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PROGRAM REVIEW  
OF  
CARE MCH (ICDS AND SNP) TITLE II PROGRAM  
IN INDIA

by

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## EXECUTIVE SUMMARY

Like most countrywide assessments made in the vastness of India, the present effort had to be a qualitative review, without representative sampling and quantitative analyses. Sheer program size boggles the mind. In its MCH program alone, the subject of this review, CARE assists 3.6 million beneficiaries in nearly 50,000 child development centers (anganwadis) and is delivering food to another half million preschool children and mothers.

As intended, this review is essentially an issues paper, highlighting those aspects of CARE's performance in food delivery which most affect program effectiveness and the related components that help to ensure improvement of health status of the target population.

The channeling of the bulk of CARE Title II food today is a dramatic alteration of setting from that evaluated in 1979 by Nelson, Sahn, and Rogers. The principal concerns of the 1979 evaluators with respect to the MCH program were: that feeding without health and education components should not be continued; that take home food, as was often done risked diluting the potential effects of the food component; that greater rigor in beneficiary selection should be exercised, based on economic need and nutritional status; that more appropriate foods ought to be provided which would primarily serve the needs of the smallest children; and that to reduce food losses through infection and infestation, sanitation should be a priority component of integrated food programs.

Most of these issues were addressed by the creation in India of an admirable infrastructure for Integrated Child Development Services (ICDS) and CARE's transfer of food assistance to that infrastructure since 1982. Over the last 10 years, the Government of India (GOI) has created an extraordinary network of village level centers for children under six years of age and for new mothers and mothers-to-be; these ICDS centers serve an average target group of 100 from populations of 700-1000. From 33 blocks in 1975, the program has expanded to 1376 blocks with 8.6 million beneficiaries today. The Government expects to reach 2,000 blocks by 1990. (There are 5,000 blocks in India.)

In 1979 much of the CARE-assisted MCH program consisted of on-site and take-home feeding stations. The few exceptional integrated program then in existence constituted less than 5 percent of the MCH program. Today 66 percent of CARE's MCH resources are supporting the ICDS program, another 6 percent serve Special Nutrition Program (SNP) centers which have been upgraded (with health and education components) and the remaining 6 percent serve as simple SNP centers.

This advance toward totally integrated MCH programs will slow somewhat at the end of the calendar year when a necessary consolidation move will occur, in the course of which CARE transfers out some of its beneficiaries (CARE will leave several States at that time) and takes on new beneficiaries (from WFP) who are not yet benefitting from integrated services. CARE and the GOI, however, share the objective of providing supplemental food in the context of other health and education services. They will be working together to upgrade these centers, either sanctioning them as ICDS areas in the near future, or eventually, as the Government massive network continues to expand through the country to cover neediest tribal, rural and periurban areas. In the interim CARE also will be working on its own to upgrade centers.

CARE assistance to the ICDS is significant. They are providing more than 100,000 metric tons of CSM and oil annually to assist 471 ICDS blocks and 3.6 million target beneficiaries. This amounts to 41 percent of coverage of ICDS beneficiaries within each CARE-assisted State. There is a vast need for resources even beyond the GOI budget for infrastructure (personnel, training, initial equipment) and indigenous foods as well as WFP contributions. The team strongly recommends that the percentage contribution of CARE toward the ICDS program be maintained for the foreseeable future. This could be achieved partially through foods saved through the progressive phaseout of school feeding and through transfers of SNP programs to ICDS and, as necessary, adding ICDS beneficiaries to CARE programming.

CARE program management is very satisfactory. Despite the enormity of volume, transportation and storage burdens, an unrelenting harsh climate in many areas, and remoteness of these neediest areas, not to mention delays from U.S. ports, 72 percent of the food programmed gets delivered on time. CARE has had some 70 field and port officers in 14 States. They cover both school feeding and MCH programs. In 1985-86 each field officer was covering 3-4 districts. In the current year CARE is working in more than 1900 blocks, and field officers make an average of four visits per year to each block. CARE provided food to more than 70,000 ICDS and preschool sites this year. A field officer has about one thousand preschool centers (about 760 anganwadis) to monitor, obviously being able to visit only a small percentage of them each year (7 percent). The field staff cover a large area in the three weeks per month spent in the field. The crucial point of contact is at the block level, which occurs on a quarterly basis, with the Child Development Project Officers (CDPOs) and Block Officers; and when planned carefully, CARE has the opportunity to see supervisors and anganwadi workers when they come for monthly meetings. Even more careful scheduling and improving the quality of visits is very important for staying in control of such an immense program. Making this possible is CARE's excellent information system which begins at the preschool centers and is used as an effective management tool up

through the CDPO and State level. A criticism has been that the information fed up from the anganwadi is not factual, and this was confirmed by the team with regard to attendance-keeping. This is an area in which CARE might provide useful assistance to the ICDS personnel with whom they are in contact, especially the monitoring of stocks, beneficiaries, and attendance.

The foods given, CSM, very occasionally bulgur, and oil, are appropriate and are being used in creative recipes, though not directed sufficiently to preparations appropriate to the youngest children. ICDS staff do not perceive CSM as a weaning food. Education on this is extremely important. It is related to the central problem plaguing the program at this time, which is the low rate of participation (and growth, monitoring) on the part of the most vulnerable groups, the under two's. There is also too little participation from the birth to three-year-old group and of pregnant and lactating women, especially to be targeted for supplementary feeding in a country with a high percentage of low birth weights. The team has made a number of suggestions for reaching this group more effectively with food and other services: giving greater focus to women and their control of family health, eg., Oral Rehydration Therapy (ORT) at home, through strengthened home visits and educational campaigns; enlisting the help of the village health workers to persuade mothers to attend and have their children attend regularly; looking into optimal times for center feeding; permitting flexibility for taking food out of the center for sick children and for women who are culturally constrained from eating in the centers, or to hamlets cut off during the monsoon; capturing the most vulnerable 6-12 month old infants and 13-24 month old toddlers through growth monitoring (in the home, if necessary) and providing baby slings for weighing; improving regularity of community surveys and screening procedures to emphasize early faltering.

The non-formal education component is an important one as an incentive to the families and motivation to the anganwadi workers (AWs) who like this part of their work best. Children 3-6 years old are most satisfactorily reached in terms of enrollment and attendance.

Water supply continues to be a problem, although the Government is attempting to provide hand pumps on a priority basis to tribal and rural areas. The need is fully recognized, but the projected expansion of the program is by itself a very large effort. Anganwadi workers were emphasizing personal hygiene, the teams noted, which was an improvement from the last assessment made by Drs. Krishnamurthy and Nadkarni in 1983.

## ABBREVIATIONS AND GLOSSARY

AIIMS	-	All-India Institute of Medical Sciences
ANM	-	Auxiliary Nurse Midwife (now Female Health Worker)
A.P.	-	Andhra Pradesh
AW	-	Anganwadi
AWC	-	Anganwadi Center
AWW	-	Anganwadi Worker
BDO	-	Block Development Officer
BEE	-	Block Extension Educator, also BEO
BEO	-	Block Extension Officer, same as BEE
CDPO	-	Child Development Project Officer
CEO	-	Chief Executive Officer (District Level)
CSM	-	Corn Soy Milk
CY	-	Calendar Year
DHO	-	District Health Officer
DPT	-	Diphtheria, Pertussis and Tetanus
EPI	-	Expanded Program on Immunization
FCI	-	Food Corporation of India
FHA	-	Female Health Assistant, formerly Lady Health Visitor
FHW	-	Female Health worker, formerly Auxiliary Nurse Midwife
FLAW	-	Functional Literacy for Adult women
FO	-	Field Officer
FY	-	Fiscal Year, U.S. October 1 - September 30 Indian Fiscal Year, April 1 - March 31
GOI	-	Government of India
ICCW	-	Indian Council of Child Welfare
ICDS	-	Integrated Child Development Services
ICMR	-	Indian Council of Medical Research
IMCN	-	Integrated Maternal and Child Nutrition
INDP	-	Integrated Nutrition and Development Program
INHAP	-	Integrated Nutrition and Health Action Program
LBW	-	Low Birth weight
LHV	-	Lady health Visitor, now Female health Assistant
MCH	-	Maternal Child Health
MIS	-	Management Information System
MO	-	Medical Officer, Primary Health Center, Block Level
MOHFW	-	Ministry of Health and Family Welfare
MOSW	-	Ministry of Social Welfare
M.P.	-	Madhya Pradesh
MS	-	Mukhya Sevika or Supervisor
NIN	-	National Institute of Nutrition
NIPCCD	-	National Institute of Public Cooperation and Child Development
NNMB	-	National Nutrition Monitoring Bureau at NIN
ORS	-	Oral Rehydration Solution

- ORT - Oral Rehydration Therapy
- PEO - Program Evaluation Organization, Planning Commission
- PHC - Primary Health Center
- P/L - Pregnant/Lactating
- RTE - Ready-To-Eat (food)
- SNP - Special Nutrition Program
- SNP(U.G) - Special Nutrition Program (Upgraded)
- TT - Tetanus Toxoid (immunization for pregnant women)
- TWD - Tribal Welfare Department
- UIP - Universal Immunization Program
- U.T. - Union Territory
- VHG - Village Health Guide
- WFP - World Food Program

- Anganwadi - Literally a courtyard, village preschool child care center, focal point for delivery of services to an average 100 less than 6 year olds and Pregnant/Lactating women. Center is staffed by an Anganwadi Worker (AWW) usually selected from the community and paid Rs.250 (\$20) per month and helper; usually covers a population of 1,000 in rural and urban areas, and 700 in tribal areas.
- Auxiliary Nurse Midwife (ANM) - Link between the village and the Primary Health Care Sub-Center; diagnoses minor ailments and distributes simple medicines.
- Block - Community Development Block, the lowest administrative unit within a district with an average population of 100,000. An "ICDS Project Area" coincides with the Block.
- Crore - Ten million
- Dai - Traditional Birth Attendant or Midwife
- District - A division of an area created for administrative purposes.
- Grade I - Normal
- Grade II - Moderately malnourished
- Grade III, IV - Severely malnourished
- Jaggery - Unrefined brown sugar
- Lakh - Hundred thousand
- Mahila Mandal - Village women's Association; a voluntary grassroots level organization of women registered as a society with the Registrar of Cooperatives, and engaged in activities related to women and child welfare, including income generating activities for women.
- Mukhya Sevika - Middle-level supervisor, a University graduate with 3-4 months training in home science colleges or departments of social work. Responsible for 20-25 Anganwadis.

- Panchayat - Elected body of the village.
- Panjeeri - Roasted RTE food in powder form, of wheat or corn with raw sugar and oil.
- Project Poshak - An integrated nutrition and health program for mothers and children carried out in Madhya Pradesh over a period of four years in three phases.
- Primary Health Center - Provides medical services per block of 100,000 population; subcenters serve 5,000 population in the rural areas.
- Sarpanch - Village Head-man
- Scheduled Caste - Untouchables (considered unclean and with whom physical contact has been considered defiling by higher castes).
- Sukhada - Roasted RTE food in cake form, of wheat or corn with brown sugar and oil.
- Tribals - Aborigines (predominantly from hill areas).

## I. FINDINGS AND CONCLUSIONS

1. CARE has significantly altered its programming emphasis since the 1979 evaluation which found a minute percentage of the program devoted to integrated child and mother programs, to 1986 when food programmed for ICDS constitutes 88 percent of CARE's MCH program. Of CARE's total resources, nearly 40 percent supports the ICDS program. Another 5% support SNPs that are on their way to being fully upgraded. Since 1979, beneficiaries and tonnages for Title II programs have declined, particularly resulting in school-feeding reductions.

2. Over the past three years, CARE has steadily increased ICDS beneficiaries and in 1986, is providing a standard ration to 40% of the total 8.8 million beneficiaries in the India ICDS program in the states they assist. Program projections for FY 1987 would slightly decrease the level of beneficiaries though the GOI will be continuing to expand (at an estimated additional two million beneficiaries this year).

3. With major exceptions in Bihar and Maharashtra, where delivery to centers has undergone serious disruptions and also where CARE staffing and monitoring appears to be weakest, CARE has managed on the whole to assure regular delivery of Title II food with two or three interruptions a year lasting for several days and due mainly to delayed U.S. shipments.

4. Though there were strongly expressed desires from most of the States visited (from all levels) for greater storage capacity beyond the district level to meet the several month stockpiling in preparation for monsoon months, it appears not to be a practical solution since neither CARE nor USAID has funds for constructing storehouses at the supervisory or anganwadi levels.

5. CARE's information system provides effective reporting, retrieval and feedback, and serves as a very useful management tool for both CARE and counterpart functionaries. Monitoring and administrative coverage are adequate to excellent. Coordination and working relationships, despite the pressures of food cutbacks and impending withdrawal from States which have been working with CARE for more than 25 years, with State and ICDS officials are effective. Problem-solving encounters handled on a partnership basis.

6. CARE's field officers' vital contact is at the Block/Sector Level where they have the opportunity to meet with Block Officers/CDPO's and through them, the AWW's and Supervisors. It is important that these field visits be scheduled to coincide to the maximum extent with the presence of AWW's and MS's in order to utilize more fully this major contact.

7. The targeting mechanisms employed by the ICDS program, which include focused geographical targeting to tribal and scheduled caste areas and beneficiary selection at the village level. They also include a quarterly community survey and monthly/quarterly growth monitoring. They are effective targeting tools when applied according to program norms.

8. Of all cohorts being monitored, targeting of children age 3-6 is the most satisfactory, principally due to their presence at preschool. Representation of children ages 2 and 3 is improving according to AWW's comments and team comparisons made against past studies. The registers reviewed for the sites visited as a whole; however, suggested low enrollment and attendance of children 13 to 24 months and very minimal participation of children from birth to 12 months. While children birth to 6 months are afforded protection through breastfeeding, the very vulnerable 6 to 12 month age group which cannot tolerate flat growth curves, which are not being appropriately weaned and which need to complete their first round of vaccinations, is not being reached. The reasons that the under 12-month age group was not participating include:

apprehension of the mothers, lack of baby slings for weighing small babies (under 12 months), non-formal community surveys, and lack of any means to detect early faltering.

In those state programs where the norms state that only the malnourished children under three years of age are eligible for program enrollment, no growth monitoring or proper screening means that this age group will not be enrolled.

In AW centers where only the moderate and seriously malnourished children below three years of age were enrolled, the program risks becoming an "unsuccessful" rehabilitation project rather than an effective preventative program. No guidelines are available at the centers for the therapeutic feeding that is needed to recuperate the seriously malnourished children nor is proper medical attention available. Little attention is given to the normal or Grade I degree children with faltering growth because the AWW usually considers these children ineligible due to beneficiary allocation. More attention should be given to preventing these children from falling to Grade II. Once children become Grade III or IV, it is very difficult and costly to recuperate them. These normal and grade I children are all at risk of becoming malnourished, given the poverty and difficult environment in which they live.

9. To increase participation of pregnant and lactating women in the feeding program, flexibility of the ICDS on-site directions should be encouraged to meet the special time constraints of these women. Although on-site feeding is the optimum arrangement, the all-day work responsibilities of women in the fields make it unlikely, as was observed on the team's visits, that

many mothers can eat at the centers during the 9:00-12:00 period. Those AW centers which were cooking food early in the morning for the mothers to take to the field and those that saved food for the mothers until the late afternoons and allowed them to take it home were the programs that had increased the participation of this important category of beneficiaries.

Given the increased nutritional needs of pregnant women beginning in their first trimester, the team suggests enrolling these women as soon as pregnancy is detected; many centers already are doing so at the third or fourth month.

The team supports take-home feeding for pregnant and lactating women although recognizing it is not the optimal strategy but perhaps the only one which will result in regular participation of this target group. With all take-home strategies the mothers need to be educated that the food is her "special" food and is not to be shared with other family members.

10. The AWW's and mothers noted that the malnourished children, particularly those under three, could not eat a double ration at one sitting. The team agrees with the decision of AW workers who permitted the remaining food to be taken home, but stresses the importance of educating the mother that this is special food for the child and that this ration should not be shared. They should be told that the food is to be given to the child at two feedings during the rest of the day in addition to his regular food.

CSM is not considered a weaning food by the CDPO's, supervisors, or AWW's although CSM was specially formulated as a nutrient-dense food for the weaning age child. This perception needs to be changed. Perhaps the CSM preparations should be adapted to meet the special needs of this age group. It is important also to teach mothers what a weaning food should be.

AWW adds spices or sugar to the cooked CSM. An unspiced portion could be set aside for the young children as their special food.

11. The food is a critical part of the ICDS program. It plays an important incentive role as reported to us by CDPO's, AWW's, as well as mothers and fathers, in attracting children and mothers to the program. It gives the AWW credibility with the community in that she has something to offer. The ration also is of sufficient size and nutritional value to help prevent serious malnutrition, if it is eaten regularly. The double ration should be adequate for assisting pregnant and lactating mothers to meet their increased nutritional needs and, if consumed in several feedings by the malnourished child, could be a significant help with recuperation.

Substitution seems not to be a problem in programs observed. However, this was not substantiated and the AWW should monitor this possibility and perhaps serve the food mid-morning rather than at 12:00 or 13:00 to prevent dilution or reduced portion for the child's second meal at home.

12. AWW use of growth monitoring seems to be improving in accuracy as a targeting tool but is not functioning in its optimal form as an educational tool or as a point of departure for linkages to other health interventions. On the whole, worker weighing and plotting skills are satisfactory but some experience difficulties due to changing technology (e.g, growth charts, scale type). The primary need is for workers to learn an amplified model of growth monitoring, in conjunction with prioritized home visits.

Monitoring, as targeting, is not directed to the most vulnerable age groups, especially the 6-12 month old infants but also the 13-24 month age group.

Despite the well-known difficulties of reaching this population, the high mortality and morbidity which this group experiences indicates that greater programmatic attention should be explicitly paid. Monthly weighing, at home if necessary, of the identified children in this age group (whose absolute numbers per village will not be large), may be the entering wedge for the necessary interventions. This will include the issue of appropriate weaning and post-infection foods.

13. The team was pleased to learn that mothers interviewed have fairly well generalized awareness of the concept of ORT including knowledge about the ingredients of home made solutions; they also understand the need to continue breast feeding and replace liquids during diarrheal episodes. Mothers were less able to cite the correct proportions of each component or the frequency of administration.

However, sugar may be an important constraint because of scarcity in some homes, so the child with diarrhea is unlikely to receive the salt-sugar home-made solution at the onset of diarrhea.

14. Nutrition and health knowledge levels of AWW's and mothers are satisfactory, but behavioral change now needs attention. AW discussions (mothers' meetings) have not produced behavioral changes, suggesting that the frequency and quality of home visits are extremely important at this stage. The AWW could use such visits, complete with weighing and family counsel, to bring back into the fold at-risk beneficiaries whose attendance has been erratic or who are not enrolled. It would be helpful to enlist the reinforcement and support of the village health workers to achieve this end.

Similarly, creative use of educational techniques at the AWC and in the nutrition camps is needed. Educational aids now displayed, such as charts and posters, are outdated and should be corrected; aids are also absent in many centers.

One suggestion is that the District ICDS Committee award prizes—just as outstanding AWWs and supervisors are currently awarded prizes—to mothers who attend regularly, whose children attain better growth rates, who use or devise recipes, and whose children have had all the required immunizations.

## II. INTRODUCTION

### A. Objectives

The objective of the PL 480 Title II - CARE/ICDS Review is to assess CARE's current and future role in Title II commodity delivery and monitoring of program effectiveness, including CARE's institutional capability and commitment to strengthening that role within the GOI-ICDS framework. The full Scope of Work is presented as Appendix A of this report.

