INTEGRATED CHILD DEVELOPMENT SERVICES

AN ASSESSMENT

PREPARED FOR UNICEF
BY
Dr. K.G. Krishnamurthy
Dr. M.V. Nadkarni
MAY 1983

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COMPONENTS OF THE INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME

- SUPPLEMENTARY NUTRITION
- IMMUNIZATION
- HEALTH CHECK-UP
- REFERRAL SERVICES
- NUTRITION AND HEALTH EDUCATION
- NON FORMAL PRE-SCHOOL EDUCATION

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ICDS - AN ASSESSMENT

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CHAPTER - I

INTRODUCTION

It is now widely conceded that the benefits of economic growth do not automatically reach the poor, and their children. Even adult-oriented anti-poverty programmes do not necessarily benefit children, or improve the environment in which they have to live and grow. The poverty-induced neglect of children ought to disappear if poverty itself disappears. Such a prospect, however, appears too distant at present. Children of the poor are victims of the process which excludes those with little or no access to productive resources from the benefits of economic growth. These benefits are usually oriented to increasing production rather than improving the quality of life.

The need for the state's intervention to correct such a distortion becomes, therefore, evident. It has to provide health, sanitation, education and an infrastructure whereby every child finds opportunities and encouragement to develop in a healthy and stimulating environment. Such a programme is most effective when it is part of an effort at community development complementing other measures to banish poverty and hunger. It cannot be operated in the spirit of charity, doles, or with bureaucratic overbearing. A child development programme operated in the right spirit can be a catalytic agent for change and serve as an entry point to improve the environment and quality of life of the poor.

The Integrated Child Development Services (ICDS) Scheme must be viewed and appraised in this broad perspective. Started on an experimental basis in 1975, comprising only 33 projects - 17 rural, 12 tribal and 4 urban, it has now received government priority and is

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included , as item 15, in the Prime Minister's revised 20-Point Programme for Social Development. By the end of 1982-83, 620 ICDS projects have been sanctioned. This number will rise to 1000 by the end of the current Five Year Plan which ends in March 1985. When these become fully operational, the Scheme will provide immunization and health check-up services to 14 million children and 2 million women, supplementary nutrition to 8 million children and women, and non-formal education to 6 million children.

This study is an attempt to take stock of the programme, to assess its implications for children and its impact on the quality of their lives. The lessons learnt from such an exercise would be useful in improving the implementation of the programme, where it is already operational, and in designing new projects more effectively. We have, therefore, taken an overall perspective of ICDS including the nutritional, medical, social and economic aspects. Several evaluations and studies have been conducted by the Planning Commission and by academic institutions but these have concentrated on one or more aspects of the Scheme. Moreover, the data for the latest report of the Programme Evaluation Organisation (PEO) of the Planning Commission was collected four years ago. Adequate feed-back based on recent information is not available. For this study, a sample survey was conducted in eight states and one Union Territory (Delhi) where the Scheme has been in operation for four years or more. It also incorporates the findings of previous evaluations and studies.

The second chapter of this study reviews the present situation of children in India and identifies some of the major problems which ICDS is designed to combat. Chapter three briefly reviews past GOI efforts to promote child welfare and outlines the background experience from which ICDS has evolved. This leads us to a discussion of the objectives, and organisational structure of ICDS. Chapter four

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discusses the objectives, the methodology and frame adopted for the survey. Chapter five attempts to assess the social and economic benefits expected from the Scheme and shows how, when it is effectively implemented, the benefits would be far more significant than the extra resources involved. While an indication of costs involved is given, it is argued here that a quantitative appraisal in terms of a social cost-benefit analysis is not possible and, if attempted, it could be misleading. However, steps to make the Scheme more cost-effective are indicated.

The sixth and final chapter, summarizes the conclusions and suggests areas for future action.

CHAPTER II

THE SITUATION OF CHILDREN IN INDIA

The majority of children in India are underprivileged. They live under social, economic and environmental conditions which hamper growth and development. Many families live at the subsistence level and are plagued with illiteracy and unemployment. Socio-religious factors, traditional values, differential sex upbringing and the health and nutritional status of the mothers hamper the birth and growth of healthy infants. The problems relating to child care and development are therefore complex. An attempt is made here to highlight some of the more prevalent problems facing the Indian child.

MORTALITY AND MORBIDITY

The two major child health problems in India are the high incidence of infant mortality and morbidity. Though the infant mortality rate (IMR) has come down from 204 per thousand live births in 1915 to 160 in 1947 and 125 in 1978, the rates continue to be very high compared to those prevalent in other developing countries. The IMR is not only higher in rural areas (136 in 1978 as compared to 70 in urban areas) but remains relatively stable while it has continued to drop in urban areas. Scheduled castes have a higher level of IMR in both the rural and urban setting (159 in rural areas and 90 in urban areas in 1978). Female illiteracy and age at marriage have been associated with IMR. In the state of Kerala, the fall in the IMR and the birth rate has been attributed to the higher level of female literacy and age at marriage. Several studies have established a relationship between the level of IMR and the availability of basic amenities like safe drinking water, proper nutrition, medical facilities, and access to communication[1].

1. UNICEF-1981: An analysis of the situation of children in India (Draft Report - UNICEF - New Delhi).

Estimates of infant mortality in rural and urban areas in different states in India are given in the following table[2].

Table I: Estimates of Infant Mortality in Rural and Urban Areas in Different States (5) in 1971

State/Union Terriroty	Infant deaths (per live 1000 births)	
	Rural	Urban
Andhra Pradesh	112.6	63.7
Gujarat	145.1	108.7
Haryana	64.0	52.0
Jammu & Kashmir	74.1	49.4
Kerala	58.1	45.0
Madhya Pradesh	141.3	75.6
Maharashtra	107.1	82.2
Orissa	132.9	79.1
Punjab	108.0	71.7
Rajasthan	112.8	74.2
Tamil Nadu	127.0	91.0
Uttar Pradesh	100.5	121.4
West Bengal	173.4	68.9

2. Office of the Registrar General, Ministry of Home Affairs, GOI - Survey of Infant and Child Mortality - a Preliminary Report - New Delhi, 1979.

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Studies indicate that approximately 40 per cent of the deaths are among children below 5 years of age. Of these, about half are in the age group 0-12 months, with a high rate of mortality in the first few days of life, i.e., less than 7 days. The main causes being diarrhoeal, gastro-intestinal and respiratory diseases. In the age group 1-4 years, mortality has been associated with respiratory, digestive and parasitic diseases. Excessive neonatal mortality is also caused by pre-natal conditions[3]. Low birth weight, maternal infections, complications arising out of pregnancy and delivery are closely linked with high mortality rates.

INFANT MORTALITY AND AGE OF THE MOTHER

It has been established that maternal age and birth order have a direct bearing on the health and survival of the infant. An inter-American Investigation of Mortality[4] revealed that infant death rates are highest for mothers under 20 years of age, and lowest for mothers in the 25-29 years age group. Data from Indian studies support these findings[5]. The average age of females at marriage is still very low. Even though it went up to 18 in urban areas, it is still below 16 in many states. This is followed by immediate and frequent pregnancies with inadequate spacing

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3. Shah M. and P.M. Udami, "Analysis of Vital Statistics from the Rural Community of Palghar" Indian Paediatrics, Vol. 6, No.11, October 1969,

4. Puffer R. R. and C.V. Gerrano - Patterns of Mortality and Childhood, Washington - Pan American Health Organisation 1973 (PAHO Scientific Publication No.262)

5. The OPCAT Palghar Study established high death rates among babies of young mothers under 20 years of age.

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Social custom and the perceived role of women in the family and society are the main obstacles to change.

INFANT MORTALITY AND BIRTH WEIGHT

According to a study conducted by Dr. B.N. Tandon and his colleagues[6] in 1981 only 23 per cent of rural and 27.4 per cent of tribal children have normal weights for their age. They estimated that 17.4 per cent of rural and 19.4 per cent of tribal children suffer from severe malnutrition (Grade III and Grade IV). Official Government estimates indicate that 30 per cent of the children born in India weigh less than 2500 grams at birth[7].

PROTEIN AND ENERGY REQUIREMENTS

It has been estimated that the diet of an Indian pre-school child, subsisting on cereals and pulses, could provide adequate protein and energy requirements if consumed in large enough quantities[8]. However, the quantity consumed is generally too inadequate to fulfil the energy needs, with the result that the child suffers from

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6. Tandon B.N. - Ramachander K. and Bhatnagar S. 1981 - Integrated Child Development Services in India - Objectives, Organization and Baseline Survey of the Project Population - Indian Journal of Medical Research - March, pp. 374-384.

7. Ministry of Health & Family Welfare, Government of India. Health for All by 2000 AD; Report of the Working Group, 25 March 1981.

8. Gopalan, C. and Narasinga Rao, B.S. (1971)/ Proc. Nutr. Soc.India, India 10, 111.

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calorie deficiency as well as incidental protein deficiency. The average Indian child, 1-5 years old, consumes 810 calories per day against the ICMR recommended allowance of 1200 calories[9]. Among adults, a large proportion receive 80 per cent of their required food input[10]. The average pregnant or nursing mother consumes 1400-1500 calories as against the 2500-2900 calories per day recommended by the ICMR.[11]

PREVALENCE OF DEFICIENCY DISEASES

In 1978, the National Nutrition Monitoring Bureau examined a total of 5823 infants and pre-school children in eleven states[12] (see Table II). The most commonly observed deficiencies are Protein Energy Malnutrition (PEM) and Vitamin A and B group deficiencies. PEM is more frequent in children under five years of age while vitamin deficiencies prevail among those above the age of five.

Clinical cases of marasmus/emaciation and kwashiorkor were identified in all the states though marasmus/emaciation is more prevalent than kwashiorkor. Similarly, ocular signs of Vitamin A deficiency like Xerosis, Bitot spots, and oral lesions of B Complex deficiency signs like stomatitis, angular stomatitis, and glossitis were identified in all states. The highest prevalence

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9. Srikantia S.G. (1973)/Proc. Nutr. Soc. of India 12

10. Narasinga Rao B.S. Visweswara Rao, K. and Nadamuni Naidu (1969), Ind. J. Nutr. Dietet. 6 238.

11. "Recommended Dietary Allowances for Indians" 1981 ICMR, New Delhi.

12. National Nutrition Monitoring Bureau, Report for the year 1978 (1979).

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Table II

Percentage prevalence of deficiency signs

Deficiency signs	Kerala	Tamil-nadu	Karnataka	Andhra Pradesh	Maharashtra	Gujarat	Madhya Pradesh	Orissa	West Bengal	Uttar Pradesh
No. of cases observed :	337	647	948	454	795	803	231	268	652	688
1.Oedema										
a) Infants	-	-	-	-	-	-	-	3.0	-	-
b) Pre-School children	-	-	0.3	1.3	0.7	0.5	-	-	0.4	0.9
2.Emaciation										
a) Infants	-	-	4.0	-	3.9	1.1	-	-	-	8.5
b) Pre-School children	-	0.2	5.2	0.5	1.1	1.4	-	-	3.3	3.0
3.Marasmus										
a) Infants	-	2.6	1.0	1.6	0.6	4.6	4.7	-	-	-
b) Pre-School children	0.7	0.6	0.5	2.3	-	3.4	-	0.9	-	0.7
4.Total vitamin										
a) Infants	-	-	-	-	-	-	-	-	-	-
b) Pre-school children	0.7	4.7	2.3	4.9	0.8	1.6	1.6	5.6	2.1	5.6
5.Total "B" Complex deficiency										
a) Infants	-	0.9	1.0	-	0.6	-	-	-	-	-
b) Pre-school children	1.0	6.6	10.3	13.3	0.8	2.4	0.5	8.5	7.7	2.7

of Vitamin A deficiency identified is 5.6 per cent among pre-school children in Orissa whereas the maximum prevalence of B Complex deficiency is 13.3 per cent in Andhra Pradesh.

