Sida Evaluation 00/2

Reaching out to Children in Poverty

The integrated child development services in Tamil Nadu, India

Ted Greiner
Lillemor Brolin
Madhavi Mittal
Amrita Puri
N. Paulraj
Angeli Gupta

Department for Democracy and Social Development

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Evaluation Reports may be ordered from:

Infocenter, Sida
S-105 25 Stockholm
Telephone: (+46) (0)8 795 23 44
Telefax: (+46) (0)8 760 58 95
E-mail: info@sida.se, Homepage http://www.sida.se

Authors: Ted Greiner, Lillemor Brolin, Madhavi Mittal, Amrita Puri, N. Paulraj, Angeli Gupta.

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SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Address: S-105 25 Stockholm, Sweden. Office: Sveavägen 20, Stockholm
Telephone: +46 (0)8-698 50 00. Telefax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se

Introduction

Sida partially financed the Integrated Child Development Services in the three districts of Tamil Nadu for about a decade, starting in 1989. An evaluation of this support was conducted in 1997. Over a year later, at the end of 1998, another team of consultants followed up on the issues raised, as well as focusing on some new questions. This document combines these two reports, first the evaluation and then the follow-up review.

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Executive Summary

Background

The nationwide Integrated Child Development Services (ICDS) scheme aims at enhancing survival and development of children from the vulnerable sections of society. It provides an integrated package of services related to the main components of human resource development: health, nutrition and education. Various services are provided to each of the following groups: children 6 months to two years of age, children 2–6 years of age, pregnant and nursing mothers, adolescent girls between 11–18 years of age, and women 18–45 years of age.

One of the most comprehensive and imaginative programmes of its kind in the world, it has four objectives: (I) to improve the health and nutritional status of children 0–6 years by providing supplementary food to beneficiaries 300 days a year, (II) to provide conditions necessary for child psychological and social development through early stimulation and education, (III) to enhance the mother's ability to provide proper child care through health and nutrition education, and (IV) to achieve effective coordination of policy and implementation among the various departments to promote child development. Services are provided from an anganwadi centre (AWC) which are staffed by an anganwadi worker (AWW) and a helper, both of whom are meant to be recruited and trained locally. Because AWCs are so widespread, they are utilized by village health nurses (VHN) and other health sector staff to provide vaccination, prophylactic nutrients and drugs, health and nutrition education, health check-ups and referral. Preschool education is also provided by the AWW to children 2–6 years old.

Tamil Nadu is the poorest state in southern India. The situation of women is better than in most of the country regarding education but many are "missing." Though education levels for children are very high, so are levels of child labour. The state government is highly committed to the social sector and funds ICDS throughout the state, though the World Bank funds a similar project (TINP) which replaces ICDS in most blocks (geographical areas with a population of about 100,000).

The main objective of the Swedish support to ICDS has been to improve the quality of certain activities and make ICDS a more comprehensive development programme by:

- encouraging innovative activities;
- integrating these activities among sectors;
- supporting special activities for girls and women;
- reinforcing the ICDS administration.

Sida support began in 1989 with only 8 blocks in Chengalpattu District, and by 1994 had expanded to 47 blocks throughout that district and two others: Pudukottai and Nilgiris. The total Sida contribution so far has been SEK 167 million.

Since 1993, the Sida support has been limited mainly to "additionalities," innovative approaches that are to be tested for possible replication on a larger scale. These consist of supplemental feeding in the afternoon to extend the period when the AWC is open and the preschool running, improved training in preschool methodology, community participation approaches, schemes to train adolescent girls, nutrition gardens at the AWC, improved communication activities, purchase of necessary materials and supplies, construction of a limited number of new AWCs, and administrative and personnel support in the form of additional posts at state levels and support for additional workers in the AWC.

Description of the evaluation

This evaluation had the following objectives:

- to describe the overall development of ICDS in the three districts in which Sida has supported it in Tamil Nadu, as well as each Sida-supported additionality;
- to assess the role of the Sida support, including financial implications, in improving the quality of ICDS in these areas and, where replicated, elsewhere;
- to provide recommendations to Sida on possible reorientation or adjustment of its support to ICDS.

It included the preparation of a desk study by Dr. Anders Björkman, the main technical consultant Sida used during the project period and a three-week field review by the authors of this report who represented Sida and the two governments and each took responsibility for different technical aspects of the project.

The Evaluation Team had access to the findings of a series of "prestudies" that Sida commissioned in the months preceding the field review. These were done by companies that won bids to conduct these studies designed to provide detailed and objective data to the evaluators on key aspects of the project:

- Review of fiscal and economic aspects of Sida ICDS in Tamil Nadu by Management Services Group,
- Sida – ICDS Study by Social and Rural Research Institute, (a combination of prestudies that examined targeting and that did a rapid appraisal of Sida additionalities in a random sample of AWCs)
- Adolescent schemes prestudy for joint Sida/GOI/GTN evaluation of the Sida-supported ICDS by Mode,
- Tamil Nadu Sida – ICDS Community Participation – A Pre-study by Research and Development Council , and
- Prestudy on health, nutritional and educational indicators done by Ted Greiner based on the project's own monitoring data.

Findings

A large number of administrative weaknesses were found, many of which had to do with the rapid transfer of state-level personnel that has occurred, especially in recent years. The management information system is not used, although the recording done by AWWs and the system for transferring it to central levels are rather good.

Targeting works well. Indeed, the project appears to be largely self-targeting to the poorer groups with monthly household incomes below SEK 150. The main challenge is that families living in smaller hamlets who tend to be poorer have in the past not been eligible to have AWCs. However, the GOI has a new policy that mini-AWCs can be established in these areas.

Supplementary feeding works well in general. Nutrition gardens, cooking demonstrations, and messages given in home visiting, increased vaccination rates and other improvements in the situations of families in these districts have probably played an important role in the finding that the nutritional status of children 0–6 years old in has gradually increased during project implementation to the point where severe malnutrition no longer is widespread and moderate malnutrition rates are also coming down.

Some of the innovative communication approaches appear to work well, but mass media and teaching materials production have fallen off in recent years. Community awareness-raising has not been very innovative nor made adequate use of the children themselves in showing what they can do.

The preschool activities have greatly improved and been a "showcase" for other states. There is evidence that primary school enrolment, retention and performance are higher for children with a preschool background. Education is valued by most parents in Tamil Nadu and the popularity of preschool is gaining ground. One measure of the increased community interest in preschools is the increased private competition with ICDS. However, there is room for increased community awareness of the importance and value of the entire anganwadi program and its messages.

New approaches were launched by the GTN to better deal with the needs of adolescent girls and the educational needs of adult women. Since these changes were made too recently to be evaluated, the outcome of both of these new programs will need to be separately reviewed before long-terms plans are made. Community participation in ICDS is uneven, but often weak.

Conclusions

Other evaluations have shown that ICDS generally has a positive effect on the health and nutrition of women and young children. Data gathered during the evaluation suggest that positive effects from the Sida support have occurred in many components of the project, but evidence is strongest regarding young child nutrition and attendance in primary school, particularly by girls.

Sida ICDS is a programme that reaches poor mothers and children. The establishment of mini-AWCs would allow it to do so even more effectively, reaching many of the very poorest.

Although this evaluation has identified a wide range of areas in which ICDS in the state could be improved, much of this improvement can be made with a feasible level of effort in a reasonable amount of time, following the recommendations given here.

The Sida approach of encouraging and funding innovation, but doing so in ways close to and compatible with existing government approaches, appears to have succeeded. Some of the additionalities have been replicated by other donors, the state or the national government. Thus the impact of the Sida support has gone far beyond the three districts that directly benefited. Sida has a good reputation now both among other donors and the two governments and thus this model of testing innovations can continue to work in Tamil Nadu.

Both the national and state governments are committed to ICDS. There is no risk that it will not prove sustainable. Government officials praised the Sida approach as innovative and yet funded in ways that are similar enough to the government system as to allow relatively straightforward replication. The evaluation team believes that the government can afford to implement most of the successful Sida additionalities. Though pilot tests tend to be expensive, at least on a per capita basis, and in many cases cheaper ways of implementing them can be found. For example, implementing the Sida additionalities in only the poorer non-TINP districts in Tamil Nadu would cost only 12.6% of the Department of Social Welfare and Noon Meals Programme annual budget.

The most difficult problem related to improving the quality of ICDS thoughout the country is that the Sida areas, like much of Tamil Nadu, have two AWWs per AWC and the GOI has so far not been willing to entertain such a costly approach. One way of overcoming this that is being discussed, however, is the idea that the education sector might provide an additional worker for each AWC who would work only with the preschool component.

Recommendations

Sida support

An increase in the resources allocated by Sida to support ICDS would be justifiable. However, the team recommends that Sida consider providing support horizontally to include certain components or additionalities throughout the state ICDS program, rather than just to selected districts. Sida support should assist in expanding the program to mini-AWCs in uncovered hamlets.

The planned merger of ICDS with TINP provides opportunities for increased efficiency and sustainability but will require increased communication among donors and government while the modalities are worked out. This will also provide increased opportunities for both GOI and WB to observe and assist in replication of successful additionalities more widely throughout the country.

It is recommended that Sida continue providing support to program administration and management, but to reinforce and restructure the organisation on a functional basis (posts with adequate seniority to be delegated responsibility for specific tasks). The focus should be on decentralization to district level.

Programme design

Planning of the new project proposal should utilize LFA and participatory planning techniques. Needs assessments should be conducted, particularly in areas like adolescent girls and women's education where new approaches are being designed. A baseline study should be done if evaluation of the outcome is intended at the end of the project.

The ongoing emphasis on MIS should redesign it to ensure feedback to each level, to achieve simplicity and ensure utilization of all data gathered. This should reduce AWW record keeping.

Supervisors should trained and encouraged to be more participatory and technically supportive in the AWC activities.

A review should be made of which AWCs no longer have a high enough attendance level to justify continuing them. Their resources and staff might better be made use of by shifting them to unserved hamlet areas. This process may also offer opportunities to shift many AWWs to locations closer to where they live and to limit any new recruitments to local women.

More emphasis should be given to communication and community participation to increase community involvement and sense of ownership of the AWC. The use of mass media and the production of other communication materials need to receive increased attention.

Greater emphasis needs to be given to the preschool aspect in communication with the community. Preschool methodology needs to be strengthened through completion of training and renewed provision of indoor and outdoor play equipment and materials as well as strengthening AWWs' capacities to make their own from local materials.

The AWW should be able to identify and integrate in to the ordinary AWC activities children with marginal disabilities. An action plan for the disability aspect should be drawn up for the next 3 – 5 years.

In designing the long-term adolescent girls programme, attention should be given to the girls' and their parents' concerns regarding income generation, violence, and other problems that they perceive.

A closer, more institutionalised, cooperation between the AWC, local women's organizations, health and education functionaries, youth groups and other NGOs needs to be established.