### B. Organization of the Report

This report is organized to reflect the analytical categories the team used to cul across a rather expansive and complex assignment. While a more or less typical team assessment approach was used, the document envisaged from the outset was basically an issues paper. It begins with a summary of the findings of the conclusions from the 1979 evaluation by Community Systems Foundation (Nelson, Sahn and Rogers), which was considered the benchmarks of progress to be addressed by this analysis. This is followed by sections which address: trends in food programming, coverage and targeting, food management and coordination, the role and use of food and a summary team assessment of program effectiveness.

### C. Methodology

#### 1. The Team

The team consisted of nine members, four of whom (King/Team Leader, Harrison, Kakkar, and Sukin) were full-time (see Appendix B for names and institutional identifications). The team included representation from CARE/India, AID/Washington, AID/India, MSH/PRITECH, and the Department of Women's Welfare of the Ministry of Human Resource Development in New Delhi. The team was additionally enriched by the participation, in each state visited, by the CARE field offices for those states. The Evaluation Team worked under the guidance and supervision of the Acting Chief of the Office of Food for Development, USAID/New Delhi.

#### 2. The Schedule

After a brief period dedicated to meetings with Mission/PVO/GOI counterparts, the team was split into three groups, each covering two states. Programmatic criteria governed the selection of states by GOI, CARE, and the USAID; the blocks to be visited in each state were selected by CARE Administrators. Sites to be visited were selected by each evaluation sub-team upon arrival in each state in random fashion from a randomly-selected basic list of anganwadis supported by CARE. A mid-term status review for the entire team was held in Calcutta halfway through the field stay (See Appendix C for team itinerary).

### 3. The Approach

The evaluation approach was the customary combination of site visits and interviews with officials at the state and block offices of ICDS and CARE, with Anganwadi Workers (AWW's), and with mothers. All visits were surprise visits, with a few sites selected as "best" sites for purposes of comparison. Other than those few purposive selections, random selection was scrupulously honored. Nevertheless, there was no pretense at either sampling or quantification. Field protocols were meant to be interview guides or checklists.

#### D. The ICDS Structure

In 1975 the GOI introduced the Integrated Child Development Services program on an experimental basis to provide services to promote the physical, mental, and psychological growth of children. The program instituted a delivery system through the Anganwadi (literally, courtyard), a site for reaching out services to the most vulnerable groups, that is children 0-6 years and pregnant and nursing women. The grass-roots worker, the Anganwadi Worker, occupies a pivotal integrating role in providing, coordinating, and maximizing the relevant services.

The primary objectives of the ICDS program are:

1. To improve the nutritional status of children 0-6 years;
2. To lay the foundation for the psychological, physical, and social development of the child;
3. To reduce child mortality, morbidity, and malnutrition, as well as school dropouts;
4. Effective coordination of policy and implementation among various departments to promote child development;
5. To enhance mothers' capability to look after the health and nutritional needs of the child through nutrition and health education.

To achieve these objectives, the following services are to be provided to preschool children and expectant and nursing mothers:

1. Supplementary nutrition;
2. Immunization;
3. health checkup;
4. Nutrition and health education;
5. Non-formal education; and
6. Functional literacy.

ICDS started with 33 experimental projects in 1975-76 and the promise of the program resulted in its expansion to 1,356 projects during the first 10 years; 240 additional projects have been

allocated in 1986-87 and the number of ICDS projects will rise to about 2,200 by the end of the Seventh Plan in 1990. At present, there are 130,000 anganwadis in the country, a number which should rise to 225,000 by March 1990. This network would extend ICDS activities to all tribal development blocks, all blocks with substantial concentration of scheduled castes population, and most of the slums in large cities (Dayal, 1986).

#### E. CARE Assistance to ICDS

In 1982 the Government of India (the Ministry of Human Resource Development) agreed that CARE food assistance should be devoted exclusively to ICDS programs and SNP's in process of upgradation. Many of the previously existing food-only programs were discontinued at this time. This decision came as a mutually desirable objective for the two entities: The GOI wished to continue to expand the ICDS program as rapidly as possible; and CARE had been trying for many years to add the health and other inputs into its MCH programs. Up to 1982, fully integrated food and health programs receiving CARE food assistance were either limited to pilot projects or confined to individual states, eg. Gujarat and Orissa, where in fact mini-ICDS programs were operating.

CARE then trained its field staff to participate in monitoring of the ICDS program. An ever-increasing number of ICDS blocks and ICDS beneficiaries have been covered with CARE food assistance today reaching 471 blocks and nearly 50,000 anganwadis with a target population of 3.6 million, over 40% of the 6.6 million total beneficiary population.

#### F. The 1979 Evaluation

In 1979 an evaluation team (Nelson, Sahn, and Rogers) made recommendations on all of the title II programs operating in India. This program review concerns itself only with CARE's MCH (now ICDS/SNP) program. School feeding is referred to only to provide a nationwide perspective of CARE operations.

The six MCH recommendations in the 1979 evaluation were:

1. Programs which provide food alone should be upgraded to provide other health and educational services. Programs which do not do this should be actively discouraged.
2. Beneficiaries should be selected on the basis of economic and nutritional need. For example, if mothers in the program have low birth weight babies, they should be given a high priority for food supplementation.

3. Coarse cereal grain (bulgur) should not be provided as a nutritional supplement for children under three. Low bulk, high nutrient-dense food should be programmed for this group.

4. If the food is to be consumed by a given individual, it should be prepared and eaten on site for maximum control.

5. A greater consideration should be given to the need for improved environmental sanitation to reduce infection and infestation, along with nutritional supplementation.

This review examines the extent to which progress has been made in addressing these recommendations, and for quick reference, the table below notes the relevant findings and sections which discuss each of the recommendations.

Report Sections which address  
the 1979 Evaluation Recommendations

<u>Recommendation</u>	<u>Relevant Finding(s)</u>	<u>Section(s) within Narrative</u>
Recommendation 1 (Integrated Programs only)	1	III, A, 1, 2
Recommendation 2 (Beneficiary Selection)	7 8 9	III, B, 1
Recommendation 3 (Appropriateness of Ration)	10	V, A, 1
Recommendation 4 (on-site feeding)	9 10 11	V, A, 2
Recommendation 5 (Sanitation)	Executive Summary	

### III. PROGRAMMING TRENDS AND COVERAGE

#### A. CARE Title II Programming Trends

The areas addressed in this section are:

- Placement of the CARE-assisted MCh programs in the perspective of countrywide CARE programming from the time of the 1979 evaluation to the present.
- Demonstration of the extent to which MCh resources are used for ICDS Integrated and SNP Upgraded since 1980 to the present, and trends of the past three years.
- Effect of reduced beneficiaries and tonnages on the CARE program in India.

##### 1. MCh from the Perspective of Countrywide CARE Programming

MCh beneficiaries in FY 1979 constituted 38 percent of the 14.5 million CARE program recipients. In 1986, some 44 percent of the 9.3 million beneficiaries enrolled in CARE programs are MCh categories. (see Table III-A.1 at the end of this section.) School feeding absorbed the overall 36 percent tonnage reduction that occurred in CARE's program between 1980 and 1986. Tonnages reserved for MCh have remained constant over the period (see Table III-A.2 at the end of this section), though the number of beneficiaries has diminished by one-third as food inputs per beneficiary intensified with the new integrated program.

##### 2. MCh Resources Devoted to ICDS/Integrated and SNP Upgraded

The 1979 evaluators described three types of MCh programs then in existence: the integrated program (combining food, health and educational inputs, community participation and local, trained community workers); the day care/health site feeding program; and the feeding only (both take-home and on-site). Excluding residual integrated programs in Kerala and Tamil Nadu from which CARE is phasing out at the end of CY 1986, there are two types of MCh programs today: the Integrated Child Development Services program, and the Special Nutrition Program (Upgraded).

Prior to ICDS, SNP referred to feeding-only programs, but since the establishment of ICDS, SNP refers to all that is not ICDS. CARE classifies all of its current SNP programs as "Upgraded" though they see two levels of upgradation:

SNP's that offer "minimum" upgraded services--limited targeting, limited worker training, some nutrition education; and fully upgraded SNP's that provide medical services including immunization, worker training, targeting, some nutrition and health education and some preschool education.

CARE estimates that their SNP (UG)'s are 50 percent minimally upgraded and 50 percent fully upgraded. Many of the existing SNPs are in priority blocks that are likely to become ICDS-sanctioned shortly. Others might become ICDS in three years while in other cases it might take another decade before the conversion occurs. CARE's own efforts to upgrade centers are not "lost" in any way, as the training and services provided in SNPs are transferable to the eventual ICDS program.

Consolidation at the end of CY 1986 and transfer of WFP SNP centers to CARE (400,000 beneficiaries) will affect this picture adversely in that fewer upgrading efforts have been made in those centers to date. This will need to be taken into consideration when judging next year's progress toward attaining the stated CARE objective of 100 percent upgrading of SNP centers.

One must also note that some of CARE-assisted ICDS centers are "sanctioned" but still in the process of being fully integrated so may only have some of the package of services intended. CARE has estimated that a year, or in some cases up to 18 months, is the lead time between initial sanction and gearing a center up into a fully integrated program. The team was satisfied with the integrity of commitment of ICDS expansion and implementation. The team discussed with CARE the possibility of providing random-sampling reporting on component richness of their assisted centers. This is feasible on a special case basis but could not be incorporated as a regular, additional reporting function.

The 1979 evaluation showed that less than 5 percent of the feeding programs were integrated with health and other child development inputs. Today 88 percent of CARE's MCH resources are supporting the ICDS and another 6 percent supporting fully upgraded SNP programs (see table III-A.3. at the end of this section).

The major change over for CARE from the 1979 coverage of largely nonintegrated programs came in 1983 when they agreed to provide food for the ICDS which the Government of India had launched in 1975. Since that time, during Fiscal Years 84, 85, and 86, ICDS beneficiaries and tonnages reserved for them have increased steadily. Though the countrywide CARE program has decreased slightly each year both in total beneficiaries and tonnages, ICDS now constitutes 39 percent of all CARE beneficiaries and 54 percent of all programmed CARE food (see Tables III-A.4 and III-A.5 at the end of this section).

### 3. Reduced Title II Food and Resulting Retrenchment

In a sense the Government pays for CARE to meet its monitoring obligation vis-a-vis Title II food in that it pays CARE for the administrative costs to carry out the food management and surveillance functions.

Thus the Government expected to be party to any projected program cutbacks. However, due to apparently urgent worldwide stress on existing food supply, an abrupt unilateral decision came on school feeding in India which is scheduled to phase out by the end of 1990. The Government has attempted to cover these former CARE-assisted programs with their own foods. However, a number of States have not been able to provide programs to cover previous CARE beneficiaries, notably in Bihar, Punjab/haryana, Rajasthan, and Uttar Pradesh. Other States have partially covered former CARE recipients.

As food programs have been progressively reduced over the past several years, CARE, State Governments, and the GOI have had to devise plans for CARE leaving a number of States, and concentrating its presence within operating States. CARE plans phase-outs in Tamil Nadu for October 1980 and in Kerala, Uttar Pradesh, Punjab/Haryana, phaseout by the end of Calendar Year 1980. While there may be benefits in so far as manageability is concerned (and discussed ahead), CARE, in many instances, has had to abandon without time for orderly takeover by the States and GOI.

Table III-A.1

Evolution of Program Emphasis Since 1979  
Evaluation to Present

	<u>Fiscal Year 1979</u>		<u>Fiscal Year 1986</u>	
III-A.1. Beneficiaries				
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
School Feeding	9,000,000	57	5,238,000	56
FFW	863,560	5	-	-
Integrated MCH Programs - ICDS	300,000	2	3,606,700	39
MCH/Day Care Feeding/SNP Fully UG	2,100,000	13	251,700	2.5
Feeding only/SNP Minimal UG	3,600,000	23	251,700	2.5
Total	<u>15,863,560</u>		<u>9,348,100</u>	

III - A.2. Metric tons

School Feeding	130,305	44	71,522	38
FFW	49,542	17	-	
MCH	113,102	39	115,592	62
Total	<u>292,949</u>		<u>187,114</u>	

Table III-A.3

Evolution of MCH Program Quality from 1979 to Present

	<u>Fiscal Year 1979</u>		<u>Fiscal Year 1986</u>	
Integrated	300,000	(5%)	3,606,700	(88%)
Preschool with H DC Comp <u>1/</u>	2,100,000	(35%)	251,700	(6%)
Feeding only	3,600,000	(60%)	251,700	(6%)
<b>Total</b>	<b>6,000,000</b>		<b>4,110,100</b>	

1/ Health and Day Care Components

Table III-A.4

Three-Year Trend in CARE countrywide Programming

	<u>Fiscal Year 1984</u>		<u>Fiscal Year 1985</u>		<u>Fiscal Year 1986</u>	
	III-A.4 Beneficiaries					
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
School	6,488,000	55	5,858,000	57	5,238,000	56
Preschool	5,295,000	45	4,412,100	43	4,110,100	44
(ICDS)	(2,164,000)	(18)	(2,601,900)	(25)	3,606,700	(39)
<b>Total</b>	<b>11,783,000</b>		<b>10,270,100</b>		<b>9,348,000</b>	

III-A.5 Metric Tons

School	92,051	41	85,015	44	71,522	36
Preschool	134,484	59	110,554	56	115,592	62
(ICDS)	(60,983)	(27)	(69,061)	(35)	101,011	(54)
<b>Total</b>	<b>226,535</b>		<b>195,569</b>		<b>187,114</b>	

## B. Coverage and Targeting

Coverage: Definitions and Issues. For the purposes of this report, coverage is defined as the percentage of target population or "eligible population" being reached by the program, i.e. attending the program 15 or more days per month. If for example the number of 3 - 6 year olds in a block is 4,000 and all are eligible for the program, then a program enrolling 3,000 would be achieving 75 percent coverage.

A further definition is needed for effective coverage: this is the number attending out of those eligible. For example, if 3,000 out of the 4,000 eligible are enrolled in the program, but 2,000 are regularly attending, then the effective coverage would be 2000/4000 or 50 percent.

The major issues to be discussed in this section include:

- Effective coverage of special population groups including 6 months to 3 years, 3 to 6 years, malnourished children, and pregnant and lactating mothers; and
- The extent to which CARE-assisted areas contribute to overall ICDS geographical coverage, including priority tribal and rural blocks.

### Targeting:

Definition and Issues. Targeting is defined as the process or system by which a program directs resources to appropriate groups. Optimal targeting is achieved when a program delivers quality benefits to the specified targeted population. Excluding ineligible beneficiaries results in the most cost-effective program delivery.

The specified target groups in the ICDS program are:

children birth to 36 months, severely malnourished children, preschool children 3-6 years of age, and pregnant and lactating women from the poorest population groups.

The ICDS program is well targeted to needy populations. Priority is given to tribal areas, scheduled castes, and other poor groups in rural areas. Nationwide geographical targeting and village level targeting of beneficiaries are important strategies for ensuring optimal reach to target groups.

This section focuses on the extent to which geographical targeting and beneficiary selection have enabled the food to reach the poorest groups, as mandated by ICDS program norms and PL 480 legislation.

### 1. Norms, Geographic Targeting, and Beneficiary Selection.

The ICDS program guidelines for targeting food include:

- Priority establishment of projects in tribal areas and for scheduled castes in rural areas; and
- Norms for selecting beneficiaries at the village level, based on economic and nutritional criteria.

Geographical Targeting. In all states visited, priority has been given to setting up projects in tribal areas. In Madhya Pradesh (M.P.), for example, out of 128 existing ICDS blocks, 83 are tribal; 30 out of 34 newly sanctioned projects are also tribal. CARE is providing food in 48 tribal blocks.

In Andhra Pradesh (A.P.), 89 projects are in operation. Approximately 30 percent of the tribal areas are covered and 19 percent of the scheduled castes. Before any other projects are sanctioned, A.P. will complete 100 percent coverage of the tribal and scheduled castes villages. CARE is contributing food to 58 projects.

In Bihar 119 Blocks have ICDS programs. Forty-seven are tribal, 66 are rural, and 6 urban. CARE is contributing food to 32.7 percent of the anganwadi centers in the tribal and rural areas. The current consolidation process will increase emphasis on tribal and remote rural sites in that state.

Thus CARE is focusing its food resources in the poorest areas of the states, mainly the tribal blocks. It appears that the geographical targeting is being effectively carried out by the States and CARE food is being directed to the poorest groups as designated by the GOI.

Beneficiary Selection. Norms for beneficiary selection at the village level include

- All 3-6 year olds;
- All 6 months to 3 years; in rural non-tribal areas only, those children who are in Grades II, III and IV of malnutrition are eligible for enrollment or are at-risk based on economic criteria or other at-risk criteria;
- Lactating mothers; and
- Pregnant women in the last trimester.

The norms specify that a community survey, to be carried out quarterly, is to be the basis for identifying and enrolling the beneficiaries. In most areas arm bands for measuring arm circumference are used to screen for malnourished children.

All children birth to 2 years and identified malnourished children (red and yellow zones on the arm band) are to be weighed monthly. All other children are to be weighed quarterly.

In some states community surveys are carried out regularly, and at-risk malnourished children identified by the survey are enrolled in the program. In other states community surveys are not being carried out regularly, so new babies or at-risk children are not being covered by the program. Following the initial community survey, it is to be updated so that it adds new data on:

births, deaths, and migration, newly pregnant women and new mothers, and screens (by armband measurement and, less frequently, by weighing) all children under six years of age.

For the most part, the quarterly community survey serves as an excellent mechanism for ensuring that all who are eligible for the program are enrolled and encouraged to participate. However, until recently the survey exercise was not identifying birth to 12 month infants for enrollment.

In all states, the teams noted that the youngest children birth to 12 months were rarely weighed. Reasons given included lack of baby slings and apprehension of mothers. Thus in programs which only enroll identified malnourished or at-risk children birth to 3 years old, the children who are not weighed are not in the program (are not yet identified as eligible). Thus detection of faltering growth and effecting enrollment may not occur until a child is older than one year and already malnourished.

In summary, where the community survey is being carried out properly and weighing of infants from birth to 2 years of age is being done monthly, selection of beneficiaries for enrollment and receipt of double rations is timely and carried out extremely well. Double rations are two portions of the daily food allotment to supplement the diets of severely malnourished children and pregnant/lactating women. In those areas where the community survey is not being updated and weighing has not been made part of the routine, the at-risk under-twos are most likely not to be captured by the program.

## 2. Coverage, National and Statewide

National. In 1986 the national ICDS program is reaching approximately 8.8 million beneficiaries in 1,356 blocks (September 1986). The GOI goal by 1990 is to reach 2,000 blocks of their most

vulnerable populations which includes birth to 3, 3-6, and pregnant and lactating women from the most backward, economic areas.

In 1986, CARE is providing food to over 3.6 million beneficiaries which includes birth to 3, 3-6, and pregnant and lactating women.

Thus CARE is providing food for approximately 40 percent of the total ICDS beneficiaries.

Statewide. In 1986 CARE has begun to consolidate its program from 13 states to 9 states. Out of a total 1356 ICDS blocks, CARE is providing food to 471 blocks, reaching 46,165 anganwadis. As the ICDS population expands, if CARE food levels remain the same, the proportion of ICDS population covered by CARE food will diminish. Since many of CARE-assisted projects are in districts with large tribal areas, new AW centers will be likely. CARE may be asked to consolidate even further to fewer districts in order to have single donor for each coverage district rather than to have CARE and GOI food programs being implemented in a same district with their different rations and procedures for food preparation.