EARLY STIMULATION

There is ample evidence to show that environmental, cultural and psychological stimulation are necessary for the child to realize his potential. However, the need for providing such opportunities to children is not fully understood by families from weaker sections due to ignorance, cultural and socio-economic realities. Recognizing this need, non-governmental agencies started kindergartens, Montessori centres largely in Metropolitan cities and urban areas which catered mainly to upper socio-economic groups. The under-privileged from tribal areas, backward areas and urban slums did not have access to such programmes. Keeping this in view, the Government integrated pre-school education with ongoing nutrition programmes.

It has been estimated that pre-school education covers hardly 1.2 million children which is about 1.5 per cent of the total population in the age group 3-6 years. Therefore, there was a need to make the communities aware to send children to pre-school programmes. ICDS, to a large extent meets this requirement by providing access, particularly to children of lower socio-economic groups in backward rural and tribal areas and urban slums.

CHAPTER - III

PAST EXPERIENCE AND THE PRESENT SCHEME

The need for special attention to women and child welfare as a part of community development has long been recognised in India. A massive increase in allocation has taken place over the period covered by the 6 Development Plans. The allocation for social services and related fields is as follows:

	Allocation in Billion Rs. (at current prices)	As % of total Plan Outlay
Ist Plan (1951-55)	4.77	23.1
IInd Plan (1956-61)	10.44	21.8
IIIrd Plan (1961-66)	15.00	20.0
Annual Plans (1966-69)	11.95	17.9
IVth Plan (1969-74)	27.72	17.4
Vth Plan (1974-79)	71.79	18.2
VIth Plan (1980-85)	148.36	15.2

Over the years, programming for children and women has progressively shifted from a rehabilitative, correctional welfare oriented approach to a broader developmental, preventive,

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multisectoral one. The adoption of the National Policy for Children in 1974 gave a new impetus at the national and sub-national levels for sustained, broad-based, long-term, integrated efforts to make children the focus of development. Subsequently, the Integrated Child Development Services Scheme (ICDS) was initiated on an experimental basis but gradually expanded to become the focal point for delivery of basic services to pre-school children. This brief review of earlier programmes traces the evolution of past experience which culminated in the formulation of the ICDS.

REVIEW OF PAST PROGRAMMES

The first systematic attempt at a programme for child welfare was introduced in 1954 through Welfare Extension Projects, administered by the Central Social Welfare Board. It covered activities for women too, and offered a package consisting of pre-primary schools known as Balwadis, limited supplementary feeding, health services for children and mothers, first aid, recreation facilities, adult education and training in arts and crafts. Each project covered 25 villages, and services were delivered at the village through a 'gram-sevika' - a woman worker. Another scheme was launched in 1967 called Family and Child Welfare Project with greater focus on children and women. The project was located at the Block or Taluka level, with a Child Development Centre and Women's Welfare Centre. They had sub-centres at key villages.

The resources allocated to these schemes were too meagre and the organisational base, particularly at the village level, was too inadequate to make them a success. Besides, a more integrated approach to the needs of women and children was considered essential, as seen from some of the evaluations subsequently done of the scheme.

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In particular, the 'Balwadis' were seen as potential centres for the total development of the child and as a venue to impart informal education to young mothers in child care, nutrition, hygiene and family planning. It was also realised that welfare schemes undertaken independently of the general programme of rural and community development were bound to suffer for want of resources and continuity.

An organisational infrastructure for community development was evolved during the First Plan with which child development programme could well have been integrated. An institution of self-government at the local level to ensure community participation in development efforts was evolved in the form of Panchayats. The administrative machinery needed for rural development was set up at the Block level, with a Block Development Officer in charge and extension services were delivered at the village level through the Village Level Worker (VLW). This machinery, however, was mostly involved in increasing agricultural production. It nevertheless provided a framework with which additional inputs could be integrated at little extra cost.

Health care programmes have been in operation in India through the Department of Health since Independence. They are concerned mainly with immunization and the supply of drugs, vitamins, iodised salts and iron. Their aim is to reduce morbidity and mortality rates among children as well as the general population, but they rely more on curative strategies. Primary Health Centres were located at the Block level which is relatively distant from the villages and approached in serious emergencies only. So, initially there was no adequate infrastructure for health check-up and referral services at the village level, nor for educating the villages in simple health care, even a vital matter like diarrhoea management.

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During the seventies, nutrition received greater attention and several programmes were launched in different parts of the country. Almost all of them tried to promote health care, nutrition and health and nutrition education.

The Special Nutrition Programme (SNP) which has been in operation since the early seventies sought to reduce the morbidity and mortality by raising the nutritional status of children and nursing and pregnant women. The latter were covered because of the impact expected on their children. Though health care programmes existed simultaneously in such blocks, they were not integrated with SNP. The Mid-Day Meal Programme (MDMP) was designed to attract children to schools and encourage regular attendance, in addition to raising their nutrition status. Both SNP and MDMP were not exclusively restricted to the severely malnourished children, but covered larger groups. SNP, in particular, has been criticized as not being selective enough in coverage, wasting resources which could otherwise have been concentrated on the most needy.

The Tamil Nadu Nutrition Project (TNP) supported by the World Bank, combines health services with nutrition inputs and informal health-and-nutrition education. Its main aim is to reduce mortality and morbidity. The nutrition programme is restricted to the severely malnourished. Children qualify for entry into the feeding programme if they suffer from third-degree malnourishment. They must exit once their nutritional status approaches normalcy. But the rehabilitation is often temporary because poverty, rather than ignorance about nutritional needs, is the main cause of malnutrition.

These programmes - SNP and TNP particularly, are not concerned about larger issues of self reliance in food or

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stimulating local production to meet the needs of feeding programmes. SNP receives donated food from CARE and WFP, and TNP has been in operation through World Bank loan assistance.

The Applied Nutrition Programme (ANP) tried to raise the nutritional status of children and women by actively encouraging local production of foods needed. Unfortunately, not enough attention was paid to administrative monitoring and other aspects of the infrastructure. As a result, the necessary co-ordination and integration between different services did not develop.

MAJOR WEAKNESSES OF THE EARLIER SCHEMES

The programme components of the schemes dealing with women and children did not correspond to the specified objectives. One of the major lacunae in the preparation of the projects was the absence of detailed project formulation, and inadequate emphasis on developing monitoring and feed-back systems. Furthermore, the financial resources provided for these projects were so limited that the objectives were beyond the realm of realization. Even though the schemes envisaged voluntary support and community participation in all aspects of programme, upon implementation, this proved to be much less than expected.

GAINS OF THE PROGRAMMES

In spite of the limitations, the schemes succeeded in creating general awareness about the need for welfare services and developed the organizational base for child welfare programmes in rural areas. The training institutions established to meet personnel demands of these schemes upgraded the existing level of skills of the middle level and field level workers.

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REVIEW BY THE PLANNING COMMISSION, 1972

In 1972, two major reports prepared by the Committee on the Pre-school Children's Feeding Programme, appointed by the Planning Commission, and by the study group on the development of pre-school children, appointed by the Ministries of Education and Social Welfare, stressed the need to develop integrated child care services. In response, the Planning Commission set up eight teams composed of representatives from the Ministries of Education, Health, Rural Development, the Home Ministry and the Planning Commission, to visit various rural, tribal and urban blocks and observe the organisational structure and the reach of services to children in these areas.

The teams recommended an integrated package of services to be delivered at the village level. They further recommended that the scheme should:

i) fully utilize the existing government infrastructure in the blocks;

ii) involve local communities to the extent possible;

iii) provide supplementary feeding and pre-school education services to the poorer sections of the population;

iv) establish a non-formal pre-school infrastructure as an entry point for health and nutrition services.

It was further suggested that the programme should be started on a modest scale and expanded after evaluation.

Subsequently, a working group was selected by the Planning Commission, comprising representatives from the Ministries of Health and Social Welfare to formulate a scheme based on the reports of the study teams.

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The Integrated Child Development Scheme is the result of their deliberations.

INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME

ICDS was initiated in 1975-76 on an experimental basis in 33 rural, tribal and urban Blocks. Its major objectives are to:

i) reduce malnutrition, morbidity and mortality of children in the age group 0-6 years;

ii) improve their health and nutritional status;

iii) provide the environmental conditions necessary for their psychological, social and physical development;

iv) enhance the ability of mothers to provide proper care to their children;

v) achieve effective co-ordination among various departments providing developmental services to children.

To achieve these goals a package of services consisting of the following was introduced:

a) supplementary feeding;
b) immunization;
c) health check up;
d) referral services;
e) nutrition and health education;
f) pre-school education; and
g) non-formal education for women

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The type of services to be provided for target groups are as follows:

	Beneficiary		Service
1.	Expectant and nursing mothers	(i)	Health check-up
		(ii)	Immunization of expectant mothers against tetanus
		(iii)	Supplementary nutrition
		(iv)	Nutrition and health education
		(v)	Functional literacy
2.	Other women 15-45 years	(i)	Nutrition and health education
		(ii)	Functional literacy
3.	Children less than 3 years	(i)	Supplementary nutrition
		(ii)	Immunization
		(iii)	Health check-up
		(iv)	Referral services
4.	Children between 3-6 years	(i)	Supplementary nutrition
		(ii)	Immunization
		(iii)	Health check-up
		(iv)	Referral services
		(v)	Non-formal pre-school education

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ORGANIZATIONAL SET-UP

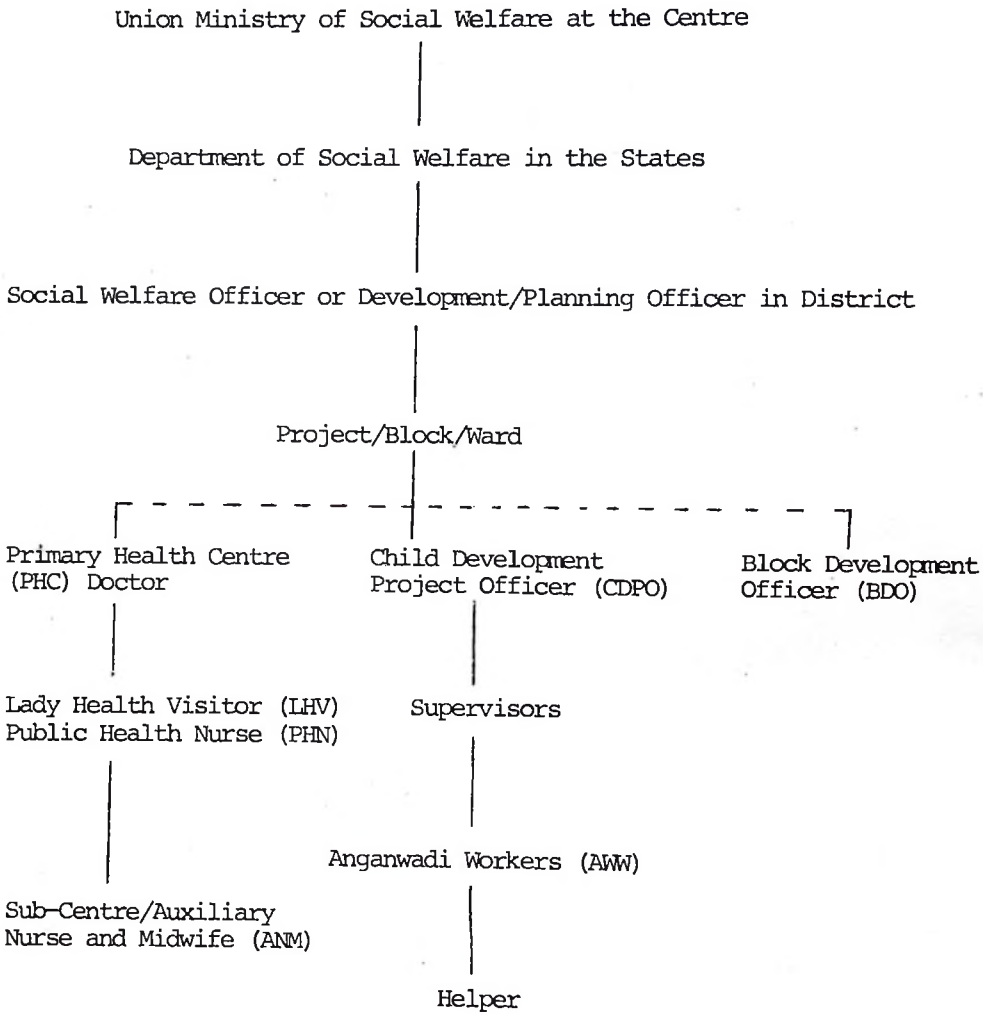
The Ministry of Social Welfare is responsible for the budgetary control and administration of the scheme from the Centre and co-ordinates activities with the Ministries of Education, Health, Family Welfare and Rural Development.