The Convention of the Rights of the Child may be used as a basis for information and training regarding sexual and reproductive rights, marriage etc. Gender issues should also receive specific attention in all project planning, training, record keeping, monitoring, reporting and evaluation.

Continued attention should be given toward improving convergence though following up referrals and joint training wherever this makes sense. A review should be made of constraints to improving coverage of prophylactic nutrients and drugs. The whole community should be made aware of key child-care issues including the goal that fathers take a more active role and responsibility.

To strengthen the nutrition garden component, increased cooperation should be sought with the horticultural sector and the use of these foods in supplementary feeding and in cooking demonstration should get more attention.

Nutrition education is the major way to further improve nutritional status of children and women. The focus should be on the promotion of exclusive breastfeeding for six months followed by the introduction of nutritious, hygienic complementary foods in gradually increasing amounts while breastfeeding continues for two years or more.

Background

The ICDS programme

This evaluation covers the support provided by the Swedish International Development Cooperation Agency, Sida, to the Integrated Child Development Services (ICDS)[1] scheme in the state of Tamil, Nadu, India. The ICDS aims at enhancing survival and development of children from the vulnerable segments of society. It provides an integrated package of services related to the main components of human resource development: health, nutrition and education. Varying services are provided to each of the following groups: children 6 months to two years of age, children 2–6 years of age, pregnant and breastfeeding mothers, adolescent girls between 11–18 years of age, and women 18–45 years of age.

ICDS is centrally sponsored by the Department of Women and Child Development in the Ministry of Human Resources Development and is implemented by state governments. The Government of India (GOI) pays the costs for salaries, equipment and supplies, estimated in 1993 to be about Rupees (Rs) 1 million per block (administrative area with a population of about 110,000 on average) per year[2] and the states pay the cost for food, estimated to be about Rs. 1.7 million per block per year (5). Initially the programme was targeted to blocks in tribal and drought-prone areas and those with high proportions of scheduled castes. Gradually it is being expanded to needy areas in other blocks. It now covers about half the blocks in the country and the intention is to "universalise" it by covering needy groups in all blocks.

Considered by the World Bank (5) to be one of the most comprehensive and imaginative programmes of its kind in the world, it is probably also the largest. It has four objectives:

- to improve the health and nutritional status of children 0–6 years by providing supplementary food to beneficiaries 300 days a year,
- to provide conditions necessary for psychological and social development of the young child through early stimulation and education,
- to enhance the mother's ability to provide proper child care through health and nutrition education, and
- to achieve effective coordination of policy and implementation among the various departments to promote child development.

Services are provided from an anganwadi centre (AWC), one per 1500 population initially, though now "mini AWCs" are being sanctioned in areas where populations are small such as hamlets on the outskirts of many villages. AWCs are staffed by an anganwadi worker (AWW) and a helper, both of whom are meant to be recruited and trained locally. Because AWCs are so widespread, they are utilized by village health nurses (VHN) and other health sector staff to provide vaccination, prophylactic nutrients and drugs, health and nutrition education, health check-ups and referral. Preschool education is also provided by the AWW to children 2–6 years old.

The ICDS is often referred to as one of the most heavily evaluated development programmes in the world. Already at the time of the national evaluation in 1992 (6), it had been subject to about 625 baseline/repeat surveys and 250 research studies. They have unequivocally shown that ICDS has a positive impact on nutrition. Positive outcomes for health and education have been noted in the smaller number of studies that have examined those aspects.

[1] See Annex 1 for a list of the abbreviations used.

[2] In 1997, there were about Rs 4.7 per Swedish Krona and Rs. 35.5 per US$.

Many development efforts, for example the Shiksha Karmi project to increase primary education levels in Rajasthan, succeed in part by focusing on only one issue and in part by developing separate, innovative management systems. ICDS success is all the more remarkable in that it has followed neither of these formulae. It is run by government ministries and institutions. Seeking to achieve a holistic set of services to meet the needs of mothers and children, it demands coordination between state and national governments and between a range of sectoral ministries and other government institutions. Each state may have a different set of additional supportive actors including university departments, non-governmental organizations (NGOs) and donor agencies.

Tamil Nadu

The Tamil Nadu state government commitment to social development is high. The statewide Noon Meals Programme invests in nutrition at a level rare for a state government (4). In the area of education, 74% of males and 51% of females were literate according to the 1991 census. Already by 1986, 97% of the Tamil Nadu population was served by a primary school located at a distance of less than one km from their homes. Drop-out rates for primary school have continuously declined from 20% of boys and 25% of girls in 1986 to 16% and 18% respectively in 1995 (2). Yet a large 1994 study of rural India (3) found that, while very few children have never attended school, over 6% of children 6–14 years old in Tamil Nadu participated in the work force.

Although per capita access to doctors is better than for the rest of southern India and births are attended by trained midwives more than anywhere else except Kerala, health rates are mixed. In general Tamil Nadu is similar to the rest of southern India in having lower morbidity and mortality rates than for most of the rest of the country. Life expectancy at birth is lower than for the rest of southern India, however. Immunization coverage is high and malnutrition rates are lower than the national average (3). Fertility rates are lower than average and contraceptive use rates higher, though lower than in other states in southern India.

According to the Tamil Nadu State Nutrition Policy, severe malnutrition in the state has decreased from 13% in the late 1970s to 4% a decade later, although moderate malnutrition stayed stable at about 46%. Anaemia in pregnancy continues at the very high level of 70%. Low birth weight is apparently still at nearly 30% of deliveries, a sign that the nutritional status of women is poor. Though most children are breast-fed, the duration is shorter in Tamil Nadu than any other state in the country (19). Over 30% of infants under 12 months of age had been given feeding bottles, more than double the national average.

Tamil Nadu has lower incomes (3) and higher poverty (1) levels than other states in southern India. The situation for women is mixed relative to other parts of the country. Based on population statistics, it would appear that nearly 3% are "missing" (2). However, women in Tamil Nadu do have more education and greater contact with the mass media than women in most of the country (1).

ICDS in Tamil Nadu

The Directorate of Social Welfare and NMP (Nutritious Meals Programme), Government of Tamil Nadu (GTN) is the implementing agency of the ICDS in Tamil Nadu. In Tamil Nadu, ICDS is run in 111 blocks. The Tamil Nadu Integrated Nutrition Programme (TINP) is supported in another 318 blocks by the World Bank. However these programmes are increasingly being harmonized and merged. Throughout the state, the NMP provides supplementary food for the children 2–6 years of age who are enrolled in ICDS as well as noon meals for school children.

Description of the Sida support to ICDS

The objectives of the ICDS activities in the three Sida-supported districts of Tamil Nadu have changed over time since the support started in 1989. A complete list of objectives for the period 1995–97 is attached as Annex 2.

The main objective of the Swedish support to ICDS has been to improve the quality of certain activities and make ICDS a more comprehensive development programme by:

- encouraging innovative activities;
- integrating these activities among sectors;
- supporting special activities for girls and women; and
- reinforcing the ICDS administration.

Sida support to ICDS was requested initially in 1985 but signing and implementation of an agreement was delayed until 1989 when Phase I began in 8 blocks of Chengalpattu District.[3] According to programme personnel, that district was chosen over the originally requested Pudukottai because it would be easier for supervision missions to visit.[4] The eight blocks were apparently chosen because ICDS had already begun there, whereas the others had not yet made the transition from TINP. These blocks turned out to be among the weakest performers in some ways, probably because they are geographically isolated and difficult to keep staffed.

The first agreement period ran until December 1992, providing a total of Swedish Kronor (SEK) 62 million toward general support to ICDS plus additionalities. Due to slow expenditure rates, support was extended to the rest of the 30 blocks of that district as of January, 1992 and the programme was extended until July, 1993. During Phase II from mid-1993 to mid-1997 (also later extended through-1998), the SEK 115 million Sida support was to include only additionalities.[5] Thirteen blocks of Pudukottai District and four blocks of Nilgiris District were also included, bringing the total to 47 of the 111 ICDS blocks in the state.

For Phase II of the Sida ICDS project (1993–97), of the total expenditure on ICDS in the Sida ICDS districts, Sida's expenditure of Rs 452 million (about SEK 96 million) was 37% (additionalities), GTN covered 22% (nutrition costs), and the GOI contributed 41% (all other costs).

The Sida additionalities consist of activities which are not part of the standard ICDS package (although in some cases they are being piloted by government or other donors as well) and the costs of which are not covered by GOI or GTN. The major additionalities are as follows:

- strengthening of preschool education, consisting of training for innovative preschool approaches and for identifying children with mild disabilities; the purchase of indoor and outdoor play equipment; and recurrent funds for producing low-cost play materials,

[3] Now divided into two districts, Thiruvllur and Kancheepuram.

[4] This had the unplanned beneficial effect that missions from other donors who usually were coming to see the more famous TINP would also see some Sida centres, as they were so conveniently located near Madras. This probably enhanced the process of replication of successful innovations funded by Sida.

[5] In its reporting to Sida, DSW blames most of the slow expenditure rates on delays of up to one year in GOI approvals.

- strengthening of community participation (CP), consisting of training for participatory planning and for CP in general; provision of funding for holding community events to spread awareness about ICDS and its activities, including centre day, motivation day, education day and nutrition week; provision of communication materials including audio-visual equipment such as televisions and video cassette recorders, and vans for transporting it,
- supplementary feeding: afternoon snacks to preschool children; therapeutic feeding of seriously malnourished children; and food for adolescent girls participating in the ICDS schemes,
- provision of a small salary increment (Rs 50) to AWWs to facilitate their maintaining a nutrition garden at the AWC, as well as support (Rs 20) for them to hold monthly cooking demonstrations, and annual cash awards to the best AWWs and best AWCs,
- provision of warm clothes for preschool children in Nilgiris to overcome cold weather as a constraint to their attendance,
- training and Rs 25/month[6] for evening WILL (Women's Integrated Learning for Life) training run by AWWs: adult education in 150 centres, functional literacy in 150, and post literacy classes in 65,
- income generating projects for women's groups (early in the project),
- special studies for improving certain aspects of the project conducted in 1992: Surveillance study of coverage among high risk families; Quality of primary health care; Nutrition and health knowledge; Dietary practices and attitudes of mothers; Referral system patterns and problems, Formative research for communication strategy, and
- family life information to newly weds in Eligible Couples Workshops to be held annually by the AWWs.

Included as Sida additionalities are also some components whereby Sida funds are actually just providing additional coverage or improving programme quality. Here could be included the following:

- salaries of 21(recently increased to 22) posts at state level and two in Nilgiris (which, however, never were filled),
- salaries of a second AWW and helper where they existed (due to the combining of previously separate feeding programmes),
- registers and health cards,
- construction of 140 AWCs in Nilgiris and Pudukottai, repair of existing AWCs that needed it, and furniture for some AWCs,
- transport support (provision of bicycles to AWWs, a few mopeds to supervisors, trailers for carrying food, and vehicle running and maintenance costs during Phase I),
- additional training on various topics to various staff,
- two adolescent girls' schemes, and
- provision of prophylactic nutrients and drugs as well as drug kits for the centres when supplies were inadequate, and some weighing scales.

