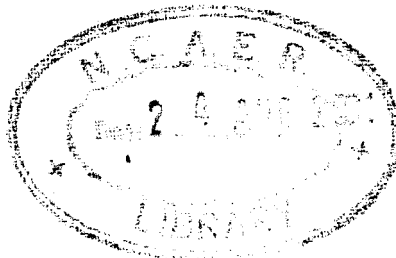


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The Integrated Child Development Services Lessons from a Pilot Study

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ABSTRACT

This paper reports the results of a pilot study aimed at evaluating the performance of the ICDS programme. The study is based on a field survey conducted in 1996 in ten selected blocks in five states comprising 1362 anganwadi centres, 2700 beneficiary households, 10 CDPOs and 40 circle supervisors. The analysis employs a set of indicators classified under five major heads viz. Infrastructure at the anganwadi centres, profile of the anganwadi functionaries, functioning of anganwadi centres, utilisation of ICDS services, and community participation.

According to the survey results, low levels of anganwadi infrastructure, inadequate training of workers, poor maintenance of growth monitoring charts, inadequate availability of equipment and medical kits, irregular food supplies, and health check-ups, limited immunisation coverage, and poor community response are found to be responsible for poor utilisation and delivery of services. However, both literacy levels and training of anganwadi workers are seen to contribute to better delivery of ICDS services.

The study also indicates that for better community participation the awareness levels in the community needs to be further improved. While the component of nutrition & health education seems to be working well, it seems to have had little impact in translating knowledge into action.

The policy implications of this study, therefore, are quite clear. With a view to achieving a steady decline in the incidence of malnutrition among children, particularly among certain socially and economically disadvantaged groups, basic infrastructure at anganwadi centres and training of functionaries must be strengthened, besides ensuring regular supplies of food and other inputs and eliciting active participation of the community.

The above conclusions are based on a rather small sample and can at best be treated as tentative.

JEL Classification

J130, 8410, 9110

Keywords

Anganwadi; Child development; Mother's health; Supplementary nutrition;
Pre-school education; Immunisation; Growth monitoring; Nutrition;
Health; Community participation and Malnutrition

environment in which children grow and nor does it automatically lead to better health and nutrition of children. The link between health status, educational achievement, productivity and perpetuation of the vicious cycle of malnourished mothers delivering low birth weight and weak babies was recognised. This was a determining factor in favour of launching a nutrition based programme for children.

The National Policy for Children " provided a framework for assigning priorities to different needs of children (both before and after birth) for responding to them in an integrated manner. Integrated Child Development Services (ICDS) is India's response to the challenge of meeting the holistic needs of the child....." (DWCD, GOI, 1995-96). The ICDS was launched with cautious optimism on October 2, 1975 in 33 blocks spread in 22 states and Delhi. This programme has now been universalised and is one of the largest outreach programmes in the country covering 5614 development blocks including 310 urban and 733 tribal projects:

Box 2 : Objectives of ICDS

ICDS is designed to promote holistic development of the children under six years, through the strengthened capacity of caregivers and communities and improved access to basic services, at the community level. The programme is specifically designed to reach disadvantaged and the low income groups, for effective disparity reduction with the following objectives :

- ◆ Improve the nutritional and health status of children below the age of six;
- ◆ Lay the foundation for the proper psychological, physical and social development of the child;
- ◆ Reduce the incidence of mortality, morbidity, malnutrition and school dropouts;
- ◆ Achieve effective co-ordination of policy and implementation among various departments to promote child development;
- ◆ Enhance the capability of the mother to look after the health and nutritional needs of the child, through proper health and nutritional education;
- ◆ Care of essential needs of pregnant women and nursing mothers of the weaker sections of the society.

Source: Annual Report 1995-96, Department of Women and Child Development, MHRD, GOI.

OPERATIONALISING ICDS

The Anganwadi Centre (AWC) managed by the *Anganwadi Worker* (AWW) along with her helper (AWH) is the single window for the delivery of the entire package of services offered by the programme. On the average one AWC covers a population of one thousand (seven hundred in rugged terrain and tribal tracts) and caters to children under 6 years, and women in the 15 to 45 years age group with special focus on pregnant women and lactating mothers. In early nineties, a special programme to address the needs of adolescent girls between 11-18 years was also started in over five hundred blocks.

Table 1: Package of Services

Children 6-12 months & 1-3 years	Children 3-6 years	Women 15-45 years especially pregnant & lactating mothers	Adolescent girls 11-18 years
1. Supplementary Nutrition	Supplementary Nutrition	Supplementary Nutrition	Supplementary Nutrition
2. Health check up	Health check up	Health check up	Health check up
3. Immunisation	Immunisation	Immunisation	---
4. Referral	Referral	Referral	Referral
5. Growth promotion	Growth promotion	Growth promotion	Growth promotion
6. Vitamin A drops	Vitamin A drops	Vitamin A tablets	Vitamin A tablets
7. Iron-folic supplement	Iron-folic supplement	Iron-folic supplement	Iron-folic supplement
8. ---	Non-formal pre-school education	Nutrition & Health education	Nutrition & Health education
9. ---	---	Antenatal & postnatal care	Literacy, recreation, skill development

To tackle nutritional deficiencies among women and children, nutritional supplements are provided in the form of cooked hot meals and in some cases 'Ready to Eat' (RTE) foods.

BOX 3 : Nutritional Composition of Supplements

- 300 calories, inclusive of carbohydrates, fats; and 10-12 gms of protein for children up to 6 years
- 500 calories and 20-25 gms of protein to pregnant women, nursing mothers, and adolescent girls
- Delivery of Vitamin A and Iron and Folic Acid supplements through the Primary Health Centres.
- Supply of double ration to severely malnourished cases.

ICDS programme facilitates provision of various health care services for children and ante and postnatal care to women. Child health care component consists of

- growth monitoring,
- health check-up,
- identification of at-risk cases,
- treatment of minor diseases,
- de-worming,
- prophylactic measures and referrals of serious health cases,
- Immunisation such as BCG, DPT, OPV, Measles, Typhoid, (and tetanus for pregnant mothers) is provided by the ANMs at the AWCs on scheduled days.

The AWCs receive the medical kits containing the basic medicines from the Child Development Project Officers. Children with serious health problems are referred to the nearest PHC or hospital. The growth monitoring and promotion component of the ICDS is aimed at early identification of malnutrition and its removal. Children below three years are weighed once a month and children between 3-6 years on a quarterly basis. 'Weight for age cards' are maintained for all children, and special care is taken of malnourished and at-risk cases.

Early Childhood Care and Pre-school Education is a unique ICDS component for promoting social, emotional, cognitive, physical and aesthetic development of the child in the 3-6 age group through play-way activities at the AWC for three to four hours. Besides this, the

Nutrition and Health Education component aims to provide effective communication of certain basic health and nutrition messages to women aged 15-45 years, with a view to increasing the mother's awareness about the needs of her child.

Location of ICDS

Each community development block has a Child Development Project Office and is the basic administrative unit of the ICDS. Each block covers a population of nearly one lakh, spread over 100 villages in rural non tribal areas and a population of 35,000 spread over 50 villages in tribal areas. In practice however, the actual number of anganwadi centres differs from project to project due to density of population, topography, communication, and other logistic considerations.

ICDS Monitoring and Evaluation

ICDS has been the subject of numerous evaluation studies (CARE-USAID 1994). Mention may be made of the studies conducted by Tandon (1981, 1989), Gujaral (1991), Thankappan et al. (1990) and Gokhale et al. (1992). Yet these empirical studies usually focussed on either small/specific regions, or on smaller sample sizes, or on selected components of the ICDS. The only detailed report at the national level is prepared the NIPCCD (National Institute of Public Co-operation and Child Development, New Delhi) survey of 1992. A sample survey of 100 ICDS projects was undertaken in 1992 for the above mentioned study, comprising 54 rural, 28 tribal and 18 urban projects. A multi stage random sampling technique was used to select seven AWCs from each of the project included for the study.

The National ICDS Management Information System (MIS) facilitates analysis of the periodic work reports like the Monthly Monitoring Report (MMR), and the Monthly Progress Report (MPR) by a central cell established by the Department of Women and Child Development (DWCD).

The Central Technical Committee of the Integrated Mother and Child Development (CTC, 1990) follows the principle of functional monitoring of the health and nutrition so as to systematically review the performance and solve the problems viz. evaluation, continuing education and supportive supervision of the functionaries at different levels of the organisation, enhancing motivation and greater commitment of the functionaries for woman and child development.

OBJECTIVES OF THE PILOT STUDY

As a prelude to a nation wide census of the ICDS projects, the DWCD and the Council decided to carry out a pilot study in order to

- a) identify problem areas and possible obstacles in the way of data collection and analysis and consequently,
- b) sharpen its methodology and questionnaire design to maximise efficiency, and
- c) ensure that the resources invested in the nation-wide study would help in making the ICDS more responsive to the needs of the people.

