the nutrition component are typically low
- The costing of nutrition based on AIIMS estimates in the 1990s need to be revised to take into account inflation over the last decade.
- The Rs. 0.90- 1.00/ beneficiary provision is not sufficient to meet the prescribed nutritional requirement or no. of feeding days.

**Support for the Programme**

- Rajasthan and MP continue to rely greatly on external support.
- In Kerela, external support has dropped from 98 to 35.83%
- UP and Assam are States plagued by political instability.

- The continuing centralized structure runs contrary to the socio-cultural complexity and variation of the country that must be taken into account for effective implementation.

**Title: Ready to Eat (RTE) food experience in Uttar Pradesh**

**Author:** Integrated Export and Shipping Service Company

**Place of Study:** UP, Rajasthan, Maharashtra

**Type of data:** Primary

**Source:** IEESCO

**Year:** 1998

**Objectives**

- Review the appropriateness of SN in the CARE supported ICDS programme in UP, Rajasthan, Maharashtra.
- Recommend alternatives to existing RTE foods, or modifications to RTE feeding practices.

**Abstract**

**Methodology**

Commissioned by CARE.

Both quantitative and qualitative data used.

Multi-stage sampling technique used to select respondents (mothers of children in the age group 6-24 months and 2-6 years, pregnant and lactating mothers)

Data collection based on interviews, case studies and focus group discussions.

Samples from RTE ingredients and RTE foods were drawn from the processing plant.

CARE UP also drew 151 samples of RTE foods from various AWCs selected at random.

The samples were analyzed to assess nutritional value and nutritional losses.

Though RTE is expensive it is found to be easier to manage, offering a regular flow. It was well-received by beneficiaries and palatable to younger children. In addition it does not require fuel and facilitates receipt and distribution of SN.

In terms of nutritive content, an increase in protein was found.

Alternatives suggested by beneficiaries included- relish halwa, laddoo, puri, pakora, wheat, daliya, sprouted dal, khichadi.

Minimal community participation. No check on nutritive value or weight of RTE bags prior to distribution.

**Recommendations**

- Community involvement (especially NHE) essential for self-reliance
- SN distributed to passive recipients can only be temporary. Developing 'self help' mechanisms imperative.

**Title: Integrated Child Development Services- Need for Reappraisal**

**Year:** 1997

**Author:** Shanti Ghosh

**Type of data:** Primary and Secondary

**Place of study:** All-India

**Source:** Journal of Indian Pediatrics

**Abstract**

- 6 months to 2 years the most vulnerable age vis-à-vis malnutrition: child dependent on someone else with inadequate knowledge, awareness, and time about how often and how much to feed him/her.
- According to NFHS data, the pattern of malnutrition the same in every state although extent varies.
- Failure to meet the mid-decade goal of malnutrition reduction i.e. reducing the prevalence of severe and moderate malnutrition among 2 yr. old children by 20% of the 1990 level by 1995.
- NFHS has identified stunting in 52.0% and wasting in 17.5% children < 4 yrs.
- Emphasis on SNP rather than breastfeeding and improved complementary feeding practices at the household level.
- The risk of death from common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child and as high as eight times for a severely malnourished child. For a malnourished child every illness is potentially fatal.
- The program has been hugely beneficial in creating awareness regarding the health and nutrition of mothers and children in child development and its size and scope have attracted the attention of the international health and development community.
- The convergence of health services at the AWC has contributed to improved immunization, frequency of health-checks and management of morbidity.
- The program was primarily meant to improve the nutritional status of pre-school children. But it has consistently benefited older children.
- To bring these younger children into the fold of the program, community participation is essential. This is conspicuous by its absence.
- Where present it is mostly in the form of material supplies like fuel or a venue but the perception is that the program is the government's responsibility.
- Even 20 years into the operation of the program the AWC still has to round up the children from their homes every morning.
- The objective of increasing the capability of the family to look after its child through community participation and NHE remains largely unfulfilled.

