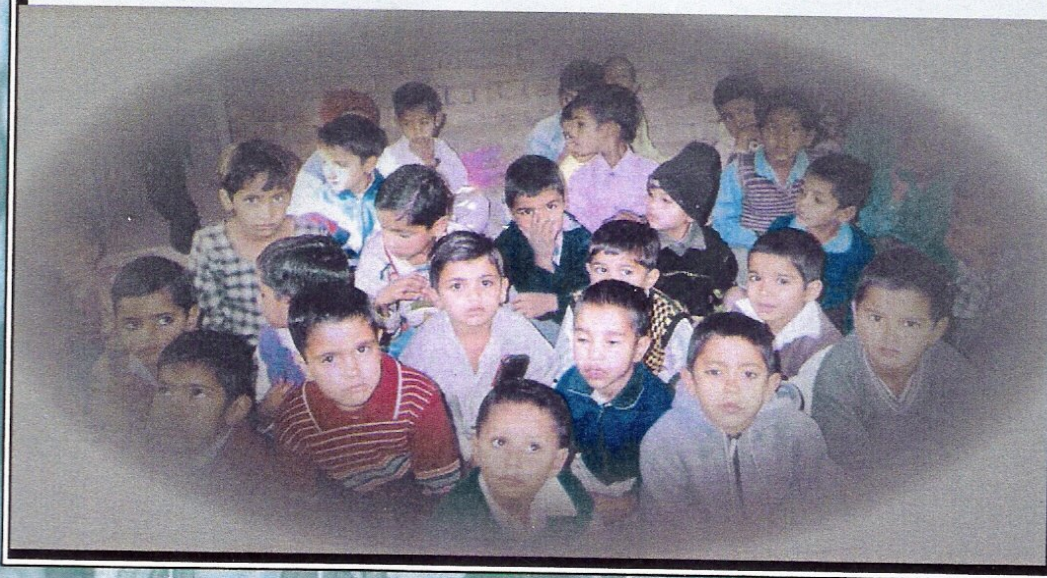


# THREE DECADES OF ICDS —AN APPRAISAL



## ***EXECUTIVE SUMMARY***



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## Executive Summary

Integrated Child Development Services (ICDS) programme continues to be the world's most unique early childhood development programme, which is being satisfactorily operated since three decades of its existence. The rich experience of ICDS has brought about a welcome transition from welfare orientation to a new challenging perspective of social change. The programme provides package of services, comprising supplementary nutrition, immunisation, health check-up, referral services to children below six years of age and expectant and nursing mothers. Non-formal pre-school education is imparted to children of the age group 3-6 years and health and nutrition education to women in the age group 15-45 years. High priority is accorded to the needs of the most vulnerable younger children under three years of age in the programme through capacity building of caregivers to provide stimulation and quality early childhood care.

The scheme of ICDS has performed considerably well in our socio-cultural system during last few years to ensure children's right for survival, growth, protection and development and their active participation in environment where they live, grow and develop. It has attempted to gear up to the popular holistic vision of a comprehensive intervention programme with a child-centred approach respecting all cultural patterns and diversity, and served as an instrument of change to bridge social inequalities in the society.

The concept of providing a package of services is based primarily on the consideration that the overall impact would be much larger if the different services are delivered in an integrated manner, as the efficiency of a particular service depends upon the support it receives from the related services. The other unique feature of the programme is that it utilises and mobilises all available governmental services at the level of the project. It is multi-sectoral in nature and its successful implementation depends on intersectoral functional linkages. It calls for coordination among concerned departments and ensures optimal use of the existing governmental infrastructure at the project level.

Addressing the interrelated needs of young children, adolescent girls and women of disadvantaged community groups, ICDS solicits convergence with other services/programmes like *Antodaya*, Micro-Credit schemes and other development programmes of the rural development, education, environmental science and technology and so on. There are presently 5652 ICDS projects functional in the country comprising 4533 in rural, 759 in tribal and 360 in urban areas (as on December, 2004).

### **Researches on ICDS**

In the past, a large number of research studies have been conducted to evaluate and assess the impact of the programme on the beneficiaries. At the national level, there have been only two evaluations of ICDS scheme, one conducted by National Institute of Public Cooperation and Child Development (NIPCCD) in 1992, and the second conducted by National Council of Applied Economic Research (NCAER) in 1998. Few studies on stabilisation of the programme; quality control and enhancing the social and economic empowerment of disadvantaged women; awareness about the value of the programme are also available. It can be seen that most of the studies have provided only piecemeal information and have not taken systematic stock of the delivery of inputs vis-à-vis output; nor have these studies investigated the impact of services on the target groups in a comprehensive and coordinated fashion. These studies also have not provided ample evidence on interdependence of various variables related to implementation of the programme and its impact on the target groups. Coverage of sample has also been limited leading to inability to generalize.

Several valuable lessons have been learnt through these studies. Nonetheless the need for a comprehensive investigation to assess ICDS programme at the national level was considered most desirable since it has now been in operation for more than three decades.

### **The Study**

The need for a comprehensive study to assess ICDS programme at the national level has been felt at the advent of the new millennium as the programme was on the verge of completing three decades of its implementation. The Department of Women and Child Development, now the Ministry of Women and Child Development, Government of India, the nodal Ministry for the implementation of ICDS

programme, desired NIPCCD to undertake a comprehensive assessment of the entire gamut of programme implementation including its impact on the intended beneficiaries. The study was accordingly conceived at the national level. Such an exercise is undoubtedly being considered essential in order to improve delivery system, ensure its optimal outreach and take decisions on matters concerning its future thrusts in the Eleventh Five-Year Plan. Accordingly, the Institute planned and carried out the present study.

### **Objectives of the Study**

The objectives of the study were to :

- assess the existing status of implementation of ICDS programme in terms of coverage, outreach, coordination, convergence, and innovations introduced by States and NGOs;
- compare the differences in implementation of the ICDS programme in rural, urban and tribal areas and in NGO-run projects;
- identify gaps and problems in the implementation of ICDS;
- find out the perception of community and local bodies about ICDS and the extent of support provided by them in implementation of the programme;
- exploring the inter-linkages of ICDS with other development programmes and their role in improving the quality of services, and
- ascertain the benefits of the scheme on selected outcome indicators related to different services provided to children, women and adolescent girls.

### **Methodology**

The study covered 150 ICDS projects from all 35 States and Union Territories covering rural, urban and tribal projects. The universe of the study was restricted to those projects which were functional for a minimum period of five years. Thus, all those projects which were in operation up to the year 2000 were included in the study. In all, 4200 ICDS projects formed the universe of the study. A sample of 150 (about four per cent) of ICDS projects was selected for the purpose of appraisal.

A multi-stage stratified random sampling technique was adopted to select state-wise total number of projects at the first stage. Whereas at the second stage, stratified sampling technique and also purposive sampling method were applied for selection of number of projects by location (rural, urban and tribal). Sample was

drawn only from blocks which were operational as on 1 April, 2000 i.e. 4200 projects (3177 rural, 273 urban and 750 tribal). For the present study, a total of 150 ICDS projects were selected as a sample i.e. roughly 4 per cent of the total universe. Number of projects selected from each state was proportionate to the total number in operation and in the categories of rural, tribal and urban. Within a project, an attempt was made to include projects run by NGOs.