Given the importance of ICDS programme on child welfare the ICDS programme is characterised by an in-built monitoring system for promoting assessment, analysis and action at different levels, the DWCD and the Planning Commission felt the need for a nation wide evaluation of the programme. It was thought that this benchmark is necessary to generate base line data on some basic indicators on quality, outreach and the range of services being offered on the ground. Using the first round as the base, it was felt that subsequent annual or biannual census would help in monitoring the programme more effectively.

METHODOLOGY AND DATA INSTRUMENTS OF THE PILOT STUDY

Questionnaires for the Pilot Survey were designed at four levels:

- The Anganwadi Questionnaires
- The Beneficiary Household Questionnaires
- The Supervisor (Mukhya Sevika) Questionnaires
- The Child Development Project Officer Questionnaire (CDPO)

Separate questionnaires were designed for the rural and urban areas. The draft questionnaires were discussed with the DWCD in detail as well as pre tested in the field before their finalisation.

Responses that were recorded all through the interview were obtained through:

- Individual face to face interviews with the respondents;
- Review of records maintained by the AWWs, AWHs, Supervisors and the CDPOs; and
- Observations of the interviewer at the time of the survey.

Sampling Design of the Pilot Survey

The sample for the Pilot Survey that commenced in July 1996 was drawn from ten ICDS blocks spread over five districts in the five states of Gujarat, Himachal Pradesh, Karanataka, Uttar Pradesh and West Bengal. These represented respectively the West, Hilly Area, South, North and East regions of the country. In each state one district was selected randomly, and two blocks from the same district was surveyed for primary investigation. Table 2 provides a list of selected districts and type of blocks surveyed. Three tribal blocks were chosen to study the impact of the programme in the poorly developed regions. A brief profile of the sampled districts is presented in Annexure 1.

Table 2: Types of Blocks Selected

State (District)	Name of Block	Block type
Gujarat (Jamnagar)	I. Bhanwad	Non-tribal
	II. Kalyanpur	State sector scheme
Himachal Pradesh (Shimla)	I. Chopal	Non-tribal
	II. Rampur	Non-tribal
Karnataka (Kolar)	I. Chickballapur	State sector scheme
	II. Srinivaspura	Non-tribal
Uttar Pradesh (L. Kheri)	I. Bankeyganj	Non-tribal
	II. Nighasan	Tribal
West Bengal (Darjeeling)	I. Kharibari P.	Tribal
	II. S. Naxalbari	Tribal

During the pilot survey all the AWCs in the selected blocks were surveyed and their functionaries interviewed.

The sample of beneficiary households was drawn in consultation with the Anganwadi worker. In all two beneficiary households were selected from each anganwadi centre. The information from the sample households and anganwadis was collected with the help of questionnaires designed for the purpose, which were canvassed by well trained investigators.

Table 3: Sample size for the Pilot Survey

Respondents	Gujarat		H.P.		Karanataka		U.P.		W.B.		Total
	Block		Block		Block		Block		Block		
	I	II	I	II	I	II	I	II	I	II	
AWCs											
Sanctioned	106	120	181	137	168	168	96	142	178	108	1404
Functional	96	116	178	137	165	165	94	131	177	105	1364
Dysfunctional	10	4	3	0	3	3	2	11	1	3	42
%Dysfunctional	9.4	3.3	1.7	0	1.8	1.8	2.1	7.7	0.6	2.8	3.0
CDPO's	1	1	1	1	NA	1	NA	NA	1	1	7
Supervisors	3	5	NA	6	NA	1	3	1	8	7	34
Beneficiary Households	186	230	342	274	334	323	190	262	351	208	2700

Note: AWC that has been sanctioned and had been functioning and reporting, but was officially found to be shut down at the time of the survey for a period of fifteen days or more has been classified as dysfunctional.

Data Issues

During the survey, the field investigators raised a number of issues having a bearing on the data quality. Some of these are:

- ◆ Prior notice to the CDPO as well as the AWC functionaries about the interview date, resulting in the AWCs being swept clean, children lined up and the records updated; besides, the AWWs ensuring that nearly all the AWCs remaining open on the day of field visit.
- ◆ No mechanism to cross check the information given by the AWW.
- ◆ The responses to the household questionnaire revealed that most of the women beneficiaries were hesitant to reveal the true facts.

MAJOR FINDINGS OF THE PILOT STUDY

The major findings of the study are discussed below under the following heads :

1. Types of Amenities at the Anganwadi Centres.
2. Profile of AWC Functionaries.
3. Functioning of the AWC, Enrolment Criteria and Attendance.
4. Delivery and Utilisation of Services :
 - (i) Supplementary Nutrition
 - (ii) Growth Monitoring and Promotion
 - (iii) Health Check-ups, Referrals and Immunisation
 - (iv) Early Childhood Care and Pre-school Education (ECCE)
 - (v) Nutrition and Health Education.
5. Degree of Community Participation.

1. Types of Amenities at the Anganwadi Centres

The physical environment and the scale of amenities of the location (village/slum), within which the AWC operates, is an important determinant of the functional effectiveness of the AWC. During the Pilot Survey, an assessment of the ground realities in terms of location of the AWC, village amenities and infrastructure base was made in order to identify the **physical constraints** under which the AWCs functions across the country. Table 4 gives an idea about the status of physical infrastructure available to the surveyed anganwadi centres.

Table 4: Infrastructure, Building and Other Facilities

Item	Mean	Range	
		Minimum	Maximum
Number of Sanctioned AWC	140.4	96 Bankeyganj, UP	178 Kharibari, WB
Percentage of Dysfunctional AWC	3.0	0 Rampur, H.P.	7.7 Bhanwad, GJ
Number of Working days/month	24.7	23.1 Kharibari, WB	26.1 Bankeyganj, UP
Percentage of AWCs in <i>Pucca</i> Building In Own Building	34.4	12.4 Kharibari, WB	60.0 Chickballarpur, KJ
	31.5	6.4 Bankeyganj, UP	67.3 Kharibari, WB
Percentage having toilet facility	12.8	0 Bankeyganj, UP	35.8 Chickballarpur, KJ
Percentage having adequate:	17.5	0 Bankeyganj, UP	60.3 Kalyanpur, GJ
Cooking space			
Storage space	20.2	0.8 Nighasan, UP	43.0 Kalyanpur, GJ
Playing area	34.5	14.3 Kharibari, WB	62.8 Kalyanpur, GJ
Indoor space	40.6	10.7 Naxalbari, WB	64.5 Kalyanpur, GJ
Percentage having access to drinking water source (water tap & hand pump)	73.2	41.8 Kharibari, WB	100.0 Bankeyganj, UP
Distance to water source (meters)	132	8 Nighasan, UP	330 Kalyanpur, GJ

While the AWCs in the sample blocks of Gujarat, and Karanataka are relatively well placed in terms of the village amenities, this is not the case in AWCs in Northern West Bengal where amenities were found to be inadequate. Besides, the blocks of Gujarat, Himachal Pradesh and West Bengal are also prone to floods and droughts and report the highest incidence of diseases, particularly diarrhoea and dysentery, requiring special attention of the AWC services to tackle this problem.

During the Pilot Survey about 97% of the AWCs were found open, and only 3% dysfunctional/non-operational. The closure of

AWCs could be the result of such factors as irregular food supply, exhaustion of the food supplement, poor quality of food supplement, non-availability of fuel, non-availability of the AWW, natural disasters, social conflict and tension, etc.

The **infrastructure base** of the sample AWCs revealed a grim picture across the five states. About half of the AWCs operated in the open space; and only about one-third of the AWCs were housed in *pucca* buildings. Further, AWWs are generally dissatisfied with the AWC facilities such as building, space for playing/storage, and provision of training materials. Uttar Pradesh and West Bengal blocks are at a disadvantage compared to the blocks of Gujarat and Karanataka regarding the AWC infrastructure. Table 4 also reveals the extent of wide inter-block variations in infrastructure, building and other facilities. Adequate cooking or storage space was a major problem area as was the availability of toilet facilities (only 12.8 per cent on the average have toilet facilities).

Table 5 provides an idea of the position of inventories and supplies in the surveyed AWCs and brings out the disparity among the ten sample blocks. Overall, the supply of the learning kit, medical kit and Nutrition and Health Education (NHE) message materials were found to be quite poor across all blocks.