Finally, some of the Sida inputs consisted of important but more subtle contributions such as encouraging and discussing with ICDS leadership in the state how to better achieve integration with the health, education and even horticultural sectors, how to better meet the needs of disabled children within the programme, and better ways of following up and reporting on the programme.

A Sida review mission in 1995 (11) reported that at that time Sida assisted ICDS activities provided health, nutrition and preschool services through 4496 Anganwadi centres to:

[6] Sida had requested that this be increased to Rs 50.

- 100,000 children six months to two years for feeding (estimates according to DSW reports sent to Sida in 1996 varied from 111,000 to 121,000),
- 154,000 children aged three to six years (154,000–178,000, according to DSW reports),
- 70,000 pregnant and nursing mothers (72,000–73,000, according to DSW), and
- approximately 17,000 adolescent girls (18,000–21,000, according to DSW).

Evaluation of the Sida support to ICDS

This evaluation has been conducted jointly by The Government of India (GOI), the Government of Tamil Nadu (GTN) and the Swedish International Development Cooperation Agency (Sida). The complete Terms of Reference is attached as Annex 3 to this report. They state that the aim of the evaluation is:

- to describe the overall development of ICDS in the three districts in which Sida has supported it in Tamil Nadu, as well as each Sida-supported additionality;
- to assess the role of the Sida support, including financial implications, in improving the quality of ICDS in these areas and, where replicated, elsewhere;
- to provide recommendations to Sida on possible reorientation or adjustment of its support to ICDS.

Methods

Preparation

Sida used paediatrician Anders Björkman as its major consultant over the years, and the reports he wrote or was first author of form perhaps the best ongoing reporting of how the programme progressed (8–12). The last of this list is a desk study he was asked to do as part of this evaluation of Sida support to ICDS. It provided the team with an organized history of the project and a more in-depth review on the components he worked most on. A chart from that desk study showing the organizational set up of ICDS is attached as Annex 4 to the present report.

The present evaluation was faced with a common challenge: it was desirable to measure the outcomes, even impact of a complex set of activities related to the many programme objectives, but there were no baseline data from the programme area, let alone any non-programme area for comparison. In 1995 the idea was formulated of designing an evaluation that would measure the "after the fact" differences between Sida and non-Sida blocks. Two Sida consultants (Lillemor Brolin and Ted Greiner) worked on the preparation of an evaluation of this nature in January 1997, but came to the conclusion that it was unadvisable. First, since the original idea had been raised, many of the differences had been minimized because Sida additionalities such as training on preschool education, disability identification and community participation had been replicated in non-Sida areas. While these areas had had less implementation time, the training was often thought to have been done better, based on lessons learned in the Sida districts. Thus it would be impossible to separate any lack of impact from rapid replication to other districts. Second, doing only a post-study is a weak research design because is has to be based on the assumption that the areas compared were the same before initiation of the programme. For example, if nutritional status was no better in the Sida districts, this could be due either to no programme impact or to those districts having been worse off from the beginning.

The method chosen instead was to field a team of evaluators[7] who would each be assigned to examine in depth certain aspects of ICDS with the help of a series of so-called "prestudies." Local firms were invited to bid on conducting studies to illuminate specific aspects of Sida support to ICDS. Their proposals were reviewed by a team composed of representatives of the three parties to the evaluation and winning agencies were contracted by Sida. The preliminary findings of the prestudies were presented to

[7] This evaluation team and the areas to which each member gave major attention were as follows: Angeli Gupta (GOI) construction and transport; N. Paulraj (GTN) targeting, research, and monitoring; Sida consultants Amrita Puri (preschool component, disabilities), Madhavi Mittal (management issues), Lillemor Brolin (community participation and adolescent girls schemes), and Ted Greiner, team leader (health and nutrition).

all three parties to the evaluation and the evaluation team itself. These prestudies were not themselves an evaluation nor intended to stand alone as separate and definitive statements on the issues they examined. Rather they were meant to provide extensive and objective data that would allow the team to do its work in greater depth in a shorter period of time. It was also decided that program-generated data on nutritional status by block would be examined over time and any changes compared to the points in time when Sida support was initiated. This was thought that this would better enable conclusions of impact to be drawn.

Prestudies

The prestudies completed and used by the team are briefly described below. Numbers in parentheses refer to the draft reports listed in the reference list at the end of this document.

Review of fiscal and economic aspects of Sida ICDS in Tamil Nadu by Management Services Group (20). This covered issues related to programme management including organizational development, human resource management practices, management information systems, budgets and expenditures by the three parties, costs of Sida additionalities, and issues related to their replicability.

Sida – ICDS Study by Social and Rural Research Institute (13). This was a combination of two prestudies. One was a survey of 921 households in the three Sida districts examining how well ICDS was targeted to the groups most needing it, including gender aspects. The second was a rapid appraisal of the Sida additionalities and how well they were implemented, conducted in 20 randomly selected AWCs and including interviews with 23 AWWs. Interviews were also held with 499 community members.

Adolescent schemes prestudy for joint Sida/GOI/GTN evaluation of the Sida-supported ICDS by Mode (21). This was a qualitative study aimed more at coming up with ideas for how better to implement the program in the future rather than in judging its past effectiveness, since all three parties were dissatisfied with the existing schemes and they had been stopped by the time the prestudy started. Discussions were held with groups of girls who had passed through these schemes. They were brought together from about six villages in each of 10 randomly selected blocks in the three districts. The main method used was "visualization in participatory programmes" (VIPP) which gives everyone a chance to participate, even anonymously if they can write (which most could do). Focus group discussions were also held with some groups of girls and AWWs.

"Tamil Nadu Sida – ICDS Community Participation – A Pre-study" by Research and Development Council (17). This study took place in 10 randomly selected villages and one urban area in the three districts. It examined how well the various components were implemented that sought to increase community awareness and feelings of ownership of their local AWC. AWC registers were reviewed and interviews were held with 304 beneficiaries or their parents, 23 community leaders, 31 village functionaries, and 16 AWWs. Ten focus group discussions were held and 8 NGOs interviewed. The respondents were asked about knowledge of activities conducted in the AWC, about campaigns, pamphlets, posters, radio and TV programmes, if they participated on specific days, if they were involved in ICDS activities, and if they were willing to be (more) involved.

A final prestudy, done by Ted Greiner, consisted of a review and compilation of data from the programme's own monitoring system on key indicators of coverage, programme output and nutritional status. Data were obtained from all 47 blocks and a selection of those variables which appeared to be the most reliable were plotted by a consultant, Shankar. From these plots percentages were calculated and tabulated comparing the situation when Sida began its support, one year afterwards, and in early 1997. From this, conclusions were drawn and discussed. This prestudy is presented below as Annex 7.

Main evaluation

The team members assigned from the governments of India and Tamil Nadu had not yet visited AWCs in Tamil Nadu and thus made five unannounced visits to such centres in Chengelpattu District. The other team members had already visited a total of 40 AWCs among them at earlier times, many of these also unannounced, and thus were able to focus their efforts on reading and interpreting the prestudies and interviewing key ICDS functionaries to obtain answers to any remaining questions they had. (The time schedule and persons met by the evaluation team are presented in Annex 5.) The prestudies effectively doubled the number of AWCs the group had information on, but provided more in-depth data than could be obtained from general observations and informal interviewing. The prestudies were also done on representative samples which would be too time consuming for an evaluation team to travel around to.

Some of the prestudy reports were not analytically strong and failed to draw useful, valid conclusions from their data. But the data itself gave the evaluation team access to both quantitative and qualitative information from which they were able to draw their own conclusions.

Findings

The findings of the Evaluation Team are organized into two sections. First are issues related to programme administration and management. Then comes a review of specific Sida contributions to ICDS activities.

Programme administration and management

Discussion of the support provided by Sida is integrated into overall discussion of these issues in this section, crucial to the functioning of the entire programme. Starting in the next section, Sida support to specific project activities will be discussed.

Project costs

Adding up the grand totals for each of the 11 years gives a total of about 2,465,000 beneficiaries. Dividing by 11 gives an average of 224,090 beneficiaries per year. Dividing this into the total Sida contribution during these years of 167 million SEK, also divided by 11, gives an average annual contribution of 68 SEK per beneficiary per year. At today's exchange rate this would be worth about 340 Rs. But the value of the Indian Rupee compared to the Swedish Crown has depreciated a great deal during these years – a reasonable average for the period would be about 270 Rs, at the 1993 exchange rate of about 4 Rs/SEK rather than today's 5.

Donor-government cooperation

As mentioned already, the pace of implementation of the Sida support to ICDS has always been slower than planned. When three relatively large bureaucratic organizations cooperate, unexpected delays should perhaps be expected. Overplanning does not offer a solution to this dilemma, because delays are not predictable. If spending goes as expected, funds will run out before new ones can be allocated, causing serious damage to the programme. Thus a flexible approach to ongoing joint planning is required. That is exactly what has been achieved through extending the area covered and the periods of time available to expend the funds based on agreements made through semiannual meetings between Sida and GTN. The team believes this has been a useful way to overcome the problem of implementation delay.

Programme management

Sida support for management development presently includes funding for 22 posts (one of which was never filled) in the GTN Directorate of Social Welfare (DSW), and salaries for AWW IIs and additional

helpers in Chengalpattu and Puddukottai. (See Annex 4.) The GTN was to gradually take over the costs for the 22 state level posts, but this still never occurred.

Some relevant training and study tours have been funded. Additional programme monitoring specified for Sida projects includes preparation of annual and biannual reports, a year planner, status reports at district level and other special studies. Overall there has been an improvement in planning of Sida assisted activities since that start of the project. However formal written reporting to Sida was usually delayed and sometimes skipped altogether.

Management capacity at state level
The 22 posts funded by Sida have reinforced overall management of ICDS. They function under the governmental administrative structure set up for ICDS at DSW. This means that they are in theory sustainable but subject to the inherent weaknesses in the system. ICDS in the state has outgrown the DSW management structure and its capacity. DSW handles many other government schemes as well. Some of the problems this has caused are as follows:

(1) No manager is able to devote full time attention to ICDS.

(2) ICDS operates under a project based organisation structure, resulting in insufficient managerial attention being available for functional aspects. Sida did support some functional posts which have worked well. For example, the post of Programmer has improved the quality of reporting as a result of training. However, often the intended functional work is lost in assignments related to general ICDS work. For example, the Communication Officer rarely is able to give attention to communication activities.

