PEO Study No.120

EVALUATION REPORT ON THE INTEGRATED CHILD DEVELOPMENT SERVICES PROJECT (1976-78) - 1982

1. The Study

The Ministry of Social Welfare, Government of India, launched in October, 1975 a total of 33 Integrated Child Development Services (ICDS) Projects (19 rural, 10 tribal and 4 urban) with the specific objectives of improving the nutritional and health status of children in the age group of 0-5+ years, reducing the incidence of mortality, morbidity, mal-nutrition and school drop-out and enhancing the capability of the mother to take care of the health and nutritional needs of the Child. The Planning Commission sanctioned 67 additional projects which started functioning during 1978-79. The components of the ICDS scheme were supplementary nutrition, immunisation, health check-up, referral services, nutrition and health education, non- formal education and functional literacy. Supply of drinking water was considered as a supportive service. The scheme was administered by the Ministry of Social Welfare at the Centre and the Department of Social Welfare in the states. Each project was under the charge of a Child Development Project Officer (CDPO). The Anganwadi in each village, manned by the Anganwadi worker (AWW) and helper, was the focal point of the delivery of services. The health services under the Scheme were provided through the Primary Health Centre (PHC) and sub-centres for which augmentation of the health staff was to be made. The Block Development Officer (BDO) was entrusted with the overall responsibility of the ICDS. Co-ordination Committees at the district, block and village levels were envisaged to be formed for the smooth implementation of the programme.

At the instance of the Planning Commission, the Programme Evaluation Organisation (PEO) undertook a study of the functioning of the Scheme in two phases - the Baseline (1976) and Repeat Round (1977-78). The present Evaluation Report on the Integrated Child Development

Projects (1976-78), published in 1982, was based on the Repeat Round of the Survey. The "Report on the State of Preparedness of the ICDS Projects" based on the Baseline Survey, was released in March 1978 and its details are presented in the PWO Study no.94.

2. Objectives

i) To study the organisational structure of the projects;

ii) To examine the background and training of the basic workers;

iii) To assess the impact and effectiveness of the delivery of package of services in terms of adequacy of funds and supplies;

iv) To understand the nature and extent of Co-ordination among the various functionaries;

v) To assess the extent of coverage of target population;

vi) To analyse the impact of the scheme in terms of attitude and response of the local communities, components of the strategy and adequacy; and

vii) To suggest modifications, if any, required in the Scheme.

3. Sample Size/Criteria for Selection of Sample

Out of the 33 ICDS projects started initially, 29 projects consisting of 17 rural, 8 tribal and 4 urban were purposively selected, keeping in view the location and availability of the PEO units. In each rural project, 6 Anganwadis were selected through stratified random sampling wherein the basis of stratification was the distance of the Anganwadi village from the project headquartes. One village was selected from within a radius of 5 kms of the project headquaters , three from within the stratum of 5 to 10 kms. and the remaining two from the stratum beyond 10 kms from the project headquarters. In the case of urban projects, 6 Anganwadis were selected on systematic random basis from the alphabetically arranged lists of anganwadis in which trained Anganwadi workers were in the position and then lists from the lists of those in which untrained Anganwadi workers were working.

If any selected village had more than one Anganwadi worker, one of them was selected at random after arranging their names in alphabetical order and the selected Anganwadi was houselisted. From the listed households, the eligible ones (i.e. households with at least one child of 0-5 years) for the receipt of benefits from the ICDS programme, were stratified into three according to their main occupation viz. i) agriculturists, ii) labourers and iii) trade/commerce/artisans/services/others. A total sample of 25% of the eligible households with a minimum of 10 and a maximum of 25 to be selected from a village, was allocated among the various strata in proportion to the number of households in them with a minimum 2 to each sttratum. The sample so determined for each stratum was selected by simple random sampling. Thus, a total of 3125 households attached with the 172 chosen Anganwadi villages were selected for the study. Apart from them, 426 selected officials including the B.D.O., Child Development Project Officer, the Doctor at the PHC, Supervisors etc, and 161 selected non-officials including the Chairman and a Member of the Co-ordination Committee at the project as well as the village/Anganwadi levels were also interviewed.