### 3. Coverage of Beneficiaries

Children 0-3 years. The 1979 evaluation stated that "children under three, the most nutritionally vulnerable and most difficult to reach group receive a small percentage of the food from the program". In 1986 children under three are a prominent part of CARE's program. Thirty-nine percent of CARE's food is programmed for under 3's. However, the question of effective coverage is still a serious question. In Madhya Pradesh for the month of February 1986, the number of 0-3 enrolled was 134,521 compared to 130,406, 3-6 years old. Average attendance for 0-3 years is 67 percent and average attendance for 3-6 years old is 75 percent. These effective coverage statistics are actually quite good. However, in most sites visited by the team, very few young children below 15 months were observed eating in the centers. Only with the introduction of the UNICEF growth charts did it look like children under 12 months of age were even weighed.

Thus the team's impression is that the children from approximately 1 1/2 years to 3 are participating in the program, but the youngest, possibly most vulnerable, children are not. The implementing officials and the participating mothers have not been trained to think of LSH as a weaning food.

Children 3-6 years. The CARE program is reaching approximately 1.7 million children 3-6 years old, which is approximately 44 percent of its programmed beneficiaries. In many of the sites visited, all the preschool children in the villages were enrolled in the preschool

program. We were told that those children who were better off would even bring their own snacks and eat with the poorer children. The pre-school program appears to be attracting its targeted beneficiaries.

Pregnant Women. The CARE program is reaching approximately 280,000 pregnant women. This category represents about 7.3 percent of the programmed beneficiaries. It is a population group, like that comprising the youngest children, that is difficult to reach. Most pregnant women in the rural areas work full days in the fields and cannot come to the centers at 11:00 or 12:00 to eat their food. Some pregnant women, also in their very first and last months of pregnancy, may not want to eat at the centers because of "shyness" as expressed by mothers and the AW workers. The team found, however, that the anganwadi workers have tried to be flexible in order to include pregnant women in their program. Some AWW's had the food cooked and ready early in the morning so that women could come by and carry the food to the fields. Other centers saved the food until mid or late afternoon when the mothers returned from work. Centers which did not accommodate women with such schemes showed less effective coverage of pregnant women.

Given the increased nutritional needs of women from the very beginning of pregnancy, the team suggests that all pregnant women from the first or at most second trimester be included in the program if the GOI approves the additional beneficiary load. Eligibility for food may also constitute an incentive for this target group to participate in special education activities eg., nutrition camps, monthly meetings.

Lactating Women. The team at various sites was told that lactating women would not eat out of the house for up to 40 days after giving birth. However, mothers with young children of 4-5 months were observed at the centers eating food. Lactating women have the same time constraints as pregnant women, and these must be taken into consideration if their participation is to be increased. At the present time lactating women make up approximately 9.2 percent of the total CARE-programmed beneficiaries.

Malnourished Children. In those centers that had routinized the community survey and growth monitoring, the screening process to enroll malnourished children seemed to work very effectively. In site visits, for example in Andhra Pradesh (A.P.), all malnourished children found in the survey were participating in the program. In several places, only II, III and IV degree malnourished children under three years of age were enrolled in the program. In these villages, however, the I degree malnourished children who did not gain weight but had not become II degree were not included in the food program. In these cases the food program became a rehabilitative program rather than a prevention program. The CARE program is currently giving double rations to approximately 560,000 malnourished children which is approximately 14.5 percent of their total beneficiary population.

#### IV. CARE-COMMODITY MANAGEMENT

Without attempting a careful audit of the program the teams paid attention to the following areas of special concern to the flow of food and its management.

- Are there delays or shortages to the centers, why did they occur, and how were they handled?
- Is storage quality and capacity a problem, does it meet the exigencies of pre-monsoon stockpiling?
- Is CARE staffing adequate to cover the program areas with effective monitoring?
- Is the management information system working?
- Is effective coordination achieved?

##### A. Delays and Shortages

USAID field reports and team AW sampling revealed that the Title II commodities are reaching the centers on time and in usable condition. Consider just the food volume, weather conditions in both U.S. and Indian ports, actual port operations and storage, then factor in the Indian monsoon season, washed-out roads in remote areas: an average of eleven handlings before reaching the beneficiaries. The team considered the delivery efficiency to be just shy of a miracle. It seemed that several key elements and program characteristics contributed to making this achievement possible: the priority accorded to the ICDS program and timely action taken by ICDS functionaries to resolve problems from state and national levels; the availability of CARE staff, middle-level, trained and experienced personnel to handle food logistics; the highly professional monitoring information system in place; and the planning and management capability of the CARE staff, many of whom have had more than 20 years of experience with commodity handling and Mother/Child Health and school-feeding programs in India.

In the states visited, there had been interruptions, the longest about one month in connection with processing plant production delays in Maharashtra due to mismanagement, as well as the most common reason for other food shortages in the states visited--delay in U.S. shipment arrivals (U.S. failure to meet call forward deadlines). Other delays, which were from 2-10 days in length and occurred 2-3 times a year were caused by:

processing plant management problems, trucking contractor reticence to take short distance loads which are seen as less profitable; lack of sufficient transport funds to pay private contracts when that becomes necessary; and inadequate advance notice that commodities were needed from the CDPOs to district godowns to ensure timely delivery.

Special efforts were made to avoid interruptions in the ICDS activities due to lack of food. Karnataka helped out with oil purchases to add to the CSM available; bulgur was transferred from another program to replace a CSM shortfall and CARE commodities have been moved from other States. Many forms of traditional transport were employed to meet transport/road crisis:

horses, bullock carts, and head loads, as CARE and ICDS attempted to lay in sufficient inventories for monsoon-inaccessible areas.

Commodity loss (as distinct from weather damaged or infested commodities) is reported at 3-4 percent for marine losses, and about 0.5 percent for inland losses (see Appendix Table #1). There is a persistent complaint from field level implementors about the quality of CSM bags. The present 3-ply paper/poly lined bag is not made to withstand sometimes as many as 11 handlings upon reaching India. Anecdotal information during the visits suggested that weevil-infested commodities were a common Aw problem, particularly CSM during the monsoon season. The team heard about a variety of methods used for deinfesting CSM, most frequently by following the common practice for deinfesting other grains: by exposure to sunlight. Less happily devised was a system of flushing the mixture with water and letting the insects float to the top (with loss of milk nutrients in the water) and remaining larvae. The point here is that infested bags are not often thrown out or returned, but a way is found to make the food usable.

Some of the ICDS staff thought that money given for local transport was not enough to pay for private contractors for short hauls. Other State officials stated that funds for transport had never been exhausted and had even been turned back. Contractors find longer runs more profitable, and the team observed that there appeared to be fewer transport problems to the most remote sites, while nearby peri-urban anganwadis experienced more difficulty.

#### B. Storage

Storage quality in the anganwadis is, on the whole, adequate for the small quantities normally stored, 3-4 bags for a month's distribution. Improved dunnage was normally utilized to keep the bags off the floor and unopened bags were stored properly.

The most frequent problems observed by the team were:

- Container damage especially in remaining old one gallon oil tins (the pails are an improvement though not totally free of serious dents) and bulgur packing, a problem which seems to be enhanced with the 50-kg bags now being distributed, results in humidity, seepage and easy access for bugs, mice, etc. It has been suggested that loops be added to the bags so they can be hooked without damaging the bags.
- Leaving bags open in the anganwadi after taking out the necessary amounts for the day; the inner layer of plastic can be effectively sealed by rolling it down inside the outer bag and then closing the outer bag for added protection.

Commodity handling and food preparation hygiene is one area where CARE FU's could significantly teach and reinforce ICDS norms. Every AW visited needed interaction on caring for Title II commodities to prevent infestation, methods of preservation, and proper hygienic measures to be used during food preparation.

Additional storage space was an expressed need of ICDS and State officials for all levels but especially for the supervisory level.

ICDS supervisors felt that more efficient, food management could be effected by godown storage nearer the AW's served rather than relying on district level storage and delivery. While the team could understand this argument, the additional storage costs and transport charges make this impractical. In any case, neither USAID nor CARE has funds available for godown construction costs.

At the moment it appears that some states have greater problems than others in having to stockpile for the monsoon season; eg., Bihar, Madhya Pradesh, and it looked to the team that storage space for 4-6 months' supplies would have to be available at the supervisory or anganwadi level to assure uninterrupted supply through the period of washed-out roads during and post monsoon. ICDS functionaries and CARE might want to explore the best means of meeting the special monsoon requirements and the most seriously affected States.

### C. Staffing

Over the years of continuous reductions in food tonnages (since 1961), CARE has had to decrease its countrywide staff in the 14 states and two union territories covered.

Bihar has the thinnest CARE staff of all the States. Its Administrator is shared with west Bengal, and CARE has acknowledged staff inadequacy in this State. CARE has assigned a new field

officer and hopes to have a separate State Administrator in the near future. Maharashtra, with its vastness and complexities of food processing, would seem to require a permanently designated Administrator as well, rather than an Acting Administrator. On the whole, though, for the other states, despite the enormity of geographic areas covered, CARE appears to be managing extraordinarily well.

While the number of visits per state does not present a meaningful picture of coverage and coordination quality, it does provide a quantitative glimpse into how the field staff move about in their areas. (Field officers spend three weeks in the field for each week in the office.)

The Table below shows frequency of CARE visits for 1984/85 and for 1985/86 at the District, Block and ICDS levels.

Frequency of CARE Visits

<u>Total CARE Assisted</u>	<u>1984-85</u>	<u># Visits/ per year</u>	<u>1985-86</u>	<u># Visits/ per year</u>
# of Districts	294	4.2 each	312	3.09 each
# of Blocks	2,247	2.8 each	1924	3.80 each
# of ICDS + preschool	65,221	(8.4% of all sites)	71,078	(7% of all sites)

N.B. Districts and Blocks are those with both school feeding and MCH programs.

CARE covers 121 Districts and 471 ICDS Blocks. The number of ICDS centers in 85/86 is nearly 50,000; the balance are SNP centers.

The positive effects of WFP/CARE consolidation would seem to balance somewhat the new demands that will come in January 1987 when CARE takes over WFP centers and assumes the dual task of opening new centers and upgrading existing ones. Nevertheless it appears that the CARE staff will be heavily burdened, at least in the first half of CY 1987.

CARE has also been upgrading its staff by a systematic reorientation of Administrators and field officers over the past few years away from the purely auditing role which characterized CARE's function up to 1982. There were some exceptions in that earlier period in states with integrated pilot projects such as Project Poshak. Field

officers were already becoming well acquainted with technical issues and were broadening their concept of program monitoring. The most significant transition occurred when CARE began cooperating with ICDS. Special training on ICDS components and objectives was provided, both within CARE by the nutritionist and contracted trainers. In Karnataka, eg., field officers have one week training in nutrition basics at the Baptist College. Where Integrated Nutrition and Development Program (INDP) projects have been initiated, field staff have received special project-specific training, eg., four days on Oral Rehydration Therapy (ORT).

#### D. Monitoring Management Information System

CARE monitors the flow of commodities to the ICDS and SNP programs through systematic annual visits to feeding sites and distribution points. On a trimester basis it collects random sample information which originate at the feeding centers (anganwadis or SNP sites). These monthly reports are then compiled at the Block level. CARE's key monitoring point is the CDPO/Block level (and it is at this level also that CARE attempts to coordinate block visits with the AWW's and MS's on a regular basis when they come (by different groups) monthly to CDPO meetings). The key indicators in CARE's monitoring system are food availability, consumption, actual versus targeted feeding days, actual versus targeted rations, attendance of under threes, 3-6 year olds, and pregnant/lactating women. A profile of the Monitoring system for ICDS supplementary nutrition is shown as Appendix D. The monthly anganwadi reporting form is shown as Appendix E.

Due to the great number of AW's, CARE employs a random sampling method for arriving at monthly and quarterly Recipient Status Reports (RSR). The RSR is used by the Volag to report program achievements in terms of actual beneficiaries consuming Title II food. A recent in-depth Food for Development management study revealed that:

- it takes an average of 168 mandays to collect and collate the information; and
- due to the many channels through which this information must pass, it reaches USAID 3-5 months after the end of the tri-yearly reporting period.

Despite these findings the team believes this is the only viable method of data collection to satisfy AID regulations at this time.

CARE's continual surveillance of food used each month by centers would seem to place the agency in a very special position to obtain increasingly accurate reporting of attendance and by age group, which are of such vital interest to ICDS programmers. CARE has been especially concerned with improving targeting effectiveness and has developed a Research and Development Proposal (discussed later).

CARE field officers, during their visits to ICDS centers also collect information concerning immunization, visits of medical staff, and referral services. This supplements the information base of the ICDS system. As part of the routine procedure this information is recorded on visitation reports (See Appendix F for format) and is shared with project functionaries. On all aspects of food management CARE notes the actions required for program improvement and reminds CDPOs in follow-up letters where corrections are needed or have failed to occur.

#### E. Coordination

CARE's counterparts vary by State and include the Departments of Social Welfare (Bihar and Karnataka), Health and Family Welfare (Gujarat), Women and Child Development (Madhya Pradesh), Rural Development (Maharashtra) and Labour and Technical Education (Andhra Pradesh).

The team observed exceptionally good rapport between CARE and State officials. Their staffs meet regularly and confront issues in a spirit of partnership. The States, of course, have borne the brunt of Title II food reductions over the years, but the discomfort of continually reduced school feeding and the pressures of supporting an ever-expanding ICDS programs seem not to have adversely affected close collaboration and cooperation with CARE.

A CARE field officer may cover 3-4 Districts (approximately 1000 anganwadies). At this level, CARE attempts to facilitate the essential link between ICDS and the public health sector through the District Medical Officer and usually takes part in a district-level coordinating committee. At the block level too, CARE checks on medical visits by the LHVs and ANMs, and again most often is a member of the block-level coordinating committee. CARE Field Officers' most vital contact is at the district and block level, with the CDPOs, Block Officers and through them, supervisors and anganwadi workers. CARE also spot-visits anganwadis. Block-level relationships appeared to be mutually supportive, CARE lending the efficiency of its follow-up action system to correct program shortcomings and the CDPOs providing CARE with the monitoring contact down to the supervisor/anganwadi level. This pattern is repeated at the state level with monthly reports compiled and highlights of current problems sent by CARE to the counterpart state official.

CARE works closely with training institutions at the national level National Institute of Public Cooperation and Child Development (NIPCCD) and at the state level where CARE staff themselves have been trained or gone for technical guidance, eg., the Baptist Hospital in Bangalore, the National Institute of Nutrition in

Hyderabad, and the Home Science College in Baroda. Where technical programs have been developed, CARE has coordinated efforts with the Nutrition Officer in the Health Department and obtained technical expertise from medical institutions (St. Johns' Hospital in Bangalore). These technical relationships need to be reinforced, and closer ties established, in order to continue CARE's efforts with its own staff upgradation. CARE also works with indigenous organizations, such as the Rotary Club, obtaining their support for assisting ORT efforts, or in one instance, attempting to get doctor club members to adopt an anganwadi or two for regular visitation, at least in urban areas.

At the national level, CARE works with the Women and Child Development Department of the Human Resource Development Ministry, and has enjoyed good relationships again despite the history or background of unexpected declines in food aid levels. Both agencies are totally committed to the continued expansion of ICDS. The Government welcomes Title II assistance for the near future, with the hope that processed indigenous foods will be the long-range supply source for the ICDS program. CARE is just as concerned that current GOI budgets and indigenous food levels continue, viewing its role as one of interim support.

Donor Coordination. The geographical reapportioning of donor assistance was negotiated jointly among the GOI, WFP, and CARE. The realignment which will be effective December 31, 1986, was motivated by the GOI in an effort to eliminate duplication, maximize personnel and resources as well as reduce commodity distribution expenses. CARE and UNICEF technical personnel work together on ORT activities - eg. in Andhra Pradesh, UNICEF will provide booklets for Anganwadi Workers, and radio and television spots directed to women, while CARE works through the communities mobilizing volunteer facilitators to spread ORT messages. Coordination is vital, when it comes to uniformity messages on health subjects, and probably needs to be intensified.

## V. PROGRAM ASSESSMENT

It has been well documented that food inputs need to be accompanied by other essential ingredients, notably health and education components, if they are to result in nutrition and health status improvements. The entire ICDS conception and structure are based on that premise. This section first addresses the food question and then examines those components most intimately related to the effective use of food: growth monitoring, diarrheal management, and nutrition education.

### A. The Role and use of Food

The principal issues regarding the role and use of food are seen as follows:

#### Nutritional Adequacy and Appropriateness of the Ration

- Is the ration providing enough calories and protein to fill nutrient deficits of the target population?
- Is the ration adequate to prevent malnutrition? Is it of sufficient quantity and nutrient density to recuperate a malnourished child and/or to help meet the increased food needs of a child recovering from illness for catch-up growth?
- Is the ration acceptable to the target population?

#### Ration Dilution/Sharing

- Is the ration being shared on site by other siblings? Or at home by other members of the family?
- Is the ration given to the child less than planned, because more children are being fed than are enrolled?

#### Substitution

- Is the amount of food a beneficiary usually consumes at home being reduced because of his food received through the program?

#### Regularity of Feeding/Program Participation

- Is the beneficiary receiving food on a regular basis? Is the food available regularly? How frequently do the beneficiaries attend?
- Is total food received enough to make a difference, particularly if the child is ill or malnourished?

1. Nutritional Adequacy and Appropriateness of the Ration

Nutritional Adequacy. The CARE ration provides 65 grams of CSM and 8 grams of oil to all under-6-year-old children. Malnourished children and pregnant and lactating women are given a double ration: 130 grams of CSM and 16 grams of oil. The following table shows the caloric and protein value of the ration and its contribution to meeting minimum nutritional requirements.

CARE Ration Contribution to Recommended Daily Requirements

<u>Bene- ficiary</u>	<u>Ration CSM</u>	<u>Quantity Oil</u>	<u>Kcal</u>	<u>Protein</u>	<u>% Contribution to Recommended Daily Require- ments</u>	
					<u>Kcal</u>	<u>Protein</u>
< 3 yr. olds	65 g	8 g	300	10	25	45
3-6 yr. olds	65 g	8 g	300	10	17	34
Malnourished < 3 yr. olds	130 g	16 g	600*	20*	39	67
Malnourished 3-6 yr. olds	130 g	16 g	600*	20*	30	51
Pregnant women	130 g	16 g	600**	20**	24	34
Lactating women	130 g	16 g	600**	20**	22	24

\*300 Kcals and 10 protein grams added for recuperation purposes.

\*\*300 Kcals and 10 protein grams added for additional P/L requirements.

Source: ICDS Guide, p. 17, Recommended Dietary Intakes for Indians.

CSM is an excellent nutrient-dense food specifically formulated to meet the nutritional requirements and bulk constraints of young children. With the addition of oil, the ration provides an outstanding supplementary food. The quantities programmed by beneficiary are reasonable for filling a 20 - 25 percent calorie deficit and at least a 30 percent protein deficit for all categories except the 3-6 year olds. The calorie contribution for this latter age group may be too low to fill the energy deficit and prevent malnutrition. The team suggests that the ration for this age group be reviewed by the GOI and CARE.