At the State level, the Department of Social Welfare is mainly responsible, although in some States, other Departments, (e.g. Tribal Welfare, Women and Child Welfare, Health or Rural Development) may take primary responsibility for implementation.

At the Block level, the Block Development Officer (BDO) exercises overall responsibility for the project, co-ordinating activities with the main ICDS functionary, the Child Development Officer (CDPO). As for the functions of other departments in the Block, see Table III.

TABLE - III

ADMINISTRATIVE SET-UP OF ICDS SCHEME



ANGANWADI

The focal point for the operation of the ICDS at the village level, is an anganwadi. It covers a population of about 1000 in urban and rural areas and 700 in tribal areas. The worker who co-ordinates and offers the services is the Anganwadi Worker (AWW).

Some of the important tasks to be performed by the AWW are as follows:

1. to survey the community and identify child and mother beneficiaries;
2. to monitor the growth of children using weight for age and identify children suffering from malnourishment;
3. to maintain growth charts and records of attendance, immunization, births, deaths, etc. at the anganwadi;
4. to provide supplementary feeding to children;
5. assist the LHV in distributing Vitamin A to children and iron and folic acid supplements to pregnant and lactating women; and refer patients to local health services;
6. to teach non-formal pre-school education to 3-6 year old children and functional literacy classes for adult women;
7. to make home visits in order to enlist community and beneficiary support to various activities;
8. to organize women's clubs (mahila mandals) as fora for health and nutrition education and centres for income-generating activities.

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HEALTH STAFF

For the projects sanctioned upto 1981-82, extra personnel, both medical and para-medical, are provided in the project areas from the ICDS budget. At present, the Ministry of Health and Family Welfare is providing 100 per cent central assistance to upgrade the health set-up to nationally accepted norms. Therefore, in rural/tribal ICDS projects sanctioned from 1982-83 onwards, no extra health personnel are needed. However, in urban projects, one doctor and four para-medicals will be provided from the ICDS budget.

CO-ORDINATION AT DIFFERENT LEVELS

The scheme provides for co-ordination committees at the district, block and village levels to ensure smooth implementation of the scheme and to elicit community participation and support. At the district level, the District Collector, District Magistrate, or Chief Executive Officer, chairs a committee composed of district level officers with representatives of the Indian Council of Child Welfare (ICCW), State Social Welfare Board (SSWB) and Voluntary Organizations. Co-ordination Committees at the block and village levels are composed of concerned officials, representatives of the Panchayati Raj Institutions and community leaders. The CDPO, directly in charge of the scheme, directs activities at the project level in collaboration with the supervisors and anganwadi workers.

MULTI-SECTORAL APPROACH

The goal of ICDS is not merely to reduce morbidity and mortality, but to lay the foundations for the proper psychological, physical and social development of the child. Insofar as it involves improving the environment in which children live and grow, ICDS could be viewed as a catalytic agent for community

development involving health, education, family planning, stimulation to the local economy and participation of the community in its own development. The goals of this programme are thus more comprehensive without sacrificing the urgent goal of reducing morbidity and mortality. The scheme attempts to achieve these goals by co-ordinating the efforts of various Ministries at the central , state, district and block levels.

FINANCIAL OUTLAYS FOR ICDS PROJECT

The annual total cost of a rural and tribal project upto 1981-82 has been estimated at Rs.0.64 million and Rs.0.38 million respectively. For the projects sanctioned from 1982-83, this has been revised to Rs.0.53 million and Rs.0.31 million. The total annual cost of an urban project is Rs.0.75 million. The table below presents the break-up by major items of expenditure.

Table IV: Financial Outlays for ICDS Projects*

	Rural	Tribal	Urban
Projects upto 1981-82		(Rs. Million)	
Staff	0.34	0.12	0.36
Strengthening PHC/ sub-centre staff	0.44	0.26	0.41
Recurring costs (medicines, POL, etc.)	0.10	0.06	0.24
Non-recurring cost	0.10	0.06	0.10
Total provision	0.64	0.34	0.75

* This excludes the cost of providing supplementary nutrition which is an additional Rs. 0.93 million per year in rural and urban projects and Rs. 0.61 million per year in tribal projects.

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Table IV: Financial Outlays for ICDS Projects (Contd.)

	Rural	Tribal	Urban
Projects after 1982-83		(Rs. Million)	
Revised provision	0.53	0.31	Remains the same
	Exceeds provision of 0.10 for health staff and 0.001 for rent of building for medical and para-medical staff	Does not provide 0.7 for health staff and 0.004 for rent	

The unit cost per beneficiary in a project per year sanctioned upto 1981-82 excluding supplementary nutrition is Rs.27.28 in rural areas, Rs. 44.00 in tribal areas and Rs. 33.29 in urban areas for 17000 children in rural/urban project and 6000 children in tribal project. In the projects sanctioned from 1982-83, the unit cost per beneficiary in an urban project is Rs. 44.22 whereas for rural and tribal projects it is Rs. 37.35 and Rs. 63.60 respectively. The following table shows the service-wise costs in these projects.

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Table V: Service-wise Cost per Beneficiary

Projects	Service		Rupees Total	Nutrition Component
	Health Component	Welfare Component		
Rural				
Sanctioned upto 1981-82	4.58	22.70	27.28	75.00
Sanctioned from 1982-83	8.00	29.35	37.35	75.00
Urban				
Sanctioned upto 1981-82	2.82	30.47	33.29	75.00
Sanctioned from 1982-83	6.11	38.11	44.22	75.00
Tribal				
Sanctioned upto 1981-82	8.00	36.00	44.00	75.00
Sanctioned from 1982-83	14.60	49.00	63.60	75.00

CHAPTER - IV

ASSESSMENT OF ICDS

From the outset, the Government of India recognized the need for a regular monitoring system and for periodic evaluation of the programme. The Programme Evaluation Organization (PEO) of the Planning Commission conducted a bench-mark survey in 1976 and a repeat survey in 1976-1978. The main emphasis in both surveys was on the state of preparedness, the reach of services and opinion/attitudes of beneficiary families. The process of implementation, not the impact, has been the focus of PEO surveys and evaluations. At the same time, a monitoring cell was established at the All India Institute of Medical Sciences (AIIMS) to review the medical and nutrition inputs into ICDS. Drawing on the assistance of medical colleges, and a cadre of especially trained medical consultants, the AIIMS has surveyed the above inputs and has issued periodic reviews of progress in the area of health and nutrition and related them to perceptible demographic changes in the beneficiary population.

Attempts to develop a monitoring system covering the social inputs into ICDS have not been very successful. At this point, no effort is under way to systematically review or evaluate the impact of these components, including the highly visible pre-school component, on the well-being of children. Existing studies and reviews of ICDS, therefore, tend to take a limited view of the programme and assess it entirely in terms of health and nutrition. Recently, several attempts have been made to compare ICDS to other health and/or nutrition programmes disregarding the fact that it is an integrated programme equally concerned with the social and cognitive development of the child and with upgrading the physical environment of the family. This study attempts to redress the imbalance.

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OBJECTIVES OF THE ASSESSMENT STUDY

The specific objectives of the assessment are:

i) to review the overall functioning of the scheme at the village level;

ii) to assess the effectiveness of the delivery of services;

iii) to determine the effect of services on attitudes, general awareness and daily practices in the local community;

iv) to assess the benefits against resources invested in the programme.

METHODOLOGY

Nine teams were organized to collect data including groups and individual researchers from the Tata Institute of Social Sciences (Bombay); the Department of Child Development, Agricultural University (Haryana) and the Institute of Home Economics (Delhi). The teams consisted of experienced research staff taken on short term deputation.

In all, 16 blocks in the states of Andhra Pradesh, Karnataka, Rajasthan, Maharashtra, Haryana, Uttar Pradesh, Nagaland, Bihar and Delhi were selected for the study. Only those blocks where the programme was initiated during 1978-1979 and 1979-1980 were selected, the rationale being that these blocks had a reasonable amount of time to establish the programme. Of these blocks, six are from rural, four from tribal and three from urban areas. Data was collected from 124 villages selected at random. In each village, five beneficiary families were selected from the list of households eligible for assistance and 620 respondents were interviewed. In addition, either the Panchayat President or a

member was interviewed. Details regarding the states and blocks selected are given below:

ICDS STUDY - 1983

Name of State	Name of Block	Type of Block	Name of District
1. Karnataka	Kanakpura	Rural	Bangalore
	Hunsur	Rural	Mysore
2. Andhra Pradesh	Ethunagaram	Tribal	Warangal
	Domakonda	Rural	Nizamabad
3. Rajasthan	Chottisadri	Tribal	Chittorgarh
	Rajasmand	Rural	Udaipur
4. Maharashtra	Worli	Urban	Bombay
	Talasari	Tribal	Thane (Bombay)
5. Haryana	Kalayat	Rural	Jind
	Beri	Rural	Rohtak
6. Uttar Pradesh	Sohawal	Rural	Faizabad (base study)
7. Bihar	Khunti	Tribal	Ranchi
8. Delhi	Jehangirpuri	Urban	Delhi
	Kalyanpuri	Urban	Delhi
9. Nagaland	Phek	Tribal	
	Jalukie	Tribal	

Three questionnaires were distributed. The first sought information on the cleanliness of the anganwadi, provision of toilet facilities, stimulation and comprehension among children, community participation in the anganwadi, contribution by families, individuals, philanthropists and voluntary agencies.

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The second questionnaire was used to collect demographic data such as the population, children in the age groups of 0-3 years and 3-6 years, numbers enrolled for nutrition supplementation and children with severe malnutrition. The third was used to assess the opinions and attitudes of the beneficiary families concerning the efficiency of the programme, family planning, family size and illnesses among children.