(3) There is a lack of clarity on functional and administrative controls and roles within the organisation and amongst the officers in DSW although these have been laid down in government orders and office orders at various points of time by different directors. As an illustration, all purchase and indenting for ICDS is handled under the Deputy Director (Special Programmes). Frequent transfers and lack of coordination between the officers have led to a state of affairs which often is confused and inefficient.

(4) There is a lack of dialogue and coordination between various the departments and sections at DSW. For example, the section responsible for passing bills against the indents does not verify with the section consolidating indents.

Midterm efforts were made by Sida to resolve certain management related problems based on recommendations in annual reviews, e.g. appointing the Secretary as Chief Programme Coordinator. However this strategy has not been very effective, as the post is transferable. Management training is provided to some staff at state and district levels, but is of a general nature, not oriented specifically to ICDS needs. A management training backlog exists and evidently little priority is placed on this aspect.

Management capacity at project level
Project Officers (Pos – district level) and Child Development Project Officers (CDPOs – block level) often seem weak in their management skills. A high level of dependency on the DSW in decision making and bureaucracy in their approach was noted. An attempt was made in 1994–95 in Nilgiris and Pudukottai districts to develop and support a participatory planning process through training. However, the impact has been limited, due to lack of follow up and transfer of trained personnel.

At this level management training is also offered and also seems to suffer from being inadequate for the same reasons. Additional training has also been conducted by State Institute of Rural Development in "Involvement of Women in training process" where participatory techniques were imparted with practical sessions to selected POs and CDPOs. Though the training was considered useful by the trainees, there has been little opportunity to use these techniques in the ongoing planning process.

The state government has taken a decision against filling up posts of AWW II, anticipating problems of meeting administrative costs and arranging alternative employment for them once Sida withdraws support.

Human resource management practices

Transfers and vacancies

At DSW, frequent transfers in top management (Director and Additional Director are from the India Administrative Services cadre) at the state level leads to instability, with decision-making and policy making often radically changing with each change in management. Four directors and four additional directors have been changed in the last two years or so. Because there are so few managerial staff with functional responsiblities, there is a lack of accountability. Only the people at the top are accountable for seeing that each of the many components of this complex programme work. It takes each newly appointed staff member a long time to understand what is required, and they may not prioritise certain aspects. In case after case the team found this to be the main reason that good initiatives died out, resulting in uneven project performance.

There is also a somewhat high turnover rate at field level of trained staff, and this too has a negative impact on the training programme and success of project implementation. There are thus always a certain number of untrained staff within the project. A turnover rate as high as 50% in CDPOs was observed at times in some areas in Sida districts (12). However, turnover rate in non-Sida projects is as high. For this reason, additional training is now planned to be imparted to staff in all 111 projects under the current Sida extension proposal.

There is considerable delay in filling up vacancies, due to long selection procedure involving setting up of panels and obtaining approvals at various levels in the government (which also allows for political interference). At present there are numerous vacancies for CDPO posts in all three districts. The key posts of PO for Nilgiris and Pudukottai districts were vacant for almost six months.

Recruitment and promotion of AWWs

Pudukottai and Chengalpattu Districts have the benefit of two AWWs in most centres, though their numbers are gradually declining by attrition. In centres with large numbers of children, this has been very beneficial to the development of the program, particular when innovative aspects have been added that demand extra AWW time. There can be no doubt that the time of a single AWW is otherwise almost completely mobilized by routine tasks including the health and nutrition activities, home visiting and record keeping.

The majority of the AWWs have been found to have a non resident status, although this is against official policy. Reasons for this include: (a) political interference in one of the former government regimes, (b) eligible candidates not being available in some villages, (c) disinterest on the part of eligible women due to the low honorarium, and (d) harmonization of the NMP, TINP and ICDS (since NMP did not require its workers to live in the village). This has a significant adverse impact on the programme, as women with long travel times do not keep the centre open as long. They are also less able to ask the community for help, since they are not viewed as "one of us." Nevertheless, on the whole the community in these three districts supports the AWW.[8]

AWWs are no longer simply volunteers, but are registered with the government. However, they are not formally government employees and thus their low salaries are compounded by a lack of job benefits. Delays in promotions and the time-consuming approval process have had a demotivating effect on staff.

[8] The statement "The AWW is very good in her work" was agreed to by 84% (93% among regular users). The highest level of satisfaction was expressed in Nilgiris, at 89% (13).

Sida has attempted to help alleviate this situation somewhat by building in various incentives, including improved in-service training, incentives for maintaining a nutrition garden at the AWC, giving cooking demonstrations, holding WILL projects, and an awards programme for best worker.

While most AWCs are only open 3–4 hours per day, in the Sida districts they are open from about 9 am to 3–4 pm. This not only provides a greater opportunity to offer quality preschool and to feed the children twice each day, it also provides needed childcare for working mothers.[9] As was earlier recommended in a Sida monitoring mission (11), since AWWs are not entitled to travel allowances, funds from the Sida budget could more often be used to give them an opportunity to make exchange visits to learn from centres that are running well or trying different approaches.

Project planning

There has been improvement in preparation of district year planners and annual progress reports since the inception of Sida support. However, there is still a lack of a long-term perspective in planning, both in the Sida districts and in ICDS as a whole. A clearer definition of quantifiable goals is needed. As observed in a 1994 review (10), plans need to be more specific and comparable from year to year. Piecemeal attempts at planning and lack of follow-up have been a result of: (a) frequent transfers of Directors, since each dictates his or her own priorities, (b) lack of time for the program among top management, (c) lack of a strong second line of officers, and (d) lack of training in the planning process. A former Joint Director who was recently trained in the logical framework analysis (LFA) technique was transferred soon thereafter with no effort being made to retain him. Trainers have been trained in LFA, but seem unable to utilize it without support from above.

At state level, policy and planning need to spell out clear objectives and targets for each planning period. New approaches appear to have been planned without doing any needs assessment or effectiveness study (e.g. adolescent girls training and WILL). This situation is compounded by the absence of clear and specific qualitative and quantitative impact indicators and a management information system to unable to compile and use relevant data in a timely fashion Training for statistical inspectors intended to deal with this aspect was limited to orientation with computers.

Coordination issues

Intra project

Coordination among the three districts is still limited amongst the field functionaries. Although they do get an opportunity to meet at state level meetings, these are mostly administrative in nature and provide little opportunity to share experiences and integrate lessons learnt formally in the planning process. More often such meetings could benefit from sharing hands-on experience in the field, as was done when Special Team Trainers from Pudukottai district were deployed to substitute pre-school and health instructors in Nilgiris.

Intersectoral

There are no formal linkages between the programme and various agencies responsible for implementing other governmental programmes that may provide infrastructural or coordination support for the AWCs. Some examples are the Central Rural Sanitation Programme that provides funds for toilets; and the Employment Assurance Scheme that provides roads and buildings. There is no forum where the AWW or any other functionaries can get information on such aspects or request cooperation in some way. Even if the AWWs are aware, coordination may not be possible unless facilitated by the District Collector, who may be constrained due to lack of policy at the state level.

[9] The female work participation rate is rising in the state. In 1991 it was 33% in Pudukottai, 30% in Nilgiris and 22% in Chengalpattu (14).

Coordination with the health department functionaries appears to work relatively well at village level on a routine basis. However, some MOs do not visit AWCs at regular intervals or attend monthly block level meetings.

Management Information System (MIS)

Reporting and monitoring

In comparison with similar projects in other parts of the world, AWWs, supervisors, and others seem to do a fairly good job of record keeping, collating this huge amount of data and transferring it in a relatively timely fashion to higher levels. However, attempts to make use of these data for the present evaluation turned up many gaps and errors of a magnitude[10] that makes it seem unlikely that anyone at state level is looking closely at these data, let alone putting it to any use.

The establishment of a management information system that takes a minimum amount of time, expertise and other resources but provides key, timely information that is analysed and utilized for managing the programme better is a visionary goal for any programme. Sida ICDS has given attention to improving this aspect since Phase I of the programme. Apparently a study was commissioned on this issue by the Christian Medical College in Vellore (8), a report was prepared and discussed on the development of indicators of training, performance and impact (10), and statistical inspectors were given increased training. But follow up of each of these seems to have been lacking and the system is thus still far from living up to its potential.

Björkman et al (11) estimated that AWWs spend on the order of 10% of their working time filling in registers, though reports to the Team suggest this figure is probably an underestimate. The AWW is overloaded with responsibilities, both those mentioned in her job description and as a resource person in the village. Thus it is not surprising that large gaps were at times observed in filling up of registers. The registers are to be reduced in number from 25 to 17 (and eventually down to 7), but the overall content needs to be reduced as well. This is a mechanical exercise for the AWW, as no attempt has been made to either apprise her of the usage or share the results of her input. In some cases, time could be saved through better intersectoral cooperation in record keeping. For example, immunisation data collected by AWW is also recorded on the child health card and independently by VHN. In any case, AWW reporting on health aspects is not considered reliable by the health functionaries.

Our review of the data collected found such anomalies as "number of pregnant women given iron tablets" commonly exceeding the number pregnant women enrolled. In all likelihood coverage was actually low.

The only information that comes regularly from the field to the state is the special performance report consolidated from the CDPOs' monthly progress reports. This is reviewed at clerical level, processed, and included in the annual reports. Occasional routine letters are written as feedback to the field, but flow of information between the field and the state can be slow.

Overall, there is a lack of regular, adequate, well-structured and timely information at DSW. This is generally true for both Sida and non-Sida projects. Very little data has been entered on the computers acquired from Sida funds and thus the process of data retrieval is tedious and laborious. Annual reports,

[10] For example, numbers of children fed increased by several-fold in Nilgiris in one year and back to original figure the next with no effort being made to locate and correct what the evaluation found was a simple bookkeeping error in one block. Similar examples were found in all districts of errors so large that they could not have gone unnoticed. When these errors were brought to their attention by the evaluation team, statistical officers were able to find and correct them fairly easily.

although their quality has improved, can be made more specific and analytical. Other weaknesses in the MIS have been summarised below:

(1) Updated information is not maintained on certain key aspects at the state level such as stock position for sathu (nutritious flour), food and medicines, status on additional training, status of AWC buildings, number and review of supervisory visits. Blockwise information is not promptly retrievable, if needed.

(2) No trend analysis is carried out regularly to indicate progress of the programme. The quality of the data analysis attempted is low.

(3) There are important weaknesses in internal controls. As an illustration, no reconciliation or verification of number of beneficiaries fed with the quantity of food, sathu supplied or expenditure made is done.

(4) Evaluation of available information is done by clerical staff. Little regular information is presented to the officers. Review at the management level is at the monthly coordination meetings with the POs, which is used mainly as an information source.

(5) The feedback system is by way of occasional routine letters to the POs. There is a lack of technical feedback and guidelines for corrective action and forward planning.