For selection of actual ICDS projects, an attempt was made to select those projects which were run by NGOs wherever possible. Second criteria for selection of the ICDS project included was maximum number of Anganwadi Centres under their jurisdiction as well as their geographical location. This was done to ensure that we have a representative sample drawn from a larger population. A total of five Anganwadi Centres were randomly selected from each sample project. An attempt was made to select not more than two Anganwadi Centres from each of the supervisory circle. Thus total sample comprised 750 Anganwadis. Actual beneficiaries were selected randomly from the list of beneficiaries available with the Anganwadi Workers of selected Anganwadis. Within the Anganwadi area, a sample of the following categories of target group was selected for in-depth information:

<b>Sample Categories and Size (Target &amp; Actual)</b>			
<b>Sl No.</b>	<b>Respondent's Category</b>	<b>Target Per Project</b>	<b>Sampled</b>
1	Beneficiaries Household	115	16138
2	Pregnant Women	20	2983
3	Nursing Mothers	20	2975
4	Mother of Children (6m to 3yrs)	25	3733
5	Mother of Children (3yrs to 6yrs)	25	3737
6	Women (15-45 yrs)	25	3771
7	Child Learning Competency Test (3-6 yrs)	30	4474
8	Community Leaders	10	1500
9	CDPOs	1	147
10	Supervisors	2	294
11	AWWs	5	748
12	AWC's Observation	5	748
13	Health Functionaries (MO, LHV, ANM)	3	444
14	Additional Observation	1	150
	<b>TOTAL</b>	<b>287</b>	<b>41842</b>

## **Tools**

In order to collect the required information and data for the study, appropriate proforma/schedules were devised. These were developed in the form of recording

sheets. Besides interview, observation method was also used for collecting information pertaining to delivery of services at Anganwadi level. The available reports, records, guidelines and other documents formed additional source of information.

A set of 12 schedules was devised. In view of the magnitude of the data to be collected for the study, these were pre-coded to facilitate computerisation of the data. A two-day Orientation Workshop of faculty members of Headquarters and Regional Centres was held to discuss the tools and other modalities. This was followed by pre-testing of tools by faculty members at Headquarters and all Regional Centres of the Institute. After pre-testing of tools, another workshop of Regional Coordinators (i.e. Regional Directors) was held to finalise the tools and other operational details.

### **Operational Details**

Forty-one teams consisting of three members each were deployed to collect data from 150 projects spread over 35 States/UTs. NIPCCD's networking with training centres, academic institutions and voluntary agencies, spread all over the country further facilitated recruitment of ad-hoc Enumerators hired locally for data collection in different projects. Thus, a total of 12 Project Assistants and 81 Enumerators were recruited locally. The cooperation extended by different institutions helped not only in identification of suitable individuals but also in holding interviews and providing venue for training of the research team. Senior faculty members at Hqrs. and Regional Directors at Regional Centres were assigned the task of coordinating the teams, monitoring and supervising data collection, and maintaining liaison with the concerned State Government for smooth completion of data collection within the stipulated time.

### **Ensuring Data Quality**

The design, scope of the study and tools were planned in consultation with faculty members and Regional Coordinators. In addition, two workshops, one for the selected faculty members and another for Coordinators, were organised to discuss the tools and *modus operandi* of data collection work. All members of the research teams concerned with data collection were given training in procedures of implementing the design, with emphasis on filling up the schedules and its coding frame. The

orientation included conducting of mock interviews, practice in coding schedules, etc. A manual containing guidelines and instructions for collection of data was prepared and provided to all concerned for ready reference.

The Institute identified M/s. New Concept Information System for computerisation and data analysis for the study. Two staff members of the said agency and a Principal System Analyst were assigned the task. The data was entered in dBase (a popular relational database package) and the resultant database was converted to appropriate file formats for further analysis. Another popular software namely, SPSS (Statistical Package for Social Sciences) was used to generate final tables.

The formats of data files were prepared in such a way that the data could be used in variety of ways for subsequent analysis. The database has been created project-wise with an intention to optimally utilise the valuable empirical information for other purposes, besides the present study. It can be disaggregated at the State and Project levels. State Departments, individuals/ agencies concerned with ICDS can have access to the information after permission from the Ministry of Women and Child Development.

It would be appropriate to mention here that ICDS programme, in its three decades of existence, has gone through both successes and failures. The present study too, has come out with many such scenario which reflects hopes and satisfaction as well as gaps and lacunae. Let us now look at both these aspects emerging from the present study with a mind to strengthen ICDS programme in future. Sample projects were spread over rural, urban and tribal areas and managed by State Governments, World Bank and NGOs in 35 States/UTs. Statistical treatment of data includes mean, SD, composite score.

The following paragraphs carry forth the conclusions and recommendations of the present study:

## **Conclusions**

### **Infrastructure**

- i) Availability of sanitation facilities is most crucial for reducing mortality and mobility in rural and tribal areas. Data from the study showed that only 31 per cent of the households had toilet facilities. Sewage/drainage

system was reported in 30 per cent of villages under regular ICDS Projects whereas 27 per cent of villages of those projects, which were assisted by World Bank, were having such facilities. Out of ten villages, 4 (40%) of projects covered by NGOs had these facilities also. While around 41 per cent of Anganwadis had toilet facilities, 17 per cent of these facilities were not found to be in good condition and 59 per cent AWCs were even deprived of this amenity.

- ii) It was found that educational facility of lower primary school (class I-V) existed in nine out of 10 villages (90%). Middle school (VI-VIII) facility was available in 61 per cent of villages whereas high schools were functioning in 39 per cent of sample areas.
- iii) About 97 per cent Anganwadi Centres in urban areas, 93 per cent in rural areas and 74 per cent in tribal areas were connected by roads. Primary Health Centres and sub-centres were available in 29 per cent and 43 per cent, respectively, in Anganwadi areas. Data thus reveals that accessibility to important services of health was limited. Data also revealed that around 89 per cent of rural project areas, 94 per cent urban and 68 per cent of the tribal project areas had telephone facilities. Another interesting information was availability of LPG in 72 per cent of the Anganwadi areas.
- iv) Hand pumps and tap water were the main sources of water in majority of the Anganwadi Centres, thereby bringing home the point that ICDS programme has succeeded, to a large extent, in arranging safe drinking water for the children attending Anganwadis in collaboration with Public Health Engineering Department of State Governments.
- v) It was gratifying to note that majority of the Anganwadi Centres were located in pucca buildings. It reflects that efforts have specially been made in housing Anganwadi Centres in pucca buildings. However, space was found to be a problem in most of the Anganwadi Centres in urban areas. Adequate outdoor and indoor space and separate space for storage was available in only 44, 36 and 39 per cent Anganwadi Centres. This situation was found to be little better in rural and tribal areas. Overall, about 49 per cent of the Anganwadi Centres had inadequate space for outdoor and indoor activities and 50 per cent had no separate space for storage of



various materials. Around half (49.0%) of the rural and tribal (50.6%) projects and 40 per cent of urban projects had adequate cooking space separately.

- vi) Most of the AWCs (60.3%) were found to be easily accessible to children as they were brought either by their parents/siblings/older ladies of the locality to the Anganwadi Centres. Helpers mainly concentrated in bringing newly admitted children to Anganwadis.
- vii) Weighing scales were available in 97 per cent Anganwadis of World Bank-assisted ICDS Projects, followed closely by NGO run projects (95.3%) and 85 per cent of regular ICDS projects. Around 89 per cent of them were in working condition also.
- viii) Non-availability of the kits in 44 per cent of the Centres is a matter of concern and this aspect needs to be looked into by the programme implementors carefully. Availability of adequate number of cooking and serving utensils in the Anganwadi Centres is of paramount importance for the success of the nutrition programme. The study revealed that cooking utensils were available in 61.8 per cent of rural, 49.2 per cent of urban and 65.9 per cent of tribal projects.