RESULTS AND ANALYSIS

I Staffing

The staffing pattern in the various surveyed projects is as follows:

Table VI: Position of staff in the surveyed projects

Category of Staff	TYPE OF PROJECTS							
	Rural		Tribal		Urban		Total	
	Sanc-tio-ned	In posi-tion	Sanc-tio-ned	In posi-tion	Sanc-tio-ned	In posi-tion	Sanc-tio-ned	In Posi-tion
CDPO	6	6	4	4	3	3	13	13
Mukhya Sevika Supervisors	26	20	24	22	10	8	60	50
Doctor	6	6	4	3	2	2	12	11
LHV/ANM	48	44	29	15	12	12	89	71
AWW	526	453	321	301	300	300	1147	1054

N.B. The data represents information from 13 blocks.
Data from one rural block is not available.

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These figures indicate that given adequate time for training and organization, the staffing is fairly well distributed although there is a perceptible problem in staffing the grassroot-level workers in both rural and tribal areas. This is attributable to several factors. The workers , all of whom are female, must contend with inadequate transportation, long distances and the constrictions imposed by traditional values.

II Programme Beneficiaries

1. Age Group

In the projects surveyed, 13.4 per cent of the rural, 14.6 per cent of the tribal and 14.8 per cent of the urban population fell in the age-group 0-6. The projected coverage in the schematic pattern prepared by the Ministry of Social Welfare for the age group 0-6 estimated this group to include 17 per cent of the total population which is nearly 2 per cent more than the observed demographic distribution. The percentage of the population in the vulnerable 0-3 age group was 5.9 per cent in rural, 6.7 in tribal and 12.4 in urban areas. Changing demographic trends, falling birth rates and improved health care facilities account for the difference between estimated and actual figures (Annexures 1 & 2).

Children in the age group 0-3 years account for almost 50% of the total enrolment in supplementary nutrition which is considerably more than the 35.4% reported in the Repeat Survey of the PEO (p.61) based on 1976-1978 data. The programme has considerably improved its capacity to reach this vulnerable group of young children who have to be carried to the centres by their mothers or older siblings.

2. Coverage of schedule tribe and schedule caste families

A substantial number of children attending the programme belong to scheduled castes and scheduled tribes (Annexures 6 & 7) which is in line with the findings of the PEO Survey (page 60). A significant

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number of children from the poorer sections of the society are enjoying the benefits of the scheme. This is partly attributable to the location of centres based on the distribution of population obtained from the baseline surveys. In some cases this has discouraged the participation of the more privileged group in the communities, who are bound by caste barriers, from partipating actively in the anganwadi. Similarly, larger numbers of pregnant women coming from poor families are availing themselves of the services. Of the 1975 pregnant women enrolled, 466 are from scheduled castes and 653 from scheduled tribes (Annexure 4).

3. Attendance in the anganwadis

The highest percentage of children attending anganwadis is in tribal blocks (63.2%) followed by urban areas (49.7%). The percentage of girls attending the anganwadis is almost 48% and is the highest in tribal projects (49.8%). Geographical and demographic factors impose a different pattern on the scheme in tribal areas, where the anganwadi centres serve smaller populations, thereby fostering better community contact and increased participation.

4. Birth and death rates

Basic information on birth and death rates is not available in all villages, only 103 centres reported births. The reported births are around 15 per cent in rural and tribal areas and 24.9 for urban areas. Similarly, reported death rates for rural, tribal and urban areas are 3.4%, 4.53% and 2.43%, respectively (Annexure 8). There is a wide variation in the records of births and deaths maintained by anganwadis and village panchayats. The birth and death rates seem to be half of the corresponding state averages for rural and tribal villages although those of urban centres seem to correspond to the national average. Likewise, the reported death rate is very low. The disparity in reported figures could be due to under reporting of births and deaths in the villages, inadequate training of the anganwadi workers and the difficulty in obtaining accurate data at the village level.

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III Programme delivery

1. Immunization

Immunization is the first step in combating infant mortality. Immunization against the major childhood illnesses is carried out by the health personnel attached to the scheme (Annexure 9). In the case of polio, there is a 33 per cent drop in coverage from the first dose to the second dose and a 31 per cent drop from the second to the third. There is a need for closer monitoring by health personnel to ensure that the whole series is administered to children.

2. Supplementary nutrition

Supplementary nutrition is provided to raise the nutritional status of young children in general and to combat the adverse effects of malnutrition. Out of 11,443 children covered by the Survey, 502 or 4.5% have been identified as malnourished. Of these, 258 are girls and 244 are boys (Annexures 2 & 3), an unexpectedly even balance. The regularity of feeding and the kind of food provided differs from centre to centre. In 64 per cent of the centres food is available for the prescribed 300 days a year (Annexure 5) whereas in others it is provided for only 150 to 250 days. In 52 per cent of the cases, food is cooked on the premises; in others, ready-to-eat food is provided. In tribal and rural areas, cooking is usually done at the anganwadis. Only 24 per cent of the centres use fresh vegetables in the cooking. This is often provided by the community.

3. Functional Literacy for Adult Women

Attendance in the functional literacy classes is very low (Annexure 10). The maximum drop out occurs between the time of the initiation of the programme and the fifth month of implementation. The main reasons for dropping out are (i) women find no spare time to attend the classes; (ii) anganwadi workers show little interest in the classes; (iii) lack of facilities at the centre; and (iv) the programme is not considered of much use by the village women.

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4. Observations of the Research Team

(i) Cleanliness and personal hygiene

Of the 124 anganwadis surveyed by the research team, 80 centres (65 per cent) have clean surroundings. Of these, the centres located in rural areas are the most clean, followed by tribal areas. Only 44 centres (33 per cent) have toilet facilities. The personal hygiene of the children, hair and dress, at the anganwadi is decidedly poor (Annexures 11 and 12). There is considerable scope for improvement in both environmental and personal hygiene.

(ii) Comprehension and cognitive development in children

The children are able to identify the animals, fruits, vegetables, sing songs and, in some cases, have acquired the rudiments of numeracy. The alphabet is taught in many centres. The overall responses on cognition and comprehension are quite satisfactory (Annexure 13).

(iii) Community Participation

About 53 panchayats or 92 per cent of those surveyed had made some contribution to the programme. Contributions were mostly in the form of land, buildings and firewood. Families do not generally contribute to the centres. Of those interviewed, only 10 per cent had made some contribution to the programme. The contribution is in the form of food commodities, firewood and labour and is on an irregular basis. Contributions by individuals and philanthropists are negligible. No contribution by voluntary agencies directly to anganwadis were reported (Annexures 12 & 13).

(iv) Coordination Committees at the village level

Co-ordination Committees were only set up in 57 of the 124 villages. Committees are composed of mostly school teachers,

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panchayat presidents and village elders. Adequate representation is given to non-official members wherever the committees have been constituted (Annexure 16).

The committees meet more often in tribal and urban areas and records of discussions are maintained in some 45 centres. The discussions concentrate on day to day implementation decisions (Annexure 17).

V Opinion of the beneficiaries

1. Family planning and size of the family

Nearly 60 per cent of the beneficiaries are in favour of family planning. The majority favour three children and a comparatively high number of the beneficiary families questioned reported having 3-5 children. This indicates a perceptible change in attitude and acceptance of family planning programmes in the project areas (Annexure 18).

2. Knowledge of respondents on immunization, health check up, pre-school education and supplementary nutrition.

Most of the respondents, almost 80 per cent, are aware of the benefits of immunization and take advantage of the 70 per cent of health check ups provided by the centre and the local PHC. Most of the respondents know of the services available through the scheme -- pre-school education, supplementary nutrition, vitamin A distribution and functional literacy classes (Annexure 19). Immunization is accepted because it prevents diseases. However, very few are able to connect immunization to the growth of the child (Annexure 20).

Of the 598 respondents, 55 per cent are aware that the programme includes vitamin and iron distribution but only 24 per cent were able to identify vitamin A with the prevention of blindness. Only 18 per cent stated that vitamins help the growth of the child

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and prevent diseases. Responses to questions regarding supplementary nutrition indicate that it is widely known to help growth but the connection between malnutrition and disease is not fully understood (Annexure 21).

Most of the respondents are aware of the existence of the pre-school programme and see it as a positive step towards formal education. The concepts of mental growth and early stimulation are not fully understood.

The Functional Literacy for Adult Women programme is equally well-known to the beneficiaries. Some view it as a programme which helps women to learn and acquire skills (Annexure 22). However, the skills often demanded are income-generating skills which are not an established part of the curriculum.

3. Community Participation

About 50 per cent of those questioned said that they would consider contributing to the programme and that they are able to provide grain, firewood and labour. There was, however, a marked difference between the responses of urban communities and those located in rural and tribal areas, confirming observations from previous studies that the urban poor are unwilling or unable to contribute materials or labour to the centres (Annexure 23).

4. Health status: Incidence of illness

Thirty per cent of respondents stated that their children had fallen ill during the last 15 days. The incidence of illness is higher in rural areas and has an average duration of 3-5 days of fever, respiratory ailments and diarrhoea (Annexure 24). The majority (91 per cent) reported illness during the last year. Fevers and diarrhoeal episodes recur most frequently and again, the incidence is higher in rural areas (Annexure 25).

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CHAPTER - V

AN ANALYSIS OF BENEFITS AND RESOURCE INVOLVEMENT

The indirect and long-term economic benefit of social welfare programmes does not lend itself to the more common economic appraisals of cost-effectiveness and social benefit/cost analysis. Instead of trying to assess what long-term impact such schemes have on GNP and appraise them in terms of such an impact, one could legitimately ask whether efforts and cost involved in raising GNP are worth undertaking in terms of improvement in the quality of life[1].

Attempts have been made to employ tools of cost effectiveness in the appraisal of social welfare projects, whose benefits cannot be quantified. Given a particular goal, like the reduction of infant mortality, an exercise could be carried out to assess and select the most cost-effective method of attaining it. But it is meaningless to isolate one variable from a project with multiple or comprehensive goals and, merely for the sake of quantification, compare it with the same variable isolated from a multi-sectoral programme with different goals. In other words, it would not be logical to compare the cost of saving one life through a

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1. Knudsen's study of supplementary feeding in the Tamil Nadu Project, for example, found that the Project was viable and economically justifiable in the sense that the social rate of return was above the opportunity cost of capital. This outcome depends on at least a 10 per cent improvement in mortality rates (and consequent reduction in wastage and enhancement of earning) and a 10 per cent increase in productivity following improved health and nutritional status.

   Odin K. Knudsen - Economics of Supplemental Feeding of Malnourished Children, World Bank Staff Working Paper No. 451, 1981.

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programme which is concerned merely with immunization, health care and diarrhoea management to reduce mortality, with one saved through a programme concerned with the psychological, physical and social development of children, in addition to providing health care. Instead of carrying out comparative exercises which are not quite meaningful, we shall try nevertheless, to indicate various economic and social benefits of ICDS, and have an idea of the resource involvement and efforts needed to make the Scheme more effective in achieving its goals.

Since the ICDS Scheme was launched on an experimental basis in late 1975, and has only recently been significantly extended, it is too early to identify any impact on infant mortality. However, the evaluations carried out by the PEO[2] and by Prof. B.N. Tandon of the All India Institute of Medical Sciences, show encouraging results. Prof. Tandon's study showed that in two separate samples drawn from groups of the same socio-economic level, more children received immunization and nutrition services in areas that had been covered by ICDS for 3 years (sample C), than in areas depending on the regular services (Lancet, Jan.15, 1983, p. 111). The relevant data is presented in Table VII.

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2. PEO, Planning Commission - Evaluation Report on the Integrated Child Development Services Projects - 1976-78, Government of India, New Delhi, 1982.