This problem is recognised by the present Director and Additional Director and several initiatives have been taken by them towards improving the system. This includes a proposal for purchase of computers worth Rs. 1.2 million, in addition to Rs. 0.5 million contributed by Sida. An attempt made to access data directly from the district level using NICnet (national informatics centre network) was not very successful. It is being planned to acquire computers at the District Social Welfare office and to connect to the state through a modem for fast flow and direct retrieval of data.

Supervision

ICDS includes supervisors at two levels: Grade II covers approximately 25 AWCs in a "sector" and Grade I covers an entire block, about four Grade II supervisors. According to national norms, AWCs are to be visited twice a month, but most supervisors are unable to make visits that often. The Grade I supervisors should visit each centre once every three months.

Presumably unannounced visits are rarely made to some centres, as the Team and the prestudies documented several cases of AWWs who open the centres only occasionally. Often these are not local women and sometimes they argue that they have to do other work due to the low salaries, but it would be better for the programme in such cases if they were relieved of anganwadi work and a more dedicated local woman found.

The national evaluation found that supervisors commonly helped AWWs with formulating their schedules, planning health and nutrition education sessions, weighing children and filling in the growth charts, coordinating with the health sector, and holding meetings with mothers (6). However, there is widespread concern that the role of supervisors and CDPOs have been reduced to inspecting authorities who do not make an effort to either involve themselves in AWC activities, provide technical guidelines, or support and facilitate the AWWs in overcoming any constraints they may face. Cross checks are made by state level officers but these are not reported on. Verbal reports from the field are not correlated against the compiled data to ensure its veracity.

Supervision in the Sida districts appears to work better than in many areas. Recently, a training programme was organised for CDPOs and Grade I & II supervisors of Sida districts to familiarize them with supervision modes and communication strategies for effective supervision. A trial was conducted successfully in Pudukottai of joint supervision missions wherein CDPOs and POs travelled together with supervisors. However, even higher quality of supervision in Sida districts is hampered by: (1) unfilled

posts, (2) lack of adequate transport for both categories of supervisors, and (3) failure to utilize existing data to monitor and make corrections in programme progress.

Targetting

The prestudy on targeting (13) interviewed 23 randomly chosen AWWs and 499 mothers. It concluded that targeting is adequate and appropriate beneficiaries are being reached by ICDS in the three Sida districts. AWWs estimated that the average number of households per AWC was 235 in Nilgiris, 207 in Chengalpattu and 138 in Pudukottai, not so much as to overburden the AWW in most cases. In Chengalpattu the AWWs estimated that about 80% of the households in their catchment area were registered at the AWC and in Pudukottai they felt that all were. (Only two AWWs were interviewed in Nilgiris.)

This study found that, among 77 pregnant women and 133 lactating women questioned, 75% of each had received supplementary food at the AWC. This is reasonably close to the figures derived from programme statistics as reported in Annex 7, Table I, suggesting that program MIS data are in this case accurate.

The targeting prestudy also examined the relationship between distance to the AWC and enrolment. This showed that 75% of children under six were enrolled where people lived less than 500 metres from the AWC but only 60% were enrolled otherwise. The rapid appraisal study found that the statement "The location of the AWC is not right" was agreed to by 25% in Chengalpattu 8% in Pudukottai and 31% in Nilgiris. "Timings of the AWC is not right" was agreed with by 25% in Chengalpattu, 6% in Pudukottai, but 41% in Nilgiris. Particularly in Nilgiris these data suggest that an expansion to mini-AWCs is likely to reach underserved groups. In addition, it would appear that factors such as income, discussed below, play a great role in who participates in the AWC.

It would be prudent in connection with decisions about this to commission a detailed review of the situation in every AWC and its surrounding areas. In many cases it may be possible to appoint one of the AWWs to take up a post in a new mini-AWC in or closer to her home village. In some existing AWCs, actual attendance may be so low that it is no longer justifiable to maintain two AWWs or two helpers. (Indeed, Nilgiris already shut down one such centre and transferred the staff to an AWC where community demand was greater.) Perhaps even some helpers living in places where mini-AWCs are to be set up may be qualified enough to be upgraded into AWWs with some additional training, again reducing the need to either lay off staff or continue with overstaffing in some centres.

The team was informed that GTN intends to redeploy existing AWWs to nearby centres before hiring any new ones. This will avoid increasing the number of ICDS workers in the state. However, it will exacerbate the problem of AWWs who are not working in their home village.

Monthly household incomes of respondents in the targeting prestudy (13) were low, varying from a mean of Rs 620 in Pudukottai to Rs 708 in Chengalpattu and Rs 1368 in Nilgiris. Table 1 shows the relationship between income and ICDS usage frequency. The mean household income in the state in 1994 was Rs 871 (3). Over half the ICDS user households earn less than Rs 500 (SEK 106) per month. At double that income, participation drops off, so in Tamil Nadu ICDS not only is serving very poor groups, it is self-targeted toward poorer households. Only 5% of the sample have a household income above Rs 2000 per month. Already at that level, the majority do not participate.

Nevertheless, there does not seem to be any stigma associated with the centre. When asked for a profile of people who go to the AWC, only 2 of 30 village opinion leaders said "poor people." Among the 497 villagers asked, none gave this response. When asked whether they agreed with the statement, "The AWW provides better services to the richer people," only 3% agreed (13).

Distance to the centre interacts with income. Those participants who live further than 1 km from the centre have an average income of only Rs 662 compared to the overall average of Rs 795.

Table 1. AWC User Frequency by Monthly Household Income (% across)

	Regular user N=189 %	Irregular user N=151 %	Non-user N=159 %
<500 Rs (56% of sample)	41	31	28
501–1000 (26% of sample)	44	28	30
1001–2000 (13% of sample)	22	40	38
2001–3000 (3% of sample)	24	12	64
>3000 (2% of sample)	11	22	67

***** Column percent in parentheses.

Table 2 shows a slight gender disparity in ICDS enrolment: 60% of the girls compared with 54% of the boys were enrolled in ICDS. The explanation for this may be that parents more often pay for boys to attend private preschools. Enrolment data probably underestimate the extent of this disparity, however, since many children in private preschools remain enrolled in the AWC, first because the AWW may not want it to be visible how few children actually attend, and second because some children come to the AWC only to get free food and then go to their private preschools. Our field observations suggested that often substantially more girls than boys were in actual attendance at the AWC preschools.

Table 2. Gender distribution among children registered at the AWCs

Gender	Enrolled	Not enrolled	Total
Male	196	165	361
Female	196	130	326
Total	392	295	687

The main reason for the gender disparity in Table 2, is that although equal numbers of boys and girls are enrolled, there are fewer girls overall and thus fewer girls are "not enrolled." As is commonly found in India, the reason for this is that some of the girls in the sample households were "missing." The male:female ratio was 1.07:1 compared to the overall for Tamil Nadu which was 1.03:1 in the 1991 census (2).[11]

[11] Recognising this problem, the GTN has had a policy of paying Rs 500 to parents who give birth to a second daughter with no son. The GOI has recently begun paying parents Rs. 500 for each girl born and is discussing a substantial scholarship fund to be provided to girls who graduate from primary and from secondary school to encourage them to continue their schooling.

Transport

Bicycles are needed by the many AWWs who live distant from the centres where they work and also for home visiting. Under Phase I, eight hundred bicycles were provided for AWWs in Chengalpattu and 17 mopeds for supervisors. The cost was recovered from their salaries, but this caused bureaucratic headaches and permission to spend the recovered funds has still not been received from GOI, years later. Therefore DSW requested and Sida accepted to provide 2500 more bicycles for Chengalpattu and Pudukottai (Nilgiris being too hilly) on a loan basis. That is, they will belong to the programme. This has the advantage that, in principle, the bicycles will remain at the AWC even if the AWW worker leaves. There may be a bit lower risk that other family members use it to the exclusion of the AWW. However, the disadvantage is that the incentive to maintain the bicycle will be gone. Unless the programme provides funds for maintenance and repair, these bicycles may not continue to meet their objective for long.

Mopeds and funds for fuel and maintenance are also to be provided for supervisors in Nilgiris in the coming year to enable them to cover a larger number of AWCs. There distances can be large and buses less common.

Construction and repair of AWCS

Sida provided funds for the construction of 80 new AWCs in Pudukottai and 60 in Nilgiris as well as repairs to existing centres in all three districts. A consultancy was provided to look into issues related to the design of those centres including truly smokeless stoves and toilets. Implementation has been delayed by bureaucratic problems, including identification and transfer of land in appropriate locations.

In Pudukottai, the land for these centres has been transferred and construction is nearing completion on 37 sites. There are no toilets, however. In Nilgiris the proposed design is on average too expensive since the cost of cutting and lifting rock in that hilly area is often high. Thus a smaller AWC has been proposed and the Panchayat has also gotten involved as another way of cutting costs. Only 24 sites have so far been identified. Consideration should be given to shifting the remaining funds to be used for other purposes and/or to Pudukottai or Chengalpattu if there are any villages that need new AWCs there.

As has been found in other evaluations (6), AWCs were sometimes found to be lacking in space, basic amenities like electricity, water and sanitary facilities and may have an unclean and run-down appearance. The main problems with the AWC mentioned by 23 AWWs were lack of electricity (12 of them), leaking roof (11) and lack of water supply (8). These factors may inhibit parents from sending their children to the centre. Although very few AWCs have toilets of any kind, only one AWW mentioned lack of toilets as a problem, so further awareness-raising may be needed on this issue (13).

Nutrition

Supplementary feeding is practically equated with nutrition in ICDS. Other aspects such as nutrition education and distribution of vitamin A capsules and iron tablets play a very minor role. In Tamil Nadu the introduction of nutrition gardens at the AWCs and monthly cooking demonstrations has, however, served to broaden the range of nutrition activities.

Historically, the distribution of state-supported food has strong political support in Tamil Nadu. The state NMP reaches 8.5 million preschool and school children. Funds for the food for ICDS children 2–6 years of age come from the NMP. These children receive a cooked meal of rice, lentils (dal) oil and salt (fortified with both iodine and iron). Each AWC is given Rs 0.18 per day per child to buy vegetables to add to it. About once every two weeks the children are to get egg and/or fish.

Food for the children 6–24 months of age consists of a flour made from grain, legume and sugar; it is basically a sweet, high-protein flour. The ingredients are roasted, powdered and sealed in small plastic packets, making it convenient to prepare at the AWC, because all that is needed is to stir it into hot water, saving time and fuel. These children are fed 80 g each in the morning before the older ones are fed and then leave the centre.

This same nutritious flour is given to pregnant and lactating women, but they receive 1 kg bags to take home (an 8-day supply). No doubt it is shared with the family and indeed during pregnancy many women do not want to eat much or have little appetite. In any case, this food contributes to improving family nutrition and reduces family food costs.

Last year the programme switched to a decentralized, district-based procurement system that led to disruptions in availability for some months, but this system is thought to be less susceptible to corruption and involves lower transport costs. Since 1989 this food has been manufactured by 26 societies spread around the state, each of which has 50–60 members chosen from among poor residents. They are provided with equipment and training and the food is said to be sent for inspection regularly.