Table 5: Inventories and Supplies

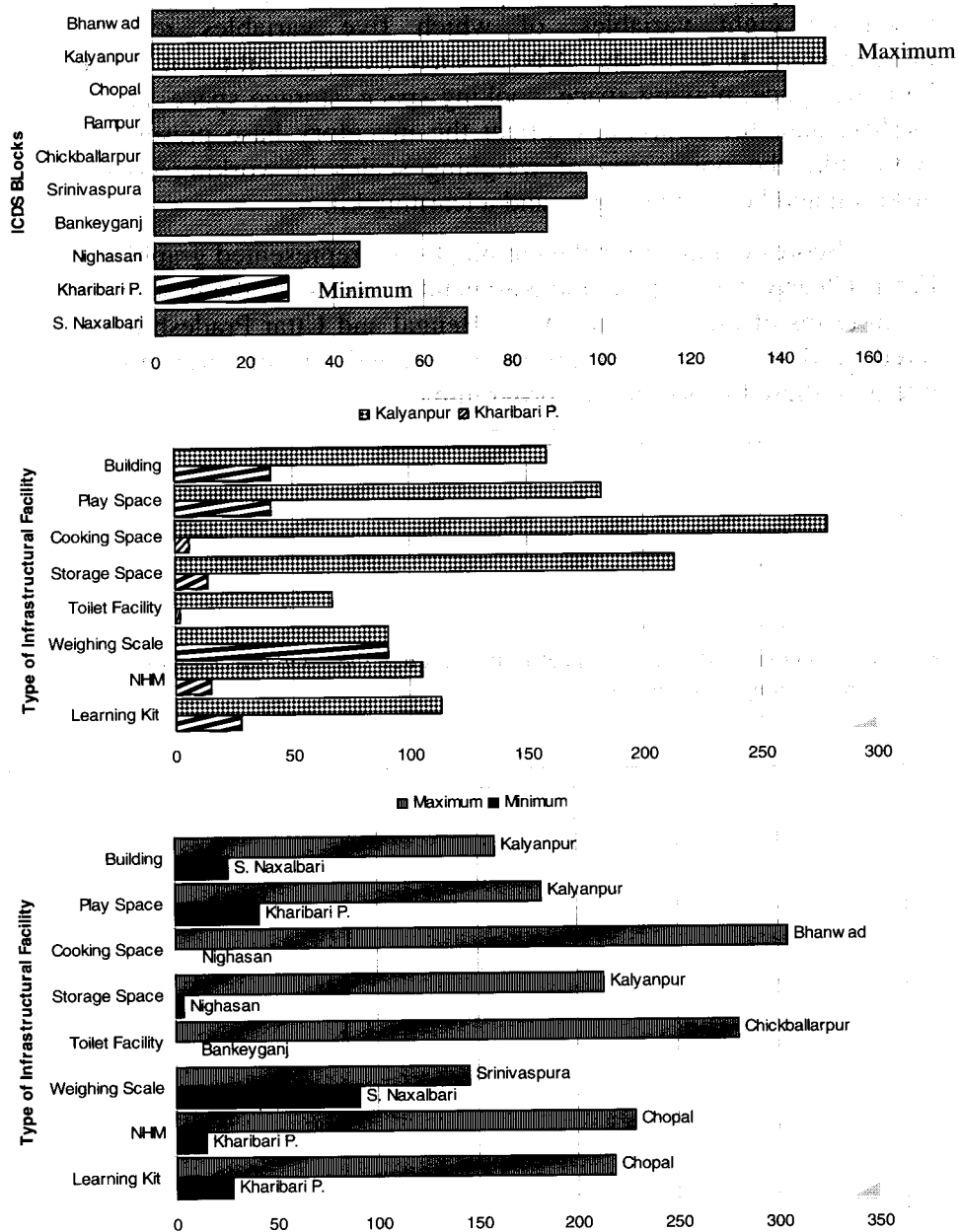
Item (Percentage of AWCs)	Mean	Range	
		Minimum	Maximum
AWCs having weighing scale	87.0	53.5 Chickballarpur, KR	98.2 Naxalbari, WB
AWCs having salter scale in working conditions	79.7	34.1 Bankeyganj, UP	96.1 Rampur, H.P
AWCs which did not have medical kit	21.0	100.0 Chickballarpur, KR	1.1 Bankeyganj, UP
AWCs having an adequate NHE message materials	26.1	3.9 Kharibari, WB	59.6 Chopal, H.P
AWCs having an adequate learning kit	19.8	5.5 Kharibari, WB	43.2 Chopal, H.P
AWCs maintaining growth registers	61.5	0.8 Nighasan, UP	89.8 Kharibari, WB
AWCs having prepared a community growth chart	29.3	3.1 Nighasan, UP	60.5 Rampur, H.P

An attempt was made to assess the relative positions of the ten sample blocks in terms of their infrastructure and other inventories at the AWC, by constructing a composite index.*The composite index is based on eight variables, of which five variables reflect the infrastructure base of the AWCs such as availability of adequate building space, playing space, cooking space, storage space, and toilet facility; and three variables reflect the inventory base present in the AWC like the possession of weighing scales in working condition, nutrition and health messages, and a learning kit.

Scores obtained for the ten blocks are represented graphically in Fig 1. Clearly, the Gujarat and Karanataka blocks are the best provided for in terms of infrastructure. West Bengal and Uttar Pradesh have not fared well and concerted efforts are called for in order to better integrate these blocks into the programme.

-
- The composite index has been calculated through the standardisation of the overall average of each indicator.

Figure 1: Variations in Infrastructural Facilities



2. Profile of AWC Functionaries

The AWC plays a pivotal role in the delivery of services under the ICDS programme. The anganwadi worker is the key person delivering these services to the beneficiaries. The AWW is wholly responsible for enrolling all women and children eligible for the programme, delivering the various services regularly and maintaining a record of all the activities carried out on a daily basis. The AWW is assisted in her day to day activities by a helper. Both these functionaries are voluntary workers selected from the local community and are paid honorarium for their services. A key determinant of the effectiveness of the ICDS programme is the performance of its functionaries, particularly those who maintain grass root level contact with the beneficiaries.

- ◆ The pilot survey reflected that a significant proportion of AWWs about 38 per cent were non-residents of the serving village. In the two blocks of West Bengal, two-thirds or more of the AWWs and almost half of the AWHs came from the neighbouring areas. Further, a considerable proportion of these functionaries came from a distance of over 5 km. These factors may adversely affect the functioning of the AWCs.
- ◆ Another determinant of the effective functioning of an AWC can be the literacy level of the AWW/AWH. The educational qualification as prescribed by the DWCD,GOI, is a matriculation for AWWs and up to primary for the AWHs. Though, nearly all the AWWs were found to be literate, only half were matriculates. Further, 40% of the AWHs were not even literate. This clearly indicates that the higher levels of education need to be aspired for while recruiting AWC functionaries wherever practically possible. In West Bengal and Himachal Pradesh, AWWs were found to be better educated as compared to the rest of the sampled blocks. However, it must be noted that performance of the West Bengal AWCs has been far from satisfactory. This clearly indicates that the education level of the AWW alone cannot ensure a truly productive and efficient functioning of

the centre. There are a host of other factors and circumstances, which together determine the overall performance of the AWC. This shall perhaps be brought out better in the main study.

- ◆ Survey data on health status reveals that most of AWWs and AWHs are in good health and are not suffering from any major diseases or having any physical disability.
- ◆ Their marital status reflects that most of the functionaries were currently married, though the incidence of widows/divorcees/those separated from their spouses was high in the case of AWHs. This difference in status between AWWs and AWHs is best explained by the higher age distribution of the AWHs.
- ◆ A rather disturbing revelation was that a large proportion of the grass-root functionaries did not attend any of the ICDS training programmes, either pre-service or refresher or both. About 40 per cent of the AWWs were found to be without any training; another 39 per cent had only been trained once (orientation training). This implies that only one out of five of the AWWs across the five states has received adequate training (orientation as well as refresher). The situation was much worse with regard to AWHs where only 9 per cent of them had received some training. Table 6 presents findings with respect to the profiles of the AWC workers and helpers comparing across functionaries as well as blocks.

Table 6: Profile of Anganwadi Workers and Helpers

Characteristics	Mean	Range	
		Minimum	Maximum
Percentage In-position :	96.1	93.9	100.0
AWW		Srinivaspura, KR	Nighasan, UP
AWH	93.6	81.9	99.0
		Kalyanpur, GJ	Naxalbari, WB

(Contd.)

Table 6 (Contd.)

Percentage of SC & ST : AWW	24.4	10.1 Chopal, H.P	61.6 Kharibari, WB
AWH	29.8	15.2 Chopal, H.P	70.6 Kharibari, WB
Percentage of widowed, divorced & separated:	5.8	0.6 Srinivaspura, KR	13.6 Bhanwad, GJ
AWW	15.5	4.0 Chopal, H.P	28.7 Bankeyganj, UP
AWH			
Percentage literate only up to primary school:	9.1	1.9 Naxalbari, WB	32.8 Kalyanpur, GJ
AWW	77.7	35.0 Naxalbari, WB	91.0 Srinivaspura, KR
AWH			
Percentage who had no training:	39.7	22.0 Kharibari, WB	73.0 Chopal, H.P
AWW	91.0	70.8 Bhanwad, GJ	99.0 Naxalbari, WB
AWH			

Two separate composite indices have been constructed for AWWs and AWHs in order to rank the ten sample blocks in terms of the characteristics of the functionaries by taking four variables into consideration, viz. age up to 30 years, educational level (matriculate for AWWs and primary or above for AWHs), residence within the village, and training experience.

Figures 2 & 3 present the scores of the ten blocks for AWWs and AWHs. The AWWs of the Srinivaspura block of Karanataka occupies the first position followed by the Uttar Pradesh blocks and Rampur of Himachal Pradesh. Kharibari P. (West Bengal), Chickballarpur (Karanataka) and Kalyanpur (Gujarat) score the lower ranks. It is interesting to note a wide contrast within the same district, between the two blocks of Karanataka-while Srinivaspura is rated the best block, Chickballarpur ranks a lowly eighth.