The double ration should substantially assist pregnant and lactating women to meet their increased nutritional needs. The high protein value of the double ration should contribute to recuperating malnourished children. The major problem in regard to the ration is a bulk constraint for the youngest children below 15 months and for malnourished children whose appetite may be suppressed. In a majority of sites, the team noticed that the youngest children could not finish a single ration at one sitting. The AWWs also confirmed that the malnourished children, particularly those under three years of age, could not eat a double ration. At some sites the AWW allowed the child or mother to take the unfinished food home. We in agreed with this practice because taking the food home and educating the mother or mother-in-law to feed the young child frequently with the CSM is the only feasible way at the moment to assure that at-risk groups will fully benefit from the double ration.

Appropriateness/Acceptability. CSM is well accepted and prepared in a wide variety of recipes that are part of the traditional diet. Most of the preparations are of a snack food type and therefore more often seen as "extra" food rather than a meal so that the ICDS and CARE objective of supplementary nutrition is being fulfilled. The mother's perception of the food is that it constitutes a health-giving extra food, not a complete meal. This was especially true in rice-eating areas where a meal without rice is not really a meal. Bulgur, however, may be perceived as more than a snack because of its bulkiness and similarity to wheat preparation that are considered meals.

In Karnataka where the second half of the double ration is in the form of Ready to Eat (RTE) food, AWW's and women said the women preferred the CSM preparations to RTE which they found "too sweet". But most often the women took the RTE ration only because they were allowed to take the RTE food home.

The most important issue with regard to appropriateness of the ration is that preparations are not made with the youngest children in mind, despite the fact that CSM was specifically designed for the needs of this group. Preparations seem to cater more to the taste of the 3-6 years olds and women beneficiaries. Very small children (under three years of age) sometimes found the food too spicy or dry. The team suggests remedies: since an anganwadi deals with a small number of weanlings, it would seem relatively simple to put aside some of the food before spicing and to dilute it further for the young ones; or, the person bringing the child to the AW could be instructed to take home the food prepared as uppma, halwa and dalia (see descriptions of these preparations at the end of this section), and there dilute it to a gruel-like consistency.

## 2. Dilution of the Ration/Sharing

With the exception of Bihar, AWW's reported that there was adequate food for all beneficiaries so that rations did not have to be decreased because of larger number of recipients coming than had been programmed. Both CARE and GOI officials confirmed that rations could be increased at AWWs should additional at-risk beneficiaries be identified.

The 1979 evaluators were concerned about the degree of sharing in CARE-assisted MCH programs in existence at that time. As the ICDS program is completely on-site feeding, sharing is significantly reduced compared to take-home or dry feeding programs. However, the team did notice that occasionally an older brother or sister who brought the younger one might eat from the small child's plate. The AWW's said that it was difficult to prevent this sharing, the older child was providing a service by bringing the younger one. It did not appear, however, that the older sibling had to be fed as an incentive to bring the younger children. It would be helpful if AWWs stress that the targeted child needs the full amount of calories and proteins on his plate and the role of the helping sibling should be to encourage the child to consume all of the food.

In some anganwadis, the pregnant women were permitted to take the prepared CSM home. When these women were asked if other family members shared the food, the reply was usually negative and the reason given, that "the children have already eaten their own food at the center". In other cases, they said they shared "a little". In many other countries, sharing of take-home food has been well documented and considered unavoidable given cultural and food shortage situations in the family. The team is of the opinion that pregnant women should be allowed to take food home given their work schedules and "shyness" about eating at centers. Along with this flexibility, however, greater attention should be given to motivating mothers to consume the food herself and to reinforcing the concept that the food is their special food and that they need it in order to have stronger and healthier babies.

## 3. Substitution

Substitution is a common problem for on-site feeding programs. The teams asked mothers about home meals given to the participating children in an effort to determine if they ate less at home as a result of the anganwadi feeding. Most mothers said that children ate "a little bit for breakfast" (rice and dhal in the southern states, or chapattis in corn, wheat or millet eating areas) and that they ate the same type of food again in the early afternoon. No mothers said their children were not eating a second meal because

they had already eaten at the AW. Timing is an important variable affecting substitution. Serving times at the centers visited were planned for the end of the morning session, at noon or 12:30. AWWs stated that children would probably leave the center if food were served earlier, but that this had not been tested. Nevertheless, because of the earliness of breakfast and the fact that children did not always consume all of their food in the centers visited, the team felt that supplementary food might be used optimally if served mid-morning. This might ensure that the children would eat the full amount of their 3:00 PM or 4:00 PM meal at home, and as an added benefit, would increase the attention and performance of the preschool children.

#### 4. Regularity of Feeding/Program Participation

Regularity of Feeding. The norms for an anganwadi include 25 days of feeding per month. This means that the center must have a food supply that will last for 25 days. The team in its center visits, made a close examination of food interruptions. With the exception of Bihar and Maharashtra, where major interruptions had occurred during the past year and are discussed above, the team noted that the usual pattern of interruptions of food supply was 2-10 days several times a year. The number of missed feeding days are by no means insignificant--one CARE official said assuring a supply for 250 days a year was a very good achievement and far above that achieved in other supplemental programs. The team felt that given the programming obstacles, especially stockpiling requirements, changing needs in centers, and relative newness in the program, CARE was turning in a very good performance insofar as food delivery is concerned.

CARE data from December 1975 through March 1986, a dry period, and from April through July 1986, the beginning of the monsoon, indicate that there are wide variations in feeding days achieved, ranging from highs of 86 percent and 96 percent in Andhra Pradesh and Tamil Nadu to a low of 38 percent in Bihar (see Table below). The most recent estimates for eight of the nine states to which CARE provides food show that from April to July 1986, an average of 72 percent of the 300 feeding days intended was achieved. This means 18 feeding days a month out of 25, or 216 a year out of 300 programmed.

Feeding Days Achieved as Percentage of  
25 Feeding Programmed per Month

State	Dec 85-Mar 86	Apr 86-July 86
Andhra Pradesh	88	70
Bihar	39	59
Gujarat	90	91
Haryana	66	64
Karnataka	78	na
Kerala	81	na
Madhya Pradesh (Tribal)	57	84
(Rural)	59	83
Maharashtra	70	83
Orissa	86	70
Rajasthan	94	62
Tamil Nadu (Child)	96	
(Pondy)	51	
Uttar Pradesh	38	

Variation in feeding days is also evident between blocks, as noted in looking at data in Madhya Pradesh. Some blocks achieved almost 90 percent of days programmed while others achieved considerably less.

Overall, CARE has achieved an average of 72 percent of feeding days programmed, a good record considering that their program is but three years old. However, there are centers, particularly in the monsoon-inaccessible areas that are not receiving adequate food supply and these centers, though few, bring the average down. Twenty-five days is the objective, but an average of 18-day level, and more than that in a majority of states, is reassuring. It means that food is available to a majority of CARE-assisted ICDS beneficiaries on a regular basis. CARE, though, needs to concentrate on Bihar and Maharashtra, and on blocks where regular food delivery is still a problem. The team was much impressed by the District Organizers and UDPOs in getting the food distributed and with the innovative ways of delivering food to the villages as mentioned earlier.

Program Participation. Various studies around the world have shown that the frequency of attendance in supplementary feeding programs is positively correlated with weight gain and nutritional improvement. In all sites the teams looked at attendance registers. In the majority of centers, the registers showed the children receiving food 25 out of 25 days scheduled. The team could

not document the extent of accuracy therein due to the difficulties of head counting in the presence of visitors in the village. It could be observed, however, that the 3-6 year old children came more regularly than the other target groups. The preschool activities and supervised daycare along with the food are strong attractions. The 4-6 year olds can easily walk by themselves to the centers. The attendance of under three year olds depends on the help of older siblings and grandmothers, so regular presence is much more tenuous. Pregnant and lactating women also attend irregularly. The team felt that it was essential to find the most convenient time for these women to come and that efforts were still needed to make them feel comfortable eating and being a part of center activity. Regular attendance of women appeared to be better in centers that were flexible and provided food for them before they went to work or saved food for them at the close of work. Further, because of work in the home and child care responsibilities, it was impractical for women to come each day to sit in the centers. However in some centers, particularly where the women had a separate room or separate space in which to sit and talk, the AW setting seemed to provide a social occasion for the mothers. AWW's need to understand the special time constraints of women and the need to make the AW a women's place too.

In tribal areas where beneficiaries come from several hamlets to the designated anganwadi, regular attendance of those from the distant hamlets is unlikely especially during the monsoon. Among suggestions for alleviating this problem was the possibility of the helper carrying food to the other hamlets on a take-home basis at least during monsoon months. Similar flexibility and innovation will be necessary if the hard-to-reach groups are to receive food as intended.

Program reach to the ill child is a special challenge. A child with diarrhea or other illness usually does not come to the anganwadi. And in fact the AWW should try to prevent children with contagious diseases from coming to the center. But it is these children in particular who need the supplemental food. The team supports the observed practice of bringing food to the home of the sick child, suggesting that the AWW be taught to tell the mothers the importance of reserving the food for the sick child and of giving it in frequent feedings.

### 5. Other Roles of Food: Incentive, Education, Credibility

Other effects of food use include the following issues:

- Does the food serve as an incentive to program participation?
- Does the food serve to enhance nutrition awareness?
- Does the food affect worker credibility?

Incentive Value. The team found that ICDS beneficiaries perceived the food component to be the key benefit of the AW package. The team could not document the direct effect of reduced food supply on attendance because the latter records are of questionable accuracy. An illustrative example, however, was obtained in a peri-urban site in Bihar (and is shown in Figure V.1 at the end of this section). It can be noted that attendance drops to half when it becomes apparent that food is not available. AWW's consistently confirmed that with interrupted food supply, the attendance drops off, almost immediately for P/L women and under three year olds, and eventually, for the preschool 3-6 year olds. The prolonged presence of this latter group without food is an indication of the second component valued most at the center--the daycare and education provided. Children between 3-6 years are the best program users and their high attendance rates are due to the value placed on the non-formal program by the children's parents. Mothers were very keen to send the children "to school" since such an educational opportunity has not normally presented itself. Very important also to women is the day care for her children at the AW leaving her free to do her own work in the fields or at home. The food is an attractive extra bonus for this group.

Women along with very small children are the poorest program users. On being asked why they did not come to the anganwadi to collect their food supplement regularly, women often said that although they would like to have the food, the distance from their home to the center was too great. Some women said they preferred to send relatives to collect their rations. In focus group discussions with women, they also said they felt shy walking through the village to get free food. They also said they were embarrassed by having to sit at the center and eat their food publicly with the children. This, coupled with the fact that the AW program is seen primarily as a child-oriented program, is a further deterrent. The unfortunate result of this is erratic participation by needy mothers. Uncertainty about mother's presence sometimes makes the correct planning of food quantities difficult at the AW so the food may run out, adding to mothers' "shame" and further disincentive to their

attendance. If the medicinal and therapeutic value of the supplementary food meant for at-risk women could be enhanced in the public eye, then women might be less reluctant to come and to consume the food.

The team thought the attendance of the 0-3 year old group might be improved by bringing the ANM more prominently into the anganwadi program, and by enlisting her influence with the mothers during her home visits to encourage them to send their children to the center regularly, especially the youngest.

In conclusion, the preschool activities and the supplementary food provided at the AW make a strong incentive for the attendance of the 3-6 year old age group. But for the smallest children and for the P/L mothers, further efforts are needed to ensure their effective use of the program.

Educational Value of Food. The supplementary feeding program at the AW has had a nutritional awareness impact on the women who view the food as having health-giving properties. Further efforts--educational campaigns--are needed to convince target groups of the importance of food supplementation especially during pregnancy and lactation and for the youngest children, whether malnourished or not, as a preventative measure. An educational campaign should dispel the misconception that food distributed at the AW is for children only. Focus on women, not only as the extension of the child, but as valued community members capable of changing family practices and improving the health of all, should be strongly emphasized in such educational campaigns.

Worker Credibility. The Anganwadi worker is seen primarily as a school teacher. Mothers mentioned repeatedly that the AWW helped in developing children's minds. The distribution of food by the AWW adds a further dimension to how she is perceived.

Not only does she build minds, she builds and strengthens bodies. Despite her youth and the benefits she can derive by working with the older village qais who have greater credibility with the child-bearing population, the anganwadi worker has developed her own standing in the community and the team observed that this has been abetted by the food supply under her control.

RECIPES MADE FROM CARE COMMODITIES

I.	Porridge/Dalia Salt	Porridge/Dalia Sweet
<u>Ingredients</u>	<u>Amount (Qty.)</u>	<u>Amount (Qty.)</u>
LSM/ICSM	65 gms	50 gms
Salt	To taste	-
Jaggery	-	16 gms
Oil	8 gms	8 gms

Method:

1. Add sufficient water and boil until the grains get soft and smooth.
2. Add salt and jaggery and mix thoroughly.
3. Add oil while boiling.
4. Cool and serve.

II.	Halwa Salt	Halwa Sweet
<u>Ingredients</u>	<u>Amount (Qty.)</u>	<u>Amount (Qty.)</u>
LSM/ICSM	65 gms	50 gms
Salt	To taste	-
Jaggery	-	16 gms
Oil	8 gms	8 gms

Method:

1. Roast LSM/ICSM for 3-4 minutes without fat until it turns slightly brown.
2. Add salt and jaggery and mix thoroughly.
3. Add oil and mix thoroughly.
4. Pour lukewarm water on the LSM and boil for 3 minutes. Keep stirring while pouring water.

<u>III.</u>		
<u>Ingredients</u>	<u>Panjiri Salt Amount (Qty.)</u>	<u>Panjiri Sweet Amount (Qty.)</u>
CSM/ICSM	65 gms	50 gms
Salt	To taste	-
Jaggery	-	16 gms
Oil	8 gms	8 gms

Method:

1. Roast CSM/ICSM with oil until it browns lightly and gives off a roasted smell.
2. Add salt and jaggery and mix thoroughly.
3. Remove from fire and cool.

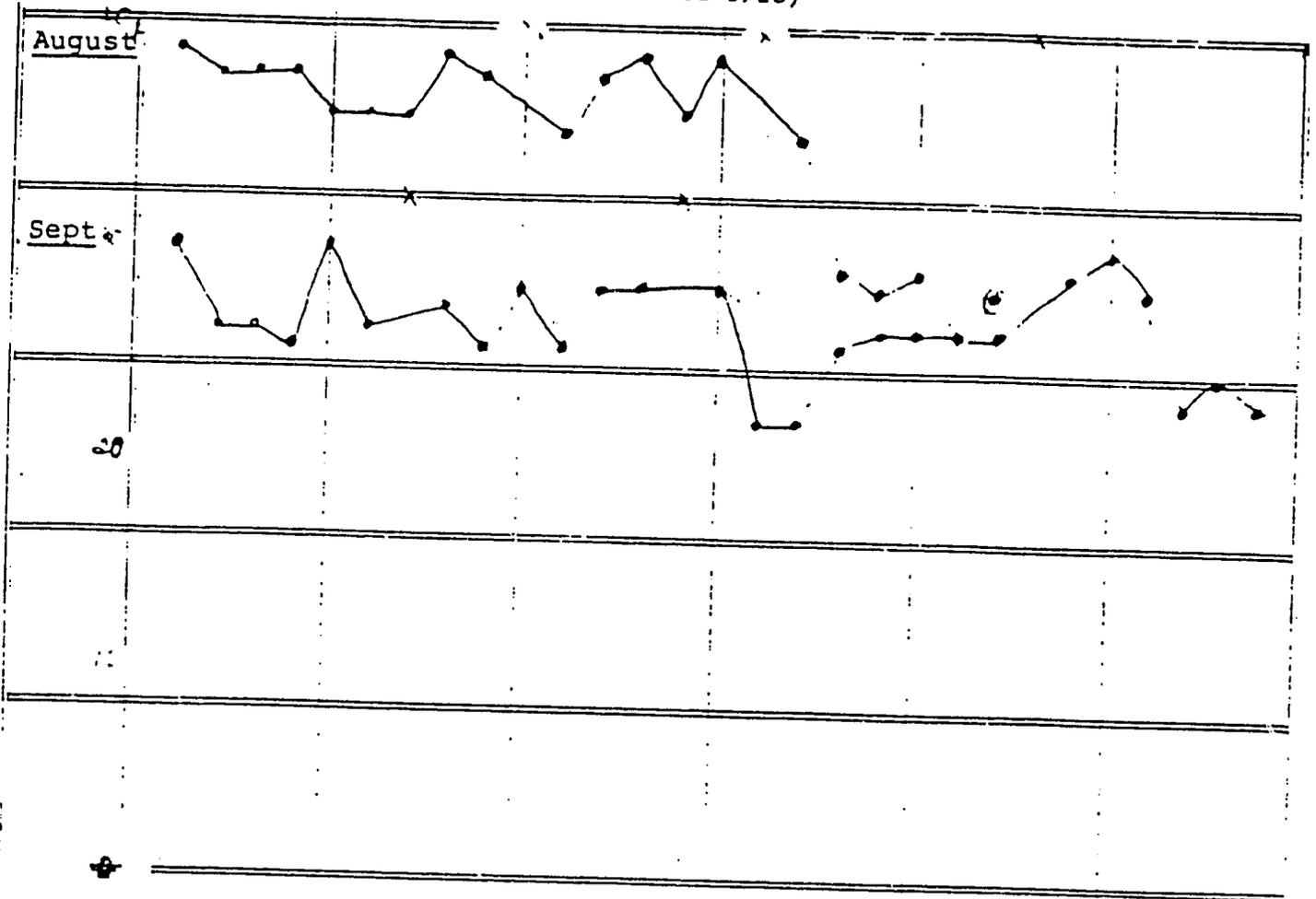
<u>IV.</u>		
<u>Ingredients</u>	<u>Mathi Salt Amount (Qty.)</u>	<u>Mathi Sweet Amount (Qty.)</u>
CSM/ICSM	65 gms	50 gms
Salt	To taste	-
Jaggery	-	16 gms
Oil	8 gms	8 gms

Method

1. Add salt to the CSM/ICSM and make a stiff dough with water.
2. Add salt or jaggery and mix thoroughly.
3. Make one big ball of the dough and press it until it spreads to the minimum thickness.
4. Cut it into small round pieces and deep fry. Similarly sweet Mathis can also be prepared by adding jaggery instead of salt.

FIGURE V.1

TABLE DECLINE IN ATTENDANCE DURING MONTH OF REGULAR FOOD SUPPLY (AUGUST, PARTIAL) AND FOOD SHORTAGE (SEPTEMBER, PARTIAL) (supply interrupted from 18 August through 22 September; first feeding day after resumed 9/23)\*



COMMENT Attendance drops off to around 50% as it becomes apparent that food is not available. However, looked at another way, 50% of the children continue to come in this essentially periurban site, partly because of child care attraction, partly because mothers fear that, if they do not send their children regularly, they will be stricken from the pre-school/feeding rolls. The quality of the pre-school education in this site was so poor that it would not seem that the educational attraction would be there, but two mothers interviewed felt that, even as limited as it might be, it might be all their children might get.

\*BIHAR: (PERIURBAN) RURAL SITE, FATUAH BLOCK

## B. Program Components Directly Affecting Food Effectiveness

Introduction. The 1979 Community Systems Foundation Evaluation recommended (see scope of work) that programs which provide food alone should be upgraded to provide other health and educational services. To review progress in this area of CARE assistance, the team selected various elements of the well established ICDS program to illustrate the remarkable steps that have taken place since the recommendation was made.

Program effectiveness, which ultimately is the protected and improved health status of the vulnerable under-six and at-risk women population is assured by the ICDS package of services, including immunizations, vitamin supply, medical checkups and referrals, non-formal education, sanitation and community participation. The three central components chosen for study as those most closely affecting the effective use of food are:

growth monitoring; diarrheal management, and nutrition education.