4. **Reference Period**

The study was conducted in two phases - the Baseline and the Repeat Round. The Base Line study was conducted between July and October, 1976 and the Repeat Round was conducted during the period October, 1977 to June, 1978. The data were collected for the years 1975-76 and 1976-77.

5. **Main Findings**

1. The co-ordination committees, at the Anganwadi level were constituted only in 61% of the Anganwadis. Again, the District level Co-ordination Committees were formed only in 7 out of 29 projects. However, at the project level, Committees were constitued in almost 90% of the projects. Women constituted half of the memebership of these Committees and Scheduleld Castes, Scheduled Tribes and backward classes were well-represented. However, their functioning left much to be desired. On an average, 3 meetings at the project level and 4 at the Anganwadi level were held in a year. In many of these meetings, the discussions were focused mainly on the administrative aspects rather than on the performance of the programme.

2. Co-ordination among the three key functionaries, viz. the Block Development Officer (BDO), Child Development Project Officer (C.D.P.O.) and the Medical Officer (MO) was far from satisfactory in about two-third of the projects.

3. The appointment of the para-medical health staff was satisfactory in the project areas. However, considerable gap was noted between the sanctioned strength and the number in position in rural and tribal projects. In the case of non-health staff, especially of the CDPOs in the tribal projects, the problem was mainly of training and orientation.

4. More urban Anganwadis than rural and tribal Anganwadis were visited by supervisory officers. The frequency of visits of the CDPO and the para-medical staff was comparatively lower than that of the supervisors and the doctors.

5. 93 out of 171 Anganwadi were situated at an average distance of 20 kms from the ICDS headquarters. Large proportion of Anganwadis in the tribal projects were located in inaccessible range of distances from the headquarters of different servicing agencies.

6. The average population of the urban and tribal projects far exceeded the assumed norms. The average population covered by an Anganwadi was 924. The proportion of expectant women and nursing mothers constituted only 4.4% of the Anganwadi population as against the normative 7%. The Scheme fulfilled its goal of covering the weaker sections i.e. Scheduled Castes, Scheduled Tribes and other backward communities who constituted about two-third of the Anganwadi population.

7. Almost all the Anganwadis had some sort of accommodation, though its quality was generally poor. There was an increasing trend among Anganwadis to be housed in rented buildings. The basic amenities like electricity, sanitation, etc. were available only in a very few of them. Similarly, the provision for safe drinking water existed only in 91 out of 171 selected Anganwadis. The availability and quality of essential equipments at the Anganwadis were generally satisfactory.

8. About 82% of the Anganwadi workers belonged to the age group 18-25 years and three-fifth of them were Matric pass. Most of them had undergone training or orientation in ICDS. About three-fifth of them were local girls or women residing in Anganwadi villages. An Anganwadi worker, on an average, spent 60% of her time on education, 17% on health and 8% on nutrition, Her duties were too large to be performed single-handedly.

9. Whereas the availability, quality and use of physical inputs in the projects were satisfactory, the flow of financial inputs was less than the allocations, particularly in rural and urban projects. There was also shortfall in the actual utilisation of allocated funds to the tune of 22%.

10. Taking all the projects together, the number of projects taking up immunisations and health check-up for women and children was observed to have gone up during the Repeat Survey when compared with the situation prevalent during the Baseline Survey. There was an appreciable increase in the number of women patients referred to hospitals. In the case of children, the improvement in health check-up and immunisation was substantial in urban projects. In the case of women, the coverage of immunisation was better in rural projects and the least in tribal projects. The coverage of health check-up of expectant women and nursing mothers was better in the rural and tribal projects than in the urban projects.