### **Profile of Functionaries**

- ix) It was gathered that 15 per cent positions of Child Development Project Officers (CDPOs), 48 per cent of Assistant Child Development Project Officers (ACDPOs) and about 18 per cent of Supervisors were vacant in the surveyed projects. However, the position with regard to the appointment and availability of AWWs and Helpers has been quite satisfactory. The training status has been quite satisfactory. It was observed that Arunachal Pradesh was the only State where 50 per cent CDPOs were untrained. In other states, by and large, training of functionaries has been highly satisfactory.

### ***Selection of AWWs***

- x) It was found that around 80 per cent of the Anganwadi Workers belonged to the same village/locality. However, wide variations were observed on

this aspect between projects supported by World Bank, NGO operated and regular ICDS.

- xi) Data on age of AWWs depicts that about 66 per cent of AWWs were 35 years and above. Percentage of AWWs in regular and World Bank-assisted ICDS projects was evenly divided in the age-group 35-45 years while 30 per cent of AWWs were in the age-group 25-35 years.
- xii) Sixty-two per cent of the AWWs had work experience over 10 years whereas 28 per cent of them had experience of more than five years. Majority (43.2%) of the AWWs were matriculate, 23 per cent Higher Secondary and about 10 per cent Graduates. There were hardly any illiterate workers, their percentage being around one only.

### ***Supervisors***

- xiii) It was found that direct, promotion from amongst AWWs and deputation from line departments and contractual appointment of Supervisors under World Bank Scheme was carried out in States like Uttar Pradesh. In 25 States of India, supervisors were promoted to the post of CDPO/ACDPO. Policy of reservation of seats was existing in 21 States and seven States did not adopt any such policy. A large majority of the supervisors were above the age of 35, either graduates or post graduates and possessed experience of more than 10 years. This is a positive sign as ICDS seems to be managed by experienced and qualified supervisors.

### ***Child Development Project Officers (CDPOs)***

- xiv) Data show that 21 States had exclusive cadre of CDPOs whereas 10 States had a joint cadre comprising deputation, promotion and contract. In all, 25 States had adopted the policy of promotion of Supervisors to the post of CDPOs/ACDPOs. Mode of recruitment in terms of reservation was reported to be followed as per orders of State Governments issued from time to time.
- xv) Though the guidelines of the scheme envisages that CDPO should preferably be a female, yet it was observed that about one-third (32.7%) of CDPOs were males.

- xvi) Most of the CDPOs (48.3%) were in the age group 45-55, followed by 33 per cent in the age group 35-45. It was found that 57 per cent CDPOs were post graduate with only 6 per cent being undergraduates. About 31 per cent of CDPOs were having less than 3 years of experience which was reflective of frequent transfers of this category of functionary in some States.

### **Profile of Beneficiaries**

- xvii) Expenditure on different services has gone up more than three times (from 144.00 crore during 1990-91 to 452.36 crore during 2004-05) in 15 years. The scenario is similar to the number of beneficiaries under various services – all categories of beneficiaries have gone up three times during the period under reference.

### ***Target Population in Sample Households***

- xviii) Data indicate that 0.83 per cent of children in households covered under the study are handicapped. Out of these children, 55.56 per cent children have been receiving benefits from ICDS programme.
- xix) Maximum percentage of beneficiaries were from backward classes (29.6%) followed by scheduled castes (26.3%). Differences between representation of other castes and that of scheduled tribes was meagre (21.4% and 20.4%, respectively).
- xx) It was found that 55 per cent of them were landless while another 28 per cent owned land which was less than one hectare. It was found that less than 8 per cent possessed land holding between one and two and above two hectares. Those who possessed land more than four hectares were residing in hilly, desert and tribal areas.
- xxi) Six out of ten families of beneficiaries were nuclear while joint family constituted one-third of all types of families. Data demonstrated that in urban areas 62 per cent families were nuclear while this type of family constituted almost similar percentage in rural (59.0%) and tribal (59.8%) projects. Increasing trend of extended families was seen in regular ICDS



projects (7.03%) and drastic reduction in other categories of projects (4.12% in World Bank projects and 4.80% in NGO-run projects).

- xxii) Six out of ten families (59.7%) conformed to the national figure in respect of size of families (upto 5 persons), followed by 36 per cent of households having family members between six and ten. Another interesting finding is that households with 11 and above family members constituted four per cent. Normal belief is that urban households are nuclear and smaller in family size but the data revealed that even urban ICDS projects also recorded family size between six and ten (32.7%).
- xxiii) A little over 60 per cent families under World Bank-assisted ICDS projects (62.48%) had monthly income less than Rs. 2000/- per month, followed by NGO-run projects (51.41%) and regular ICDS projects had this share with 47 per cent of households. Income of households was analysed as per location of projects in rural, tribal and urban areas. It revealed that a little over half (52.8%) tribal families had income less than Rs. 2000/-, followed by rural families (49.5%). Forty per cent urban families belonged to this income group. Four out of ten families in urban projects had also income ranging between Rs. 2000/- and Rs. 4000/- per month, followed by rural (32.1%) and tribal projects (30.4%).

### ***Main Occupation of Sample Households***

- xxiv) One-fourth of heads of households (25.7%) had non-agriculture labour as main occupation, maximum being in urban areas (36.4%), followed by heads of households in rural areas (24.2%) and tribal areas (21.9%). It was interesting to know that a little over one-third of respondents of tribal projects (34.3%) were cultivators who constituted 27 per cent in rural ICDS projects. Cultivators in urban projects were those who lived on fringe of urban areas and went to adjoining villages for cultivation were of negligible percentage (3.4%). Percentage of self employed and agricultural labourers was almost equal (16.0%). Self employed were mostly blacksmiths, carpenters, cattle grazers, potters, shoe makers, weavers, petty shop keepers etc. Around 12 per cent were in service – Government, semi-government, private companies etc.

## **Coordination in ICDS**

### ***Project level Coordination Committee***

xxv) More than 70 per cent projects of rural and tribal areas were having Coordination Committee at the project level, whereas urban projects (83.0%) were having Coordination Committee at project level. So far as existence of Coordination Committee at project level by type of management is concerned, regular ICDS projects and projects supported by World Bank were having lesser number of Coordination Committees as compared to the projects run by NGOs. In urban regular ICDS projects more than 80 per cent CDPOs, Supervisors and health functionaries reported adequate coordination at their level. In NGO-run projects, coordination at CDPO level was somewhat adequate but at the field/village level, it was not up to the mark. The situation is similar to tribal projects too. Coordination with health department was somewhat lacking at field/village level especially in tribal areas. By and large coordination at project level was found to be satisfactory. A little over two-third (68.0%) CDPOs were of the view that meeting of Coordination Committee was effective whereas about one-fifth (21.0%) found it very effective. The Research team found that around 73 per cent CDPOs had reported adequate coordination between ICDS and health functionaries. But remaining 27 per cent mentioned inadequate coordination.

### ***Convergence of Services in ICDS***

xxvi) Data made it amply clear that efforts were made in rural areas to involve village *Panchayat* in activities of AWCs. It is also interesting to note that efforts were made for organising community convergence to inter-link programme and services as a substantial percentage of CDPOs reported.

### ***Community Participation***

xxvii) Thirty-two per cent women (15-45 years) extended supportive role in *Anganwadis* like assistance in cooking food, providing fuel, collecting

children for health check-up, bringing children to *Anganwadis* for immunisation, fetching drinking water. In tribal projects (39.6%) this type of support was found maximum. Contribution in kind like carrying supplementary nutrition upto AWCs using own means of transport, repair of AWCs was also found maximum (16.0%) in tribal projects. Majority (69.7%) of community leaders extended their contribution to AWCs in the form of supervision, solving personal problems of AWWs and protecting them against undesirable elements. Forty-five per cent also cooperated and supported AWWs as and when it was necessary.