### 1. Growth Monitoring

Introduction. Growth monitoring, in India as elsewhere, has become a disputed topic. A few comments are in order, therefore, before going on with observations about how it is proceeding in the CARE-assisted ICDS projects.

To begin with, growth monitoring is not a religion but a technique. As such, it has a variety of purposes and plausible forms. None of these necessarily excludes the others. In fact, it may be useful to think of them as placed on a continuum - from lesser to greater complexity; smaller to greater involvement of the mother; and, theoretically at least, a little to a lot of effectiveness. In the life of any program of which growth monitoring is a part, there may also be an historical evolution in the way the technique is applied.

First, growth monitoring can be used as a screening and targeting tool, to determine nutritional status, eligibility for supplementary feeding, and need for medical attention.

Second, it can be used to monitor nutritional status, either by focusing on a child's position in some nutritional category and following change from one status to another, or by tracking trends in child growth, or both. Such surveillance can be more or less activist:

The less active approach is typically limited to recording child weights periodically, so as to capture those which fall into a danger grade or to graduate improving children from therapeutic or supplementary programs. The more activist

approach to surveillance incorporates the concept of optimum child growth and development and uses regular weighing for early identification of growth faltering, to be followed by appropriate and prompt action.

Third, growth monitoring can be utilized as an educational tool. Again, the process can be more or less active. In the latter, the mother is informed about her child's nutritional status and any changes therein; she may also be informed about the implications of this for her child's well-being and perhaps receive some information and prescriptions for behavior. In the former, the mother is recruited, independently or in the context of some group, and supported in her attempts to sustain positive development in her child or to address the problems that have produced any deterioration in that development.

The most "complete" model is committed to: (1) frequent measurement and tracking of growth trends, particularly in the age groups 0-36 months where so much vulnerability is concentrated, in order to identify faltering before it has had time to express itself in grade change or in some visible physical manifestation; and (2) use of the weighing encounter as a platform for mother and even community participation in learning and action. The assumptions are: (1) if mothers know and understand what is happening to their children and are given precise and practical advice for the appropriate corrective responses, they will make those responses; and (2) even within the constraints of economic disadvantage, there is a margin for adjustment in diet and intrafamily caloric allocation. Growth monitoring is also seen as an opportunity to provide other primary health care services, either directly or through referral, and to regularize the contact between mothers and outreach workers.

A final assumption is that the most complete model is an evolutionary advance over the simpler uses of growth monitoring for screening and even surveillance; that it has positive impact on child growth; and that it is low in cost or at least cost-effective. While the worldwide evidence for these claims is spotty, there is no solid evidence that growth monitoring has no useful effect whatsoever, nor has it really been tested in its full-blown form in many places on a large scale. Furthermore, it has not yet been proven to be inherently unreasonable and there is presently no plausible alternative for addressing post-birth malnutrition problems, particularly during the critical period of weaning.

Growth Monitoring in the CARE-Assisted ICDS Program. A few additional introductory comments are in order. The first is that, while growth monitoring is properly the province of ICDS, it sits at the frontier of CARE's appropriate concerns with food and food use and with targetting. Because growth monitoring has been used to date principally as a screening tool, its determinations have been felt in the area of decisions about how much commodity is required and, in some instances, what kind of commodity is appropriate.

Second, while it is an integral part of the ICDS program, growth monitoring is just one technique in an integrated effort to serve the under-6 preschool population and is so valued by mothers and workers alike. As such, growth monitoring is a tool in a larger child development kit which goes beyond child survival.

Finally, the use of growth monitoring is relatively new as both technologies and project lifetimes go. The GOI and the states have been absorbed with putting the ICDS infrastructure into place:

an anganwadi with a trained worker (and an assistant) in position and sufficient equipment and supplies for continuous enrollment, monitoring, and food distribution. Where CARE has been involved in the support of ICDS, it has had to assure a well-functioning and well-supervised commodities logistics system. Furthermore, the original conceptualization and norms for application of growth monitoring in the ICDS prescribe and instruct about weighing, charting, and assessing nutritional categories. However, they do not stipulate the structure of the growth monitoring encounter, whether at home or in the AWC, nor is worker/supervisor training consistently and precisely designed to teach a more expanded use of growth monitoring.

From these perspectives, the comments which follow should be seen as observations about how a particular intervention is currently being used in some randomly selected areas, rather than as some sort of global critique.

Frequency of Growth Monitoring. The ICDS norm is for all children 1-5 years to be measured for arm circumference at baseline and every three months thereafter. Additionally, all children 0-2 years of age, all severely and moderately malnourished identified on the basis of arm circumference, and all children with any illness of over five days' duration are to be weighed monthly. There is consensus that children under age 1 are not well represented in the

groups weighed. The cohorts ages 2 and 3 did somewhat better according to the registers we reviewed, but we were not doing a quantitative study. Furthermore, there was little indication of systematic attention to sick children. From the standpoint of the AWW, she has the following channels for identifying sick children for follow-up and/or referral:

(1) they are identified at the time of the monthly weighing of 0-2 year olds and III and IV degree malnourished; (2) they appear in her anganwadi for preschool and/or feeding if they are not too sick to come; and (3) she picks them up in her home visits which are, given her schedule and the demands of her time and her clients' schedules, characteristically unscheduled and ad hoc. The obviously unattended group of possibly sick children is the 2-3 year age group which is only erratically captured through these channels. The other is, of course, the children in the younger age cohorts mentioned earlier who are not being weighed at all. In places where weighing is not yet widely institutionalized because of such factors as lack of growth cards (e.g., Bihar), scales (e.g., Gujarat), the holes in the net the AWW has for capturing sick children are even larger. The AWW is, in fact, not required to formally report morbidity. The AWW Monthly Progress Reports in the recently published ICDS MIS Manual\* requires only one morbidity datum (beyond information on number and percentage of Grade II, III and IV malnourished under b) and that is the number and rate per 1,000 cases of diarrhoea.

### The Technology

Weighing. Both the spring-and-dial Salter scale and the UNICEF bar scale were seen at the sites visited. In some sites the UNICEF bar had only recently arrived and was not yet in use. A common field reaction was that the bar was difficult to calibrate, "hit babies on the head", and had more pieces than the Salter scale which could get lost.

While the Salter scales were found easy to use, the most frequent criticism was the imprecision produced by the 500-g. dial divisions; this encourages error and is certainly inadequate for monthly

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\* Ministry of Human Resource Development, Department of Women's Welfare. A Manual on the Integrated Management Information System for the Integrated Child Development Services Programme. New Delhi: National Institute of Public Cooperation and Child Development. 1986.

weighing\*. However, in all but one of the sites visited, the Salter scale was in apparent working order. In the site of exception, only the glass was cracked, which had led the AWW to conclude that the scale was broken; in consequence, weighing had been stopped and the worker was in a state of high anxiety.

For neither scale type were baby-slings available, a condition which was cited as a reason for mothers not bringing small babies in for weighing or even permitting them to be weighed at home. In Madhya Pradesh, the AWW and mothers came up with the innovation of using a sari as a cradle, which was apparently successful.

As for worker management of the Salter technology, there appears to be general comfort with it in those sites where weighing is occurring regularly. Scales were hung freely. Most sites had the hanging rope stored with the scale, suggesting customary use, and workers seemed to check automatically to make the zero-error correction before taking each weight. No adjustments were made for clothing or shoes, which may be academic in most high-temperature rural and tribal areas. Workers did not, however, typically take two readings for accuracy.

One can expect some disruption in the growth monitoring process as shifts occur from the Salter to the bar scale technology, in areas where this is about to happen. There will also be associated data and recording problems. This disruption could be particularly acute in instances where the shift in hardware does not occur simultaneously with the shift in the recording modality, *i.e.*, the switch from handwritten ledgers to the Big Blue printed growth chart register.

Ideally, the new weighing technology would be taught, preferably through on-site practicum; a re-survey would be taken of the entire site to establish a new baseline; the data would be recorded in the new register; and a follow-up ledger or listing would be set up for use by the AWW and her supervisors. Subsequent supervisory visits and any necessary refresher training would be used for quality control. It may well have been the idea to introduce both technologies simultaneously as complementary to each other. However, that is not what seems to be happening in the field, whether the Blue Book is already in use but in conjunction with the Salter scale, or where the AWW's are beginning to use the bar scale but are still recording weights in their standard registers.

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\* We understand that a Salter scale with 100 g. markings may be gradually substituted for the existing technology through UNICEF. While this change represents a marked improvement, it is another in a long series of technological and reporting changes the AWW has had to adjust to.

Growth Cards. The variety of paper records of child growth and the similarly variegated internal structures of those paper documents is difficult for workers, supervisors, and observers to encompass intellectually or practically. This is a predictable product of state-to-state differences in India, as well as of the number of experts, foreign and national, who have been involved in the conceptualization of growth recording formats, including cards and/or handwritten and/or printed and bound books.

Every state visited had been, was going through, or was about to go through a transition in its approach to child growth recording. Mothers typically were not allowed to keep their own child's card. A number of programs worldwide have found this to be an effective motivational and chronicling tool despite inevitable card losses by some mothers.

While there was appreciation of the Big Blue Book because it was neater, the overall field view of the book was that it was cumbersome; did not lend itself comfortably to use as a follow-up tool; did not incorporate the child's immunization, Vitamin A, and deworming schedules; and did not provide fine enough weight discriminations. Some users and supervisors expressed their preference for use of color to discriminate weight zones.

There is general recognition that this situation of variability has been one of the reasons why, in some areas, the supply of growth cards has been interrupted. Workers and supervisors also have trouble dealing with changes so that the data base is frequently under onslaught. Finally, a number of the instruments are simply inadequate. Since we understand that UNICEF, USAID, and the GOI (NIPCCD) are currently engaged in field testing a much improved recording format for eventual national use, there is no purpose in further observation here, except to express the personal hope that this change will be the last one for enough time to permit growth monitoring to prove itself (or not) as a useful technique for child development.

Arm Circumference. The November 1983 ICDS Information Document published by AIIMS set forth as a norm that arm circumference was to be taken every quarter (January, April, July, and October) in all children under age five. The ICDS Working Guide published in April 1985 by the Ministry of Social Welfare and prepared by CARE-India revises that norm and prescribes quarterly arm circumference measurement only in children age 1 to age 5.

While arm circumference does increase with age, it does not change much from the first to the fifth birthdays, when baby fat is gradually replaced by muscle. Because of this it is at its most sensitive as a measurement tool in the 0-12 month age groups and not very sensitive in the older cohorts. For those older age groups it can be useful for baseline purposes and because it is, as the Guide points out, not necessary to know the precise age of the measured child in order to know its nutritional status. However, there are some indications that the tape is not being used correctly and, in some cases, is being used as a monthly monitoring tool. In the older age groups, its sensitivity is inadequate for such frequent readings and is most likely to be misleading. Supervisors were also reporting having trouble with lack of coincidence between the determinations of nutritional status through weighing and the indications given by armband measurements. Even where there is coincidence, it is not clear that AWW's understand why the two measurements are taken and how to consider them together.

Recording and Interpretation. There was substantial variation among states, blocks, and sites in the consistency and accuracy of weight-recording and register maintenance. As might be expected, the greatest consistency was among the sites in a block which were attended by the same supervisor and where AWWs had been through the same training.

There were different kinds of variations found, some more frequently than others. Roundings to the nearest 500-g. mark and adjustments for the time of month in which the weighings were taken were not correctly performed, the latter sometimes not at all; there was confusion about which gradewas between which grade-line divisions; dots were not joined; weights were not converted into grades; in the sites where the grade designations A, B, C, and D had been substituted for I, II, III, and IV, there was major disruption, even for the most alert and meticulous AWW's; lines between dots were curved rather than straight; the January for each new year was misplaced and the baseline months not written in; and children were not registered in descending chronological order so that it was difficult to add new births. Some of these are of an order that just make recording difficult; others are frank errors. To these should be added errors in reading weights and recording them, and transfer mistakes when data are rewritten from one register or list into another.

This list should not be interpreted as a description of disaster; it is simply a notation of the kinds of error found where those were encountered. Most AWW's in the sites visited seemed to understand the concept of weighing and plotting, as well as the not-easy concept of the relationship among age of child, date of weighing, and absolute weight. Notebooks were available and, for the most part, up to date; there were relatively few cases of total chaos and utter lack of comprehension. When nonweighings occur, the reason is not usually noted, although most AWWs know why.

In summary, the broad conceptual infrastructure for the growth monitoring technique is largely in place in terms of its use as a screening and targeting device. CDPOs, CARE field officials, and some mukhya sevikas commented that there were, nevertheless, problems of accuracy and consistency; they felt this could be redressed by some on-site refresher training and by having a standard checklist for supervisory reviews of growth monitoring procedures and record-keeping.

Follow-Up and Education. At the outset of this section, a description of a "complete" model of growth monitoring was presented, in the context of its optimal and potentially most effective utilization. In the context of the ICDS program, the argument would be that supplementary feeding cum growth monitoring offers an important opportunity for nutrition and health education, an entry point for mother-worker interaction, and a place where meaningful behavior change could be generated. At present, the focus for the worker and for the mother, when she is informed about her child's status, is on the dot, not on the slope; the emphasis is on category, not movement, on grade, not on the detection of early growth faltering whatever the grade.

This optimal event was not occurring in the ICDS sites visited, although we have been told there are exceptions which indicate that the optimal model can, in fact, be implemented. The mother-worker contact at the time of weighing at the AWC is too brief to permit an exchange which is rich in content. However, the simple joining of the lines in the presence of the mother, whether or not she is the holder of a weight card, can be used to indicate to the mother whether her child is gaining, losing, or faltering. If the press of people and events is too great to permit worker counseling of the mother at time of weighing, the AWW can flag that mother in her book for a follow-up visit in which she can investigate any case of malnutrition; review with the mother the possible causes of the condition; and consider with her what solutions are available to her, including additional supplementation, dietary changes, intrafamily food reallocation, and/or medical referral.

Reorientation of all levels of field workers, from the CDPO down, toward a more dynamic view and utilization of the growth chart could be achieved through in-service workshops. A fairly simple corollary to that activity would be to teach the AWW how to proceed to use her weight registry and the growth slope to flag not only children who are in a danger grade but those who are going in a danger direction.

At present, while many AWW's do follow up Grade III and Grade IV children with home visits, most do not maintain a list for prioritized home visits to sub-populations (mothers or children) currently at risk. Even if an AWW does not complete her monthly round of all houses, she or, in two unusual cases when the AWW's assistant was the village dai, her assistant will at least be sure to appear regularly at problem homes.

The more difficult aspect of enriching growth monitoring so that it is an optimally effective tool is the style and content of the educational interaction. While it is important for AWW's to have appropriate educational media at their disposal, which many of them do not have, it may be more important for them to dominate the concepts of consultation and joint problem solving, as well as the idea of priority messages. AWW's are telling mothers about what should be added to children's diets, often in terms of what is feasible for them economically and logistically. This concept should be fostered and expanded; workers can be encouraged to discuss nutritional and health problems with mothers, rather than lecture to them on more or less related subjects. AWW's know a surprising amount about nutrition; this needs to be strengthened with crucial information and helping strategies in the areas of weaning and post-infection recuperative feeding. AWW's could also be helped to prioritize and weed out all the information they have acquired so that they emphasize at crucial times a minimal set of crucial messages.

Since this section on Growth Monitoring was written, we have had a probing and stimulating discussion with the GOI on the subject of growth monitoring, targeting, and special populations for special attention. The group shared its concerns about the effectiveness and impact of the approach, agreeing that it had only rarely been fully and ideally implemented.

The paradox of targeting for food supplementation in India was also addressed. There is some consensus that the system is doing increasingly better at "catching up", i.e. gaining/regaining weight of children III and IV degree malnourished, even in the age groups 2 and 3 years where coverage had been low. As this improves, the implication will be that preschool children 3 to 6 will be "caught" simply because they come to preschool, and children ages 2 and 3

will be increasingly picked up as the program continues to improve its technical outreach skills. There are also indications that this net is gradually spreading to encompass children from 13 to 23 months of age.

The populations that are not being picked up for supplementation and recuperation are (1) the non-11, III and IV degree children who may fall unnoticed into malnutrition and (2) the children 0-12 months of age who do not come in for weighing at all or who come in very small numbers. The observation was made that, as children grow older, a stretch of flat growth curves may not necessarily be a matter of concern.

In some age periods, a child whose weight is stable may not, in fact, be faltering. At present this rests at the level of anecdote and hypothesis which merit further careful scrutiny. It may be that alarming mothers of children over age 1 about several months of "flatness," which do not move a child into a lower nutritional grade, may produce unnecessary anxiety.

At the same time, there appears to be little controversy about the implications of flat curves in children under age 12 months. A child under 1 who maintains a flat curve for two consecutive months will automatically move to a lower grade; for children under 6 months this phenomenon takes only one month. We assume that, for the most part, children under 6 months are protected by adequate supplies of breastmilk. However, we also know that children over 6 months who are not beginning to receive additional food, or when that additional food is bulky, low-quality carbohydrates, are at great risk. Weanlings are increasingly vulnerable to diarrheal infections since they are ingesting things other than breastmilk and some colostrum protection may be attenuating, and because they are becoming more mobile. Because they are less protected, they may also be getting more acute respiratory infections. They are not yet old enough to physically press more vigorously for food or to articulate their needs and wants. Furthermore, this is the period in which a child should, ideally, have completed its entire first round of immunizations. Finally, while all periods of child development display exciting changes for which there are a number of recognizable markers, the period 6 to 12 months is associated with a number of leaps in different visual, auditory, and manual skills, the absence of which may be cause for concern.

In summary, the discussion concluded that there are a number of very sound reasons for turning programmatic attention to children 6 to 12 (or even 15) months of age, where so much morbidity and mortality resides and where there are increasing threats to child welfare and development. This will have to be thought about systematically. It incorporates such admittedly difficult interventions as the production of low-cost, attractive weaning foods. It is also an area where growth monitoring can be particularly informative and

establish a platform for different kinds of crucial interventions. This would suggest that a crucial priority for the AWW is identification and follow-up, probably through home visits, of this group of high-risk children. Their numbers will not be large, but their potential problems command our attention.

## 2. Diarrheal Management through ORT

There was consensus that among Anganwadi Workers and mothers there was fairly well generalized awareness of the concept of oral rehydration therapy, including knowledge about the basic components of home-made solutions. Similarly, there was well-generalized understanding of the need to continue breastfeeding and replace liquids during diarrheal episodes. These are important achievements and should be considered heartening.

Where there was more variability--more among mothers than among AWWs, as one would expect--was in the proper proportions of each sugar-salt solution component and the frequency of administration. Mothers could often display manually the concepts of pinch and scoop (or spoonful), but amounts and timing of administration for children of different ages was much more vague. Packet knowledge and use was very low, in fact, almost non-existent, including presence of backup packets at the AWC. ORS use at the household level may, in some places, be constrained by lack of sugar in the home or community. In Madhya Pradesh, for example, where this is a problem, the AWW's are providing their own sugar and mixing ORS for mothers. Still, a child who has diarrhea may not come to the AWW's attention until the second or third day of an episode, by which time a child could be substantially dehydrated.

Where strengthening of this technology appears to be desirable is in the area of "effective use" of ORT, with an emphasis on appropriate feeding not only during diarrhea but, perhaps more importantly, during the post-episode period when a child's weight must be recuperated. The fact that there is sometimes anorexia associated with the episode, or perhaps after it, has been tested only on a limited basis. The jury is still out on whether it is purely physiological or at least partly a by-product of medical or household culture.