## **Supplementary Nutrition**

- Considered the core of the program (recording, storing, cooking major responsibility of AWW)
- Food supplies erratic, large gaps in feeding (reports and personal interactions)
- Food of poor quality and tasteless
- Acceptability higher in tribal areas
- Quantity typically far below stipulated amount
- It is unclear whether it is a supplement or a substitute.
- One of the reasons for the limited participation of women is that many consider it undignified.
- The AWC characteristically closes when the food supplies run out. (this is symptomatic of the perception that this is the essence of the program and that NHE, PSE etc. are secondary)

## **Preschool Education**

- Contribution to increase in school enrollment and retention
- Impact largely 3-6 yr. old rather than younger children who would benefit the most.
- AWWs stretched too much to be able to devote too much time to this.

## **Growth Monitoring and Promotion**

- Large amount of time devoted to this.
- Ritualistic recording of weight without entering it into the growth charts or interpreting it or providing any feedback to the mother. (this is largely because the AWWs do not have the education/skill to do so)
- Obsessive focus on categorizing children into grades of malnutrition (irrespective of growth history)
- GMP as it is practiced is largely a waste of time. It is only useful if it provides information that is useful for assessment and analysis of growth faltering, followed by appropriate actions.

## **Training and Supervision**

- Supervisor cannot and does not make the stipulated monthly visit to the AWC and almost never to the community.
- The visits are more in the nature of an inspection than a supportive supervision.
- Interaction with Mahila Mandals and Panchayats seriously lacking.
- There is virtually no on-the-job training.
- The 300 odd training centers are ill staffed and ill-equipped and leave the AWW grossly under-prepared.
- Very mechanistic view of program with little understanding or concern for its essence.

- Several of the AWs feel a sense of helplessness
- Application of uniform norms irrespective of differences in levels of development, socio-cultural environment problematic, over-centralization.
- Introduction of mini-AWCs in some tribal areas.

### **Nutritional Status Evaluation**

- The National Institute of Nutrition (1992) found no difference in the nutrition status between ICDS and non-ICDS areas in the 5 States studied, although immunization and vitamin A coverage was higher in ICDS areas and significant inter-State variations were noted.
- A CARE impact evaluation (1994) found hardly any difference in the nutritional status of ICDS and non-ICDS groups. ICDS typically focuses on rehabilitation of the severely malnourished rather than preventing growth faltering.
- The operating of ICDS III in Maharashtra (1996) did not demonstrate that ICDS SN had any significant impact on the state of severe malnutrition.

### **Convergence of Services**

- Kennedy and Slack (1993) pointed out that there has been an increased convergence ( Health, SN and PSE) with ICDS participants as compared to non-ICDS individuals in the same areas.
- Reports and interaction with local communities also indicate better psycho-social development in ICDS areas and these need to be strengthened rather than merely SNP

### **Conclusions**

ICDS needs to reinvent itself as a development program for women, children and adolescent girls in the holistic sense with the active involvement of the community rather than merely a food-disbursement scheme with single-minded focus on proliferation in quantitative rather than qualitative terms.

**Title: Survey, Evaluation and Research System in ICDS (1975-1995)**

**Year:** 1996

**Place of study:** All-India

**Author:** Editors: Sacchdeva Y., Tandon B.N.; Editorial Assistance: Gandhi Neeru, Dasgupta J.

**Type of data:** Secondary

**Source:** Central Technical Committee, Integrated Mother and Child Development

**Objectives:**

To present in brief the evaluation and research data on ICDS from studies carried out by faculty and students of medical colleges in the last 20 years

**Coverage of the ICDS:**

- 3907 projects in operation (2924- rural, 723- tribal, 260- urban)
- Population of children (under 6) – 40 mn, population of women (14-45) - 7 mn.

**Results:**

**ANTENATAL SERVICES**

Increase in MCH since 1976 in both ICDS and non-ICDS areas

- Superior performance in ICDS areas especially in the first 2-10 years of functioning (trained paramedical personnel for ANC, immunization, consumption of SN)
- ANC, tetanus immunization- maximum success in urban areas
- Distribution of iron, folic acid tablets, SN- maximum success in tribal areas.
- Diminishing success: significant increases in initial years followed by slowdown.