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TABLE VII: Receipt of Essential Health Services and Nutrition Status (1979-80) - Percentages of Children

	NON-ICDS	ICDS
Services from	Sample B	Sample C
Immunization		
BCG	17.4	43.6
DPT	14.0	35.4
Poliomyelitis	9.2	Not recorded
Health Check-up	15.3	61.3 (57.7)*
Vitamin A	17.7	57.1 (52.7)*
Supplementary Nutrition	26.0	55.5
Nutritional Status		
Normal + Grade I	56.2	62.7
Grade II	28.2	26.2
Grades III + IV	15.1	10.8
Not recorded	0.5	0.3

* Data for 4 urban projects not included

Source: Tandon et al, Lancet, Jan 15 1983, p. 110

ICDS has been relatively successful in reaching the poorer groups in isolated as well as urban areas. Still, according to the PEO, only 62 per cent of children from poor families are covered by ICDS. There seem to be two factors behind this. Very poor families are inhibited by the fact that their children have no

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proper clothes, even by village standards, to attend anganwadis, either for feeding or for non-formal education. The second factor is that where there are younger children at home, pre-schoolers are required at home to look after them, while adults can work. Some anganwadis overcame this problem by permitting pre-schoolers to bring their younger brothers and sisters to anganwadis. If the anganwadis are kept running for sufficiently long time to allow adult women to work, it provides an important, though indirect benefit to them, in increased income and production. The ICDS can thus be a good complement to anti-poverty programme in more ways than one.

The pre-school non-formal education provided by ICDS removes an important disparity between rural and urban areas, and within urban areas, between the rich and the poor. Only the urban rich and the middle class can afford the preparatory and kindergarten schools which prepare children for the school. Such facilities do not exist in rural areas or for the urban poor. This has been related to the high dropout and failure rates among older children from poor backgrounds. The ICDS Scheme fills this gap, attracting children through its nutrition programme. In this context, it is impractical to restrict nutrition programmes to the severely malnourished. There are many poor children who are not malnourished and need to be oriented to schooling. The cost of feeding the children from non-poor families could be recovered in the form of a tax levied by village panchayats (local self-governing bodies) on the better-off sections in villages.

An indirect, but significant benefit of the nutrition programme, is the breaking down of social barriers for children from scheduled castes, who are encouraged to attend the anganwadis, where they mix with others.

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The Sixth Plan (1980-85) mentions that though 75 per cent of children in the primary and middle school age group are enrolled in schools, about 38 per cent of scheduled caste children and 56 per cent of scheduled tribe children are yet to receive elementary education. Unless these children receive a minimum education, they will not be able to participate in the mainstream of economic development. The ICDS has, if properly implemented, the potential not only to break down the isolation of such children by attracting them to anganwadis, but also to help them to develop themselves.

India has adopted the policy of "Health for All by 2000 AD" and the ICDS is an important part of the strategy to achieve this goal. The Infant Mortality Rate, which was 126 per 1000 live births in 1976, is expected to come down to 60 by 2000 AD: the crude death rate from 14.2 to 9.0; and the crude birth rate from 33.3 to 21.0 . The reproduction rate should decline from 1.51 (in 1980) to 1.0.

Potentially, ICDS can play a larger role in achieving these targets, by complementing other programmes and contributing significantly to human resource development.

Apart from this optimistic scenario, there are some direct features with short-term benefits also. It has the potential of creating new avenues of socially productive employment. If 1000 blocks (projects) are covered by 1985 as targetted, it would employ 85,000 women as AWWs and another 85,000 women as their helpers. It would also employ 1000 Child Development Project Officers, 1000 Assistants, 3000 to 5000 supervisors, 1000 clerk-typists, 1000 drivers, 1000 peons, 1000 more doctors, 2000 lady health visitors and 4000 to 8000 auxiliary nurse-midwives, not counting multiplier effects on further employment created by this initial employment.

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Most of the categories are those "manned" by women. This will have an impact on the economy of families and on the birth rate.

The extra cost of creating an additional infrastructure at the village level would appear meagre on a per beneficiary basis. The cost of AWWs alone is calculated by Tandon et al to be only Rs. 12 per beneficiary per year, over and above the cost of health services infrastructure. The important point that we need to note here is that considering the extra benefits generated by the ICDS in filling vital gaps in development programmes and in offering a co-ordinated package of services, the extra cost invested appears quite meagre.

On the basis of financial allocations made by the Planning Commission, we can have some idea of the resource involvement. It is not possible to aggregate all costs on a per beneficiary basis because the target population per block for health care is much more than per target population for the nutrition programme. The former is about 17,000 in each rural or urban project, whereas the latter is only 6800 children and 1600 women. The target population for non-formal education in health and nutrition is even more than that for health care. The official scheme (as revised in 1982) provides details of the target population which are presented here in Table VIII.

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Table VIII: Target Population of ICDS Scheme in each Project (Block) - Service-wise

Type of population covered		Service	Total Population		Target Population	
			Rural or urban project	Tribal project	Rural or urban project	Tribal project
I.	Children	Immunization	17,000	5,950	17,000 (100%)	5,950 (100%)
	- do -	Health Check up	- do -	- do -	- do -	- do -
	- do -	Supplementary nutrition	- do -	- do -	6,800 (40%)	4,462 (75%)
	- do -	Referral	- do -	- do -	Wherever necessary	
II	Children (3-5 years)	Pre-school education	8,000	2,800	4,000* (50%)	2,100 (75%)
III	Nursing & expectant mothers	Supplementary nutrition	4,000 (2400 + 1600)	1,400 (910 + 490)	1,600 (40%)	1,050 (75%)
	Expectant mothers	Health check up	2400	910	2400 (100%)	910 (100%)
	- do -	Immunization against tetanus	- do -	- do -	- do -	- do -
IV	Women 15-45 years	Nutrition and health education	20,000	7,000	20,000 (100%)	7,000 (100%)

Note: Figures in brackets are percentages of target population to the total. Beneficiaries are selected as per guidelines issued by the Ministry of Social Welfare; their actual number can differ from project to project.

* This appears to be lower than needed and is likely to be revised upwards

Source: Ministry of Social Welfare, Government of India, "Integrated Child Development Services Scheme" (Revised July 1982) pp 17 & 18

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When the targetted population differs for different services, it is difficult to assign costs service-wise. The very idea of an integrated scheme is to increase cost-effectiveness by combining diffferent services. Thus the same AWW provides pre-school education, nutritional supplement, non-formal health education to women and co-ordinates health services. Keeping these limitations in mind, we can express costs on a per beneficiary basis only in the case of some components, but not in the case of the total resources involved.

The resource involvement, ignoring non-recurring costs for the moment, consists of three main components. The health component composed of salaries for the health staff, medicines and related expenditure on health care. The welfare component mainly consists of salaries for other staff and contingencies at the block and village level. The nutrition component consists only of food costs, which is supposed to be met by the concerned state governments. The cost of the first two components is met by the Central Government. The details of financial allocations for each project as per the revised scheme (1982) are presented here in Table IX. It also indicates costs per beneficiary in each of the three components.

The recurring costs add upto Rs. 1.28 million for each rural project, Rs. 1.40 million for each urban project and Rs. 1 million for each tribal project. Since the population in a tribal project is smaller, the costs are lower. Though the population in rural and urban projects is assumed to be the same, rents have to be paid in the latter. The buildings for anganwadis are provided free by the village panchayats and even where they have to be hired as in the case of buildings for health staff, the rents are lower in rural areas.

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Table IX: Cost estimates of ICDS project (Revised 1982) (Rs. in thousand in each project or block, except in the case of per beneficiary costs which are in rupees)

	Item	Rural	Urban	Tribal
I	Health			
	Salaries for health staff	100	50	70
	Medicines	30	30	15
	Rent	6	24	4 @
	Sub total Health	136	104	89
	per beneficiary per year	Rs. 8.00	Rs. 6.11	Rs.14.60
II	Welfare			
	Salaries	338	358	198
	POL maintenance etc.	30	15	25
	Contingencies for			
	- Anganwadis	18	18	9
	- at block level	5	5	5
	Rent for anganwadis (in urban projects only)	-	144	-
	Sub total welfare	391	540	237
	per beneficiary per year	Rs. 29.35	Rs.38.11	Rs.49.00
III	Nutrition supplement (Food Cost)			
	Children (normal) *	510	510	510
	Expectant & Nursing mothers (normal) *	240	240	158
	Severely malnourished children ** (extra cost over normal)	3	3	2
	Sub total Nutrition	753	753	670
	GRAND TOTAL	1280	1397	996

@ for projects sanctioned upto 81-82 only

Note: These refer only to recurring costs. Non-recurring costs in supplies and equipment are about Rs.200,000 for each Project.

* for 300 days, at the rate of 25 paise per child per day (Rs.75 per year).

** for 45-60 days only (60 days assumed here), the additional food supplement over normal feed costing 35 paise per child per day (Rs.21 in a year). Such children are assumed to be 20% of the normal.

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The lion's share of the total cost goes to the nutrition supplement, which is Rs. 0.75 million per rural or urban project and Rs.0.67 million per tribal project. It amounts to 58 per cent of the total recurring costs in rural projects, 54 per cent in urban projects and 68 per cent in tribal projects.

Assuming that, due to inflation and related factors, the estimated cost by the end of 1985 will be 20 per cent higher and assuming the cost of rural projects to be the average for all projects, the total resource involvement (excluding non-recurring costs) for 1000 blocks by 1985 would only be Rs.1,540 million in 1985. Using 1982 estimates (without the inflation factor) and expressing it as percentage of the average annual plan outlay for the Sixth Plan in the public sector, the recurring costs for operating 1000 ICDS projects would be less than 1 per cent (0.66 per cent to be more precise) of the total budget. As a percentage of Gross Domestic Product in 1979-80, it amounts to a mere 0.13 per cent. One could even legitimately argue that considering the vital role of the ICDS project in stimulating change at the community level and improving the quality of life, as well as the GDP of the country and the committed outlay on planned development, the resources allocated to ICDS are insignificant. There is scope both to extend the coverage of the scheme to more blocks and to allocate more resources for each project to increase its effectiveness in achieving its goals.

As already noted, a cost comparison between different programmes bristles with difficulties, particularly if the costs are calculated on a per beneficiary basis. If the total project cost is considered, the cost of an ICDS project is only marginally higher than the cost of an SNP project, though the former has comprehensive goals. The total cost of an SNP project is estimated by the Planning Commission to be Rs.1.04 million in rural areas, as against Rs. 1.28 million for

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an ICDS rural project. If the data presented by David Sahn* in his report to USAID in 1980 is to be taken as a guide, the cost per project per year in the Tamil Nadu Nutritional Programme is much higher than that of an ICDS project. The Tamil Nadu project cost varied from Rs.11 to 40 million per year.

Apart from recovering some of the costs as proposed above of feeding the children from the community, there are other means of economizing while increasing the effectiveness of ICDS. One would be to restrict the expansion of the programme to the poorest and most backward geographical areas though,in the process, the poor in more developed areas are excluded. Such a policy is justified since the poverty of the individual household is not the only variable determining morbidity and the child's nutritional status.

Environment conditions contribute to the fact that the poor in more developed areas are generally better off than the poor in less developed areas. This is not to suggest that poverty is a regional rather than an inter-personal or inter-class phenomenon, but to note that the spatial dimension of poverty is an important consideration in planning the geographical coverage of child development programmes.

Another consideration is that poverty or hunger is not a constant phenomenon. It has a seasonal character and in lean seasons when employment and even wage levels may be lower, the landless face more hunger. When lean seasons coincide with the wet seasons,the incidence of morbidity is also higher, requiring

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* Sahn, The Integrated Maternal & Child Nutrition Project India: Recommendations based on a review of Past Experiences 1980, p.115.