## **Assessment of Delivery of Services**

### ***Supplementary Nutrition (SN)***

- xxviii) Data of the appraisal revealed that in 80 per cent projects, source of arranging nutrition in Anganwadis was State Government which procured food item(s) from Food Corporation of India and other sources identified by them. World Food Programme (WFP) was found to be supporting six per cent of Anganwadis while CARE contributed its nutritional facility to four per cent of Anganwadis. A trend was also visible wherein village panchayats/Self-Help Groups were serving cooked food to beneficiaries.
- xxix) Forty-two per cent of Anganwadis received raw food items which were cooked/prepared at AWCs and served to children. This practice was found mostly in Anganwadis of tribal projects (53.5%). Ready to Eat (RTE) food was provided in all types of projects, maximum being in Anganwadis of urban projects (45.8%), followed by rural (33.6%) and tribal (23.5%) projects. Some Anganwadis (18.0%) were providing both cooked and RTE. In some states like Gujarat, Rajasthan, Maharashtra and Madhya Pradesh, all children below six years identified as severely/moderately malnourished, on the basis of weight, were given therapeutic diet cooked in soft form (pulverised) or tinned milk by benevolent organisations/individuals. This is an indication of significant efforts made by ICDS functionaries to mobilise resources at the grassroots level to make the programme effective and meaningful.



### ***Interruption in Distribution of Supplementary Nutrition***

xxx) It was heartening to note that 46 per cent of AWCs (rural-47.6%, tribal-38.2% and urban-50.8%) had no interruptions at all in terms of supply of nutritional ingredients. However, a significant number of AWCs (52.9%) reported interruptions. In such cases, tribal AWCs scored the maximum interruptions (61.2%), followed by rural (52.0%) and urban (45.0%) AWCs.

### ***Coverage of Women under Supplementary Nutrition***

xxxii) Maximum number of pregnant women (49.5%) were registered in AWCs run under World Bank-assisted ICDS projects, followed by AWCs under NGO-run ICDS projects (48.6%) and regular ICDS projects (47.2%). Interestingly, maximum coverage of pregnant women was found in tribal AWCs of regular ICDS projects (61.8%) and NGO-run ICDS projects (58.3%).

xxxiii) The most interesting finding was that in NGO-run ICDS projects, all registered nursing mothers were availing of benefits from AWCs in tribal and urban areas, while in rural areas, the percentage was 75.6 per cent. On the whole, little more than 50 per cent nursing mothers (52.8%) were registered. Of these, 89 per cent received supplementary nutrition. More than 80 per cent nursing mothers were found to have been registered for supplementary nutrition in the States of Arunachal Pradesh (82.9%), Mizoram (80.3%), Nagaland (81.8%) and UTs of Dadra & Nagar Haveli (85.5%) and Lakshadweep (87.7%). It was also found that nutrition was provided to a high percentage of nursing mothers in these states.

### ***Children (6 months to 3 years)***

xxxiiii) Data presented that there was evidently more registration of male children (59.1%) than those of female children (55.2%). This depicts the normal scenario of male-female representation. In all categories of ICDS projects, percentage of female children availing supplementary nutrition was quite high – 82 per cent in all – rural (81.0%), tribal (84.0%), and urban (82.5%), as against male children – 75 per cent in all – rural (72.6%), tribal

(81.1%) and urban (74.4%). Another interesting feature emerged from this information was that in some of the States and Union Territories more than 90 per cent children, both male and female, availed supplementary nutrition.

### ***Children (3-6 years)***

xxxiv) Despite the fact that more girls were registered (57.8%) than boys (51.1%), share of benefits had gone to boys in higher percentage (75.9%) whereas less percentage of girls (74.6%) got the benefits. Most children, both male and female, registered for supplementary nutrition belonged to tribal areas (62.8% and 67.5%, respectively). However, high percentage was observed for female children who availed supplementary nutrition in tribal areas (75.5%), male children scored the lowest in tribal areas (71.9%), in comparison to rural (77.3%) and urban (76.1%) areas.

### ***Acceptability of Supplementary Nutrition***

xxxv) Eight out of ten Anganwadi Workers (79.8%) reported that food was totally acceptable to children and mothers. They found it well prepared, tasty and enjoyed its consumption. Around seven per cent found only some of the items of nutrition served as acceptable. Eleven per cent did not find food items served as acceptable. Major complaints were found in rural projects (13.5%) followed by urban (8.4%) and tribal projects (7.1%). Acceptability of food was maximum in tribal projects (84.7%), followed by rural (78.8%) and urban projects (76.7%). AWWs of 16 States/UTs mentioned that some of the items of RTE food supplied by contractor were below the level of consumption. AWWs reported that food was acceptable below 75 per cent beneficiaries in the States of Rajasthan (67.9%), Assam (66.7%), Orissa (65.0%), Haryana (55.0%), Meghalaya (40.0%), Uttaranchal (40.0%) and the lowest was reported from Uttar Pradesh (25.7%).

### ***Growth monitoring***

xxxvi) It was found that AWWs weighed 63.5 per cent of new born children and mothers cooperated in this exercise inspite of stigma attached to weighing of new born children. AWWs (67.5%) of urban projects weighed new born. Rural AWWs (64.0%) also succeeded in weighing newborn whereas tribal AWWs (59.4%) were also able to convince mothers and could weigh new born. Eighty-two per cent AWWs adhered to this guideline and weighed children below 3 years once in a month. However, weighing of children in the age group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so. Entire onus of weighing and plotting was shouldered by AWWs (85.8%). Supervisors extended helping hand to monitor the growth of severely malnourished children and new born on the day of their visit to AWCs.

### **Pre-school Education (PSE)**

xxxvii) On an average, 37 children were registered for pre-school education at Anganwadis. This signifies that AWWs made positive efforts for bringing children from deprived sections to AWCs so that they could utilise nutrition and health services as well. On the whole, 75 per cent of registered children attended the Anganwadis. Children enrolled and attending AWCs were comparatively on almost equal footing. However, contrast may be seen from figures of attendance which points out that number of girls was more in AWCs than that of boys for taking benefits. In all likelihood, therefore, boys were preferred to be sent to attend private schools especially in urban areas and towns for PSE.

### ***PSE Activities***

xxxviii) Children were engaged in singing songs in almost all AWCs (95.1%). Story telling and counting were other two activities which were organised by 91 per cent AWWs. While 78 per cent AWWs reported involvement of children in indoor activities, three-fourth of them (74.7%) also engaged children in free conversation to speak freely and apply their mind in order to organise small activities. Outdoor games could be organised by 70 per cent AWCs. Activities like painting, printing, drawing, threading and matching colour related to fine muscle coordination and development, as



also activities for emotional and intellectual development could get only limited attention in selected AWCs.

## **HEALTH**

### ***Iron and Folic Acid (IFA) tablets***

xxxix) Data obtained from mothers revealed that six out of ten children (59.6%) between six months and 3 years were given IFA tablets. AWWs were required to keep a close watch on pattern of consumption of these tablets with special reference to pregnant mothers during home visits and NHED sessions as also in the process of health check-up. Consumption of IFA tablets by pregnant women showed that women of this category (68.9%) consumed tablets regularly whereas another 16 per cent used it sometimes as and when they felt like swallowing it. Mothers (13.5%) kept the tablets in their possession but did not consume it because they did not like its taste.

### ***Immunisation***

xl) Immunisation against tuberculosis, diphtheria, whooping cough (pertusis), tetanus, measles and polio for children under one year of age and immunisation against tetanus of all pregnant women in ICDS project areas has been carried out by Primary Health Centre (PHCs)/ Community Health Centres (CHCs) and their subordinate health infrastructure. Two-third of children (66.1%) were immunised, highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. Health functionaries reported that the status of fully immunised children depended upon their availability when the immunisation schedule was in operation. In urban areas, status of immunisation seemed to be below expectation while situation was comparatively better in rural ICDS projects (71.6%). It was interesting to observe that records of vaccination were correctly maintained by health functionaries/AWWs.