**POSTNATAL SERVICES**

Increased utilization in both ICDS and non-ICDS areas

- Higher coverage in ICDS areas
- Maximum improvement in 5-10 year old projects
- Rural women covered: 32-54%; tribal: 55%

**IMMUNISATION**

Coverage has improved but overall performance poor

- Better results for children covered by AWs (67.3%) as compared to those not under ICDS (53.4%)
- Clear male bias

**NUTRITIONAL SERVICE**

Progressive, significant increase in coverage over initial 10 years of scheme, Subsequently steady or diminishing

- Maximum success in tribal areas, although success achieved in urban, rural areas as well
- Quality of food, interruptions to supply to AWs, motivation to mothers to bring children continue to be problems

### **NUTRITIONAL STATUS OF PRESCHOOL CHILDREN**

- % with normal nutritional status- 75.8
- % of severely malnourished children
- Male-female disparity striking

**Title: ICDS and Tamil Nadu (TNIP) II: A comparative study**

**Author:** Sachdeva Y. and Tandon B.N>

**Place of study:** Tamil Nadu

**Type of data:** Primary

**Source:** CTC

**Year:** 1996

**Objectives:**

To make a comparative study of the TNIP and ICDS:

- Evaluate the implementation and achievement of the program.
- Estimate impact of coverage and assessment of community participation.

**Abstract**

**Methodology:**

Study conducted in 30 community centers of TNIP II and 30 AWCs of the ICDS blocks in 1992-3.

Data collected community nutrition worker and AWC registers.

Health information collected from the records of the ANMs.

Information also collected on the basis of questionnaires and interviews.

**Results:**

- Larger no. of pregnant and lactating women receiving SND under the ICDS than the TNIP in 1992-3.
- Avg. coverage for AN TT was 95% under TNIP and 96.3% under ICDS.
- Avg. no. of health-checks to AN mothers 5 (# provided to almost all in areas under survey)
- % of children receiving supplementary feeding under ICDS (40-69%) greater than under TNIP (24-57%).
- No. of children with normal nutritional status were found to be more under TNIP (54.9%) than the ICDS (41.8%)

**Conclusion:**

The outcomes of the program appear to be similar, except on the count of supplementary nutrition. (The difference here may be attributable to the entry-exit policy of the TNIP that removes children who have attained normal nutritional status)

**Title: National Evaluation of the ICDS**

**Year: 1992**

**Place of Study: All-India**

**Author: NIPCCD**

**Type of data: Primary**

**Source: NIPCCD**

**Objectives:**

- Determination of benefits of scheme
- Determination of differences in implementation and utilization of scheme in rural, urban and tribal areas.
- Identification of problems and bottlenecks
- Evaluation of community participation and community support

**Abstract**

**Coverage:** 100 ICDS projects (9% Of total approx), 98 districts in 25 States and 1 Union Territory

Multistage sampling to select 7 AWWs from each project

Tools: interview and observation (in addition to reports, records, guidelines and other official documents)

**Implementation of ICDS**

**(a) Achievements:** accessibility- 80% (located with 3kms of beneficiaries residence); majority located in clean surroundings (60%) with an environment safe from traffic and other disruptions; pucca buildings in urban/rural areas- 67%; tribal- 50%; storage- 67%; educational qualifications of AWWs- 13 > matric, 50% matric.; over 95% of AW fnaries in position.

**(b) Failures:** sanctioned posts not filled- 20% of ACDPOs, 28% of supervisors, 5% of AWWs: training backlog- AWWs (20%), Supervisors (16%), CDPOs (25%); AWWs spend < 1 hr/day on home visits (this is estimated to be < than the time required to visit 1 Hh); CDPOs end up visiting < 20 AWWs p.m. due to lack of transport, burden of admin work etc. (avg. 1 in 3 months) – limited support services; 40% of Supervisors looking after 30 AWWs => only 2% able to make monthly visits

**Beneficiaries (status in ICDS vs. non-ICDS areas)**

**Utilisation of health services by expectant mothers**

ICDS areas: check-up (50%), immunization (46%), SNP (47%)

Non-ICDS: health services provided by PHCs/ sub-centers- 30%  
(Difference highest in tribal areas)

Nutritional status of children in ICDS areas only slightly better than in non-ICDS areas.

% of severely malnourished children in ICDS areas were only slightly better than non-ICDS areas: The % of severely malnourished children < 3 in ICDS areas < by 1.8 % points, for 3-6 yr. olds, by 1.5 % points.