11. Taking all the selected Anganwadis together, the coverage of the target population of women and children by the three health services namely, immunisation, health check-up and referral services was rather meagre. While about one-fourth of the children could be immunised against DPT, only one-fifth could get immunisation against small pox and BCG and barely 1.4% against TAB innoculation. The tetanus toxoid innoculation could cover only 15% of the pregnant women. Similarly, under health check-up, only 22% of the children , 27% of the pregnant women and 10% of the lactating mothers were covered. Referral services were availed of by 2.2% of the children and 2.5% of the women.

12. At the selected household level, although there was an appreciable gain during the Report Round over the Baseline in the coverage of the eligible beneficiaries under the supplementary nutrition programme (SNP), about 46% of the children, 70% of the pregnant women and 63% of the nursing mothers yet remained to be

covered. The coverage of children within the age group 0-1 by the SNP continued to be extremely unsatisfactory. The SNP was rated by the respondents as the most useful of all the programmes under the ICDS. Among the beneficiaries of the SNP, Scheduled Castes and Scheduled Tribes constituted the majority.

13. The education component of the scheme included, mainly, nutrition and health education for all women falling in the age group of 15-44 years and non-formal education for children in the age group of 3-5 years. Although 73% of the women were aware of the nutrition and health education services, only 19% had availed of these benefits. The main bottlenecks in this regard included paucity of spare time for the daily wage earners, unsuitable timings of classes, stale methods and contents of education and the inability of the Anganwadi workers to motivate the women. While 25% of the Scheduled Tribe and 19% of the Scheduled Caste women were benefited by these services, only 17% of the backward classes and 16% of the 'others' availed of the benefits.

14. Non-formal education for children, conducted in Anganwadis was aimed to develop desirable attitudes values and behavioural patterns in the child. In the improved scenario of the Repeat Round, 97% of the selected households were aware of this programme while it benefited 76% of the eligible children. The coverage was better in the case of Scheduled Castes and Schedule Tribes than in the case of others. 83% of the respondents ranked this as one of the three most useful programmes under the ICDS.

15. The coverage of the programme of functional literacy, administered for women in the age group of 15-44 years, was as low as 10 % of the target group . About 48% of the respondents opined that it was a valuable activity.

16. Signs of changes in food habits like increase in the proportion of children of all age groups fed on breast milk, incrase in the percentage of children in the age group of 1-5 + years reporting consumption of green vegetables and rise in the percentage of expectant women and nursing mothers consuming milk and green vegetables were noticeable during the Repeat Round. However, the consumption of fruits and pulses by these women came down. It could not be located whether these changes had been due to the ICDS or not.

17. Immunisation programme did not receive high rating of the respondents. Gaps in the coverage of immunisation were caused by the lack of time with the parents of the children, the fear that the child would fall ill after taking small pox vaccination, absence of awareness about the programme, etc.,

6. **Major Suggestions**

1. The target population needs to be properly identified with a view to plan effectively the delivery of various services.

2. A workable mechanism to ensure better co-ordination among the CDPOs, the BDOs and the MOs may be evolved. Besides, there is a need to constitute Co-ordination Committees, particularly at the Anganwadi and project levels, wherever they do not exist. These Committees should meet regularly and discuss problems regarding the implementation of the various services under the ICDS.

3. There is a need to step up the supervisory visits of the paramedical staff to Anganwadis. The job chart of the Anganwadi worker needs to be revised. Some minimum standards need to be specified with regard to the accommodation of Anganwadis.

4. Various services under the health components of the scheme should be re-examined. The modus operandi to reach the SNP benefits to the most vulnerable group of the children of 'below threes' needs to be evolved. Efforts should be intensified with regard to the health and nutrition services. Potable drinking water should be ensured in all the ICDS projects areas.

5. Health education of parents and others who perform the decision making role in the Community needs to be intensified. The package of functional literacy should be given its required momentum to cover the target group satisfactorily.