### ***Reasons for Inadequate Immunisation***

xli) Major reason as reported by around one-fourth of health functionaries was indifferent attitude of parents towards immunisation (23.3%), followed by

disbeliefs attached to immunization (17.6%). Another major reason included age-old beliefs, customs, superstitions, stigma attached to castes/creeds. One out of ten health functionaries (10.8%) mentioned that there was stiff resistance from certain sections of communities due to inadequate awareness about advantages of immunisation.

#### ***Immunisation of Pregnant Mothers***

- xlii) Data revealed that pregnant mothers (76.2%) received tetanus toxoid immunisation. Twenty-seven per cent of pregnant women received first dose and 48 per cent of mothers also availed of second dose. Coverage of immunisation in rural projects was the highest in percentage (79.0%) followed by tribal and urban projects which showed very marginal difference of one per cent between them. However, administration of first dose in tribal projects was better among tribal mothers (29.9%) in comparison with rural (26.8%) and urban (25.3%).

#### ***Immunisation of Children (0-6 months)***

- xliii) Nursing mothers (77.4%) reported that their children got immunised. This coverage was slightly better in urban projects (79.7%) than in rural projects wherein mothers (79.4%) reported that their children got immunised. The lowest coverage of 70 per cent was found in tribal areas.

#### ***Immunisation of Children (6 months to 3 years)***

- xliv) Data shows that BCG vaccine coverage was the maximum (82.4%), followed by polio 3rd dose and measles (both 70.5%), DPT 3rd dose (38.9%) and booster DPT dose (17.8%).

#### ***Immunisation of Children (3-6 years)***

- xlv) Mothers (54.9%) of these children reported that their children got D.T. booster for their protection against tetanus. Immunisation coverage of children in this age-group was not as wide as it was found in case of children below three years. It seems that major focus of AWWs was on ensuring coverage of children below 3 years. Rural areas had better immunisation as narrated by mothers (56.7%), followed by tribal (52.5%) and urban (51.5%) projects.

### ***Weighing of Children at Birth***

- xlvi) It was found that birth weight of seven per cent children was below 2 kg. This situation invariably calls for encouraging mothers to do breast feeding of these children. Among the reasons behind parents not agreeing for weighing of children, AWWs reported that superstitious beliefs, such as ‘child will be victim of evil spirit,’ ‘fall sick’ and the like were prevalent. Around three-fourth of children were above 2.5 kg of weight in tribal ICDS projects.

### ***Health Check-up***

- xlvii) According to AWWs (75.1%), health functionaries conducted health check-up of children which included checking of eyes, ear, nose, teeth, hair and other external physical parts of the body regularly, including administering medicines of fever, eye and ear trouble, skin diseases etc. The highest percentage was prevalent in urban projects (80.8%) followed by tribal projects (78.7%) and rural projects (72.3%) in descending order.
- xlviii) Fifty one per cent health-check up were carried out by ANMs, while 22 per cent health check-up was conducted by Medical Officers. In respect of LHV/PHNs it was only 14 per cent. AWWs made every possible effort for coverage of needy mothers and children of poor and marginal families who mostly remained at home and were generally deprived of the service of health check up and medical care. Health check up “once in a month” was followed for all categories of beneficiaries ranging between 47 per cent and 61 per cent. In the health check-up the focus was more on children below 3 years (56.1%) once in a month and ante-natal check-up of pregnant mothers as per version of 61 per cent AWWs.

### ***Nutrition and Health Education (NHED)***

- xlix) As regards the frequency of organising this programme, 69 per cent of them mentioned that they organised NHED once a month on topics related to mothers and children. Fourteen per cent organised this activity as per expressed needs of beneficiaries. Around seven per cent conducted this activity once in two months. Seven out of ten tribal Anganwadis organised this activity once in a month, followed closely by even percentage of rural and urban projects (68.3%). Data also demonstrated that on an average 20.94 mothers participated actively in tribal Anganwadis, 18.43 in rural Anganwadis and 18.68 in urban Anganwadis. Average of attendance of mothers in these three areas was 18.68 mothers.

### ***Methods adopted for NHED***

- l) Almost all AWWs (92.1%) used inter-personal contact and discussion as a method to talk to mothers individually or in groups. Another method which was used more frequently than others was demonstration on recipes, preparation of oral dehydration solution, purification of water to mothers and adolescent girls (36.6%). AWWs (16.6%) also organised exhibitions on issues related to diarrhoea, immunisation, small family norms, role of Mahila Mandals/Self-Help Groups, care of severely malnourished children etc. AWWs focused on issues related to “at risk” mothers and children and imparted education to women (15-45 years) and other family members.

### ***Problems and Difficulties in Organising NHED***

- li) This was mentioned by 46 per cent AWWs. AWWs (36.9%) were also found to be in a situation where they were handicapped due to non-availability of materials/aids. AWWs (18.3%) devoid of skills in NHED, also pointed out inadequacies of training imparted to them in training centres.

### ***Home visits***

- lii) Data reflected that average number of visits to families was highest in urban projects (46.7 families) whereas AWWs of tribal projects visited 43.1 families. Aggregate of these visits was 42.6 families in a month.

When asked to explain the purpose of home visits, maximum number of AWWs (90.2%) reported that early registration and care of pregnant and lactating mothers was their foremost responsibility. Another important purpose of home visit reportedly was to ensure regularity and punctuality of children in attending AWCs. Almost equal percentage (68.9%) of AWWs made visits to arouse a better sense of responsibility of parents in taking care of malnourished children and taking sick children to hospital and meeting their nutritional requirements.

### ***Referral Services***

- liii) A vast majority of AWWs referred the cases to Primary Health Centres which were at the nearest distance and easy to approach. Beneficiaries belonging to this service were mostly from rural (63.5%) and tribal (67.1%) ICDS projects. Beneficiaries were also referred to sub-centres (16.8%). Facility of district hospital was mostly utilised by 37 per cent AWWs of urban projects. Among various problems faced by AWWs in enhancing efficiency of referral service, most prominent ones included reluctance of parents to take children to hospitals (26.3%), far off location of PHCs/CHCs (23.3%) and absence of transport facility (25.8%).

### ***Adolescent Girls***

liv) In the sample ICDS projects 44 per cent AWWs were also rendering services under the Adolescent Girls Scheme (*Kishori Shakti Yojana*) started during the year 1992. AWWs (32.2%) provided iron and folic acid tablets to adolescent girls daily – one tablet of iron and folic acid containing 60 mg of iron and 0.5 mg of folic acid. ANMs and AWWs monitored consumption of these tablets and its likely effects on the health of individual girls. Adolescent girls registered in Anganwadis also received supplementary nutrition, according to AWWs (30.7%). In order to ensure lasting impact of services rendered in Anganwadi programme of family life education was conducted by 27 per cent of AWWs. Topics covered by AWWs were appropriate age of marriage, care during puberty, personal health and hygiene, dangers of early pregnancy, psycho-social development, life cycle approach etc. Almost equal percentage (22.2%) of AWWs also emphasised on health



check-up and counselling (21.4%) on issues related to this age and adjustment potentials within the peer groups and family.

## **Benefits and Outcomes of ICDS**

### **Comparison of findings of present study with earlier studies**

An attempt has been made to compare the findings of the present appraisal with those of other national level evaluation and macro-level studies undertaken earlier. These studies included National Evaluation of ICDS (NIPCCD, 1992) and Concurrent Evaluation of ICDS (NCAER, 2001).