Figure 2: Variations in Socio-economic Background of AWW

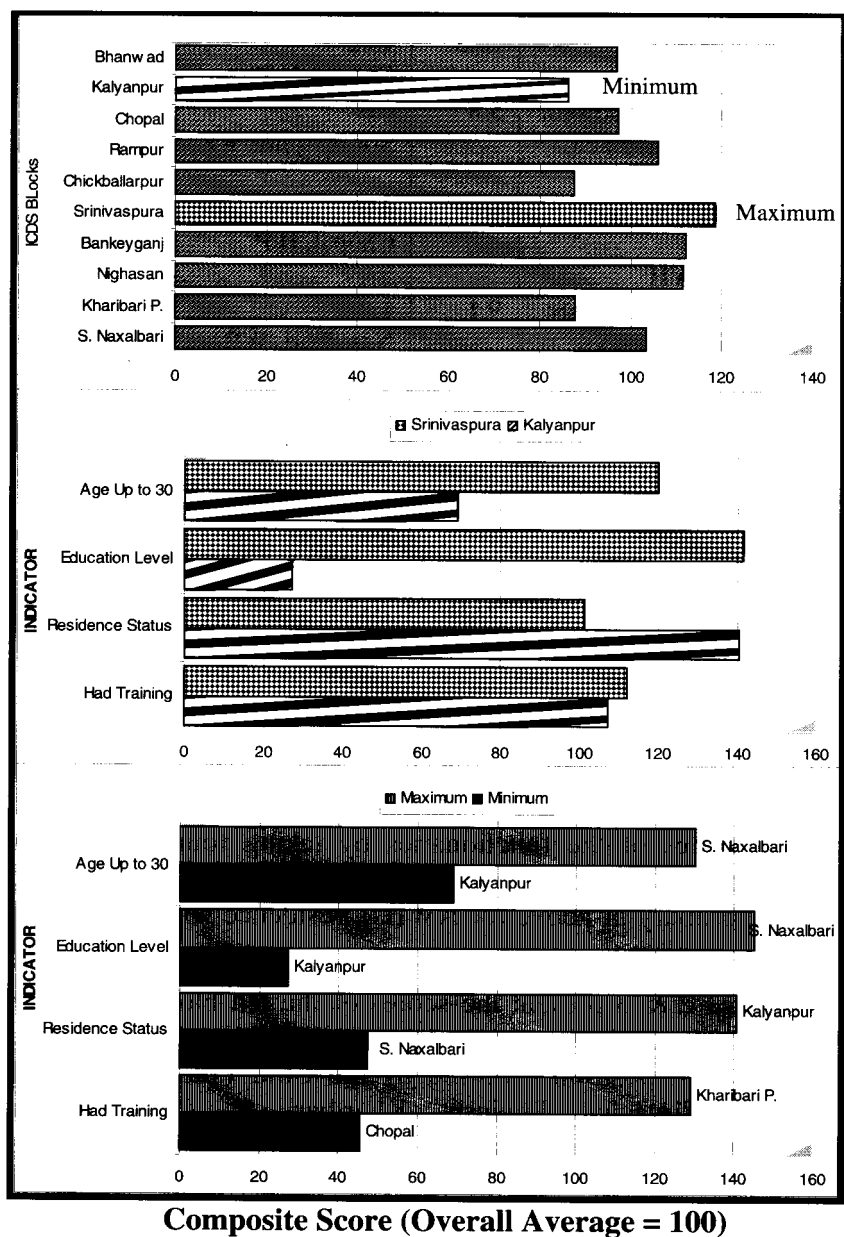
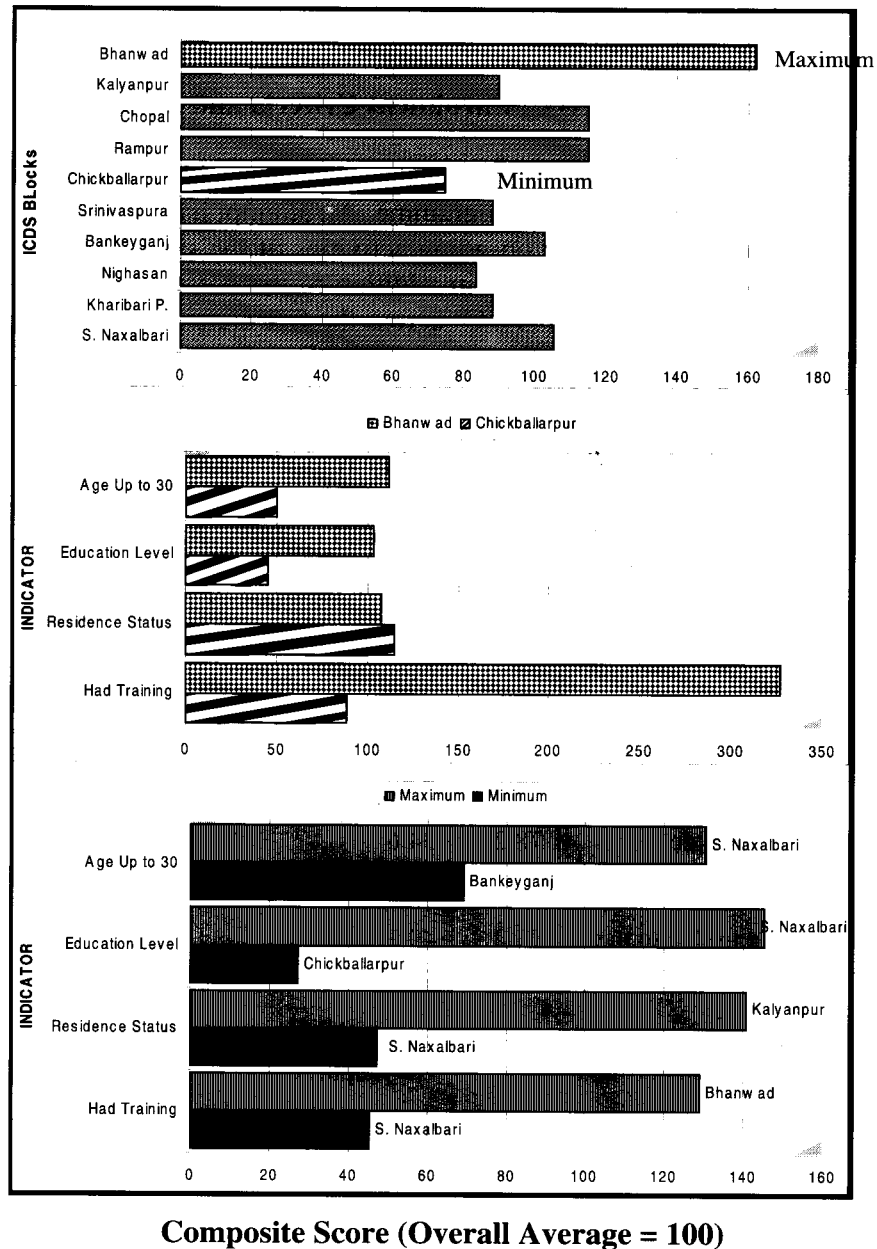


Figure 3: Variations in Socio-economic Background of AWHs



The composite index for AWHs revealed a different picture. Here Bhanwad, Gujarat occupies first position, both the blocks of Himachal Pradesh were at the second position. Chickballarpur (Karnataka) and Nighasan (Uttar Pradesh) are at the lower end.

3. Functioning of the AWC, Enrolment Criteria and Attendance

The day-to-day functioning of the AWC is a critical indicator of the effectiveness of the ICDS programme. An attempt has been made in the Pilot Study to assess the on-going activities of the samples through observations and record reviews in addition to the personal interviews with the AWWs. Almost all AWCs across the five states were managed either by the Department of Women & Child Development (DWCD) at the Centre or by the State Governments themselves. The average beneficiary population per AWC was about seven hundred, ranging from about only 332 persons in the hilly region of Chopal, Himachal Pradesh to 1001 persons in Bankeyganj, Uttar Pradesh. Details of the beneficiary population covered are presented in Table 7.

Table 7: Coverage of Beneficiary Population

Item	Mean	Range	
		Minimum	Maximum
Population covered	677	332 Chopal, H.P	1001 Bankeyganj, UP
Percentage of SC and ST	36.7	20.6 Srinivaspura, KR	77.4 Kharibari, WB
Number of Eligible Children	78.2	34.6 Rampur, H.P	134.6 Kharibari, WB
Percentage enrolled to the total eligible children	71.2	49.3 Bankeyganj, UP	95.8 Rampur, H.P
Percentage present on the day of visit to total enrolled children	39.6	18.7 Kalyanpur, GJ	48.7 Bankeyganj, UP

(Contd.)

Table 7 (Contd.)