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more health care and nutritional assistance. Apart from the seasonal factor, there are fluctuations in agricultural conditions which dictate economic conditions. In drought years, enhanced feeding may be needed with corresponding reductions in good years - good both from the point of view of output and market conditions.

Anganwadis are instituted only in villages with a population of 1000 or more. Small villages are not often in a position to provide even the minimal community support required. The scheme thus bypasses small isolated villages which may actually be poorer than larger villages. The importance of size in rural development has been recognized and a cluster approach to rural development is now being tried in India. Attempts must be made to bring the benefits of ICDS to smaller communities.

If the cereals, pulses or other food used for supplementary feeding are locally procured, it would be possible to procure much larger quantities with the same resources. It may also stimulate local production. Bureaucratic rules, however, dictate that foodstuffs must be procured only through a public distribution system. If a local committee is formed to look after anganwadis on an honorary basis, it can be empowered to procure food at the least possible cost, provided the prices in no case exceed the prices offered by the public distribution system. Such a committee can be encouraged to procure food outside the market system, specially meant for anganwadis.

CHAPTER - VI

SUMMARY AND CONCLUSIONS

The ICDS scheme embodies the summation of previous experience in India to promote the welfare of the young child born into socially and economically disadvantaged circumstances. Welfare programmes initiated in the 50's, 60's and 70's have been carefully analyzed to avoid duplication of unsuccessful efforts and to learn from positive experience. A comparison of ICDS with earlier Child Welfare Schemes reflects this effort.

BENEFICIARIES COVERED -- Evaluations of earlier schemes reported the limited coverage of the services. The ICDS is area-based and designed to provide comprehensive coverage to all children in a block with special emphasis on reaching under privileged groups. By the end of the Sixth Plan in 1985, ICDS is expected to provide 10.30 million children with immunization and health check-ups; 6.1 million children and 1.1 million women with supplementary nutrition and 3.4 million mothers with non-formal education classes.

ORGANIZATIONAL STRUCTURE -- Previously, the BDO at the block level was in charge, since his work-load and responsibilities encompassed all aspects of overall rural and agricultural development, child welfare received little attention. In ICDS, the organizational structure was strengthened by providing the posts of CDPO and supervisory staff.

DELINEATION OF RESPONSIBILITIES -- The responsibility for the delivery of health, welfare and other services was not clearly identified at the field level in earlier projects, leading to inadequate delivery of services from other departments, particularly health. This was

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taken into consideration at the planning phase and attempts were made to allocate responsibilities to each department. For instance, the health department provides health inputs and the anganwadi worker is expected to assist the ANM and effect co-ordination at the village level.

FINANCIAL INPUTS -- The provision of medicines, equipment, personnel and other recurring and non-recurring costs were inadequate in earlier schemes. The ICDS inputs were carefully identified and recommended by the eight Study Groups set up by the Planning Commission.

LOCAL RECRUITMENT -- In earlier schemes, a Balsevika with a matriculate qualification and 11 months' training was recruited, and was usually an outsider. In its efforts to keep ICDS community based, the educational qualifications and the period of training were reduced so as to encourage recruitment of local young women. Further, in order to avoid creating a rural bureaucracy with a fixed salary structure (based on governmental rules and regulations), the local field worker is recruited as an honorary worker of the community.

TRAINING -- Training programmes have been designed for every level of functionary. The training for CDPOs and supervisors emphasizes administrative and managerial skills. Anganwadi workers, in keeping with their limited educational background (mostly primary school level), are given substantive training in the areas of child development at locally-run institutions supervised by State Governments and non-governmental organisations.

Trainers/instructors, drawn from established academic institutions also receive special orientation programmes to acquaint them with the areas covered by ICDS. The involvement of academic institutions and departments of medicine has enriched the quality of training and

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further strengthened the commitment of members of the medical profession to community-based child development programmes.

Inservice training is necessary to develop an efficient cadre of child development workers. Refresher courses for supervisors and CDPOs are organised regularly. Anganwadi workers receive periodic re-orientation to update their knowledge and equip them with skills to combat specific problems like infant mortality and morbidity. Currently, new approaches are under investigation to use mass media for community education using the ICDS structure as the focal point.

INVOLVEMENT OF ACADEMIC INSTITUTIONS -- Academic institutions were involved in this scheme from the beginning. At the national level the All India Institute of Medical Science expertise monitor and evaluate the health components of the scheme. At the field level, medical consultants and colleges monitor the progress of specific projects and training of personnel. Home Science colleges and Agricultural Universities are involved in training field level workers.

MONITORING AND EVALUATION -- Accordingly, a baseline survey and a repeat survey have been conducted by the Programme Evaluation Organisation of the Planning Commission. Continuous monitoring and evaluation of the health and nutrition components is done by the AIIMS.

The present assessment is based on a review of randomly selected projects initiated in 1978-79. A comparison with the findings of earlier reviews done by the Planning Commission indicate some positive changes in the five years which separate the two reviews.

One such area is in coverage of the vulnerable 0-3 age group. The PEO repeat survey, based on 1976-78 data, indicated that 35 per cent of the children in the age group 0-3 were covered. The present study

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shows a coverage of 50% for this age group and an over-all coverage of 60% for the 0-6 group as a whole. Of these, 4.5% are identified as malnourished. Estimates of attendance by pregnant and lactating women are not very reliable although there are clear indications that the services only reach the very poor. There is a need to work out the physical targets more accurately at the State level analysing the age composition of the block in order to reach this group and to plan financial inputs more realistically.

HEALTH COVERAGE -- Health coverage generally, and immunization in particular have improved. Before the launching of ICDS, immunization coverage was under 20 per cent in some blocks, in others less than 10 per cent. The present coverage has gone beyond 50 per cent but there is a high drop out rate in vaccinations administered in a series. In tribal and rural blocks vaccines are not available, the visits of the para-medical and medical staff are irregular. Arrangements for referral services in some of the blocks are not made because the workers are not aware of this component and do not know how to make necessary arrangements. The study also found that some of the important drugs are not generally available when needed specially in rural and tribal blocks. In these blocks it was observed that the visits of the medical and para-medical staff were irregular as most of the time they were busy with family planning and other campaigns. Even though severely malnourished children were detected by doctors, there has been no special diet developed for them. The usual food supplement is merely doubled. Some of the medical staff suggested that a budget for medicines should be placed at the disposal of the CDPO to make local purchases since Medical officers had no means to purchase medicines.

PRE-SCHOOL COMPONENT -- The non-formal education component of ICDS functions reasonably well in some areas but is decidedly weak in others.

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Tests administered to children show a normal level of cognitive development. The observed personal hygiene and appearance of the children, however, is generally poor. This is linked with another weakness, namely, the health and nutrition education component. Responses from mothers indicate that although they are aware that health care and immunization are generally "good" , they do not make the vital connection between malnutrition and disease which diminishes the preventive impact of the programme.

COMMUNITY PARTICIPATION -- Community contribution and participation is rather poor. Local participation in developmental programmes has always been low as indicated in evaluations of previous schemes. Ad hoc assistance takes the form of land and buildings, offered by the Panchayats: grain, firewood, or labour offered by families; and help from mothers to the anganwadi workers. The programme is likely to have only limited success unless systematic efforts are made to involve Panchayat Raj Institutions, local communities and beneficiary families in an organised manner. The quality and applicability of training administered to various functionaries, the magnitude of community involvement, the regularity of the delivery of supplementary food, the social and cultural barriers which limit participation by certain castes of beneficiaries, the weak link between the grassroot-level worker and the block-level administration, are a few of the questions raised, to which no conclusive answer can be given in the limited scope of this study.

ATTITUDINAL CHANGE

Although there is a decided change in attitudes at the village level, it is not possible to attribute this solely to the scheme. The discrepancy between the records of births and deaths kept at the

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Anganwadi, the records of the Panchayat and government figures based on national averages, make it difficult to generalize on questions of morbidity and mortality at this stage.

Is ICDS cost-effective? The study (Chapter V) outlines the cost of the scheme based on recurring expenditure per project, comparing ICDS with the project cost of other feeding programmes like SNP, ANP and TNP. Despite a wider range of services and larger coverage, it concludes that ICDS is less expensive. Using 1982 estimates, the estimated operating cost for 1000 ICDS projects is 0.66% of the GDP of India. It concludes that there is scope both to extend the coverage of the scheme, as well as allocate more resources to existing projects.

Annexure - 1

DEMOGRAPHIC DATA

NUMBER OF CHILDREN IN THE AGE GROUP OF 0-3 ENROLLED IN FEEDING PROGRAMME

Type of Project	Total population	Children in the age group 0-3		No. of children enrolled for feeding		S.C. Children enrolled for feeding		S.T.children enrolled for feeding		Other enrolled for feeding	
		Total	%age to the total population	Number	%age to the tot. children	Number	%age to the tot. enrolment	Number	%age to the total enrolment	Number	%age to the total enrolment
RURAL	103167	6123	5.9	2347	38.3	738	31.4	162	6.9	1447	61.7
TRIBAL	37281	2495	6.7	1618	64.8	238	14.7	1069	66.1	311	19.2
URBAN	24947	3099	12.4	1360	43.9	624	45.9	244	17.9	492	36.2
TOTAL	165395	11717		5325	45.4	1600	30.0	1475	27.7	2250	42.2

Annexure - 2

DEMOGRAPHIC DATA

NUMBER OF CHILDREN IN THE AGE GROUP 3-6 ENROLLED IN FEEDING PROGRAMME

Type of project	No.of projects	Tot. population	Children in the age group 3-6		No.of children enrolled for feeding		S.C. children enrolled for feeding		S.T.children enrolled for feeding		Others enrolled for feeding	
			Total	%age to the tot. population	Number	%age to the tot. children	Number	%age to the tot. enrolment	Number	%age to the tot. enrolment	No.	%age to the tot. enrolled
RURAL	6	103167	7671	7.4	3065	39.9	951	31.0	320	10.4	1794	58.5
TRIBAL	4	37281	2950	7.9	1825	70.4	207	11.3	1162	63.7	456	25.5
URBAN	3	24947	2107	8.4	1228	58.3	378	30.8	215	17.5	635	51.7
TOTAL	13	165395	12728		6118	48.1	1536	25.1	1695	27.7	2885	47.1

Annexure - 3

NUMBER OF CHILDREN ATTENDING ANGANWADIS

Type of anganwadi	Tot.No. of children in the age group 0-6	No.of children attending anganwadi 0-6		No. of boys attending anganwadi		No. of girls attending anganwadi		No. of children identified as severely malnourished		
		Number	%age to the tot. attending	Number	%age to the tot. attending	Number	%age to the tot. attending	Boys	Girls	Total No. of children with malnutrition
RURAL	13794	5412	39.2	2955	54.6	2457	45.4	125	111	236
TRIBAL	5445	3443	63.2	1728	50.2	1715	49.8	54	62	116
URBAN	5206	2558	49.7	1363	52.7	1225	47.3	65	85	150
TOTAL	24445	11443	46.8	6046	52.8	5397	47.2	244	258	502

Annexure - 4

ENROLMENT AND ATTENDANCE OF PREGNANT WOMEN

Type of Centre	Number of Pregnant Women Enrolled of which						
	Total	Scheduled Caste		Scheduled Tribe		Others	
		Numbers	Percentage	Numbers	Percentage	Numbers	Percentage
RURAL	1149	318	27.6	300	26.1	531	46.2
TRIBAL	348	46	13.2	224	64.4	78	22.4
URBAN	478	102	21.3	129	26.9	247	51.6
TOTAL	1975	466	23.6	653	33.0	856	43.3