Normally centres receive 40–45 days' worth of food at one time. Transport from where it is stored at block level to the AWC can be difficult and expensive, especially in hilly Nilgiris where AWWs can be required to travel up to 50 km to get it.

Nutrition messages are communicated mainly through home visits, although group lessons are occasionally conducted, for example on the day when women come to get their weekly food ration. Cooking demonstrations are also utilized to convey certain messages.

Sida inputs

In Phase I, Sida funds were used for all ICDS costs, including buying supplementary food, which composed about 80% of the budget. In Phase II, Sida's contributions were restricted to food for "additionalities," reducing this aspect to about 50% of the budget (9). This consisted of (a) a double ration of "nutritious flour" for therapeutic feeding of severely malnourished children, (b) food for participants in adolescent girls schemes I and II, and (c) so-called "sundal feeding" which provides boiled chick peas to the preschool children in the afternoons. Sida provided funds for the purchase of small trailers that are used to transport the food to block level.

Sida funds were also available for purchase of scales, growth charts and registers. Nutrition education was to be an integral part of the general communication effort funded by Sida. An extra component was cooking demonstrations for which AWWs were provided with Rs 20 per month to pay for the supplies needed.

Another additionality[12] related to nutrition is the "kitchen garden" located at the AWC. Seed and some other supplies were initially supplied. Since then AWWs have received Rs 50 per month to cover their costs for supplies and to pay for the extra time required in maintaining the gardens. This was perceived as a way to both increase indirectly the salary of the AWWs (who in Sida districts work longer hours than in others) and at the same time strengthen the nutrition component of the project. First, the vegetables and fruits grown could be used in the children's food. Second, the garden at the AWC could serve as a demonstration garden for women who attend and other family members who deliver children to or from the centre.

[12] As in the case of certain other additionalities, these were activities that some AWWs were already doing before the Sida support started (13), either on an ad hoc basis or within TINP. Sida sometimes added a feature and/or funded their complete implementation within these districts.

Findings

Nutrition and health are the aspects of ICDS that have been given most attention. When asked what the main service of the AWC was, 57% of community members said supplementary nutrition and 35% said vaccination (13).

Supplementary feeding

The supplementary feeding components have worked relatively smoothly. Though disruptions in supply occur intermittently, they are usually not severe until recently when sundal feeding has had to stop. The State stopped purchasing the sundal from its open-tender supplier due to poor quality. The programme was allowed to buy from a state company at first but the governor ordered them to buy through open tender again starting in July 1997, caused months of disruption in availability.

Malnourished children were earlier given therapeutic feeding consisting of a special soy/milk blend earlier, but this was changed to a double ration of the equally appropriate and already available nutritious flour, greatly reducing procurement costs. Since malnourished children often cannot consume this much on site, the mothers are allowed to take the rest home. However, severe malnutrition is now so rare that therapeutic feeding is now only a tiny component of the project.

The nutritious flour seems to work well, both in its local production and in its use in the AWCs. Sida was earlier asked to provide funds for switching to another type of food, a Nutrobiscuit made commercially. This would have been more convenient, since water would not need to be boiled to prepare it. However, it is not normally part of the diet and not even available on the local market. Indeed, there was a risk that the example it set would lead some families to assume that biscuits in general were good for young child nutrition. Therefore Sida declined this request, a decision the team agrees with.

The sundal feeding is the most innovative aspect. It allows mothers to keep their children at the AWC until 3–4 in the afternoon, whereas in most other ICDS projects, children go home soon after eating their mid-day meal. However, chickpeas cause problems both in procurement and at AWC level. Funds are not provided for additional fuel to cook them and they do require a good deal of time and fuel to cook. When asked whether they could simply be removed from the programme, functionaries unanimously were against this. The reasons given were (a) they are high in protein which was felt to be important for the nutrition of the children, (b) the children are now used to getting an afternoon meal and are already upset by the current disruption in availability, and 8 this afternoon food helps to keep the children longer at the centre in many cases.

The protein argument is not convincing. However, it is likely that many children would receive fewer meals per day without this feeding and that is an important nutritional argument for keeping some kind of afternoon feeding as part of the programme.

Nutrition education

The nutrition education to the adolescent girls in Scheme I appeared to have been much appreciated, well understood and remembered by them (21). Unfortunately, it appears to a large extent to have been advising foods that were too expensive for most families to be willing to purchase and thus may not have had much impact on family diets. Except for this and the cooking demonstrations, there is little to indicate that nutrition education has been given much attention in the rest of the ICDS programme.

Nutrition gardens

Observations, including the prestudies, have shown the nutrition gardens to be very widespread. According to DSW reporting to Sida in 1996, all but 16 AWCs (over 99% of the total number) had gardens. The rapid appraisal prestudy found nutrition gardens to be actively maintained by 9 of 12 AWWs

in Chengalpattu but not mentioned by AWWs in the other districts.[13] Eight of 12 who grew them felt they were achieving expected outcomes (13).

Cooking demonstrations
Cooking demonstrations were found to be the most successful additionality in terms of community awareness and participation. In one prestudy, six of the 22 AWWs interviewed (13) said they conducted cooking demonstrations once a month and another six said they did so more often than once a month, probably a sign that they enjoyed doing them. Twenty of the 22 AWWs who conduct them said they felt the expected outcomes were being met. Women said that they learned useful new recipes, learned ways to make certain dishes less expensively, and learned how to introduce more nutritious food into the family diet. In another prestudy (17), all AWWs reported that cooking demonstrations are an integral part of the monthly routine. Indeed, they were the best-known ICDS activity besides supplemental feeding and vaccination. In addition to their nutrition-related function, these occasions are used to spread knowledge on the other activities of the AWC.

Nutritional status among beneficiaries
The monthly weighing of all participating children has gradually increased in coverage during the period of Sida support and now includes about 93% of enrolled children (see Table III in Annex 7). This is an unusually high level of coverage and suggests that most AWWs are relatively conscientious in their work, at least in this regard. The centres do not have scales suitable to weigh very young babies (and thus birth weight data are lacking or unreliable), but new ones are being ordered.

During the term of the project, it would appear that ICDS in Tamil Nadu has nearly eliminated severe malnutrition and substantially reduced moderate malnutrition among participating children. (See Annex 7.) This is probably not due only to supplementary feeding, but is an indicator of a wide range of improvements that ICDS has brought to the lives of some of the poorest women and children in the state.

From the calculations presented above on project costs, it can be estimated that the total amount spent annually per beneficiary on the ICDS in the Sida districts was about US$24 (using an exchange rate of Rs. 35 per US$). About half of this was related to food and nutrition costs. Thus the impact of this project is consistent with other international experience that when about US$5-15 per capita per year is spent on nutrition programs, they lead to about a 1–1.5% per year decline in rates of malnutrition.

Health

As an integrated approach, ICDS has always striven to achieve optimal integration with the health sector. VHNs are to make weekly visits to each AWC, vaccinations are given at the AWCs, AWCs have simple first aid kits and medicines, AWWs distribute deworming medication routinely, and they give sick children and women referrals to the primary health care centres. (Whereas there may be an AWC in each village, health centres tend to cover about five of them.) Check ups may be given at the AWC, in some places even antenatal checkups. Health education is conveyed mainly through home visits. In theory some group educational sessions are held at the AWCs. Urban projects have MOs seconded to work with the CDPOs.

[13] Nutrition gardens have existed for longer in Chengalpattu, where they were introduced already during Phase I. Team members have however observed small gardens at AWCs in the other districts, so this prestudy "finding" may have been due to chance or perhaps the researchers failing to ask about the garden in those districts.

Increasingly, ICDS projects are attempting to do joint training, with ICDS and equivalent health sector staff receiving in-service training at the same time. Only when they are trained together is it possible for the staff of the two sectors to understand and respect each other's work and the importance of cooperating closely, including referral and follow up of seriously ill women and children.

Sida inputs

Sida financed the appointment of a Joint Director (Health) at state level. The first person to fill the post was seconded from the health department for five years and has recently been returned to his ministry and a second one seconded. Sida made funds available that would allow the programme in the three districts to purchase additional quantities of prophylactic medications on the common occasions when government supplies were inadequate. These included iron (ferrous sulfate tablets, FST, given as daily doses to pregnant women and young children), large doses of vitamin A (given to young children once every six months), and deworming medication (increasingly given once every six months to all rather than sporadically to only those with presumed infestation). Funds were also available to buy additional drug kits for the AWCs (simple curative medications).

Health education was to take place throughout the programme. For newly-married couples, "eligible couple" workshops were to be conducted to inform them on issues like child health, child care and the small family norm.

Several special studies were done in 1992 to elucidate better what the weaknesses and needs were in health and nutrition. Then improvements were made to health worker training, referral and laboratory facilities and coordination workshops were held for health and ICDS workers.

There was a strong component of external technical input for health and to some extent nutrition, through the inclusion in most supervision missions of a paediatrician from Sweden. The same one was used throughout the period of Sida support, ensuring continuity and familiarity with programme details and its history.

Findings

The special studies (copies of which the team was never able to maintain), training workshops and discussions during supervision missions seem to have had a positive effect. Generally, the health component is a success story. Collaboration between ICDS and the health sector remains a challenge, but at least at AWC level it seems to be going smoothly in most places now. Most VHNs make regular if not weekly visits to the AWCs. In the rural areas, MOs are more apt to shirk on the regular visits they are supposed to make.

Vaccination rates were surprising poor when Sida began supporting ICDS. They increased to relatively satisfactory levels in all three districts a few years ago and have remained reasonably stable since then. This is a popular service that is now identified with the AWC in the minds of both beneficiaries and AWWs themselves (13). One-third of mothers said that the immunizations were actually given by the AWW herself. Referrals seem to work better than before, though this is still considered a weak link by the current Joint Director (Health).

The rapid appraisal prestudy respondents stated that group health education rarely took place. On the other hand, when asked if they agreed with the statement, "mothers get knowledge on health care from the anganwadi," 65% agreed, 78% among regular users (13). As discussed below in the chapter on community participation, the programme is missing opportunities to produce more effective teaching materials to assist the AWWs in their health and nutrition education and to utilize the mass media to add status to key messages. The eligible couples workshops did not appear to have been given much attention by the programme. Only one of 23 AWWs who were interviewed about it (13) had ever conducted an annual eligible couples workshop.

The Joint Director (Health) post has led to greatly improved collaboration between the health and social sectors at every level, improved training, facilitated ordering of medicines and in general improved the health component. This illustrates what functional administrative arrangements can achieve.

Some joint training with the health sector has been done and was considered useful. It does place extra demands on planning and has costs but is too important to neglect.

Visits to AWCs found that medicines were properly stored and none with expired dates were found. When asked, AWWs seemed to know what they were and how to use them.