Number of eligible women	16.5	6.5 Rampur, H.P	36.6 Nighasan, UP
Percentage enrolled to the total eligible women	64.2	44.3 Nighasan, UP	93.1 Srinivaspura, KR
Maximum radial distance to the beneficiary household (meters)	730	367 Chickballapur, KR	963 Rampur, H.P

Note: The AWC population is not precise & is based on the guesstimate of the AWW.

The eligible population is identified based on a survey conducted by the CDPO when a centre is first set up. It is the responsibility of the AWW to update the survey register every year. The beneficiaries are enrolled primarily from households below poverty line (IRDP beneficiaries), landless families, scheduled castes/tribes, or those enlisted by the ANM as malnourished mothers and children.

- ◆ On the average an AWC functions for twenty-four days in a month for four hours per day, which is below the prescribed norm of five and half hours. The monsoon season has affected the functioning of some AWCs in Uttar Pradesh and Gujarat. More than half (57%) of the AWWs **did not follow any criterion** in enrolling pregnant women and nursing mothers. This was particularly the case in the Rampur block of Himachal Pradesh and in the selected blocks of West Bengal and Karanataka. The reasons for this are the following :
 - a) If an AWC serves a tribal population, it is mandatory to enrol all women and children in the area, irrespective of levels of malnourishment, and
 - b) If an AWC falls short of the target, all eligible women and children in the area are enrolled irrespective of the socio-economic status.
- ◆ It has been found that most of the AWWs are burdened with paperwork maintaining as many as seven to nine registers. Given the low levels of education among the AWWs this is an uphill task. AWWs in Karanataka and Uttar Pradesh blocks maintained the largest number of registers. Also, the

growth monitoring records are poorly maintained. Less than two-thirds of the AWWs reported maintaining growth registers, notably less than one-third maintained growth cards (the situation was the worst in Uttar Pradesh).

- ◆ The average number of meetings with the various functionaries, like the Child Development Project Officer (CDPO), Supervisor, Medical Officer, Lady Health Visitor (LHV) and the Auxiliary Nurse Midwife (ANM) by the AWW are in accordance with the ICDS guidelines (being the highest in the two blocks of Karanataka and the poorest in the two blocks of West Bengal and Nighasan of Uttar Pradesh).
- ◆ It was found that about 123 AWCs (9%) in the surveyed blocks across the five states could not provide services on a regular basis. The majority of these dysfunctional AWCs were in Himachal Pradesh: the non-availability of the AWW was cited as the primary reason for discontinuous functioning.
- ◆ Attendance at the AWC is an important indicator of utilisation of the ICDS. It was found that on the average, only two out of every five eligible children were attending the AWC on the day of the survey team's visit. Attendance was particularly low in both the blocks of Gujarat. The highest attendance was recorded in the Rampur block of Himachal Pradesh. However, the same cannot be said for the Chopal in Himachal Pradesh, which recorded one of the lowest attendance levels. Attendance in the two Karanataka blocks was satisfactory— more than 90 per cent of the eligible children in the area attended the AWC in the week previous to the date of the survey.

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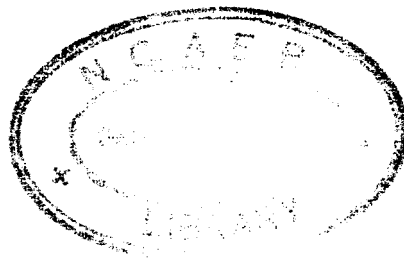
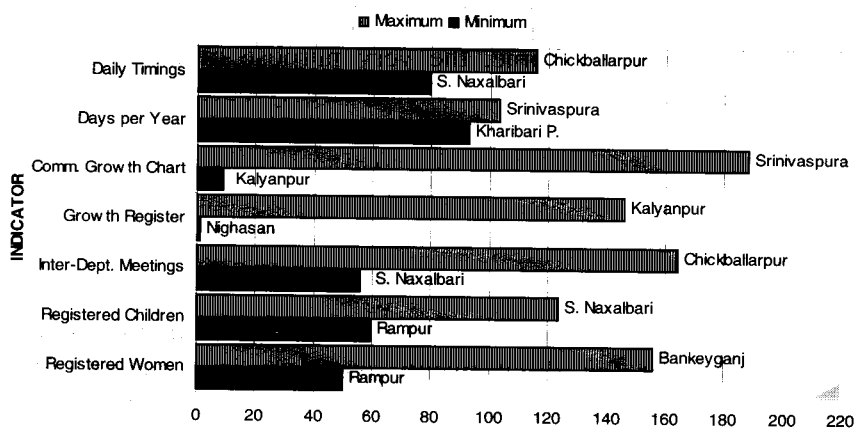
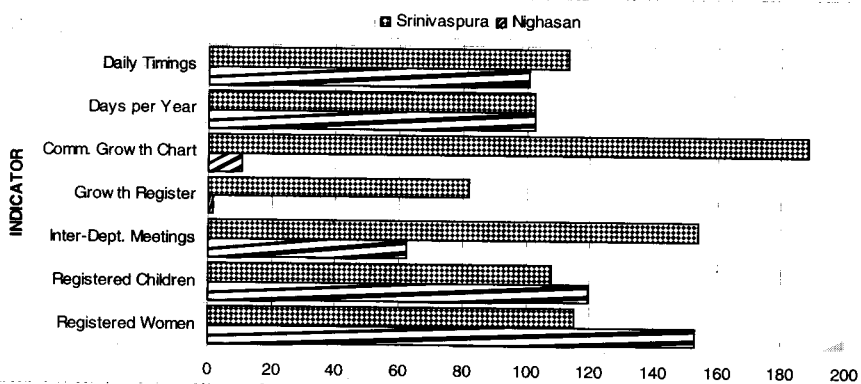
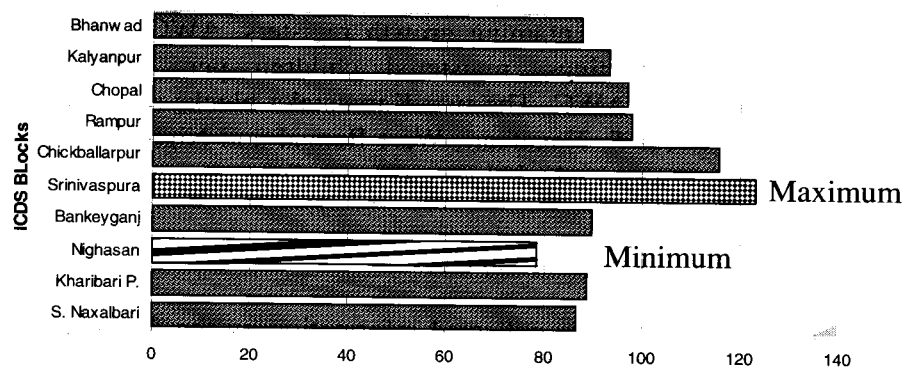


Figure 4: Variations in Functioning of AWCs



Composite Score (Overall Average = 100)

A composite index was computed taking seven variables to rank the AWCs according to their respective day to day functions. These indicators are: daily timings, days opened per year, AWCs maintaining growth charts, AWCs maintaining growth registers, AWCs reporting inter-departmental meetings, registered children per AWC, and registered women per AWC. The two Karanataka blocks received the highest score whereas S. Naxalbari, West Bengal and Nighasan, Uttar Pradesh were the lowest ranked blocks. (Figure 4).

4. Delivery and Utilisation of Services

The pilot survey has collected information on the delivery and utilisation of services by the beneficiary household. Here, specific types of services provided by the AWCs and the responses of beneficiary households with respect to these services have been discussed below:

a) Supplementary Nutrition

Provision of the nutrition supplement is the most common service delivered at all the AWC. Evidently, this appears to be the driving force for attendance at the AWC in case of a majority of beneficiaries. Findings however indicate that, on the average, across all blocks, about 16 beneficiary children per AWC took the food supplement home on a daily basis. This is despite repeated emphasis on site feeding by the ICDS guidelines. By allowing the beneficiaries to take the food supplement home, the very purpose of providing the nutrition supplement seems to be defeated largely because of the fact that

- a) Being shared with other siblings,
- b) Not being consumed/getting wasted, and
- c) Substituting the regular meal of the child.

The households' views reveal that a majority of them received the food supplement for about twenty-one days in a month. This translates to two hundred and sixty four days in a year, which is less than the ICDS norm of three hundred days a year. About 38 per cent of the households received food supplements for less than even twenty-

one day. Provision of food supplements was observed to be adequate in the two Karanataka blocks, Rampur (Himachal Pradesh) and Kalyanpur (Gujarat) blocks.

When asked to rate the quality of supplementary nutrition, two-thirds of the households rated it either good or excellent, mainly in Himachal Pradesh and West Bengal. Households in the Uttar Pradesh and Karanataka blocks were greatly dissatisfied with the food quality.