The percentage of moderately malnourished children in ICDS areas is 2.5 and 3.4 % points lower than in the non-ICDS areas for the 2 age groups respectively.

Across projects- higher percentages of families in tribal areas came forward to participate in the ICDS

Community participation, though limited in ICDS areas, was non-existent in non-ICDS areas.

## **Delivery and Impact**

### **(a) Nutrition:**

- Increase in coverage: Majority of registered beneficiaries receiving supplementary nutrition- nursing mothers (50%), expecting mothers (36%), children (0-6) > 40%: lower in rural, urban rather than tribal areas.
- Disruptions: 63.7 days per AW on an Avg; rural/tribal > urban; due to inadequacies in fuel, utensils etc, tendency to take food home etc. (> 90% in 27% of AWs); higher proportion in rural and tribal as compared to urban areas.
- Unacceptable food: Incidence of food being unfit for consumption, causing diarrhea, indigestion- urban (38%), rural (29%), tribal (19%).
- Nursing mothers- 57% supplementary food
- Nutritional Status of children: 35% of ICDS children normal; 13% of non-ICDS.
- About 36.3% unable to monitor growth monitoring alleged due to unavailability of growth charts, dysfunctional weighing scales.

### **(b) NHE:**

- 78% of AAs conduct the program at least once in 3 months;
- Only 50% of those enlisted (women b/w 15-45) participated
- Non-attendance, apathy problem although useful

### **© Health:**

- 50% of ICDS mothers conducted examination of child (WHAT???)
- 85% of AAs once in 3 months; (WHAT???)
- Immunization: BCG (50%), measles (32.6%), polio (37.5%) for < 1 yr olds > for ICDS areas (maximum % in urban areas)

**(d) PSE:**

- 3-6 yrs.: 56% (> 40%) norm in rural and urban areas (short by 5% in tribal areas) - no significant gender differences.
- 61% full participation
- Non-ICDS- Only 23.5 %
- Significant role in promoting enrollment in elementary schools, decreased drop-out rate, increased retention (89% of children with PSE continuing education, 52-60% without PSE)

**(e) Community Participation**

- Ltd. Support: women (55%), community leaders (47%), adolescent girls (33%)
- Negligible contribution made in kind in the form of provision of site, building, firewood
- Mahila mandals operational in only 49% of AWs (help in the form of collecting children for immunization (47%), organizing camps (38%) and preparing supplementary food (35%))
- In a large majority of cases, the ICDS functionaries did not approach the community representative for help
- 80% of community representative are unaware of how they can contribute to the operation of the program

**Recommendations**

- Up gradation of infrastructure
- Innovation in training
- Increased frequency of workshops
- Increasing effectiveness of monitoring and evaluation
- Increased coverage ( the only one that seems to have been , somewhat mindlessly achieved)

**Title: ICDS**

**Author:** Nutrition Foundation of India

**Year:** 1987

**Type of data:** Secondary

**Source:** NFI

## **Abstract**

### **(1) AWWs:**

- Enthusiastic response of married/unmarried women
- SC/ST not at a major disadvantage
- Those with less than the minimum educational requirement performed reasonably well
- Must not be incorporated into the bureaucracy (the community participation component must be retained)

### **(2) Training:**

- Several well-trained, motivated but need for improvement
- Recorded cassettes as training aids
- Need to improve refresher courses and in-service training (especially where the educational requirement is not met)

### **(3) Outreach:**

- More successful in targeting children older than 3; not so successful vis-à-vis younger children, pregnant women.
- Home visits not adequate

### **(4) Community Participation:**

- General support, regard for AWW
- Actual participation apathetic

### **(5) Programme of AW:**

- Growth monitoring, NHE weak
- SNP- important incentive for attendance (often irregular; initially meant to be selective, in effect all children attending schools have access)
- Introduction of medical kit improves community support and attendance but replenishments, proper administration of drugs, procurement of additional drugs important.

**(6) Institutional Arrangements:**

- Monthly conferences must take place
- Orientation programs must be conducted
- Periodic, quick evaluations
- “Think tanks” to suggest innovations