For various reasons, full use of the funds for medicines has not been made for the past 3–4 years. One previous director refused to sign all purchase orders[14] and another did not think additional drugs were a priority in the short period she had in the post before being transferred. Finally a purchase was just placed for over Rs 3 million under the current Director.

Data on the coverage rates for the prophylactic drugs are presented in Table II, Annex 7. For 1997, these data may overestimate the true situation, but even so, coverage rates are far from satisfactory. In addition to purchasing failures, as mentioned above, the following reasons have been posited for unsatisfactory coverage rates in the case of vitamin A:

- It comes in bottles and does not keep for long. If a given centre needs for example 2.3 bottles, they may only be given two to reduce waste.
- In some cases, vitamin A bottles were stored poorly, for example in the sun or near the stove. Then when given to the children it caused vomiting, reducing parents' willingness to have their children receive it in those areas.

It is planned to give the deworming medicine two weeks before vitamin A dosing, since worms may reduce vitamin A absorption. This may also increase the impact of the deworming, since it may reduce reinfection rates if many young children in the same community are dewormed regularly at the same time. Iron prophylaxis for young children clearly is not working; coverage rates are very low.

Preschool component

The ICDS preschool is for children 2–6 years old. The GOI and GTN see it as vital for achieving the objective of universalisation of education. Providing stimulating experiences to children at this age is thought to facilitate cognitive development. There is a growing effort to even locate the AWC and the primary school in the same compound. In any case, there is substantial evidence that primary school enrolment, retention and performance are higher for children with a preschool background (6).

The preschool component is to be conducted for 2–3 hours each day but the national survey (6) found that less than half the AWWs devoted as much as two hours to it. Also, only about 60% of mothers left their children at the AWC for the full duration. Most others took the child after the feeding was over. The quality of this component was found to be low in the national evaluation: rote learning of numbers and singing a few rhymes were the main activities. Creative activities and free play were lacking.

[14] Part of the reason for this was said to be the corruption scandal that surfaced just as a new government came to power and she came to the DSW in mid-1996. This scandal was concentrated to other sectors; very little was even alleged to have occurred within the DSW. But she appeared to be trying to win "political points" with the new government by claiming to see evidence for it and with this excuse reduce amounts allocated for food expenditure and refused to spend on drugs and nutrient supplements.

Education is valued by most parents in Tamil Nadu and the popularity of preschool is gaining ground. Today parents are willing to pay for private preschools, especially for boys as they see this as investment in the future. Thus private preschools have mushroomed, some run by NGOs, especially in Nilgiris.

Sida inputs

Additionalities have included support for training for preschool and the provision of play materials. The first training during Phase I was in the Montessori method. In 1995 the Training Team received training from an NGO called THREAD in the thematic approach that is widely used in the Sida districts today. The Early Childhood Education Project Cell in the Directorate of Teacher Education Research and Training in Madras also conducted some training. The Training Team and Supervisors recently received training in the Joy of Learning which they are now teaching the AWWs all over the state.

Training materials were developed and the Anganwadi workers were provided with training and Rs 15 per month to develop their own play materials and teaching materials using locally available aids such as stones, leaves, trees.[15] The use of traditional games and plays was introduced. Funds were provided once for the purchase of large outdoor play equipment and for indoor play materials.

Findings

AWWs report a migration to private schools, though they say that some children come back if their parents can no longer afford the fee or because they were happier at the AWC. However, there is a danger that ICDS shifts toward formal education, use of English medium, and provision of furniture just in an attempt to keep up with the private schools. The ICDS is on the right track using the Joy of Learning curriculum.

Community awareness

Community awareness and appreciation of the Anganwadi preschool could be better; 41% of community members were unaware that it existed (13). But nearly 90% of those who were aware of it felt it was very useful. Only 4% of the mothers named preschool first when asked what an important activity at the AWC was; but another 32% mentioned it as another important activity.

The AWWs felt that nutrition and health were the most important activities at the AWC, but preschool was next in importance and many feel it to be their most satisfying work. Possible reasons for this mismatch in perception and the poor opinion of the community are:

- Poor communication from the AWC to the community
- The community perceives the formal education of the private schools as "real" education resulting in immediate reading and writing skills, whereas they may not understand the educational value of the "playway" system used in AWC preschools
- A little English is taught in the private schools
- In the absence of widespread training in preschool methodology, all the children are not fully occupied in preschool activities at the AWC
- The poor condition and lighting in the AWC, limited space and drabness are quoted by the AWWs as reasons for the parents preferring other schools
- The absence in many AWCs of colourful charts, posters and toys
- Parents value the amenities like transport, uniforms, chairs and tables provided by the private schools
- Some private preschools sponsor children for primary education

[15] This was supposed to be increased to Rs 30 but some AWWs say they only receive Rs 20.

- The frequent disturbance of the preschool programme because the AWW is absent or has other duties like filling registers, pulse polio, health or census work.
- The preschool cannot devote full time to the activities because many children come late

In the centres visited, nearly all the children participated in the games and songs. In the poetry recitation, language, and pre-number work, only a few "bright" children took part. Others, particularly those looking after siblings or themselves disabled, were on the periphery for most activities.

Participation in the AWC preschool
Enrolment and attendance data refer to children who are fed; no data are kept on how many actually attend the preschool. Some may stop attending after enrolling but their name is kept on the registers, as the AWW does not know after what period she is to strike the name off. The CP prestudy (17) found that the community may "help" the AWW maintain the preschool strength. A periodic review needs to be done to gather information on alternative preschool and childcare available and the need if any to enrich, shift, or close the AWC and instead perhaps cater to the deprived isolated hamlets.

At present the supervisor merely forwards data on enrolment to the CDPO without understanding trends or doing any follow-up. There is no uniform data format for attendance or dropout at the preschool level nor follow-up on the children who join primary school and their progress. Where this is available, it is not accessible or used. For example, there is little documentation of which children joined primary school, how long they stayed,[16] or how they fared in terms of competencies acquired. The local primary school headmaster does usually come to the centre to see which children are likely to enrol.

Staffing
When asked how much time they spend daily on the preschool component, the 23 who were interviewed by SRI (13) could be divided into three groups: 7 of them spent 15 minutes or less, 7 of them said they spent 7 hours or more and the rest were in between. When asked what they thought about the low cost teaching aids scheme, most of the CDPOs felt it was not a very successful activity because the AWWs were not motivated. The private preschools pay almost double what the AWW earns.

Though they have the field experience, the AWWs views are rarely sought on training needs or to find solutions to common problems.

Worker training
The initial Montessori-type training improved the quality of the preschool compared to other areas (8). None of the centres visited two years ago had any Montessori equipment, nor did the workers know about this equipment (11). Presumably achieving a true Montessori type of education was never the ambition, in any case, and more general playway training has been provided since then, which is similar in intention.

However, many AWWs feel that the theme approach, as decided upon centrally, is inflexible in its application. For example, if the theme is Rain and it has not been raining for a long time at a particular centre, the AWW might want to skip or delay this topic. Also she has to continue with a topic for two weeks even if the theme has been exhausted and the children are bored with it.

[16] Indeed, there is a need to define the term "dropout." There is no clarity or uniformity in defining after what period of absence a child becomes a dropout. Also, a child who leaves is called a dropout irrespective of whether s/he has joined another preschool, migrated or dropped out of the educational system. Data on dropouts is not always gender specific nor easily accessible.

After years of relatively good performance, there was a period of disarray in ICDS training. There was a gap of a year between the time the Trainers received training and were able to train Supervisors I. In a situation like this there is a risk of transfer loss especially as the new training has not been tried out in the field. However, discussions at the Directorate showed that there is now again a more cohesive training plan.

It was encouraging to see that the CDPOs undergoing training had recently been asked to give their comments anonymously. This is perhaps the first time that the trainees' assessment of the programme has been collected.

Teaching materials
Most of the AWWs said that they would like more indoor and outdoor play equipment and materials, especially colours (crayons), laminated flash cards, and musical instruments. Supply of such materials is irregular and inadequate. Better storage facilities are also needed, as much of the equipment is damaged or eaten by rats, especially in centres that do not have their own buildings.

Supervision, monitoring and evaluation
There is now a greater emphasis on preschool activities and supervisors have participated in the in Joy of Learning training, so presumably they are paying more attention to it. However, there is at present no assessment of the skills and competencies acquired by the child.

Available data show that the situation in Tamil Nadu is now quite favourable, as reviewed in Annex 7. Data from Chengalpattu and Pudukottai suggest that primary school dropout rates are under 1% and there are no gender differences. This would appear to be substantially better that state-wide data. It also would appear to represent a remarkable improvement in the past decade, no doubt in large part due to the successful implementation of the Sida ICDS. Indeed, as the success of the preschool component in the Sida districts has become more widely known, other donors have followed suit and are now stressing the preschool aspect in their support to ICDS in other states.

Disability

GOI and GTN education plans mention disabled children but there has been little attention given to them in the ICDS programme. The AWWs report that some centres have 2 – 3 children with some disability. In the absence of training in identification, it is probable that there are other children already in the AWC with sight, hearing, and various learning disabilities that the AWWs do not recognize.

Sida input
Sida has continually raised this issue in its discussions with both governments. Funds were provided for training, organized by an NGO called the Spastic Society, to be given to supervisors and over 500 Anganwadi workers. It focused on early detection of children with mild disabilities.

Findings
Progress has been very slow since the initial training was held. There was neither much follow-up nor was the training of all AWWs completed. The quality of the attention given to these children is questionable, as the AWW has not been trained to implement any special education for them. The linkage with the primary school is weak and the referral system and support from the health sector has also been poor. The financial support to the Spastic Society is at present on an ad hoc basis that makes for difficulties in staff deployment.

On the positive side, it was encouraging in a discussion with a gathering of 95 AWWs, 5 CDPO's, 30 supervisors, and 10 trainers to note the shift in attitudes from the diffidence of two years ago to confidence. These functionaries made the following points:

- The parents of disabled children are now keen to send them to the centres not only for the nutrition but because they learn from other children. The resistance from parents of other children is not a major problem now as it was earlier.
- own attitudes and were enthusiastic about training the AWWs in special education.
- The AWWs are more confident of being able to actually teach as against providing merely custodial care for these children.
- The optimism to meet the challenge appears to be a result of greater awareness due at least in part due to the training they have undergone.

In 10 blocks in Chengalpattu, the NGO Darc is providing mobile service on a weekly basis to advise and train AWWs who have disabled children as well as providing direct support and physiotherapy for disabled children participating in ICDS.

Adolescent girls schemes

During the preparation of the evaluation, we found out that the adolescent girls schemes had stopped functioning. When the evaluation took place, a new temporary scheme had already been initiated, using the Sida extension period budget. The opportunity to use the findings from the evaluation prestudies as input for new approaches was thus limited. However, the team hopes that ICDS decision-makers in Tamil Nadu and Sida take account of the findings of the evaluation and carefully review the performance of the new, temporary scheme before embarking on a long-term programme.