### ***Infrastructure/Equipment /Kit***

- lv) A definite improvement was found in building structure of Anganwadi Centres over the past 14 years. It was found that the percentage of AWCs housed in *kutchha* structure (38.7%) in 1992 has gone down in 2006 (19.9%). On the other hand, in 1992 only 43 per cent AWCs were found to be housed in *pucca* structure whereas in 2006, this percentage has gone up to 75 per cent. This progressive trend would have been because of provision of constructing *pucca* building of AWCs under World Bank and *Jawahar Rojgar Yojana/Nehru Rojgar Yojana*. Improvement has also been noticed in terms of supply of weighing scale to AWCs and availability of pre-school education (PSE) kits.
- lvi) Increase in percentage of staff in position has been seen at all levels over a period of time except that there has been a decline in the position of helpers by 1.5 per cent. So far as training of ICDS functionaries is concerned, a progressive trend has been witnessed over the years. In case of CDPOs, the number trained has increased from 74 per cent (in 1992) to 82 per cent (in 2006) while in respect of supervisors, the increase is from 84 per cent in 1992 to 95 per cent in 2006 and in case of AWWs an increase of more than 18 per cent from 1992 to 2006 has been found. It was found that more AWWs have obtained higher qualifications.

## ***Services***

lvii) The overall coverage of beneficiaries under supplementary nutrition had increased substantially. In our sample more than 56 per cent children were registered out of which more than 77 per cent were availing the services. Trend in case of women beneficiaries was also same but percentage availing services were quite high (more than 87%). A significant reduction has also been found in percentage of low birth weight babies. It has been reduced from 41 per cent in 1992 to 29 per cent in 2006 in respect of children born with a birth weight below 2500 gm. On the other hand, however, there was substantial increase in the percentage of children having a weight of more than 2.5 kg (from 58.9% in 1992 to 71.0% in 2006). Further, it was found that percentage of severely malnourished children had reduced drastically. In case of 0-3 years children, percentage of grade III > IV children has gone down to 1 per cent in 2006 from 7 per cent in 1992, that of grade II, 7 per cent (2006) from 22 per cent (1992) and that of grade I, 16 per cent (2006) from 35 per cent in 1992. Similarly, in case of 3-6 years children, present study scores only 0.8 per cent from Grade III and IV while the earlier study (1992) scores 4 per cent. Over the years, decline in disruption in supplementary nutrition has been noticed in percentage of both AWWs reporting disruption from (62.3% in 1992 to 54 % in 2006) and average number of days of disruption (from 63.7 in 1992 to 41.3 in 2006) Surprisingly, percentage of coverage of children per AWC – registered for PSE and attending the same has reduced.

## **Overall Assessment of ICDS projects on the basis of input and output/ outcome variables**

lviii) For the present study, some of the crucial variables necessary for successful implementation of the programme and impact of these in terms of output/outcomes were identified. Scale free method was used to calculate a standard score for each of the input and output/outcomes variables. For this individual score, each variable was divided by mean of that variable. The values thus arrived for each variable were then added to arrive at a composite score for each project which was called as composite input and output/outcome variable score.

- lix) On the basis of a composite inputs variable score, all the 150 projects were arranged in descending order showing the rank order for all input variables. Based on the total composite input score, minimum maximum range of composite input variable score was found to be between 3.1 and 19.3. Again, based on these scores, projects were rated as very good (scoring more than 15), good (between 10 and 15) and poor (less than 10).
- lx) According to composite score of input variables, it was found that out of 150 projects studied, a total of 63 projects were very good, 71 were good and 16 were poor in terms of input management.

***Appraisal of ICDS management – input variables and appraisal of output/ outcomes of programme***

- lxi) It has also been observed from the composite score of input variables that majority of the projects had performed well in terms of both input management and output/outcomes. However, it also clearly shows that few projects of northern BIMARU States have not performed well but all the southern states have performed upto the mark.
- lxii) Further, it is found that though 63 projects had Very Good inputs yet only 29 could show Very Good and 30 Good. Only 4 projects with very good inputs showed poor outputs/outcomes. One needs to go into detailed reasons for this situation which could be their being located inaccessible or poorly developed areas. Forty-six of the projects had good inputs and they were rated Good on outputs which is quite understandable. However, on the whole, a large majority of ICDS projects (n=132) out of a total of 150 projects taken for the sample of the study have been rated as Good and Very Good which is an encouraging sign for the programme.

**Recommendations**

The present study has come out with lots of findings which have come as a ‘pat on the back’ so far as the implementation of ICDS programme is concerned. But at the same time, the study has been able to highlight certain gaps and shortcomings of ICDS programme which need to be addressed with priority concern and attention. The following paragraphs would contain recommendations, both specific and general in nature, emanating from the findings of the study and a critical analysis of those findings having direct bearing on the programme.

## Specific Recommendations

- i) About 60 per cent AWCs studied has no toilet facility and in 17 per cent AWCs this facility was found to be unsatisfactory. This requires immediate attention and a concrete measure of action to provide toilet facility to all the AWCs.
- ii) Accessibility to health services at the grassroot level has always remained an issue of concern and the present study has substantiated this concern. In many Anganwadi areas, availability of important health services was found to be lacking. It was found that only in 29 per cent Anganwadi areas PHCs were available and in 43 per cent Anganwadi areas sub-centres were available. It is therefore suggested that efforts should be made to coordinate with health department to make health service available in Anganwadi areas as near as possible.
- iii) Almost half of the AWCs, particularly in urban areas, are lacking space for conducting outdoor and indoor activities. This problem needs to be sorted out as it amounts to AWCs not being able to conduct PSE activities properly and meaningfully.
- iv) About 44 per cent AWCs covered under the present study were found to be lacking PSE kits. Efforts need to be initiated at all levels to ensure availability of PSE kits which is an essential part of PSE activities in all the AWCs. Cost effective and popular local resources need to be optimally utilised to develop play materials. However, it does not stop the AWCs to develop a toy bank like project in each AWC by collecting play materials from external sources.
- v) Owing to certain constraints, in many AWCs cooking and serving utensils cannot be expected to be available in desirable quantity and quality. This needs to be given a fresh thinking and initiative on the part of the Government to make sure that these facilities are available in each AWC in good quantity and quality routinely.
- vi) The present study revealed that coordination of ICDS functionaries with Health Department was somehow lacking at field/village level, especially in tribal areas and even in projects which are run by NGOs. This resulted

in not-so-regular health check-ups at Anganwadi level. Concerted efforts are required to be initiated jointly by ICDS and health functionaries to have close coordination between them at all levels so that proper planning takes place to organise health check-ups.

- vii) A special drive needs to be initiated by both ICDS and health functionaries to cover all pregnant women in a given Anganwadi area to encourage them to take iron and folic acid tablets which are not otherwise consumed by these women as highlighted in the present study.
- viii) Agencies responsible for supply of supplementary nutrition need to be given clear instructions so that no disruption of supplementary nutrition takes place at Anganwadi level under any circumstances except those caused by natural calamities or extremely bad weather conditions. Apart from issuing necessary instructions to concerned agencies for regular supply of supplementary nutrition, Government must also look into the reasons for such disruption in each case and initiate necessary actions required in the given situation.
- ix) The present study reports that the boys, though registered less in number, avail more benefits than the girls. AWWs should ensure that all eligible girls avail benefits of supplementary nutrition as the future health of a nation depends largely on how healthy the girls are grown up.
- x) Efforts related to enhancement of immunisation coverage need to be strengthened so as to cover all the children for full immunisation. Therefore, concerted efforts on the part of ICDS and health functionaries are required in this direction. Community also needs to be sensitised adequately to the need and importance of immunisation so as to eliminate the chances of non-availability or non-cooperation of families in the process of immunisation.
- xi) The study revealed that 29 per cent children were born with a birth weight which was below normal (less than 2.5 kg). In the backdrop of this scenario, there is undoubtedly a need for regular supply of supplementary nutrition at Anganwadi level and more serious efforts for the care of pregnant mothers. This calls for regular health check-up, supply of supplementary nutrition and health and nutrition education for the pregnant mothers. AWWs should encourage mothers to breastfeed the



children without fail and take personal health and nutritional care of themselves as well as their children.