In any event, for the child with appetite or the child with an appetite that could be coaxed, it is crucial for the AWW and the mother to know about nutrient-dense, low-bulk, locally-available foods for post-infection recuperation, in order to diminish what we know are the cumulative insults to children's nutritional status.

### 3. Nutrition Education

According to the ICDS norms, women between the ages of 15-45 are to receive nutrition education. The objectives are to raise the level of knowledge and induce behavioral change with respect to sound nutritional and health practices. The educational messages that are to be transmitted to these women are:

- Breastfeed as long as possible;
- Introduce semi-solid foods to infants at 5-6 months;
- Keep children's diets "normal", *i.e.*, as similar as possible to those of adults;
- Increase the frequency of food consumption to meet child growth requirements;
- Have infants and toddlers immunized;
- Observe hygienic practices in feeding children and in keeping their environment clean; and
- Continue feeding during illness.

The AWW is to teach these messages in womens' groups gathered at the AW, in the course of home visits on a one-to-one basis, and in nutrition camps (usually held at the sector level with assistance of the public health staff). In general, the knowledge level of the AWW's and of the mothers was satisfactory.

In a program where additional funds were available the ideal would be to also target young unmarried women. Now they are not considered a priority and the messages may not be as relevant to this group. The AWW does need to be reminded about the importance of "preventive education" for these "pre-mothers". To attract and retain the interest of the different age groups, it may be worthwhile to adapt both the manner of presentation and the materials to specific clients. For example, in the case of young unmarried women, certain concepts and practices could be presented persuasively as "new" and "modern". In the case of mothers, the primary appeal could be simply love for the child. Finally, to complete the illustration, the message to older women (grand-mother, mother-in-law) might be that health status of their family is a reflection of their wisdom and experience.

The team found that mothers' knowledge was satisfactory, but that notable in two respects, their behaviour was not congruent with knowledge. This was especially evident in mothers with under three year old children. These areas of incongruence were:

- though cognizant of the need to increase quantity and frequency of food consumption for the growing child and knowing that leafy vegetables and dal are good for the child, in practice mothers do not give these foods until their children are three years old;
- mothers were aware that their children need to be immunized and had done so, but they did not know what the immunization was for.

Not only education content, but methods employed, are important, and communication techniques need to be improved. At present messages are given through talks, discussions and cooking demonstrations at the AWC, and one-on-one home visits by the AWW. The efficacy and economy of the group approach are not doubted, but there is room for varying the program. This could be by way of folk songs, mimes, theatre, lullabies and other familiar village media. Staging these activities can involve the children as well as the Mahila Mandal members with resulting community support and commitment and improved message delivery. These innovations cost little.

Pictures and charts that are used for nutrition education should be changed regularly. It is important that they be unambiguous, but they should also stimulate and retain interest by their variation.

Home visits give the AWW the opportunity to develop personal rapport as well as to observe actual behaviour. The importance of this opportunity for the AWW needs to be heightened, especially in the context of low attendance at the AW by at-risk women. If the AWW brought along the weighing scale and growth cards to the home, she could monitor growth in the presence of the entire family and explain the importance of gaining weight or faltering growth. A good strategy would be to enlist the health worker participation in home visits, capitalizing on her mother care identity in helping to persuade mothers of immunizations.

The home visit also serves as a way of reinforcing discussions held at the AWC not only reinforcing positive beliefs and attitudes, but also overcoming negative predispositions. This is an important point, although operationally somewhat difficult. Home visits can also attack behavior directly, should the anganwadi discussions fail as the first effort; changing behavior before affecting cognitive or attitudinal change can work. Sanitary practices, such as washing of hands before feeding the child, may be good targets for such a behaviourist approach.

In traditional society, it was thought there might be some role confusion of the AWW. This hypothesis is as follows:

AWW's self perception is that of a teacher. The community's perception of her is also that of a teacher. When asked what she enjoys most in her work in the anganwadi, the answer is always "the teaching aspect". The teacher is a role model for the community at large, whether it be tribal, village, periurban or urban population. The AWW is on a pedestal as the educator of children, even though she may lack formal training. As a teacher she earns the esteem of the community whose confidence she enjoys fully in matters pertaining to education.

The "role confusion" occurs when she also operates as a paramedic, weighing children, advising on immunization, initiating sanitary practices, and conducting health and nutrition education meetings. Some activities like weighing the children, and washing their hands may not be considered "befitting" to her higher status as the teacher. These activities may be perceived as menial tasks not only by her, but by the community. Although we know that a holistic approach was taken when the AWW's role was conceptualized as a change agent, it is possible that in a stratified traditional society, especially in rural areas, such a shift in role might not be understood or approved. The question merits investigation.

In conclusion, the nutrition education thrust of the program has produced a satisfactory level of knowledge. In order to carry this forward into the behavioural realm, continued and creative efforts are required, especially increased support from the public health sector, involvement of the health worker's participation whenever that is feasible, and improved motivational and communication techniques.

## VI. TEAM IMPRESSIONS OF OTHER ICDS COMPONENTS

### 1. Immunization

There are several sources and varying aggregations of data on immunizations at the different field levels in the various states. The perception in the field and our own perception is that these different data bases are presently non-comparable and that the data at the AW level, where they are available, are not meaningful for management or epidemiological purposes. It is not clear that the AWW is an appropriate gatherer of data on immunizations for statistical purposes, since she is not the person who actually administers them.

Notation of immunization data is useful at the AW level when it is used for follow-up and support of health system efforts to immunize. This potential is diminished by the fact that mothers do not have their own health cards; the result is that mothers and children get over/ or under-immunized. The AWW is a source of support to the PHC for identifying and mobilizing children and pregnant women for immunizations and seems to have played an important role in modifying attitudes toward immunization. The ICDS provides an effective infrastructure for EPI and UIP mobilization at the most fundamental level.

### 2. Vitamin A

UNICEF reports that there are over 30,000 children going blind in India each year. This number indicates that the Vitamin A deficiency problem is of epidemic proportions. In most of the AW centers the team visited, Vitamin A tablets were available as part of the AW health kit. It was unclear however if the AW worker had the authority to dispense Vitamin A or whether this was the responsibility of the ANM. Records on Vitamin A distribution were being kept by some, but not all, AWWs.

Given the magnitude of the Vitamin A problem in India, the team feels that the ICDS program provides a cost-effective delivery system for distributing Vitamin A pills and that the coverage potential is enormous. The AWW should be able to dispense the pills herself. This might be done in conjunction with two holidays or special occasions during the year. It is critical for the GOI or other donors to ensure continued availability of Vitamin A. For the young children syrup would be preferable to crushing the pills, as is now being done in the centers visited by the teams.

### 3. Medical Referrals

Medical referrals are a critical part of the ICDS Program. The AWW is being instructed to identify the seriously malnourished child as well as those suffering from diarrhea and other infectious diseases. As part of her training, the AWW must be taught when medical referrals are necessary. For example, during an episode of diarrhea, a child who has blood or mucus in his stools, is vomiting, has fever or is becoming dehydrated should be sent for medical attention. A III or IV degree malnourished child should be seen immediately by a health professional particularly since other diseases may be associated with the malnutrition.

Most AWW's had referred cases to the nearby hospital, PHC, or Medical Officer. The team was not able to document if these were timely referrals. However the constraints for actually receiving care are great in most tribal and hard-to-reach rural areas. The PHC's or subcenters may be far from the villages. Transportation costs and time constraints hinder parents' enthusiasm and receptivity to taking their children for medical attention. Also Medical Officer, LHV, and ANM posts often go unfilled in remote rural areas, and their means of transport is extremely limited.

In one block the CDPO takes medical referrals to the PHC in her jeep. In another, the CDPO had the MO check all the malnourished children in her block in one day. She and her supervisors and AWW's organized the effort. This seems like an excellent idea, when transportation can be procured. Coordination between the CDPO and the MO as well as other health staff was quite good in several of the blocks visited. In other areas effective coordination was lacking between ICDS and PHC personnel. The interests and priorities of the two programs require better understanding. Until this is achieved and the vacant posts for MO's, LHV's and AWW's are filled, the medical follow-up for either sick children or at-risk pregnant women will be the weak link in the chain.

### 4. Non-Formal Education

Non-formal education is an important motivational component of the AW program. Workers are happiest with this part of their work at the center, preferring the teaching segment of the job to the health and nutrition role. Mothers cited preschool education, along with feeding, as the principal reasons for participation in the program. Several mothers stressed how important it was for their children to learn numbers and letters and take part in the other education activities since it might be "the only education her child would get."

As the favored AW activity, preschool education can be seen as a possible competitor with other program components. However, the preschool and other activities do not really overlap. Preschool begins when the center opens, at the time most convenient for mothers to drop off their children on the way to work usually in the fields. The smaller children come later, at feeding time around noon, the precise hour varying by center and, sometimes, by circumstance.

Space is an inhibiting factor particularly for physical activities since many anganwadis lack the open courts from which their name is derived. Many children sit in small dark rooms, often crowded, which can make discipline difficult, particularly as heat increases and the morning wears on. Despite this, in most of the AW's visited, the children seemed to enjoy one another's company and took turns leading each other in songs and rhymes. The amount of skills development that occurs is widely variable:

some AWW's had developed a number of toys, others had done little.

Appropriate scheduling of overall AW activities and the most effective contact time with mothers and their small children may become an issue when the AW program includes growth monitoring and related counselling of the mother, which do not now occur at the center. In the meantime, the day care arrangement is convenient for mothers, and both mothers and fathers esteem this part of the program which may be a factor in the apparent stigma-free nature of this feeding program.

##### 5. Sanitation

The team noted that the AWW and her helper kept the anganwadi and its immediate surrounding area clean. The AW was swept clean before the meal was served.

The main public health hazard at the AW seem to be the presence of flies. The jaggery used in some of the preparations drew large numbers of flies into the AW. The helper should be told to cover the cooked food so as to prevent the risk of infection.

Before the food was served, the children were made to wash their hands. Wells and toilets were not seen in the immediate vicinity of the AW. Water for drinking and cooking purposes had to be fetched from a nearby water source and stored at the AW.

A frequent mother's answer as to what the AWW taught was "cleanliness", and fathers expressed their pleasure about the improved appearance of their children since enrollment in the ICDS.

## 6. Community Participation

The ICDS program has involved the community which it is serving in varying degrees. At best it receives manpower, logistic support, facilities and funds from the community. In other cases, the willingness of the villagers to take part in the program - to answer questions - may be the extent of participation, which seems however to be increasing with the age of the program.

The AW has become a focal point in some of the areas visited. In West Bengal, notably, local bodies like youth clubs, mahila mandals and panchayats actively support the AWW. Sometimes the AWW helps to organize women groups which are soon to be registered as mahila mandals. Members of mahila mandals and unorganized mothers are helping the AWW in various ways like cooking, helping organize nutrition camps, though in many instances more encouragement is needed. In some centers, young girls of the village are helping the AWW with pre-school activities and in serving the children food. During the monsoon it was reported that members of youth clubs helped to carry the CSM sacks from the main road to hard-to-reach centers.

The village health worker also helps, especially in health-related matters. A potential dynamite partner with the AWW, she now helps motivate the parents to bring the children to the AW for immunization. The ANM is a person of high esteem in the village and a closer working relationship with the ANM would be beneficial to the program. She could help the AWW disseminate "new" medical information and this would enhance her role in the village. This partnership would also lessen some of the heavy workload of the AWW. The health worker could assist the AWW with the village census, weighing of children, growth monitoring, and regular home visits to children on the critical list.

The panchayats have in many places allowed the AW to use a part of their building. In some places panchayats have even constructed centers for anganwadi activities. The Sarpanch takes a keen interest in the AW and very often came to meet the visiting teams. The panchayats often provide space for storage of the food and fuel.

The villagers have also contributed funds. One AWW raised Rs. 600 to buy educational toys.

Through the CDPO, government and non-government departments and agencies are increasingly getting involved in the ICDS Program.

Finally, the anganwadi worker is seen as a role model by the women of the village and the men folk of the village also perceive her as a dedicated individual, and every effort is made to solve her problems which often are the villagers' problems as well.

PROGRAM REVIEW  
OF  
CARE MCH (ICDS and SNP)  
TITLE II PROGRAM

PART II

FOR DISTRIBUTION  
WITHIN AID  
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VII. PRESENT AND FUTURE CARE ROLE

A. CARE Capability:

As noted earlier under IV above, CARE has been upgrading its staff for some time, especially from the early 80s in order to extend its capability beyond food logistics. Prior to this time, new field officers learned their work by accompanying a senior field officer for two to four weeks; after that, they were on their own. The CARE staff levels shown at the end of this section will further be cut at the end of the current calendar year. CARE's departure from States (after 25 years of presence) will abolish Field Officer positions. Of the 14 Field Officers affected, five will drop out of CARE work permanently, and others will transfer to other States. Twenty-five percent of its total state level staff, 82 people who are non-transferable will be affected; 45 will have no place to go while CARE may be able to place the other 37. This is to underline the personnel hardship the consolidation move will entail, and to bring to the attention of all concerned with CARE/ICDS work what the retrenchment means in human terms.

The brighter side of the consolidation move is that not all highly experienced staff will be lost, but nine of the field officers whose positions have been abolished will be transferred to other States and enrich capability there. In the smaller geographical territories, resulting from consolidation, the officers will spend less time on the road and be able to cover their areas, (often 3-4 districts) more efficiently. It is CARE's plan to improve the quality of their visits, not try to make more frequent visits.

Today, new field officers are given several months' program orientation and existing staff are given further training, both in management and in nutrition basics. Technical training is provided by CARE technical staff (a highly experienced Indian nutritionist/trainer/field worker) or by nearby institutions (the National Institute of Nutrition in Hyderabad; the Home Science College in Baroda; the Baptist Hospital, which has a child rehabilitation center attached, in Bangalore). Beyond this general health and nutrition training, subject-specific (eg., ORT) training is given on site by the CARE nutritionist/trainer in hands-on learning style. Following initial training, field officers further learn content and communication techniques by observing three sessions of for instance, ORT; they themselves then teach under the supervision of the trainer, and are able to train alone thereafter.

It is the team's opinion that more systematic infusions of technical expertise and continuous professional guidance, at least at the State level, are vital to ensure quality training and periodically to test and evaluate training effectiveness. CARE obviously agrees and has asked for Primary Health Care-Specialist for the central level, and trainers for each state under the Institutional Development Grant.

However, the impression sometimes given that, until CARE has this additional technical staff aboard, through the staff upgradation grant, the agency will be doing food logistics only is highly inaccurate. CARE has developed a very well presented (and received) working guide book for the anganwadis, which has been used throughout the program for some time. CARE actively participates in NIPCCD training: they have developed nutrition education modules which are used for teaching CDPOs and Supervisors; and the CARE nutritionist herself teaches at the Institute. The ORT modules have been used to carry out major projects involving voluntary village participation in the states of Orissa and Gujarat. In Rajasthan, CARE has carried out water and sanitation and health education training.

#### B. Non-Food Role:

Because of current sensitivities regarding CARE's nonfood role, there was no opportunity to explore CARE's potential from other eyes than those of the state governments. Thus the team had severe constraints with respect to effective brainstorming with Government and non-governmental entities at the national level in the fear of contributing further to existing strong apprehension about (U.S.) CARE intentions with regard to ICDS.

State officials were not only highly enthusiastic but even unrealistic about what they would like CARE to do: monitor nonCARE feeding programs in the state; train all levels of staff in monitoring techniques; construct godowns and anganwadi buildings; provide and supervise delivery and use of health kit items; continue and expand ORT training.

CARE would like to concentrate on ORT, stressing community participation (volunteer facilitators from villages) nutrition education (or what we will call appropriate feeding practices with an emphasis on weaning and diarrhea), growth monitoring, and targeting of supplemental food.

CARE has already taken steps to proceed with these priorities, which seem most appropriate in our view as activities which reinforce GOI objectives for the ICDS. Among the activities which CARE feels are most successful is the training in ORT in Orissa and Gujarat. CARE will also shortly proceed with similar projects in Andhra Pradesh and West Bengal (and, possibly, Madhya Pradesh in 1967), using Title II Enhancement and CARE funds. CARE has recently submitted a proposal to AID for reinforcement of ICDS with an ORT emphasis in Karnataka. Interest at the state government level in this support from CARE is high and feedback from other international groups working in ORT concerning CARE's involvement has been most positive. CARE is accumulating experience through reiterating and testing an approach to ORT within the ICDS framework; this seems to us a most useful area for CARE to continue with.

The team's main concern with regard to future nonfood activities is that CARE not spread itself too thin in technical areas, and that CARE should follow the signals made loud and clear by the Ministry of Human Resource Development that the criterion of project validity is replicability and replicability only. Small projects of the type voluntary agencies worldwide have so capably undertaken are not appreciated in the enormity of the ICDS task. Thus, as CARE is fully aware, they will want to make every effort in Research and Development activities as precedents to project application on a countrywide scale. CARE also wants to train staff to refocus on ORT.

Even noting the enormous differences among the states of India, and the need to test models in limited populations, it is not less appropriate to keep the central goal ever in mind. CARE will be in a much better position to strategize this objective once a primary health care specialist is working at the central level with a team of technical staff in the states. Continuing with the same line of thinking, CARE should heed the clear statement of Human Resources that the "super components" are not desirable (as possibly in the case of USAID-assisted centers in Maharashtra and Gujarat which some GOI officials have considered unreplicable elsewhere due to the amount of money involved).

CARE is already aware that the ICDS program is not a nutrition and health program only, but has wider social objectives; that neither is it a child survival activity per se, but a child development program.

USAID has not yet approved a Growth Monitoring proposal presented by CARE, because of the same concerns for uniformity of approach and replicability just cited. The proposed project, to be implemented in Madhya Pradesh, is designed to promote healthy child growth by increasing the understanding of mothers and of ICDS workers (AWW and supervisory staff, including ANMs) of the importance of child growth. Weighing will be accompanied by motivation, social marketing, and education inputs to bring about appropriate behavioural responses, with an emphasis on monthly weighing of children from birth to three years and children with severe and moderate malnutrition. The proposal is a well written and thoughtful one which should be given active consideration. At the same time, we would like to note that some key GOI officers are not persuaded of the effectiveness and certainly not the impact of growth monitoring as anything but a targeting tool and there are also reservations about targeting per se. In our conversations with the GOI, however, there was concern about the need to attend to the crucial age group 6 months to 1 year where a flat growth curve for two consecutive months not only indicates growth faltering but grade deterioration;

when weaning, typically inadequate in terms of timing and quality of diet, occurs; when breastmilk and environmental protection are attenuating; and when children should, ideally, have completed their first full round of immunizations. It might be that the GOI would be interested in the CARE proposal as a vehicle for exploring the degree to which growth monitoring could be used as an entry point into this age group which, so far, has been brought into ICDS activities in relatively small numbers and to limited apparent effect. We would recommend review of this project in the light of these considerations.

CARE also has a proposal, in draft form and/in the process of being refined, for the upgradation of SNP-UG and SNP programs using funds generated through the monetization of commodities, based on the Integrated Nutrition and Health Action Program (INHAP) conducted in Gujarat from June 1980 through August 1983 and similar activities under way in selected centers in Orissa as well.

Finally, CARE has proposed to the USAID utilization of PD&S funds for a small research effort to look specifically at targeting of birth to three year-olds and pregnant and lactating mothers. This would be essentially an operations research project, in eight states, which would involve assessment of the problem and reasons for lack of attendance, followed by specific interventions to address the problems identified. Given GOI and CARE's own priority concern with reaching the "pre-preschool" children, most importantly

the highly vulnerable 6-12 month-old group, as well as in the possibility of extending supplementary feeding to mothers earlier than the currently-normed last trimester, this is a topic where such research would be immediately pertinent. CARE points out in its proposal that this is an area where a Child Survival Fellow (CSF) could be of particular benefit. The concept is a good one but the CSF title might prove troublesome.