The provision of vitamin A and iron-folic acid supplements is far from satisfactory. IFA is administered to fight nutritional anaemia in pregnant women and infants, a crucial component of the ICDS. Only one in five households seems to have received vitamin A tablets/syrup from the AWC on a regular basis and one in ten households seems to have received an IFA supplement on a regular basis.

b) Growth Monitoring and Promotion

Growth Monitoring is crucial in identifying cases of malnutrition in the early stages and taking timely measures to lessen the extent of malnutrition. Unfortunately, more than half of the beneficiary households have reported that the growth of under six children was not monitored by the AWWs. Though this proportion was somewhat lower in Srinivaspura (Karanataka), Rampur (Himachal Pradesh) and Kalyanpur (Gujarat), the situation was reported to be extremely disappointing in both the blocks of Uttar Pradesh. Even in the AWCs where records were maintained, the promotion component of the GMP was not stressed upon at all.

c) Health Check-ups, Referrals and Immunisation

In the sample population, a total of 1651 children reported sickness during the past fifteen days (fever, diarrhoea and respiratory infections being the most common complaints).

While a large majority of the households (82 per cent) were aware that the AWW had provided medicines for minor ailments; only two out of five households mentioned carrying out of regular health check ups at the centre. Large proportion of households in Karanataka (68-75 per cent) followed by the Rampur block in Himachal Pradesh (51 per cent) reported the delivery of this service. In general only one

in four households reported the provision of referral services by the AWW.

Data on immunisation against preventable diseases reveals that one in three households was not even aware of the provision of this service at the AWC. It is thus observed that the assessment of nutritional status, immunisation, health check-ups, referrals, registration of births or pregnancies, etc. are poorly served components and in many AWCs these components were missing altogether.

d) Early Childhood Care and Pre-school Education (ECCE)

This is found to be the most frequently utilised service next only to supplementary nutrition. Almost half of the households recognised the fact that sending their pre-school children (between 37 months and 72 months) to the AWC had helped their children in various respects. The importance of this service was greatly emphasised by households in Uttar Pradesh and the Rampur block of Himachal Pradesh. On an average, across all blocks.

- 48 per cent reported that it helped in obtaining an entry into primary school.
- 45 per cent stated that it developed the habit of going to the school in the child.
- 40 per cent of the households reported development of communication skills.
- 39 per cent reported social development of the child.
- 23 per cent of the households confirmed the promotion of intellectual development.
- 20 per cent reported emotional development.
- 9 per cent reported personality development.

Considering that pre-school education at the AWC forms an important component of the ICDS Programme, it is disturbing that half of the households have not mentioned any of these benefits of sending their children to the AWC. In this context, increasing the awareness of the community about the ECCE component and its positive effect on the child needs to be addressed.

e) Nutrition and Health Education

The impact of the Nutrition and Health Education (NHE) component on infant mortality and maternal mortality in the villages has been quite encouraging. NHE has also enabled the stabilisation in the birth rate in the community. That this is a tangible effect of the NHE programme has been recognised by more than 30% of the households.

However, hardly 17% to 28% of the households perceived a clear impact of NHE on the enhancement of health consciousness, the decline in the incidence of disease (morbidity), and nutritional deficiencies.

A review of the inter-state variations shows that households in West Bengal did not perceive NHE to be too beneficial. In contrast, a very high proportion of households in the two blocks of Karanataka and the Rampur block of Himachal Pradesh felt that NHE had a key role in reducing both mortality and morbidity in the community.

The perception of the households regarding the effect of the NHE on pregnant women is as expected. In general, a majority of the households felt that NHE has provided:

- vital information on food requirements during pregnancy (76 per cent),
- promoted antenatal check-ups (70 per cent),
- promoted breast feeding (64 per cent) and colostrum feeding (61 per cent),
- encouraged mothers to opt for trained birth attendants for delivery (56 per cent).

Overall, only twenty-nine motivational house visits are made in a month by an AWW across ten selected blocks, the highest being in Gujarat and the least in Himachal Pradesh. Table 8 gives an account of the average number of times the various services are conducted in the AWCs in a month. Nighasan, (U.P.) recorded the lowest frequency of supplementary food distribution, as well as the lowest instances of weight measurement. Kharibari, (W.Bengal) is ranked the lowest in terms of NHE meetings conducted.

Table 8: Activities and Other Indicators

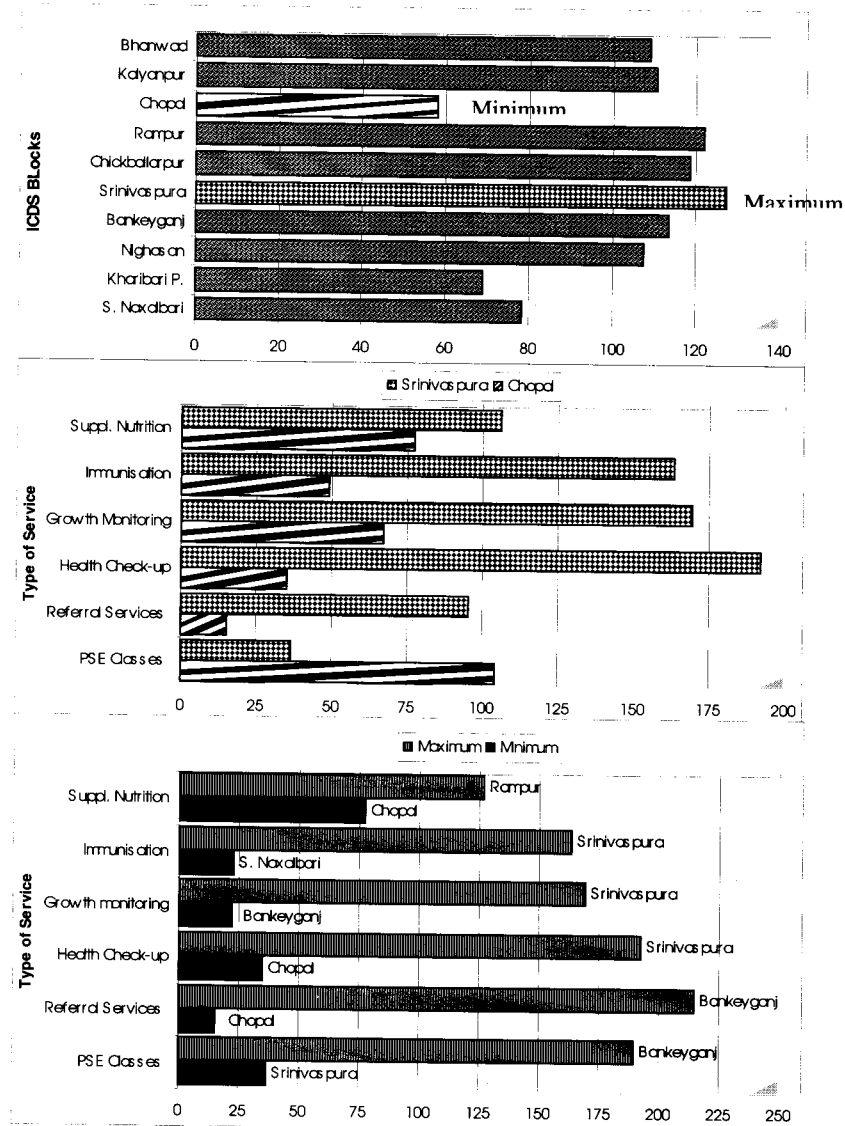
Item	Mean	Range	
		Minimum	Maximum
Number of times various services conducted in the month Food supplement	22.1	15.6 Nighasan, UP	25.4 Kalyanpur, GJ
PSE	22.0	15.1 Chopal, H.P	23.4 Bankeyganj, UP
Weight measurement	11.8	0.9 Nighasan, UP	21.9 Bhanwad, GJ
NHE meetings	6.1	0.6 Kharibari, WB	3.1 Bankeyganj, UP
Number of motivational house visits in a month	29.3	8.3 Chopal, H.P	56.1 Bhanwad, GJ
Percentage of AWCs reported functioning of Mahila Mandals	35.0	11.5 Chickballarpu, KR	74.8 Rampur, H.P

Two composite indices have been calculated based on the six ICDS components - one on the perception of beneficiary households regarding provision of services at the AWC, and the other on the services that have been provided at the AWC. The six components include Supplementary Nutrition, Immunisation, Growth Monitoring, Health Check-up, Referral Services, and Pre-school Education.