- xii) It was observed from the study that the attendance of target groups in NHed sessions was quite low. It should be the responsibility of CDPOs and Supervisors to provide full support to AWWs and encourage them to continue with their efforts so that they are not discouraged by poor attendance in NHed sessions. CDPOs and supervisors, in such cases, can accompany the AWWs to pay more home visits and be a part of the process of motivating the women to participate in NHed sessions.
- xiii) Another feature observed in the present study is that 37 per cent AWWs reported non-availability of materials/aids for NHed. Whatever aids were available with them, were procured from CDPOs as well as during their training and were not attractive at all. In many centres, available NHed aids and materials were not found to be in regional or local languages. These aspects need to be looked into seriously for remedial action.
- xiv) AWWs were found to face problems in providing referral services mainly due to non-availability of transport facilities to take the needy to health centres which are often located at far-off places. It was reported that many families cannot meet the cost of transport. In this regard, Panchayati Raj Institutions could be mobilised to extend transport facility to poor families so that they are able to avail health services. It is suggested that necessary funds may be made available at the disposal of AWWs to meet costs of medicines and transport. This would undoubtedly give referral services a shot in the arm.
- xv) Adolescent girls are the most potential groups which can do wonders provided they are properly involved in Anganwadi activities. A special provision should be made in ICDS scheme to involve and train adolescent girls in Anganwadi activities as they have the potential to extend all out support to AWWs and helpers in all the spheres of Angawadi activities.
- xvi) Weighing of children at birth needs to be made compulsory as it determines the course of action required immediately after the delivery. The present study reveals that 36.5 per cent mothers did not report weighing of new born children. This is a matter of grave concern. Health

and ICDS functionaries should be issued necessary instructions to ensure weighing of children at birth without fail.

- xvii) Monitoring of growth of children is another important aspect of ICDS programme. Though not in a very high scale, yet non-availability of growth charts in 11 per cent AWCs and weighing scales in 4 per cent AWCs is something which needs to be seriously looked into. ICDS programme should ensure appropriate growth of all the children under its coverage.

### **General Recommendations**

- xviii) Past experience as well as observations by the research teams have shown that mothers and children have responded enormously to supplementary nutrition programme wherever SHGs were involved in preparing cooked food in Anganwadis and serving the same to children and pregnant and lactating mothers. Since the ICDS programme is intended to be a people based one, it should, in its stride, involve the SHGs which are potentially the most effective and active grassroot level action groups. It is the high time that their contributions is sought not only to enrich the supplementary nutrition component but also to consider the shifting of responsibility of running the AWCs to SHGs in those states where the SHG movement has shown positive contribution to the ICDS programme specially in the delivery of supplementary nutrition.
- xix) Some of the project functionaries reported that the spirit of community participation and contribution was somehow lacking in Anganwadis. People are found to be treating ICDS programme as merely Government programme rather than their own programme. They feel that everything is to be done by Government. This impression needs to be washed out by involving Panchayati Raj Institutions (PRIs) in ICDS programme. PRIs should necessarily be tapped so as to ensure suitable infrastructural support and other support such as providing toys and play materials, tables, chairs and promoting attendance of children and mothers in Anganwadi activities.
- xx) Financial provisions to social sector and its prime programme like ICDS are required to be augmented and released timely at project level to pay

honorarium to AWWs and helpers and arranging supplementary nutrition. Besides, higher allocations in this programme, in view of the great cause ICDS programme has taken up, may be considered not as an expenditure but as an investment.

- xxi) Supervision should not be carried out in its old, rudimentary manner like inspection, Rather, it should be in the form of support and guidance to the supervisee. Participatory supervision in teams comprising ‘programme-friendly’ and ‘people-friendly’ members and those who have required time and skills from different set ups and institutions should be initiated in ICDS programme. They can be drawn to monitor the efforts of ICDS programme and its problems. This kind of supervision can help preparing the ICDS programme for providing better services to children of present and future generations.
- xxii) Since networking and information and knowledge sharing assumes great significance in the area of evolving a multi-sectoral endeavour more particularly from the perspective of mother care and child development, it is equally important, to rope in PRIs, to carefully forge partnership with district and block level officials including local bodies such as Zila parishads and municipalities. To actualise this process it is important to orient district and block level officials about ICDS programme and their role in implementing the programme successfully. This exercise will accelerate the pace of coordination and convergence of services and programmes as also ensure better understanding among functionaries.
- xxiii) Popularisation of ICDS programme will call for launching of special campaigns as was done in the past in certain ICDS projects by involving state, district and block level officials as also elected women representatives to raise consciousness of community on issues related to women and children. This would also generate community contribution, cooperation and support. The whole process would necessarily involve mahila mandals, self-help groups, youth clubs, mahila mandals, religious leaders and other functionaries of civil society organisations. Thus AWCs have to emerge as a “nerve centre” of activities and be a place where mother and children could assemble in their spare time, pursue hobbies, develop creative talents and equip themselves with different skills.

- xxiv) In Anganwadi areas where attendance of children is relatively low, crèches and day care centres need to be set up and attached to AWCs. This would widen the opportunities for all children to develop. More particularly girls would be allowed to pursue their interests. As it has been done in the States like Kerala and Tamil Nadu.
- xxv) So far as supplementary nutrition is concerned, variety and improved quality of items are required to be served. Mothers and AWWs need to be given skill training in preparing local recipes. They should be encouraged to serve freshly cooked food. It is suggested that at least two mothers should necessarily help AWWs and helpers, in rotation, in cooking and serving supplementary nutrition. AWWs should be given suitable kit materials on personal hygiene, environmental sanitation, testing of iodised salt, safe drinking water etc. for use in AWCs as also in families covered by an Anganwadi.
- xxvi) The erstwhile Department of Women and Child Development, Government of India long back issued a circular suggesting development of “CDPO’s office as a Resource Centre”. However, this guideline has not received due attention and support from Nodal Department of State Governments, District ICDS cells and CDPOs. It would be desirable if each ICDS project develops a resource centre for dissemination of information, providing counselling and support services to mothers and adolescent girls, organising skill training of AWWs and generating awareness on various issues related to women and children. It may also keep data on campaigns/exhibitions/melas, rallies organised at project level as well as have adequate stocks of materials and aids to organise such events. The schemes and programmes of other departments may also be procured and disseminated among community at this resource centre to avail benefits from these schemes and programmes. Adolescent girls need to be involved in developing educational programmes through role play, drama, songs, discussions as also in the process of developing training materials. Sample training module for adolescent girls on specific subjects may also be drawn up in consultation with project functionaries and personnel conducting various training programmes. Schools of Social Work, Home Science Colleges, teachers training institutions, extension

training centre, Krishi Vigyan Kendras etc. may also provide professional support in their respective areas of expertise in developing training modules and conducting training programmes.