Annexure - 5

PROVISION OF FOOD AT THE CENTRE

Type of Centre	Type of food given at the Centre			Use of local vegetables, fresh vegetables		Number of days		
	Cooked at anganwadi	Ready-to-eat	Others	Used	Not Used	250 days or above	150 to 250 days	Less than 150 days
RURAL	17	21	12	13	40	38	7	8
TRIBAL	33	2	10	8	37	33	12	0
URBAN	14	11	11	9	17	20	6	0
TOTAL	64	37	23	30	94	91	25	8

Annexure - 6

Total number of children enrolled for feeding and the percentage in the age group 0-3

Type of village	Total number of children in the age group 0-6	Total number of children enrolled for feeding	Total number of children enrolled for feeding in the age group 0-3	Percentage of children in the age group 0-3 in the total numbers enrolled for feeding
RURAL	13,794	5,412	2,347	43.36
TRIBAL	5,445	3,443	1,618	46.99
URBAN	5,206	2,588	1,360	52.5
TOTAL	24,445	11,443	5,325	46.53

Annexure - 7

Children in the Age Group 0-3 and 3-6 - Numbers enrolled for feeding

Type of village	Children in the age group 0-3			Children in the Age group 3-6		
	No.of children enrolled for feeding in the age group 0-3	%age of children belonging to S.C. in age group enrolled for feeding 0-3	%age of children belonging to S.T. in the age group enrolled for feeding 0-3	No.of children enrolled for feeding in the age group 3-6	%age of children belonging to S.C. in the age group 3-6	%age of children belonging to S.T. in the age group 3-6
RURAL	2,347	31.4	6.9	3,065	31.0	10.4
TRIBAL	1,618	14.7	66.1	1,825	11.3	63.7
URBAN	1,360	45.9	17.1	1,228	30.8	17.5
TOTAL	5,325	30.0	27.7	6,118	25.1	27.7

BIRTH AND DEATH RATES REPORTED AT CENTRES SURVEYED

		Rural	Tribal	Urban
1.	BIRTH RATES			
	a) Total number of villages/centres reporting	48	37	18
	b) Total population of villages/centres reporting	92437	30657	17275
	c) Total number of births	1390	477	430
	d) Average number of births per village	28.95	12.89	23.89
	e) Birth rate	15.03	15.56	24.89
2.	DEATH RATES			
	a) Total population of villages reporting	92437	30657	17275
	b) Number of villages reporting	42	37	18
	c) Total number of deaths	314	139	42
	d) Average number of deaths per village	7.47	3.76	2.33
	e) Death rate	3.40	4.53	2.43

Annexure - 9

IMMUNIZATION COVERAGE

	No. of villages reporting	41	41	18
1.	Polio			
a)	Number of doses			
	1st dose	2013	1887	669
	2nd dose	1357	1615	534
	3rd dose	935	1062	466
b)	Average			
	1st dose	49.09	46.02	37.17
	2nd dose	33.09	39.39	29.67
	3rd dose	22.80	25.90	25.89
2.	B.C.G.			
a)	No. of doses	1280	810	780
b)	Average	31.22	19.75	43.33
3.	D.P.T.			
a)	No. of doses	2026	868	679*
b)	Average	49.41	21.17	37.72
4.	Vitamin A			
a)	No. of doses	1251	1588	1210
b)	Average	30.51	38.73	67.22

* Break-up of information on three doses not yet available

Annexure - 9

IMMUNIZATION COVERAGE

	No. of villages reporting	41	41	18
1.	Polio			
a)	Number of doses			
	1st dose	2013	1887	669
	2nd dose	1357	1615	534
	3rd dose	935	1062	466
b)	Average			
	1st dose	49.09	46.02	37.17
	2nd dose	33.09	39.39	29.67
	3rd dose	22.80	25.90	25.89
2.	B.C.G.			
a)	No. of doses	1280	810	780
b)	Average	31.22	19.75	43.33
3.	D.P.T.			
a)	No. of doses	2026	868	679*
b)	Average	49.41	21.17	37.72
4.	Vitamin A			
a)	No. of doses	1251	1588	1210
b)	Average	30.51	38.73	67.22

* Break-up of information on three doses not yet available

ATTENDANCE IN FLAW CLASSES

		Rural	Tribal	Urban
a)	Number of villages reporting operation	40	29	18
b)	Number of villages reporting no operation	13	16	8
c)	Total enrolled in 1982	1431	607	305
d)	Average enrolment	35.77	20.93	16.9
e)	Total attendance in July 1982	855	339	264
f)	Average attendance in July 1982	21.37	11.69	14.67
g)	Total attendance in November 1982	908	330	265
h)	Average attendance in November 1982	22.7	11.37	14.72

Annexure -11

OBSERVATION OF THE RESEARCH TEAM AT THE ANGANWADI

Type of Anganwadi	Surroundings		Toilet Facility	
	Clean	Not clean	No. of anganwadi without toilet	No. of anganwadis with toilet
RURAL	33	20	52	1
TRIBAL	29	16	43	2
URBAN	18	8	10	16
TOTAL	80	44	105	19

Annexure - 12

OBSERVATION OF RESEARCH TEAM ON THE PERSONAL HYGIENE OF CHILDREN

Type of Anganwadi	PERSONAL HYGIENE															
	Nails cut				Dress				Cleanliness of Dress				Combing			
	For all	For most	For some	For few	All fully clad	Most fully clad	Some fully clad	Few fully clad	All wore clean dress	Most wore clean dress	Some wore clean dress	Few wore clean dress	All well combed	Most well combed	Some well combed	Few well combed
RURAL	0	19	20	14	10	20	17	6	4	9	16	24	3	16	18	16
TRIBAL	5	13	16	11	2	19	12	12	1	11	16	17	0	11	21	13
URBAN	4	15	5	2	4	14	7	1	2	12	11	1	6	12	8	0
TOTAL	9	47	41	27	16	53	36	19	7	32	43	42	9	39	47	29

Annexure - 13

ASSESSMENT OF COMPREHENSION AND COGNITIVE DEVELOPMENT

Type of anganwadi	Identification of pictures					Story telling, recitation, etc.				
	All of them identify 10	Most of them identify 7-9	Some of them identify 4-6	Few of them identify 1-3	None of them identify 0	All of them do so 10	Most of them do so 7-9	Some of them do so 4-6	Few of them do so 1-3	None of them do so 0
RURAL	4	24	9	14	2	6	22	6	10	9
TRIBAL	1	25	8	7	4	1	23	14	7	0
URBAN	0	14	8	4	0	4	11	9	2	0
TOTAL	5	63	25	25	6	11	56	29	19	9

Annexure - 14

ASSESSMENT OF COMMUNITY PARTICIPATION

Type of anganwadi	Contribution by Panchayats		Nature of contribution by Panchayats							Contribution by Families		Nature of contribution by Families							
	Numbers contributed	Nos. did not contribute	Financial	Land	Building	Equipment	Food Commodities	Firewood	Any other	Numbers contributed	Nos. did not contribute	Financial	Land	Building	Equipment	Food Commodities	Firewood	Labour	Any other
RURAL	29	24	0	10	19	2	0	13	3	35	18	1	0	4	2	9	30	8	0
TRIBAL	22	23	1	19	18	1	2	4	1	19	26	2	0	0	1	2	17	17	0
URBAN	2	24	0	1	2	0	0	0	0	9	17	4	0	0	1	2	1	6	5
TOTAL	53	71	1	30	39	3	2	17	4	63	61	7	0	4	4	13	48	31	5

Annexure - 15

ASSESSMENT OF COMMUNITY PARTICIPATION

Type of anganwadi	Contribution by Individual/ Philanthropists		Nature of contribution by individual/ Philanthropists (No.)							Contributed by voluntary agencies
	Nos.contributed	Nos.did not contribute	Financial	Land	Building	Equipment	Food commodities	Firewood	Any Other	Nos.contributed
RURAL	7	46	0	1	1	0	2	4	2	0
TRIBAL	7	38	1	0	1	0	0	4	1	0
URBAN	0	26	0	0	0	0	0	0	0	0
TOTAL	14	110	1	1	2	0	2	8	3	0

Annexure - 16

CO-ORDINATION COMMITTEES AT VILLAGE LEVEL

Type of Village	Committee set up in village		C O M P O S I T I O N								
	Yes	No	School teacher	Pancha-yat pre-sident	Pancha-yat Member	Village Elders	Mahila Mandal Ladies	Local Women	Social Workers	Pastor	Angan-wadi worker
RURAL	24	29	13	13	14	15	2	8	2	0	24
TRIBAL	20	25	10	16	11	13	2	8	0	3	20
URBAN	13	13	7	0	0	0	9	5	5	0	13
TOTAL	57	67	30	29	25	28	13	21	7	3	57

Annexure - 17

FUNCTIONING OF THE VILLAGE LEVEL COMMITTEE

Type of village	No. of times the committee met in a year					Records Maintained		Follow-up mechanism		Decisions in meetings executed		
	Once	Twice	Thrice	Four to 6 times	More than 6 times	Yes	No	Yes	No	Early	Delayed	Not executed
RURAL	4	2	1	10	7	21	3	20	1	21	3	0
TRIBAL	0	4	0	3	13	12	8	7	5	14	3	3
URBAN	0	0	0	1	12	12	1	6	6	7	6	0
TOTAL	4	6	1	14	32	45	12	33	12	42	12	3

Annexure - 18

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	NUMBER OF CHILDREN			FAMILY PLANNING			OPINION ON THE SIZE OF FAMILY			
	2 & LESS	3-5	5 & ABOVE	IN FAVOUR	NOT IN FAVOUR	NOT AWARE	1 CHILD	2 CHILDREN	3 CHILDREN	4 OR MORE
RURAL										
BENEFICIARY FAMILY	36	74	54	231	34	11	1	53	148	29
PANCHAYAT MEMBERS	0	4	1	18	3	0	0	6	12	0
PANCHAYAT PRESIDENT	0	0	2	8	1	0	0	2	4	2
TRIBAL										
BENEFICIARY FAMILY	41	55	47	95	99	28	2	23	40	30
PANCHAYAT MEMBERS	2	2	2	5	4	8	0	2	3	0
PANCHAYAT PRESIDENT	0	3	4	11	6	3	0	4	6	1
URBAN										
BENEFICIARY FAMILY	15	28	29	84	32	0	2	28	52	2
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0	0
TOTAL										
BENEFICIARY FAMILY	92	157	130	410	165	39	5	104	240	61
PANCHAYAT MEMBERS	2	6	3	23	7	8	0	8	15	0
PANCHAYAT PRESIDENT	0	3	6	19	7	3	0	6	10	3
TOTAL	94	166	139	452	179	50	5	118	265	64

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	KNOWLEDGE OF ICDS				PRESCHOOL EDUCATION		SUPPLEMENTARY NUTRITION		FLAW		VITAMIN A DISTRIBUTION	
	IMMUNIZATION		HEALTH CHECK UP									
	Aware	Not Aware	Aware	Not Aware	Aware	Not Aware	Aware	Not Aware	Aware	Not Aware	Aware	Not Aware
RURAL												
BENEFICIARY FAMILY	276	0	242	34	228	48	269	4	256	20	236	40
PANCHAYAT MEMBERS	20	1	15	5	15	5	21	0	20	0	16	4
PANCHAYAT PRESIDENT	9	0	9	0	5	4	9	0	9	0	9	0
TRIBAL												
BENEFICIARY FAMILY	222	0	177	45	208	14	221	0	211	11	207	15
PANCHAYAT MEMBERS	17	0	9	8	17	0	17	0	17	0	15	2
PANCHAYAT PRESIDENT	20	0	17	3	20	0	20	0	19	1	19	1
URBAN												
BENEFICIARY FAMILY	115	1	85	30	114	1	117	1	115	0	96	19
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL												
BENEFICIARY FAMILY	613	1	504	109	550	63	607	5	582	31	539	74
PANCHAYAT MEMBERS	37	1	24	13	32	5	38	0	37	0	31	6
PANCHAYAT PRESIDENT	29	0	26	3	25	4	29	0	28	1	28	1
TOTAL	679	2	554	125	607	72	674	5	652	32	598	81