According to the perception of the beneficiary households, the Karanataka blocks indicate superior performance, scoring the highest, whereas at the other end of the scale we have the lowly performing West Bengal blocks. However, Chopal in Himachal Pradesh scores the last position. (Fig. 5)

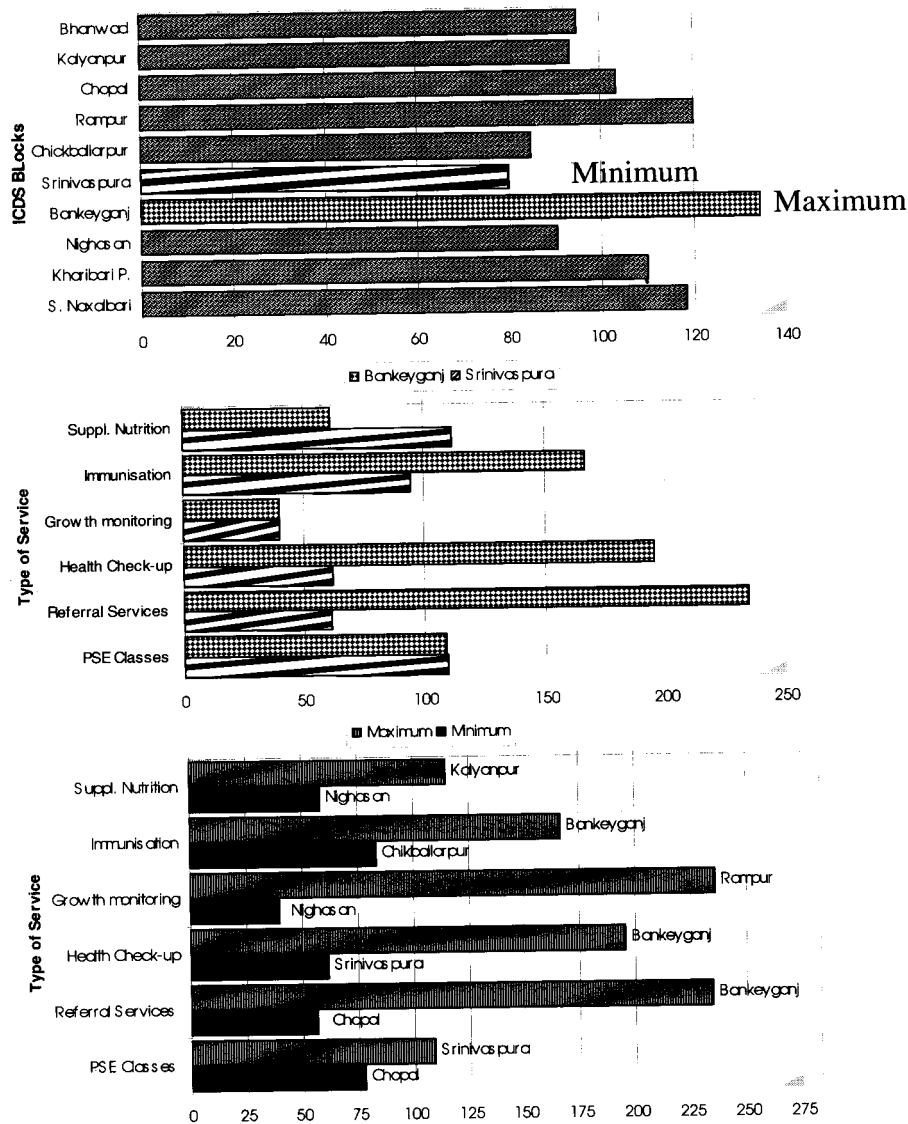
The second index regarding services provided by the AWC however reveals a different picture altogether. Here Bankeyganj, Uttar Pradesh scored the first position, and surprisingly the Karanataka blocks occupied the last two ranks (Fig.6). This wide difference in the performances needs to be investigated during the main study.

Figure 5: Variations in the Perception of Beneficiary Households on the Delivery of Services



Composite Score (Overall Average = 100)

Figure 6: Variations across Blocks in the Delivery of Services at AWC during the Previous Month



Composite Score (Overall Average = 100)

5. Community Participation

The ICDS has been envisaged and conceptualised as a community based programme. Community participation in the ICDS is important:

- a) to raise the community awareness about the needs of child development,
- b) to involve the community in the planning of the programme,
- c) to generate awareness about the programme and to convince the community about the efficacy and usefulness of the services offered, and
- d) to state clearly the nature of support and involvement required from the community.

But despite efforts towards incorporating community participation as an in-built element of the ICDS programme, it appears that it has not succeeded well in involving the community to a great extent.

Although it is a woman and child development programme, the findings indicate a very low level of community participation, not only among the women in general but even among the beneficiary women themselves (Table 9). Clearly the ICDS is unlikely to succeed if these primary target groups are adequately addressed and motivated to participate in the activities of the programme. Further work in the area of investigating reasons for non-participation of mothers, particularly the beneficiary mothers is required.

Table 9: Community Participation

(in percentage)

Activity	Mothers	Other women	Panchayat member	Comm-unity leader	Adole-scent girls	Family members of	
						AWW	AWH
Providing fire wood	5.5	2.6	15.6	2.0	1.8	6.7	12.1
Immunisation	16.5	9.5	7.0	3.2	4.3	16.2	15.8
NHE	2.1	2.2	1.1	0.4	1.1	7.5	3.0
Preparation & serving of food	15.9	8.6	3.4	1.4	7.4	12.8	15.7

(Contd.)

Table 9 (Contd.)

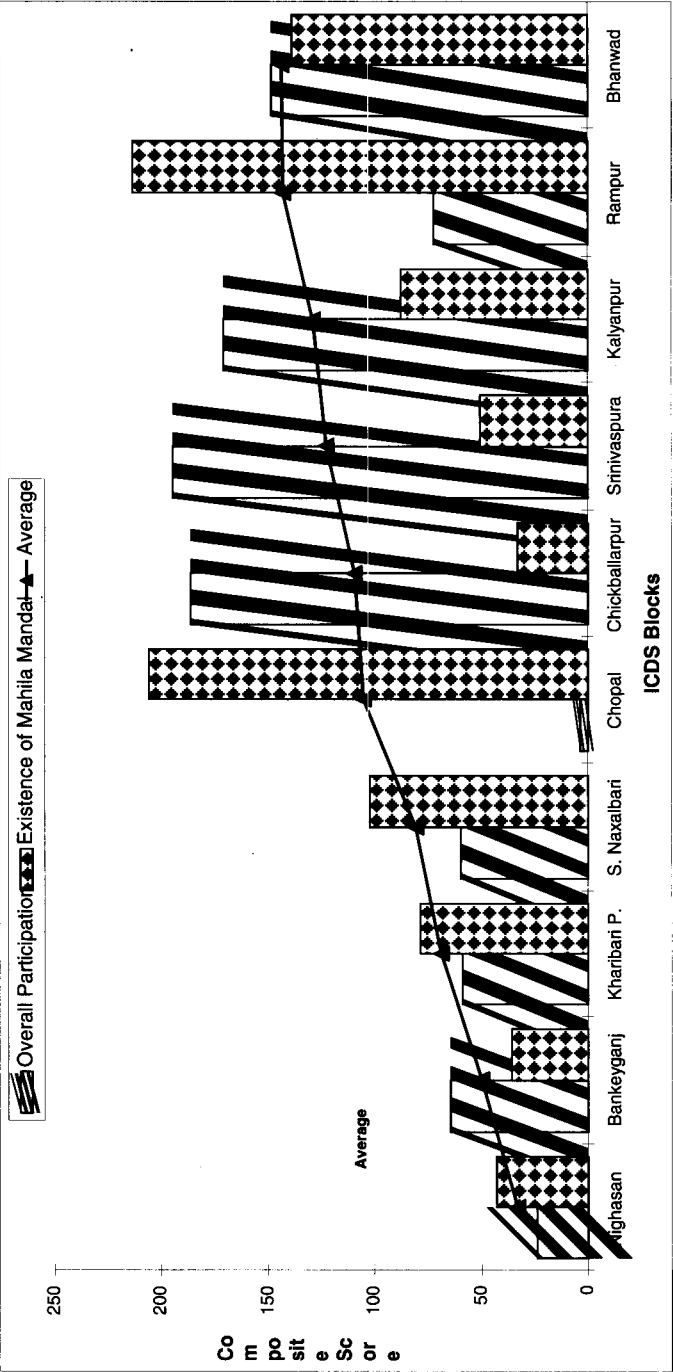
Improving environment	0.9	0.8	0.6	0.4	0.3	0.7	0.7
Registration of births & antenatal care	3.3	2.8	1.6	0.2	0.7	6.3	1.9
Identification of disadvantage households	2.5	2.1	1.3	0.7	1.0	2.1	1.9
Literacy activity	1.5	0.8	0.6	0.4	0.7	1.3	0.4
Providing space/ building	2.0	2.3	4.7	2.1	0.5	2.3	2.2
Others	1.5	1.2	0.7	0.2	0.4	0.7	0.8

Participation of community members is generally poor. The fact that this is true for even beneficiary women and adolescent girls is particularly alarming. These two segments clearly, form the foundation for any childcare programme. Involvement of these segments is imperative for successful implementation of the development services. The almost negligible participation by influential community leaders including the panchayat members is disturbing, as their involvement is critical for the successful implementation of the programme.

Still, somewhat better participation was observed among the family members of the AWW and the AWH in helping the grass-root functionaries in dispensing the services. However, even this involvement is not adequate, as it is limited to certain services only, for instance, motivation for immunisation services and the provision of supplementary nutrition. The higher levels of involvement among the families of the AWWs and the AWHs can best be explained by the fact that often the AWC is located within the functionary's house. Even this elementary level of participation was concentrated in the blocks of Karanataka and Gujarat.

The Mahila Mandals as vehicles for opinion forming and opinion building do not seem to be fully made use of. Based on the survey data, a composite index showing overall community participation as well as the existence of Mahila Mandals in the various blocks has been constructed. Here, Gujarat takes the lead whereas Uttar Pradesh is at the bottom (Fig. 7).