- xxvii) Since Anganwadi Centre is a focal point for activities of ICDS programme it has always been emphasised that as far as possible AWC should be built with community involvement, be of low cost design using local materials and indigenous construction techniques. Further, it should be owned and maintained by community/village panchayat/urban local bodies. This type of centre is also required to organise other activities related to different women's programmes, to provide forum for youth activities, to use for meetings of frontline workers and for gathering of mothers and children. Ministries of Rural Development and Panchayati Raj may play major role in collaboration with State Governments to provide this facility. Voluntary organisation(s) working in the field of rural development can also act as a catalysts in mobilising the community. Experience of Social Work Research Centre (Tilonia), may be of immense help as also experience of a low cost panchayat ghar in Khori village in Rewari district of Haryana which was constructed by local craftsman in less than five months and at one-third of the cost estimated by the PWD. Local materials were used and villagers participated actively in the design as well as construction of AWC.
- xxviii) The strategy of convergence and integration of services has proved to be highly effective in ICDS programme after devolution of responsibilities and resources under the 73rd amendment of Constitution strengthening Panchayati Raj system became operational. Towards this direction, Ministry of Women and Child Development, Government of India needs to convene frequent meetings of coordination committees not only at central and state levels but also at district and block levels so as to enable the implementing machinery to carry the benefits of different programmes at the door steps of people with a synergetic effect.
- xxix) Strengthening of ANM centres in ICDS project areas will play crucial role in the delivery of health care services to pregnant and lactating mothers as also adolescent girls. Hence, all village level voluntary health workers like ASHA, Trained Birth Attendants (TBAs), Dais need to be placed at her



disposal. This will also facilitate supply of basic drugs, vaccines and equipments in abundance. Sharing of responsibilities of entire project areas among the doctors, LHV/PHNs and ANMs is utmost important so that smooth functioning of health infrastructure could be ensured in letter and spirit.

- xxx) The supply of therapeutic nutrition requires special attention at project and district level. Children with grade III and IV malnutrition are given special food which is called “therapeutic nutrition” which has to be in semi-solid form and can be easily digested by the child. Such children require a minimum of four feeds, of which two can be given at Anganwadi and two at home. The mother must be properly explained about the importance of special care for such a child and necessity of proper feeding at home. Locally available food stuff could be used to develop therapeutic food. In some Anganwadis, in the absence of therapeutic food, AWWs were found to be giving double the amount of supplementary food to the malnourished children. This practice needs to be discouraged as it is not only the amount of food required by the child but also more importantly the appropriateness of the same for the young malnourished child. Besides these, medical care for all “at risk” children need special attention in terms of their nutrition intake.
- xxxii) The Persons with Disabilities (PWD) Act of India makes a mandatory provision of early detection and early intervention services for childhood disabilities. Certain studies conducted in ICDS projects showed prevalence of developmental delay among children. This finding has led to the inclusion of Anganwadi-based developmental screening and early therapy programmes for children up to two years of age in the new World Bank supported ICDS-III projects in Kerala. It is suggested that in those areas where under 5 morbidity has come down to an acceptable level, next immediate priority should be adoption of morbidity management strategies including early detection and early intervention of disability as envisaged in PWD Act.
- xxxiii) The present study has brought forth the fact that early childhood stimulation and care for children in the age-group 3-6 years in ICDS programme calls for skill development training of AWWs in certain areas

which were identified as weak areas in effective organisation of PSE activities in this appraisal. These areas include skill-based requirements, preservation of aids, use of aids and theme based programme planning. ICDS functionaries can persuade Panchayats to provide essential play equipments required in AWCs. The present study finds out absence of many essential items which are required in an AWC to stimulate an enabling environment for pre-school children. These items include toys which teach colour, size, shape etc., puzzles for creative development, toys or games requiring refined movements, real or toy musical instruments, toys that teach names of animals, birds etc. In order to make PSE activity an effective component, it is essential to make the presence of the above-mentioned items in all AWCs mandatory.

- xxxiii) Pregnant women represent approximately 3 per cent of the population. Hence, in any village having a population of 1000 or so there will be approximately 30 pregnant women who need to be given priorities in order to provide services such as NHEd, counselling, and supplementary feeding. It is well known that pregnant women are aware and scared of the risks of pregnancy, childbirth, and neonatal death and therefore, receptive to options for safe delivery, neonatal care, and family spacing. Pregnant women are marked by physical changes, which facilitate their identification for NHEd and other services. There is no denying of the fact that the importance of reaching women during pregnancy is being increasingly recognised as critical to improve maternal health, birth weight, birth outcome, and neonatal health, and has proven effective in improving the nature of care which women provide to infants in their first year of life. Hence, ICDS needs to give top most priority to reach out to all the pregnant women with counselling and information on health issues as well as motivate them to avail supplementary food, so as to prevent malnutrition and death. This all out effort to identify and reach out to all the pregnant women would not only improve women's health, but also would influence infant and health care.
- xxxiv) In any village of about 1000 population, there are about 60 mothers who are having children under 2. This indicates that there are about 60 priority households in every village for follow-up visits. These women need to be

educated not only about the importance of feeding the child, but also as to how to feed and take care of the child. This will have greater impact on health and nutritional status of children. As a means of ensuring good health and nutrition of children under 2, reaching their mothers with health education and counselling should be given utmost priority. In addition, take home rations and guidance to lactating mothers on the preparation of foods to complement breast milk after 6 months of age is a welcome measure which needs to be incorporated in ICDS. It should be followed up vigorously to ensure proper utilisation of this facility.

- xxxv) Though coordination with health functionaries was reported to be satisfactory by a vast majority of project functionaries, the participation of ANMs/PHNs in referral services, health check-up, home visits and NHED was found to be marginal. There is a need to further improve the coordination between the ICDS and the health staff. The health workers should realise that at the end, their role would become easier if the activities of AWCs were properly implemented. The CDPOs and the Medical Officers of PHC should conduct joint visits to the Anganwadi areas to increase the performance of the programme. AWWs and ANMs should work in close collaboration. In order to improve accountability, work assessment report of ANMs/PHNs working in ICDS areas may include evaluation/comments of the CDPO incharge of the project as well.
- xxxvi) It was observed that delivery of NHED services was far below the desired level. In this regard, it is recommended that Supervisors should be given the responsibility of organising formal NHED sessions at regular intervals in AWCs under their supervision. Continuous and effective monitoring by CDPOs and district officials, as also active participation of health functionaries, can go a long way in the effective implementation of this component. For group formation and collecting women at one place for NHED sessions, locally popular social or recreational event or activity may be organised. Utilisation of folk media such as *nautanki*, *kathputli*, etc., need to be included in the training component of AWWs to strengthen their skills in imparting NHED effectively.
- xxxvii) Undoubtedly, whatever success ICDS programme has been able to achieve so far, it has been because of strong community support and cooperation.

However, there is still much to be done in this direction to ensure community participation in ICDS programme at the expected level. In this regard, it is suggested to experiment with an idea of having community mobilising team comprising functionaries, teachers having skills to effectively communicate and energise local voluntary organisations, youth clubs, community formations as well as representatives of village committees concerned with health, education, drinking water and sanitation so as to provide all back up support to ICDS programme. The other functions of the community mobilising team may include, mobilisation of people using methods like participatory rural appraisal, advocacy on local social development issues, consensus on and articulation of key issues, awareness building among people on priority issues, liaising with the intersectoral team of the village and initiating processes for thrift and credit.

xxxviii) The concept of community monitoring could be experimented with a different perspective by technically ensuring developmental goals of ICDS programme. A community level monitoring team comprising local people from all sections of life could be developed. The team members should be trained by service functionaries and professional experts to monitor ICDS programme based on certain process indicators and outcome indicators. This will ensure tracking of locally relevant indicators vis-a-vis developmental goals set for children, adolescent girls and women at community level.

xxxix) Moulding the mind of people, especially with such issues as discrimination against girl child is major challenge to the ICDS programme. Female infanticide has remained to be a problem for a long time. The institution of Anganwadi can play a very important role in creating awareness in the villages about the dwindling sex ratio and its likely impact on future of the country. It is therefore imperative that project functionaries including the AWWs and the helpers are involved in creating such awareness through campaigns and other means.