Annexure - 20

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	FEEL IMMUNIZATION IS		IMMUNIZATION		
	Good	Not Good	Prevents Diseases	Help growth of child	Others
RURAL					
BENEFICIARY FAMILY	235	7	196	20	19
PANCHAYAT MEMBERS	15	0	15	1	2
PANCHAYAT PRESIDENT	9	0	7	0	2
TRIBAL					
BENEFICIARY FAMILY	176	1	162	12	4
PANCHAYAT MEMBERS	9	0	6	3	0
PANCHAYAT PRESIDENT	17	0	14	4	0
URBAN					
BENEFICIARY FAMILY	83	2	73	14	0
PANCHAYAT MEMBERS	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0
TOTAL					
BENEFICIARY FAMILY	494	10	431	46	23
PANCHAYAT MEMBERS	24	0	21	4	2
PANCHAYAT PRESIDENT	26	0	21	4	2
G-TOTAL	544	10	473	54	27

Annexure - 21

VITAMIN A AND IRON AND FOLIC ACID
DISTRIBUTION AND SUPPLEMENTARY NUTRITION

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	PRG. INCLUDES VITAMIN & IRON DISTRIBUTION		IF YES PROGRAMME				PRG.		IF YES PROGRAMME		
			HELPS PREVENT BLINDNESS	HELPS GROWTH	PREVENTS DISEASES	OTHERS	INCLUDES SUPP. NUTRN.		HELPS GROWTH	PREVENTS DISEASES	OTHERS
	Yes	No					Yes	No			
RURAL											
BENEFICIARY FAMILY	149	87	62	29	38	19	268	1	155	20	88
PANCHAYAT MEMBERS	10	6	5	0	2	3	21	0	0	1	11
PANCHAYAT PRESIDENT	4	5	1	0	3	0	8	1	4	0	4
TRIBAL											
BENEFICIARY FAMILY	118	89	45	30	40	2	221	0	166	32	21
PANCHAYAT MEMBERS	7	8	2	2	3	0	17	0	14	3	0
PANCHAYAT PRESIDENT	15	4	3	9	3	0	20	0	16	2	2
URBAN											
BENEFICIARY FAMILY	78	18	24	32	20	2	116	1	83	27	4
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0	0	0
TOTAL											
BENEFICIARY FAMILY	345	194	131	91	98	23	605	2	404	79	113
PANCHAYAT MEMBERS	17	14	7	2	5	3	38	0	23	4	11
PANCHAYAT PRESIDENT	19	9	4	9	6	0	28	1	20	2	6
G-TOTAL	381	217	142	102	109	26	671	3	447	85	130

Annexure -22

PRE-SCHOOL EDUCATION AND FLAW

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	PROGRAMME INCLUDES PRE-SCHOOL EDUCATION		IF YES PROGRAMME			PROGRAMME INCLUDES FLAW		IF YES PROGRAMME			
			HELPS MENTAL GROWTH	HELPS OTHERS EDUCATION				HELPS LEARNING	FLAW HELPS OBTAIN SKILLS	HELPS OTHERS ACQUIRE KNOWLEDGE	
	Yes	No				Yes	No				
RURAL											
BENEFICIARY FAMILY	256	7	40	188	26	148	108	71	29	30	21
PANCHAYAT MEMBERS	21	0	4	11	6	11	10	1	2	5	3
PANCHAYAT PRESIDENT	6	1	1	4	1	3	4	0	0	1	2
TRIBAL											
BENEFICIARY FAMILY	216	2	57	152	4	113	98	52	35	23	3
PANCHAYAT MEMBERS	17	0	4	13	0	12	5	3	7	1	0
PANCHAYAT PRESIDENT	20	0	8	12	0	6	13	2	2	4	0
URBAN											
BENEFICIARY FAMILY	112	5	43	71	0	94	27	33	30	30	2
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0	0	0
TOTAL											
BENEFICIARY FAMILY	584	14	140	411	30	355	233	156	94	83	26
PANCHAYAT MEMBERS	38	0	8	24	6	23	15	4	9	6	3
PANCHAYAT PRESIDENT	26	1	9	16	1	9	17	2	2	5	2
G. TOTAL	648	15	157	451	37	387	265	162	105	94	31

Annexure - 23

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING - COMMUNITY PARTICIPATION

	BENEFICIARY WOULD LIKE TO HELP THE PROGRAMME		HELP THE PROGRAMME THROUGH CONTRIBUTION OF			
	Yes	No	Grains	Firewood	Vegetables	Labour
RURAL						
BENEFICIARY FAMILY	150	115	45	113	11	106
PANCHAYAT MEMBERS	15	4	9	13	2	11
PANCHAYAT PRESIDENT	7	2	4	6	2	2
TRIBAL						
BENEFICIARY FAMILY	113	107	13	75	7	70
PANCHAYAT MEMBERS	13	4	0	9	0	13
PANCHAYAT PRESIDENT	9	11	0	7	1	6
URBAN						
BENEFICIARY FAMILY	75	46	28	8	24	68
PANCHAYAT MEMBERS	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0
TOTAL						
BENEFICIARY FAMILY	338	268	86	196	42	244
PANCHAYAT MEMBERS	28	8	9	22	2	24
PANCHAYAT PRESIDENT	16	13	4	13	3	8
G. TOTAL	382	289	99	231	47	276

Annexure - 24

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING: HEALTH STATUS

	CHILD FELL ILL DURING LAST 15 DAYS		IF YES				TYPE OF SICKNESS		
	Yes	No	1 day	2 days	3-5 days	More than 5 days	Fever	Diarrhoea	Respiratory Ailments
RURAL									
BENEFICIARY FAMILY	97	178	14	18	32	35	204	148	116
PANCHAYAT MEMBERS	3	11	0	1	0	2	11	4	8
PANCHAYAT PRESIDENT	0	6	0	0	0	0	2	1	2
TRIBAL									
BENEFICIARY FAMILY	70	149	17	20	18	18	140	84	104
PANCHAYAT MEMBERS	2	10	0	2	0	0	4	2	3
PANCHAYAT PRESIDENT	2	12	0	1	0	1	9	5	6
URBAN									
BENEFICIARY FAMILY	34	87	7	8	8	11	79	63	95
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0
TOTAL									
BENEFICIARY FAMILY	201	414	38	46	58	64	423	295	375
PANCHAYAT MEMBERS	5	21	0	3	0	2	15	6	11
PANCHAYAT PRESIDENT	2	12	0	1	0	1	9	5	6
G.TOTAL	208	447	38	50	58	67	447	306	392

Annexure - 25

OPINION OF BENEFICIARIES ON ICDS AND ITS FUNCTIONING

	Child fell ill during the last one year	IF YES, THAN THE TYPE AND INCIDENCE OF ILLNESS											
		FEVERS				DIARRHOEA				RESPIRATORY AILMENTS			
		On-ce	Tw-ice	Th-rice	More than 3 times	On-ce	Tw-ice	Th-rice	More than 3 times	On-ce	Tw-ice	Th-rice	More than 3 times
RURAL													
BENEFICIARY FAMILY	240	57	56	31	61	40	46	34	29	27	51	42	58
PANCHAYAT MEMBERS	11	2	4	2	3	2	0	2	0	2	0	2	4
PANCHAYAT PRESIDENT	2	0	0	0	2	0	0	0	1	0	0	1	1
TRIBAL													
BENEFICIARY FAMILY	169	66	35	25	20	25	34	15	13	34	32	20	21
PANCHAYAT MEMBERS	5	4	0	0	0	0	1	0	1	2	0	0	1
PANCHAYAT PRESIDENT	10	6	3	0	0	3	1	1	0	5	1	0	0
URBAN													
PANCHAYAT MEMBERS	0	0	0	0	0	0	0	0	0	0	0	0	0
PANCHAYAT PRESIDENT	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL													
BENEFICARY FAMILY	516	139	123	75	93	80	91	65	62	73	117	94	96
PANCHAYAT MEMBERS	16	6	4	2	3	2	1	2	1	4	0	2	5
PANCHAYAT PRESIDENT	12	6	3	0	2	3	1	1	1	5	1	1	1
G.TOTAL	544	151	130	77	98	85	93	68	64	82	118	97	102

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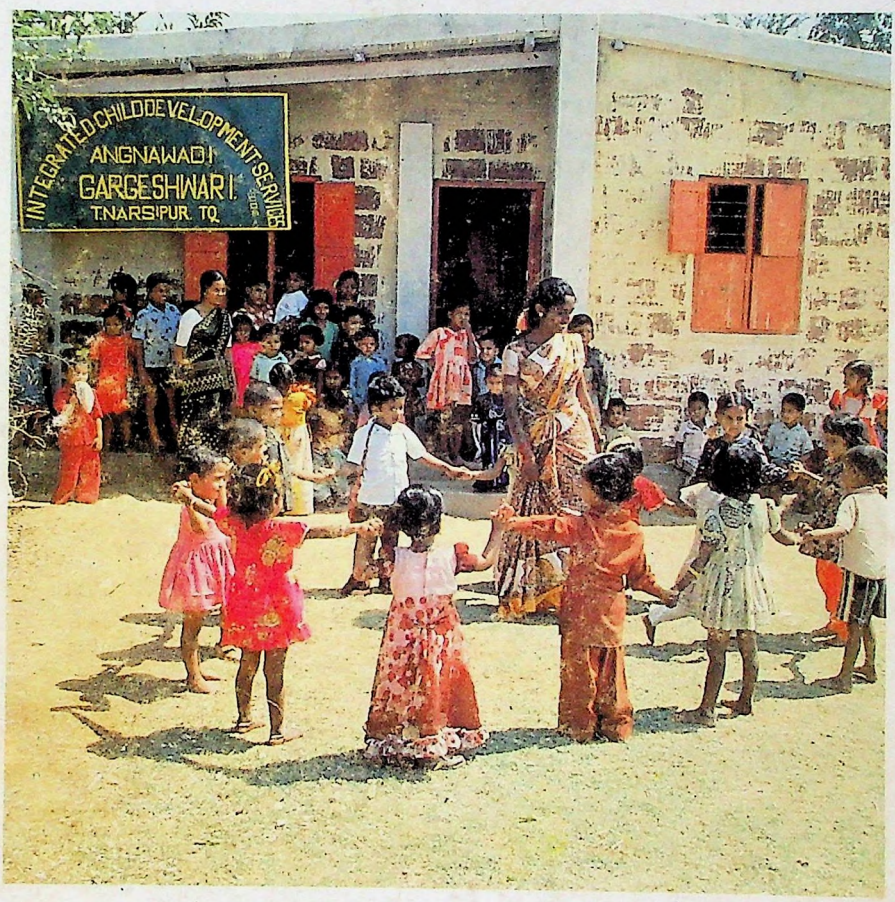
INTEGRATED CHILD DEVELOPMENT SERVICES

AN ASSESSMENT



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