Figure 7: Variation in Community Participation and Existence of Mahila Mandal



PRIORITIES IN STRENGTHENING THE ICDS PROGRAMME

In order to meet the basic needs of the population, direct intervention by the government is required, especially on issues concerning human capital development, in a Welfare State. The GOI has made a pioneering effort in extending maternal and child development services in an integrated package for the first time in India. The Pilot Survey has indicated certain critical gaps in the implementation of the ICDS Programme. These are:

- In a vast country like India the application of universal norms across all terrains, population, cultures and practices, is not likely to yield satisfactory results. The delivery of ICDS needs to be reviewed in the light of the regional variations, prioritising components according to specific requirements of regions. Shanti Ghosh (1995), in her article has also expressed similar views.
- The most common problem faced by the AWCs is the lack of a permanent physical structure. Hence there is a need to ***upgrade the physical infrastructural facilities*** of the AWCs. Moreover, several of the AWCs do not have separate space for the daily round of activities, particularly cooking space and proper space for storing rations. The provision of toilet facilities and improvement of general hygiene and sanitation should receive priority. The NIPCCD evaluation study of 1992 has also pointed out the lack of infrastructural facilities in most of the AWCs. Taps and hand pumps should be provided in areas where there is a scarcity of drinking water facilities. The equipment and inventories present in the AWCs have not been found to be adequate in many centres. Irregular supply of equipment, toys and learning material, food items as well as medicine kits has adversely affected the proper implementation of the programme.
- The **training component** of the grassroots functionaries has to be strengthened- especially, that of refresher training. At the same time certain innovative methods of imparting refresher training have to be experimented upon. Also, the possibility of involving academic and technical institutions in imparting training and continuing education has to be explored. The Programme and Project Officers should take responsibility of organising frequent training

workshops at the project level. The concept of establishing a resource centre at the CDPO's office also requires serious consideration. The NIPCCD had also emphasised the need for strengthening the refresher-training course package and for arranging more frequent training workshops.

- AWCs should **function regularly** and the problems arising out of the vagaries of the monsoon and that of the peak agricultural season should be ascertained and minimised. In the Pilot Survey it has also been observed that some of the AWCs have become dysfunctional, thus cutting at the root of the GOI commitment to children in these areas. **Inter-departmental meetings** should be made more frequent so as to yield meaningful results. Participation of ANMs not only in providing referral services, health check-ups and home visits but also in immunisation and NHE sessions need to be promoted. Both the AWW and the ANM should work hand in hand. Most of the ICDS functionaries are often so busy in paperwork that they get side tracked from dispensing services effectively. The pilot survey has reflected that most of the AWWs are often busy in maintaining the registers/growth cards/community growth charts rather than concentrating on their implications on the growth promotion and participation of the mothers and the community.
- **Supplementary Nutrition** is a high cost input of the programme. It is imperative that it is monitored and delivered properly so as to have the desired impact on the target population. More children (specially those less than 3 years of age) should be brought under the coverage of supplementary nutrition through awareness generation which may involve door-to door campaigns. These campaigns should focus on encouraging the mothers to feed their children at the AWCs and educating mothers regarding appropriate weaning practices.

Further, the nutrition supplement should neither substitute the original meal nor should it get distributed among other siblings or family members. Carrying the supplementary nutrition home, specially in the case of the Ready to Eat (RTE) foods, defeats the very purpose of the Programme. Also, Vitamin A and other micro-nutrients are not administered in time in some of the AWCs. As a

result they get wasted. Some of the AWCs run out of supplementary nutrition and micro-nutrients; and this may be a result of the slow delivery of these items by the GOI to the State Government and finally to the respective AWCs.

- The ICDS, with a view to tackling the infant mortality problem, conducts immunisation in co-operation with the Ministry of Health and Family Welfare. Infant mortality rates continue to be high in India, i.e. 78/1000 (1992), with some states even as high as 116/1000 in Orissa, 109/1000 in Madhya Pradesh, and 96/1000 in Uttar Pradesh (Srinivasan and Shariff, 1997). Immunisation is an economical and cost - effective health intervention of the ICDS. PHC and its subordinate health infrastructure usually carry out the immunisation process. Yet, the low immunisation coverage suggest the existence of certain drawbacks such as the lack of awareness of the immunisation schedule, belief in the traditional practices and the existing superstitions, inconvenient timings, non acceptance of vaccine, lack of community participation, etc.
- **Growth Monitoring and Referrals** was found to be among the weaker components of the ICDS. The inherent problems are the lack of physical infrastructure at the AWC, insufficient training and too much work pressure and paperwork for the AWWs. The importance of this service in identifying cases of malnutrition well in time for effective intervention must be communicated to the AWWs. Mothers should be motivated for regular health check-ups and stress should also be laid on the referral service component of the ICDS so that health services have a greater impact on the target population.
- **Pre-School Education** is beneficial for the all round mental development of the child and AWCs do play a definite role in providing play way learning activities to the children, but in order to increase the effectiveness of this component the daily attendance at each AWC has to be increased further. This is affected by of various factors the most important being the quantum of stock and supply of food. Ensuring adequate inventories at the AWCs, together with a set of motivational activities to encourage more children to attend classes regularly may strengthen this component

further. Also it has been noticed that attendance drops sharply during climatic extremes, harvest seasons and festivals.

- **The Nutrition and Health Education component** of the ICDS, aims at increasing the knowledge of women regarding nutritional impact, childcare and family planning. The ICDS cannot be compared with the family planning programmes, as it does not have provisions for direct interventions in population control. But lowering of infant mortality has a positive impact in reducing fertility by extending breast feeding and increasing birth intervals (Khullar, 1998). The NHE component of the ICDS and post-natal care of the nursing mother tackle the issue indirectly.

The NHE component is a relatively low cost component and can be strengthened further. The supervisors have to play an increasing role in imparting NHE and making it more innovative and interesting. To bring in the desired results, ICDS can be more effectively linked with female education and empowerment, along with strengthening the NHE component. Linking ICDS with other programmes like Development of Women and Children in Rural Areas (DWCRA), can also be useful in this direction.

- **The Adolescent Girls Scheme** is one of the weakest components of the ICDS. The lack of awareness and the lack of motivation are both evident in the low coverage of the adolescent girls. The proper integration of this programme into the ICDS could mean freedom from the perpetuating cycle of malnutrition for the children and adolescent girls of this country. This scheme was not operational in a majority of the AWCs in the surveyed blocks.
- Mobilising **community participation** and disseminating information to increase awareness have been emphasised from the outset and yet the ambition of empowering the community to gradually handle the programme is still a dream. The pilot survey has highlighted poor motivation and participation on the part of the community. If at all, any community involvement does exist, it is limited to food distribution, collection of firewood and provision of space for the AWC. Local groups should be encouraged to actively participate in the day to day functioning of the AWC. An improvement in community participation would ensure the

effectiveness of the various services, identification of the beneficiaries, growth monitoring and promotion, etc.

- **The weak integration among various related departments** and the lack of inter- departmental co-ordination has affected the performance of the programme. The lack of access to safe drinking water, toilet facilities, sewage and waste water disposal systems and rampant incidence of communicable diseases such as malaria, especially in the urban slums could be an outcome of inter-departmental communication gap. Unfocused and disorganised one time efforts by individual departments need to be substituted by a cohesive, comprehensive, co-ordinated approach to attack the problem areas.
- Lastly it can be mentioned that one of the most debatable issues is the '**indiscriminate expansion of the programme**' and its '**large expenditure component**' (Khullar,1998; Ghosh,1995). Given the enormity of the task ahead, no expenditure is really 'large enough'. 'Indiscriminate expansion', of course, is neither advisable nor affordable for India. Care must be taken to ensure that expansion is not at the cost of efficiency. Maximum benefits with minimum wastage should be aimed at with respect to each and every aspect of the programme.

This investment into human capital today, even at this huge expense, shall reap rich results in the future. It need not be reiterated that in the long run, no economic growth and development can be sustained on a wobbly foundation of an under developed human resource base.

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ANNEXURE 1

Profile of Study Districts

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Jamnagar	West Gujarat	109	955	40%	50%	39%	74%	45%	8%	-	18.6	67
Shimla	South Himachal	120	894	20%			97%	37%	27%		17	121
Kolar	South Karnataka	270	965	23%	63%	38%	93%	17%	26%	7%	17.4	56
Lakhimpur Kheri	North UP	315	842	11%	30%	16%	66%	52%	27%	1%	17.4	119
Darjeeling	North WB	424	923	31%	58%	48%	92%		16%	14%	18	89

Note: Column Heads:

1. Name of District
2. Location of District
3. 1991 Population Density in persons/sq km
4. females per thousand males
5. percentage of population in urban areas
6. Percent Literate in total population
7. Percent Literate in female population
8. Primary school enrolment rate
9. Dropout rate
10. Percent SC Population
11. Percent ST Population
12. Mean age at marriage
13. IMR per thousand births

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