To summarize, all the areas -- UKI, growth monitoring, (with emphasis on community participation) targeting, nutrition education -- are germane and needful of the sorts of interventions and activities CARE suggests. Assuming a climate in which such support would be valued, we think CARE's priorities are right on target.

#### C. Additional Resources for future CARE Programming

There is no question in our minds that the ICDS program offers an excellent infrastructure for reducing infant and childhood mortality in India. In fact India may enter the ranks of the few countries whose investments in health and nutrition services were able to overcome slow economic change to affect significantly mortality and malnutrition trends.

##### 1. Title 11

The role of CARE food in the program is an important one. The expansion schedule of the ICDS supplementary feeding program is ambitious, hoping to attain coverage of 17 million children, pregnant and lactating women, in 2,000 blocks, by 1990. Progress to date starting with 33 blocks in 1975 and covering more than 1,300 in 1986, is an incredible feat. However the costs of the food are staggering and may well become the obstacle to reaching the expansion goals. Cost of the food component is estimated at 65 percent of the total recurrent program cost which is about \$12 - \$13 per year per potential beneficiary.

It is the team's recommendation that Title 11 levels be increased from the approved 1987 ICDS beneficiary level of 3.45 million to approximately 4.36 million. This would be an increase of approximately 24,486 tons of food at an increased dollar level of 8 million annually. To increase the FY 87 AER it would entail a provision of commodities for six months only (April-September 1987) or a \$4.0 million increase. The team also recommends that in subsequent years CARE continue to increase ICDS beneficiaries and tonnage as SHF numbers decline.

Under the current approved 1987 levels, CARE's contribution to total ICDS coverage would fall from 41 percent in 1986 to 32 percent in 1987. (The ICDS is expected to expand by 2.0 million annually.)

## 2. Section 41b

Section 41b seems to be a less favorable source of food for the ICDS Program given the requirement of the GOI to support overseas freight costs as well as lack of multiyear commitments. Calculations show that the GOI would have to pay \$30 million of GOI hard currency for \$50 million of USM<sup>1/</sup>.

Oil would certainly give a better exchange rate. GOI costs would be \$15 million for approximately \$50-million worth of oil that is valued locally at \$70 million<sup>2/</sup>. However a waiver would be needed to authorize use of this commodity under Section 41b, as it is not on the surplus commodity availability list.

Since the states have to support the costs for the food, it is possible they would not mind using 41b commodities for one year if it freed up funds they would otherwise have been used for food or other program costs. The danger is that once they take the money for food out of their budget it will be difficult to put it back in subsequent years.

The team is also concerned about a government-to-government Section 41b program supporting ICDS because it would undermine CARE presence and effective food delivery. In all the states visited, it was made quite clear to the team that only CARE-managed food was delivered regularly to ICDS centers. In one state, officials asked if CARE could manage the WFP food and if CARE could train the government staff with responsibility for moving the GOI food too. AID and CARE have made a real contribution to the program, not just in providing the food donation but by getting the food delivered to the beneficiaries.

Monetization is the least developed of CARE's programming ideas but the one they consider to have the greatest potential. If the GOI

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<sup>1/</sup> Calculation made by CARE, September 1986; see table at end of this Section.

Source: CARE estimate fair price shop Ks 12/Kilogram.

<sup>2/</sup> 66,027 metric tons @ 1,000/mt = \$ 66 million The barter idea, for example, WFP or an oil exchange for use of indigenous wheat, may be an interesting option and one that should be explored further. It depends on whether indigenous wheat is a problematic commodity? UNICEF is providing funds for 15 processing plants that will be using indigenous wheat.

decides that CARE does have a real role in the ICDS, monetization would provide a sound ongoing base from year to year without the need for special grants and the uncertainty and annual investment of time and human resources that seeking such grants entails. Monetization might be attractive to the GOI from the standpoint of representing a stable income source for any cooperative endeavors that are undertaken. There is, however, a lot still to be known about the approach (eg. price setting, marketing mechanism, programming) that would merit some research. We would recommend a preliminary study of what would be involved in the implementation of a monetization strategy, at a level which would permit at least some initial conversations.

### 3. Other Child Survival Inputs

The ICDS program, as mentioned earlier is certainly a CS activity as defined by AID. In fact the food seems to be such an effective and critical part of the program that those PL 480 Title II resources should be counted as child survival inputs; CARE's interest in ORT, growth monitoring and nutrition education (appropriate feeding practices) is certainly supported by AID/W and the team. Central resources that are available to CARE and other PVO's include the FVA PVO Child Survival Competitive Grants Program. Each year PVO's working in health and nutrition are asked to submit three year proposals for funding CS projects based on FVA guidelines. CARE/Headquarters has been sent these guidelines and in FY 1987 will again be asked to submit relevant country proposals.

Since USAID bilateral aid for CARE is problematic in FY 87, the team recommends that CARE apply for a grant under FVA's program. It is, however, not clear if India will be one of the selected countries for PVO Central support. This will still have to be worked out. The Asia Bureau may have similar central funding sources, and that should be explored.

If CARE applies for grants, as suggested above they would request funds for the specific activities described above.

Table VII-A

Staff Levels

Staff	80/81	81/82	82/83	83/84	84/85	85/86	86/87 (Up to Dec.1986)
1. Management International National	7 15	5 16	5 16	7 14	7 14	5 13	5 13
2. Field/Port Officers	100	92	81	73	88	73	69
3. Mid-Management/ Assistant/Supply Staff	294	224	236	224	247	237	226
<b>TOTAL</b>	<u>416</u>	<u>337</u>	<u>338</u>	<u>318</u>	<u>356</u>	<u>328</u>	<u>313</u>
No. of States Covered:	14+ 2 UTs	13+ * 1 UT					

\*Until September 30, 1986 - 14 States + 2 U.Ts

Table VII-B

\$50 Million Food Package

Commodity	Quantity (MTs) Worth \$50 Mil	Clearing and Overhead Costs (\$000's)	Inland Transp. (\$000's)	Ocean Freight (\$000's)	Total Cost to GOI (\$000's)
CSM	187,970	2,068	3,947	24,248	30,263
NFDM	71,429	786	1,500	9,214	11,500
S. Oil	68,027	748	1,429	10,612	12,789

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**EVALUATION OF PL-480 TITLE II  
CARE-ASSISTED ICDS PROGRAM IN INDIA**

**Scope of Work**

**I. OBJECTIVE**

To assess CARE's current and future role in Title II commodity delivery and monitoring program effectiveness which includes CARE's institutional capability and commitment to strengthening that role within the GOI-ICDS frame work.

**II. BACKGROUND READING/INFORMATION**

The following documents (available with Ms. Hope Sukin, FVA/PPE, AID/W) will serve as background information for the subject evaluation. It is recommended that background reading is completed before coming to India.

1. The Impact of ICDS on the Status of Child Health in India, by Prof. B.N. Tandon, Prof. of Medicine, All India Institute of Medical Sciences, New Delhi.
2. ICDS Integrated Child Development Services (Working Guide), by CARE/India in collaboration with Ministry of Social Welfare, Government of India.
3. Project Paper, India, Integrated Child Development Services (386-0476) by USAID/India.
4. The Integrated Maternal & Child Nutrition Project in India Recommendations based on a Review of Past Experiences, by David E. Sahn.
5. An Evaluation Report of the PL-480 Title II Program in India, by Community Systems Foundation, Ann Arbor, Michigan.
6. Story of Integrated Child Development Services.
7. Integrated Child Development Services, by Central Technical Committee on Health & Nutrition, All India Institute of Medical Sciences, New Delhi.
8. Integrated Child Development Services in India, by UNICEF.
9. A Guide-Book for Anganwadi Workers, by Department of Women, Child Development, Ministry of Human Resource Development, Government of India.

10. Manual on Integrated Management Information System for ICDS, by Department of Women's Welfare, Ministry of Human Resource Development, Government of India.
11. Integrated Child Development Services - An Assessment, prepared for UNICEF by Dr. K.G. Krishnamurthy and Dr. M.V. Nadkarni.

### III. AREAS TO BE REVIEWED

#### A. CARE-ASSISTED ICDS PROGRAM

1. Ascertain the adequacy of storage facilities and movement of Title II commodities from ports to district/block godowns or feeding centers.
2. Extent to which CARE is supervising food commodity distribution including accountability.
3. Ascertain the commodity availability and regular functioning of food processing facilities to ensure uninterrupted feeding at Anganwadis.
4. Extent to which children 'under three' years of age and pregnant and lactating women are covered; also, the regularity in receipt of supplementary foods.
5. Extent to which Title II nutritional input is supporting other child development services.
6. Extent to which CARE is coordinating with GOI/State Governments in the phased upgrading of the ongoing Special Nutrition Program (SNP) to the level of ICDS.
7. Ascertain present and future PVO staff capability (both in Headquarters and State offices) in terms of administration, supervision, technical inputs etc.
8. Extent to which progress has been made in addressing the various MCH recommendations made in the 1979 CSF Evaluation (pages 36, 117-119). For reference pertinent recommendations are detailed below:
  - i. Programs which provide food alone should be upgraded to provide other health and educational services. Program which do not do this should be actively discouraged.
  - ii. Beneficiaries should be selected on the basis of economic and nutritional need (For example if mothers in the program have low birth weight babies, these should be given a high priority for food supplementation).

- iii. Coarse cereal grain should not be provided as a nutritional supplement for children under three. Low bulk, high nutrient-density food should be programmed for this group.
- iv. If the food is to be consumed by a given individual, it should be prepared and eaten on site for maximum control.
- v. A greater consideration should be given to the need for improved environmental sanitation to reduce infection and infestation, along with nutritional supplementation.

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TEAM MEMBERS

- Mrs. Joyce King (Team Leader) (Independent Consultant)
- Dr. Polly Harrison (Management Sciences for Health/PRITECH)
- Ms. Hope Sukin (AID/Washington, Bureau for Food For Peace and Voluntary Assistance)
- Mrs. B. Kakkar (World Wildlife Federation, Calcutta)
- Mr. R.K. Saha (Deputy Secretary, Department of Women's Welfare, Ministry of Human Resource Development)
- Mr. Swaleh Karanja (CARE/India Headquarters,
- Ms. Chrisitne Adamczyk (USAID/India)
- Mrs. Hema Ramaswamy (USAID/India)
- Mr. Rajendra Mishra, Department of Women's Welfare, Ministry of Human Resource Development

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ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

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TRAVELLER: Ms. JOYCE KING \*

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
THURSDAY	SEPT. 11	NEW DELHI	IC 403	1210	BANGALORE	1445	Meet with CARE Officials - Night Halt Bangalore
FRIDAY	SEPT. 12	BAGALORE	BY ROAD				Proceed to Field - Night Halt Davangere
SATURDAY	SEPT. 13	BAGALORE	BY ROAD				Visit Hirekerur Block - Back to Davangere for Night Halt
SUNDAY	SEPT. 14	BAGALORE					R E S T - Night Halt Field
MONDAY	SEPT. 15	BAGALORE					STATE HOLIDAY - MOHARAM - Night Halt Field
TUESDAY	SEPT. 16	BAGALORE	BY ROAD				Visit Davangere Block - Night Halt Davangere
WEDNESDAY	SEPT. 17	BAGALORE					Travel Back to Bangalore - Night Halt Bangalore
THURSDAY	SEPT. 18	BANGALORE	IC 272	1820	CALCUTTA	2045	Wrap up Session - CARE & GOK Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRIASAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 402	1745	NEW DELHI	1950	Night Halt New Delhi
SUNDAY	SEPT. 21	NEW DELHI	IC 433	0635	BHOPAL	0830	Meet with CARE Officials - Visit Bhainsdehi - Night Halt Field
MONDAY	SEPT. 22	BHOPAL	BY ROAD				Bhainsdehi - Night Halt Field
TUESDAY	SEPT. 23	BHOPAL	BY ROAD				Bhainsdehi - Night Halt Field
WEDNESDAY	SEPT. 24	BHOPAL	BY ROAD				Field Visits & Return to Bhopal - Night Halt Bhopal
THURSDAY	SEPT. 25	BHOPAL	IC 434	1530	NEW DELHI	1725	Wrap up Session - CARE & GOMP Officials - Night Halt New Delhi

09 September 1986

\* Sectors: New Delhi-Bangalore-Calcutta-New Delhi - travelling with Ms. Christine Adaczyk

New Delhi-Bhopal-New Delhi - travelling Mrs. Hema Ramaswamy

2

ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: Ms. HEMA RAMASWAMY \*

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
WEDNESDAY	SEPT. 10, 1986	NEW DELHI	IC 419	1830	NAGPUR	1955	Meet with CARE Officials - Night Halt Hotel Radhika, Nagpur
THURSDAY	SEPT. 11	NAGPUR	BY ROAD		YAVATMAL		VISIT YAVATAMAL DISTRICT - Night Halt GOM Rest House
FRIDAY	SEPT. 12	YAVATAMAL	BY ROAD				VISIT YAVATAMAL DISTRICT - Night Halt GOM Rest House
SATURDAY	SEPT. 13	YAVATAMAL	BY ROAD				VISIT YAVATAMAL DISTRICT (PUSAD) - Night Halt GOM Rest House
SUNDAY	SEPT. 14	YAVATAMAL					R E S T - Night Halt GOM Rest House
MONDAY	SEPT. 15	YAVATAMAL	BY ROAD				VISIT YAVATAMAL (Pandharkawada) - Night Halt GOM Rest House.
TUESDAY	SEPT. 16	YAVATAMAL					STATE HOLIDAY - Night Halt Field - GOM Rest House
WEDNESDAY	SEPT. 17	NAGPUR	IC 130	2105	BOMBAY	2220	VISIT YAVATAMAL (Kalaub) & back to Nagpur - Night Halt Bombay
THURSDAY	SEPT. 18	BOMBAY	IC 274	1640	CALCUTTA	1900	Wrap up Session - CARE & GOM Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRAISAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 402	1745	NEW DELHI	1950	Night Halt New Delhi
SUNDAY	SEPT. 21	NEW DELHI	IC 433	0635	BHOPAL	0830	Meet with CARE Officials - Visit Bhainsdehi Block - Night Halt Field
MONDAY	SEPT. 22	BHOPAL	BY ROAD				Field Visit at Bhainsdehi - Night Halt Field
TUESDAY	SEPT. 23	BHOPAL	BY ROAD				Field Visit at Bhainsdehi - Night Halt Field
WEDNESDAY	SEPT. 24	BHOPAL	BY ROAD				Field Visit and return to Bhopal for Night Halt
THURSDAY	SEPT. 25	BHOPAL	IC 434	1530	NEW DELHI	1725	Wrap up Session - CARE & GOMP Officials - Night Halt New Delhi

09 September 1986

\* Sectors: New Delhi-Nagpur-Bombay-Calcutta - travelling with Ms. Polly Harrison

Calcutta-New Delhi-Bhopal-New Delhi - travelling with Ms Joyce King & Ms Hope Sukin

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ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: Ms. CHRISTINE ADAMCZYK

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
THURSDAY	SEPT. 11	NEW DELHI	IC 403	1210	BANGALORE	1445	Meet with CARE Officials - Night Halt Bangalore
FRIDAY	SEPT. 12	BAGALORE	BY ROAD				Proceed to Field - Night Halt Davangere
SATURDAY	SEPT. 13	BAGALORE	BY ROAD				Visit Hirekerur Block - Back to Davangere for Night Halt
SUNDAY	SEPT. 14	BAGALORE					R E S T - Night Halt Field
MONDAY	SEPT. 15	BAGALORE					STATE HOLIDAY - MOHARAM - Night Halt Field
TUESDAY	SEPT. 16	BAGALORE	BY ROAD				Visit Davagere Block - Night Halt Davangere
WEDNESDAY	SEPT. 17	BAGALORE					Travel Back to Bangalore - Night Halt Bangalore
THURSDAY	SEPT. 18	BANGALORE	IC 404	1535	NEW DELHI	1810	Wrap up Session - CARE & GOK Officials - Night Halt New Delhi
FRIDAY	SEPT. 19	NEW DELHI					
SATURDAY	SEPT. 20	NEW DELHI					
SUNDAY	SEPT. 21	NEW DELHI					
MONDAY	SEPT. 22	NEW DELHI	IC 461	0610	AHMEDABAD	0725	Proceed to Field - Night Halt Express Hotel, Baroda
TUESDAY	SEPT. 23	AHMEDABAD	BY ROAD				Visit Padra Block - Night Halt Express Hotel, Baroda
WEDNESDAY	SEPT. 24	AHMEDABAD	BY ROAD				Visit Halol Block and Kathlal Reg. Godown - Halts Exp. Motel, Baroda
THURSDAY	SEPT. 25	AHMEDABAD	IC 454	1935	NEW DELHI	2225	Wrap up Session - CARE & GOK Officials - Night Halt New Delhi

09 September 1986

Sectors: New Delhi-Bangalore-New Delhi

- travelling with Ms. Joyce King

New Delhi-Ahmedabad-New Delhi

- travelling alone to Ahmedabad and joins B. Kakkur on 22 September

ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: MS. B. KAVKAR \*

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DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
THURSDAY	SEPT. 11	NEW DELHI	IC 439	0620	HYDERABAD	0815	Meeting with GOAP & CARE Officials - Plan for field trip Night Halt Hyderabad
FRIDAY	SEPT. 12	HYDERABAD	BY ROAD				Anganwadi Visit of Banswada Project - Night Halt Hyderabad
SATURDAY	SEPT. 13	HYDERABAD	BY ROAD				Anganwadi Visit of Raayanpet Project - Night Halt Hyderabad
SUNDAY	SEPT. 14	HYDERABAD	BY ROAD				R E S T - Night Halt Hyderabad
MONDAY	SEPT. 15	HYDERABAD					STATE HOLIDAY (MOHARAM) - Night Halt Hyderabad
TUESDAY	SEPT. 16	HYDERABAD	BY ROAD				Anganwadi Visit of Devarkonda Project - Night Halt Hyderabad
WEDNESDAY	SEPT. 17	HYDERABAD	BY ROAD				Anganwadi Visit of Gajwel Project - Night Halt Hyderabad
THURSDAY	SEPT. 18	HYDERABAD	IC 270	1720	CALCUTTA	2000	Wrap up Session - CARE & GOAP Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRAISAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 295	1605	AHMEDABAD	1925	Night Halt Ahmedabad - CAMA Hotel
SUNDAY	SEPT. 21	AHMEDABAD					Night Halt Ahmedabad - CAMA Hotel
MONDAY	SEPT. 22	AHMEDABAD	BY ROAD				Proceed to Field - Night Halt Express Hotel, Baroda
TUESDAY	SEPT. 23	AHMEDABAD	BY ROAD				Visit Padra Block - Night Halt Express Hotel, Baroda
WEDNESDAY	SEPT. 24	AHMEDABAD	BY ROAD				Visit Halol Block and Kathlal Reg. Godown - Halt: Exp. Hotel, Baroda
THURSDAY	SEPT. 25	AHMEDABAD	IC 494	1935	NEW DELHI	2225	Wrap up Session - CARE & GOG Officials - Night Halt New Delhi

09 September 1985

Sectors: New Delhi-Hyderabad-Calcutta

- travelling with Mr. Swaleh Karanja and Ms. Hope Sukin

Calcutta-Ahmedabad-New Delhi

- travelling alone and Ms. Christine Adanczyk joins in Ahmedabad on Sept. 22.

ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: Ms. HOPE SUKIN \*

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
THURSDAY	SEPT. 11	NEW DELHI	IC 439	0620	HYDERABAD	0815	Meeting with GOAP & CARE Officials - Plan for field trip Night Halt Hyderabad
FRIDAY	SEPT. 12	HYDERABAD	BY ROAD				Anganwadi Visit of Banswada Project - Night Halt Hyderabad
SATURDAY	SEPT. 13	HYDERABAD	BY ROAD				Anganwadi Visit of Rauyanpet Project - Night Halt Hyderabad
SUNDAY	SEPT. 14	HYDERABAD					R E S T - Night Halt Hyderabad
MONDAY	SEPT. 15	HYDERABAD					STATE HOLIDAY (MOHARAM) - Night Halt Hyderabad
TUESDAY	SEPT. 16	HYDERABAD	BY ROAD				Anganwadi Visit of Devarkonda Project - Night Halt Hyderabad
WEDNESDAY	SEPT. 17	HYDERABAD	BY ROAD				Anganwadi Visit of Gajwel Project - Night Halt Hyderabad
THURSDAY	SEPT. 18	HYDERABAD	IC 270	1720	CALCUTTA	2000	Wrap up Session - CARE & GOAP Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRAISAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 402	1745	NEW DELHI	1950	Night Halt New Delhi
SUNDAY	SEPT. 21	NEW DELHI	IC 433	0635	BHOPAL	0830	Meet with CARE Officials - Visit Bhainsdehi - Night Halt Field
MONDAY	SEPT. 22	BHOPAL	BY ROAD				Bhainsdehi - Night Halt Field
TUESDAY	SEPT. 23	BHOPAL	BY ROAD				Bhainsdehi - Night Halt Field
WEDNESDAY	SEPT. 24	BHOPAL	BY ROAD				Field Visits & Return to Bhopal - Night Halt Bhopal
THURSDAY	SEPT. 25	BHOPAL	IC 434	1530	NEW DELHI	1725	Wrap up Session - CARE & GOAP Officials - Night Halt New Delhi

09 September 1986

Sectors: New Delhi-Hyderabad-Calcutta - travelling with Mr. Swaleh Karanja and Ms. B. Kaktar

Calcutta-New Delhi-Bhopal-New Delhi - travelling with Ms. Joyce King and Mrs. Hema Rameshwar

SV

ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: Ms. POLLY HARRISON \*

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
WEDNESDAY	SEPT. 10, 1986	NEW DELHI	IC 419	1830	NAGPUR	1955	Meet with CARE Officials - Night Halt Hotel Radhika, Nagpur
THURSDAY	SEPT. 11	NAGPUR	BY ROAD		YAVATAMAL		VISIT YAVATAMAL DISTRICT - Night Halt GOM Rest House
FRIDAY	SEPT. 12	YAVATAMAL	BY ROAD				VISIT YAVATAMAL DISTRICT - Night Halt GOM Rest House
SATURDAY	SEPT. 13	YAVATAMAL	BY ROAD				VISIT YAVATAMAL DISTRICT (PUSAD) - Night Halt GOM Rest House
SUNDAY	SEPT. 14	YAVATAMAL					R E S T - Night Halt GOM Rest House
MONDAY	SEPT. 15	YAVATAMAL	BY ROAD				VISIT YAVATAMAL (Pandharkawada) - Night Halt GOM Rest House
TUESDAY	SEPT. 16	YAVATAMAL					STATE HOLIDAY - Night Halt Field - GOM Rest House
WEDNESDAY	SEPT. 17	NAGPUR	IC 130	2105	BOMBAY	2220	VISIT YAVATAMAL (Kalambi) & back to Nagpur - Night Halt Bombay
THURSDAY	SEPT. 18	BOMBAY	IC 274	1640	CALCUTTA	1900	Wrap up Session - CARE & GOM Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRAISAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 295	1605	PATNA	1700	Night Halt Patna
SUNDAY	SEPT. 21	PATNA					R E S T - Night Halt Patna
MONDAY	SEPT. 22	PATNA	BY ROAD				Visit Patna Urban Project/Meet with Director of Social Welfare and CDPO & Supervisors - Night Halt Patna
TUESDAY	SEPT. 23	PATNA	BY ROAD				Visit Fatwah Block - Proceed to Gaya - Night halt Gaya
WEDNESDAY	SEPT. 24	PATNA	BY ROAD				Visit Anganwadi in Gaya - Travel back to Patna for Night Halt
THURSDAY	SEPT. 25	PATNA	IC 412	1600	NEW DELHI	1910	Wrap up Session - CARE & GOB Officials - Night Halt New Delhi

09 September 1986

Sectors: New Delhi-Nagpur-Bombay-Calcutta - travelling with Mrs. Hena Ramaswamy

Calcutta-Patna-New Delhi - travelling with Mr. Swaleh Karanja

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ITINERARY FOR EVALUATION TEAM OF PL 480 TITLE II ASSISTANCE TO ICDS

TRAVELLER: MR. SWALEH KARANJA \*

DAY	FLIGHT DATA						REMARKS
	DATE	FROM	FLT. #	ETD	TO	ETA	
WEDNESDAY	SEPT. 10, 1986	NEW DELHI	IC 439	0620	HYDERABAD	0815	Night Halt Hyderabad
THURSDAY	SEPT. 11	HYDERABAD					Meeting with GOAP & CARE Officials - Plan for field trip Night Halt Hyderabad
FRIDAY	SEPT. 12	HYDERABAD	BY ROAD				Anganwadi Visit of Banskada Project - Night Halt Hyderabad
SATURDAY	SEPT. 13	HYDERABAD	IC 440	0745	NEW DELHI	0940	Night Halt New Delhi
SUNDAY	SEPT. 14	NEW DELHI					
MONDAY	SEPT. 15	NEW DELHI					
TUESDAY	SEPT. 16	NEW DELHI					
WEDNESDAY	SEPT. 17	NEW DELHI	IC 540	1900	HYDERABAD	2055	Night Halt Hyderabad
THURSDAY	SEPT. 18	HYDERABAD	IC 270	1720	CALCUTTA	2000	Wrap up Session - CARE & GOAP Officials - Night Halt Calcutta
FRIDAY	SEPT. 19	CALCUTTA					MID-APPRAISAL SEMINAR - Night Halt Calcutta
SATURDAY	SEPT. 20	CALCUTTA	IC 295	1605	PATNA	1700	Night Halt Patna
SUNDAY	SEPT. 21	PATNA					R E S T - Night Halt Patna
MONDAY	SEPT. 22	PATNA	BY ROAD				Visit Patna Urban Project/Meet with Director of Social Welfare and COPD & Supervisors - Night Halt Patna
TUESDAY	SEPT. 23	PATNA	BY ROAD				Visit Fatwah Block - Proceed to Gaya - Night halt Gaya
WEDNESDAY	SEPT. 24	PATNA	BY ROAD				Visit Anganwadi in Gaya - Travel back to Patna for Night Halt
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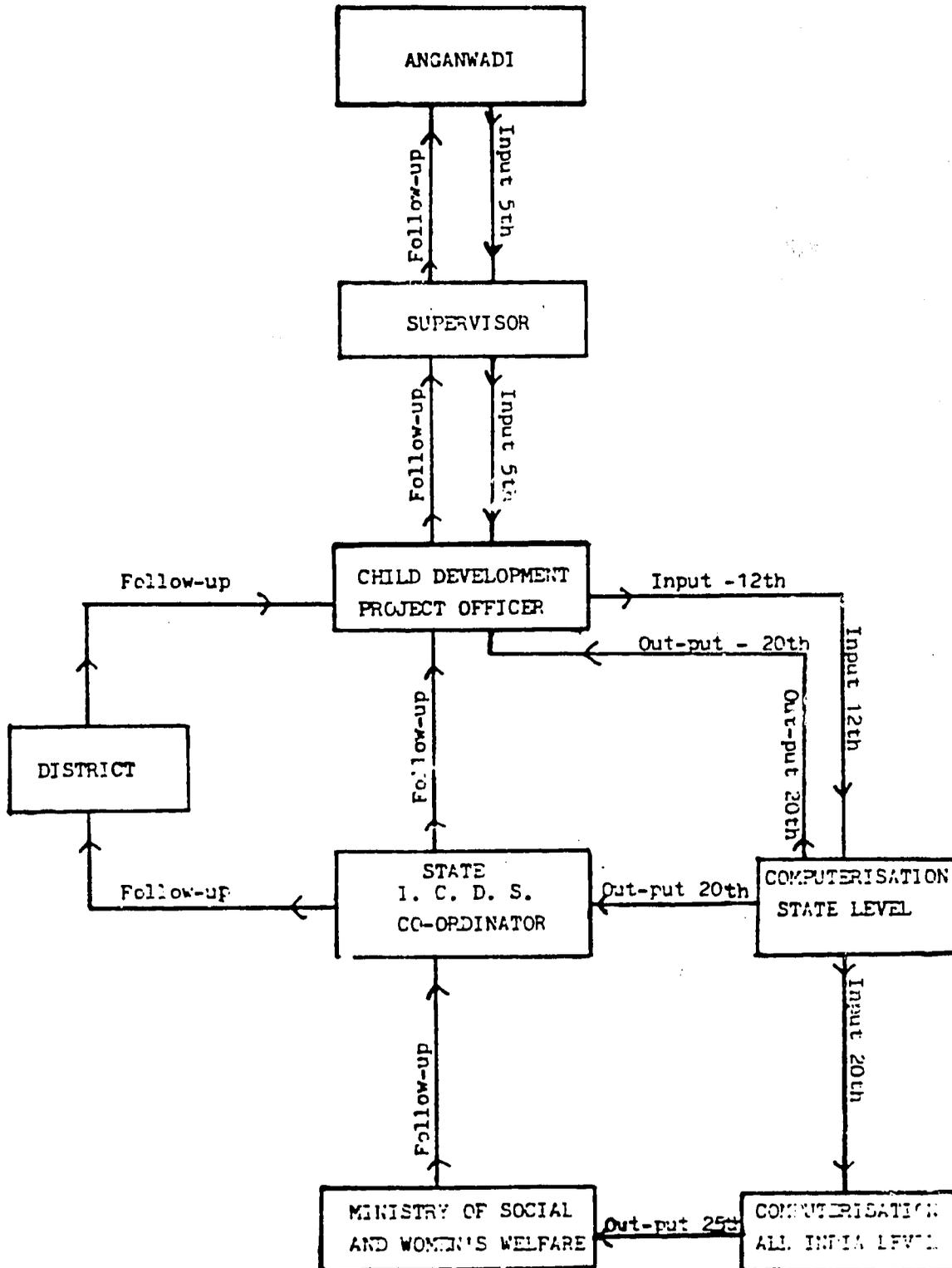
09 September 1986

\* Sectors: New Delhi-Hyderabad-Calcutta - travelling with Ms. Hope Sukin and Ms. B. Kakkar

INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME

Supplementary Nutrition Program

PROFILE OF MONITORING SYSTEM



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GOVERNMENT OF \_\_\_\_\_ ANCAWADI STOCK REGISTER AND MONTHLY REPORT : ICDS PROGRAMME

Month : \_\_\_\_\_ Year: \_\_\_\_\_

Population/Enrollment : Details										Shortages/Damage - awaiting authorisation for removal		Details of Ration Containers					Date	
Description	Women		Children		TOTAL	Commodity	Q.T. (Kgs)	Total Number of	Q.R.	Returned	Balance	Metallic	Polythene	Paper	Tins	Cartons	Assigned	Date
	1 Year	2-3 Yrs	4-5 Yrs	6 Yrs & Above														
Total Population								Feeding Days	Working Days								Project	.....
Enrolled																	District	.....
Attending 3 days or more																		.....

Notes: 1. Malnourished - Severe - 4th Age Circumference or 1st or 4th degree weight-for-age.  
 2. 'Prog.' - Pregnant and 'M.R.' - Nursing with 'DR' - Single Ration and 'DR' - Double. Source of Food ..  
 3. Hand over the original and Duplicate copies to your CDPO on or before 5th of every month.  
 4. Feed on all working days. Adhere to prescribed rations.

Write Commodity Name in appropriate space provided below this line

Date	Voter	CHILDREN					TOTAL	Receipt	Therapeutic Food		Milk Food		Grain		Oil		Dishes		Sugar/Savoury		Remarks
		1 Year		2-3 Yrs		4-5 Yrs & Above			U.S.		U.S.		U.S.		U.S.		U.S.		U.S.		
		DR	OR	DR	OR	DR			Issue	Balance	Issue	Balance	Issue	Balance	Issue	Balance	Issue	Balance	Issue	Balance	
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30																					
31																					
TOTAL																					

LIST OF REGIONS IN USE

A1	B1	C1		B2		E1		F1		G1	
Commodity	Ration										

KVR-CD:198:24 / 12.11.1984

SIGNATURE OF THE ANCAWADI JOURNAL

Date: \_\_\_\_\_

Best Available Document

"The Food Provided Through "CARE" is Furnished by the People of the United States of America"

# CARE - KARNATAKA

36, LAVELLE ROAD, BANGALORE-560 001

## FEEDING CENTRE VISIT REPORT

PROGRAMME..... DATE.....

FEEDING CENTRE..... BLOCK/RANGE..... DISTRICT.....

NAME OF CENTRE INCHARGE..... NAME OF F.O.....

TIME OF VISIT..... FEEDING TIME..... DISTANCE FROM BLOCK.....

A. BENEFICIARY DETAILS :      6 Months to 3 Yrs      3(+) - 6 Yrs      Pregnant/ Nursing Mothers      School Children

1. Total Enrolment	:	.....	.....	.....	.....
2. Allotted Bens	:	.....	.....	.....	.....
3. Attendance on the day of visit	:	.....	.....	.....	.....
4. Headcount on the day of visit	:	.....	.....	.....	.....
5. Bens fed on the day of visit	:	.....	.....	.....	.....
6. Monthly Average Attendance	:	.....	.....	.....	.....
7. No. of ineligible bens present at the time of visit	:	.....	.....	.....	.....
8. Reallotted beneficiaries	:	.....	.....	.....	.....
9. Explain difference between 3, 4 & 5	:	.....	.....	.....	.....

B. COMMODITY ACCOUNTABILITY :

Commodity	Book Balance	Physical	Difference*	Shortage/ Damage Status**	Cut off date for physical Balance

\*Explain difference.....

\*\*Explain shortage damage status and action taken.....

C. PROGRAM PERFORMANCE-LAST THREE MONTHS :

Months	Availability		Consumption	Feeding Days	
	Target	Actual	Actual	Actual	Target

Remarks.....

**Reasons for shortfall in feeding days.....**

**Food not available due to**

- a. Insufficient stock at Block : YES/NO
- b. Failure of Block to deliver : YES/NO
- c. Inaccessibility due to monsoon : YES/NO
- d. Transportation bottleneck : YES/NO

**Not fed due to :**

- Non-availability of stock at Centre : YES/NO
- Local festival : YES/NO
- Absence of Aww/Helper : YES/NO
- Monsoon : YES/NO
- Others (specify) : .....

**D. REPORTS AND RECORDS :**

- 1. i) Delinquent monthly report : YES/NO
- ii) Number .....
- iii) Period .....
- iv) Reasons for non-submission .....
- 2. Adequacy of accounting records Adequate/Inadequate
- 3. Empty containers accounts maintained : YES/NO
- 4. Feeding Attendance Register maintained : YES/NO

**E. BASIC SUPPLIES :**

- a. Storage Adequate/Inadequate
- b. Cooking Vessels Adequate/Inadequate
- c. Eating Vessels Adequate/Inadequate
- d. Measuring Cups Adequate/Inadequate
- e. Dunnage Adequate/Inadequate

**F. KITCHEN :**

- a. Kitchen Pucca/Temporary/Open Air
- b. Preparation observed YES/NO
- c. Feeding observed YES/NO
- d. Clean YES/NO

- G. a. Are beneficiaries/Aww aware of the commodity source . YES/NO
- b. Are empties defaced before their sale ; YES/NO

**H. FOLLOW-UP ON PREVIOUS VISIT :**

Name of F.O..... Date.....

Exceptions .....

Current status of previous exceptions.....

**I. REMARKS/RECOMMENDATION/ACTION TAKEN**

Signature of Field Officer

Signature of Centre-in-Charge as  
Having Read and Understood/Having  
Been Read to and Explained

**NUTRITION AND HEALTH COVERAGE DURING THE PREVIOUS MONTH:**

1. Gradation of Children being done :— Yes/No
2. Method used : Coloured Strip  Weighing Scale
3. Health Charts maintained well : Yes/No
4. Nutrition Health Education Classes conducted regularly : Yes / No
5. Home visits carried out regularly by AWW : Yes / No
6. Immunization done per schedule : Yes / No
7. Prophylactic Treatment provided regularly : Yes / No
8. Health Check-up regular : Yes / No
9. Number of visits by Supervisors in last 3 Months   
by CDPO  ANM  LHV  MO
10. Anganawadi Workers – Trained : Yes / No
11. Community involvement present : Yes / No  
Explain its nature :

**Comments by FIELD OFFICER FOR ACTION**

**FOR INFORMATION**

SIGNATURE : \_\_\_\_\_  
FIELD OFFICER

SIGNATURE : \_\_\_\_\_  
ANGANAWADI WORKER

TURNONER FOR FURTHER COMMENTS

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Table - 1

CARE/INDIA  
PL 480 Title II - Commodity Losses (MTs)  
Per Commodity Status Reports

U.S. FY	Nature of Loss	Milk	Wheat Flour	Veg. Oil	Bulgur	CSM	SFCM	Corn	Rice	ICSM	Total MTs
1984	Inland Loss	73	21	102	544	48	10	40	10	87	935 MTs 0.57% of Distribution (163,242 MTs)
1985	Inland Loss	1	-	103	393	153	15	1	2	32	700 MTs 0.54% of Distribution (130,509 MTs)
1984	Marine Losses	-	-	127	2,655	674	-	-	494	892	4,845 MTs 2.9% of B/L Arrivals (167,932 MTs)
1985	Marine Losses	-	-	202	1,781	2,346	-	-	80	-	4,409 MTs 3.8% of B/L Arrivals (116,033 MTs)

A.P.

REFERENCES

1. M. S. Dayal, ICDS - Seventh Plan and Beyond, undated reprint.
2. Prof. B.N. Tandon, Prof. of Medicine, All India Institute of Medical Sciences, New Delhi. The Impact of ICDS on the Status of Child Health in India.
3. CARE/India in collaboration with Ministry of Social Welfare, Government of India. ICDS Integrated Child Development Services (Working Guide).
4. USAID/India. Project Paper, India, Integrated Child Development Services (386-0476)
5. David E. Sahn. The Integrated Maternal & Child Nutrition Project in India Recommendations based on a Review of Past Experiences.
6. Community Systems Foundation, Ann Arbor, Michigan. An Evaluation Report of the PL-480 Title II Program in India.
7. Story of Integrated Child Development Services.
8. Central Technical Committee on Health & Nutrition, All India Institute of Medical Sciences, New Delhi. Integrated Child Development Services.
9. UNICEF. Integrated Child Development Services in India
10. Department of Women, Child Development, Ministry of Human Resource Development, Government of India. A Guide-Book for Anganwadi Workers.
11. Department of Women's Welfare, Ministry of Human Resource Development, Government of India. Manual on Integrated Management Information System for ICDS.
12. Dr. K.G. Krishnamurthy and Dr. M.V. Nadkarni. Integrated Child Development Services - An Assesment, prepared for UNICEF

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