Sida input

The need to pay attention to adolescent girls was pointed out early in the planning of the Sida support. Within ICDS there was already a pilot project under way with GOI funds in seven blocks in the districts of Dharmampuri and South Arcot. Sida provided support for it to be expanded throughout the Sida districts. Two schemes were involved, the target groups being girls who had dropped out from school before completing standard X and girls who had just finished school. Both groups were supposed to be in special need of support and guidance, and to attract them to the centres they would be offered training.

The main target group for Scheme I was girls of 11–15 years of age who did not attend school. The original idea was to let three girls participate in the activities at each AWC daily for three months, but after some time the scheme was prolonged to a six-month-period. As an introduction, the girls were offered a three-day training course at which medical doctors, nurses and lawyers informed the girls on health, nutrition, menstrual management and preschool activities. The aim was two-fold: to strengthen the girls' capabilities to assist the AWW and to encourage them to go back to school.

After the three-day training the girls were expected to spend as much time as possible, at least two days a week at the AWC during a six-month-period, including follow-up training one day per month.

The main target group for Scheme II was girls between 15–18 years of age. Its purpose was to train girls in vocational skills, to enable them to become self reliant, and to postpone the age of marriage.

The training took place at certain AWCs selected on the basis of having transport facilities and AWWs interested in vocational skills. Training of the girls was to go on daily for a period of six months under the responsibility of the AWW. For this purpose, the AWWs themselves underwent training on voca-

tional skills conducted by NGOs. Consequently, different kinds of training were offered in different AWCs, depending on the skills of the AWW and others involved.

Findings

Participation
More than 50.000 girls participated in Scheme I in the three Sida districts. The schemes were criticized for reaching rather few girls, and not addressing the problems of the majority of the girls in the villages. One reason for the low participation in scheme I was that in Tamil Nadu very few girls drop out from school before 13–14 years of age now.

Also the most socio-economically needy girls were not reached by these schemes. For when girls do leave school before finishing standard X, it is usually because they have to assist the family economically. Consequently, they make all efforts to get a paid job and are not willing to assist in an AWC without remuneration.

More than 13.000 girls participated in Scheme II. About 75% of the interviewed girls participating in scheme II had earlier participated in scheme I.

Neither the girls nor the parents interviewed saw much purpose of the skill training. They looked upon it as a hobby or a spare time activity. Difficulty with transport to the AWC was another factor contributing to a high drop-out rate among the girls.

Achievement and constraints
As a result of their participation in scheme I, many girls named increased self-esteem and self-confidence as the main outcome of the training. They felt they were specially selected due to smartness and talents, and that they had become more open after the training. Furthermore, they stated that they learnt a lot during the initial training.

Many girls expressed pride in assisting at the AWC and liked singing, dancing and playing with the children.

To come to the AWC every day for six months was however impossible for the majority. The mid-day meal or dry ration provided to them was not considered to be much of a benefit. Many girls stated that they did not even like the food they got.

Do the girls who participate go back to school? Many girls would like to do that, but most doubt that they will be able to. Family responsibilities, including bread winning, lack of courage to convince the parents, and feared inability to pass exams are the major constraints. Thus, the program alone could not be expected to have much impact on re-enrolment rates among adolescent girls.

Both fathers and mothers felt that the initial training had been useful but questioned whether an entire six-month period should be spent at the AWC. Fathers considered that the girls should get some money for their assistance, while mothers hoped for future remuneration in the form of a job in the Government service for their daughters. These same attitudes and views were expressed by villagers in general.

The girls who have participated in Scheme II learned many different skills. Tailoring was the most popular, particularly in the areas where the girls saw a chance to get a job in export garment factories. However, many girls had their own preference for learning certain skills. If the AWW could not help them realize their goals, the initial enthusiasm gradually disappeared, they said.

Will they be able to postpone their marriage? From the initial training, the girls learned reasons for it, and in a few cases the skills learned may have increased their chances of getting employment, thus providing an additional means for achieving that goal. Many girls felt that they might be able to convince

the parents to postpone their marriage but others were doubtful, saying "girls are helpless in this matter."

Thus, these schemes had a level of ambition that was too high, given the complex situation of these girls. They responded to community needs, but failed to take adequate account of socio-cultural factors in their conception and implementation.

The new scheme

According to the Directors of ICDS in Tamil Nadu, schemes I and II are to be replaced with a new programme for which a proposal was made to Sida for support during the next year. It is a training programme for all adolescent girls described as an orientation of two days' duration. These seminars will either take place in the AWC or in a school if the AWC building is too small. The target group is not only the drop-outs but all girls from vulnerable and weaker sections of the society who attend school.

These girls will be informed about health, nutrition, prevention of anaemia and other diseases, sanitation, hygiene, maternity and child welfare as well as family life. There will also be given information on the importance of education, age of marriage and career options. Half a day will be dedicated to information on legal rights and illegal social practices, issues concerning all women. Women gynaecologists and lawyers will present the information. All participants will be given "My friend," a small book covering these topics.

The new programme incorporates many of the changes recommended in the prestudies:

- The target group is not confined to drop-outs
- the training at the AWC is shorter
- the training will take place in or near the village

One question already being asked about this proposal is whether two days is enough, as the girls need at least half a day to get used to the environment, and to get to know each other. Another is the need to follow-up on this initiative.

The WILL programme

It is well known that literacy among mothers is linked to improved child welfare. Since ICDS is reaching many of the poorest households, it makes sense for it to include a component that can meet the needs of women who want to attain literacy. However, the linkage between the AWC and the WILL female literacy programme was never very strong. Gradually it seemed to die out. Only 2 of 23 AWWs randomly interviewed in the three districts had worked with it. First, there were not many illiterate women in areas where WILL was not already ongoing. Second, the team got the impression that AWWs were not able to engage themselves in it with adequate intensity to really help women achieve literacy.

As in the case of the adolescent girls' schemes, the team found that DSW had stopped implementation by the time the evaluation exercise was carried out. It was replaced with an approach that focuses on "post-literacy" needs of women. Four women's recreation centres were established in each block, each centre targeted to twenty women. Books, games, sewing machines and other materials are to be provided in each centre at a cost of Rs 1000 per beneficiary. The team wonders what the overall objectives are, how all women who need these services can be reached, and whether the state can continue to meet such high costs per participant when Sida support withdraws.

Community participation/communication

ICDS was originally conceived as a community-based program, based on the vision that communities would readily come forth and participate in its implementation. When the national evaluation was conducted in 1992, it was however concluded that this vision had not materialized. Contrary to the conception, the programme had acquired the profile of a government programme and people accepted the ICDS services as a dole (6). An overall conclusion was that strategies to improve community participation (CP) should be elaborated.[17]

Sida inputs

In this context, Sida decided to support the communication aspect of the programme and training to ICDS functionaries in participatory planning. Among other things, the intention of the communication component was to raise awareness of the importance of AWCs. In assessing this component, it is important to clarify that communication is a necessary, but not a sufficient precondition for community participation. It may increase the degree of awareness, but may not necessarily lead to acceptance, let alone enthusiastic participation.[18]

A communication strategy was elaborated, including communication on three levels:
a. Mass media communication to spread information to the whole community,
b. awareness raising through group meetings, and
c. influencing attitudes and behaviour through face-to-face contacts.

Personal contact between the AWW and the beneficiaries is one of the cornerstones of the strategy to make ICDS a community-based program. The AWW has a schedule stipulating that she should spend one day a week visiting the households in her area. The aim of these visits is to enhance reciprocal communication and benefit. The beneficiaries get information and knowledge on relevant issues, and the AWW gets a better understanding of and can give more attention to the situation each family member.

Each AWW is encouraged to contact or to form mothers' groups in her area and to hold monthly meetings with them.

According to the project proposal for 1995–1997, the Sida support should consist of extra resources to improve communication and two sets of special training focused on this issue. The following activities were mentioned: regular information, education and communication activities at block and district levels, cooking demonstrations, motivation days, centre days, and periodic programmes through radio, TV

[17] In the National Evaluation (6) six conclusions are made on CP:

1. Of the help offered to the AWC (mainly building and firewood), 55% came from women, 47% from community leaders, and 33% from adolescent girls. More assistance was forthcoming in rural than in urban areas.
2. Mahila mandals (women's groups) were created in 49% of the AWCs. They helped in gathering children for immunisation (47%), organising camps (38%), and preparing supplementary food (35%).
3. Sixty per cent of the community representatives had motivated the community or provided space for the AWCs. Tribal communities were more active.
4. Between 10–30% of these representatives had been consulted at the initial stages, e.g. to identify AWWs and helpers.
5. However, 80% of the representatives said they did not know how to contribute.
6. In 39% of the AWCs, adolescent girls were involved.

[18] The degree of participation may be described in four categories: a. little or no knowledge of the AWC, b. Acceptance, but no active involvement, c. Expression of a feeling of ownership of the AWC, d. Active participation, e.g., in planning and decision-making.

and listeners' clubs in each village. Communication material and films were to be produced and circulated to all theatres, railway stations and bus stands.

The Sida support consisted of materials for those activities, for example, posters, folders, flash cards, exhibition boards and wall hangings for use in public exhibitions. Each Sida-supported block was provided with an audio-set, a TV-set and video cassettes, and ten video programs on the different ICDS activities. Audio-visual vans were supplied to facilitate showing the videos throughout the districts. A monthly newsletter, "Chittkuruvi," was to be published and distributed to each AWC, and they were to be brought on home visits by the AWW to be lent to the mothers for reading. During the last agreement period, approximately 6% of all the Sida disbursement for ICDS was used for communication.

Centre days and motivation days are "celebration days" intended to show what is done at the AWC and to motivate the community to participate in these activities. These special days are to be celebrated once a year. Centre days take place at the centre and motivation days at block level. Balmelahs are similar but feature cultural activities. The CDPO has the main responsibility for these activities, assisted by the supervisors and AWWs.

Findings

Communication activities

Home visiting
The prestudy shows that a large majority was visited regularly by an AWW, often together with the Village Health Nurse. No discrimination was made on the basis of caste, religion or economic status, and almost all the persons interviewed stated that the AWW visits them without bias towards anybody.

Sometimes, the AWW used these visits to express need for involvement in the AWC-activities. This was more common for contacts with local functionaries than with beneficiary families.

Women's groups
In Phase I of the Sida support more attention seemed to go toward the possibility of developing income generating activities as part of ICDS. One of these was the provision of seed, seedlings and fertilizers to 14,000 families through women's groups (8). In the Sida monitoring (11), it was concluded that at least some women's groups in Chengalpattu are supportive of the ICDS.

A pilot program in Dharmapuri District shows that they can play an important role in mobilizing the community to take collective action and to assist the AWW. (See Annex 6.) However, according to several sources it seems as if these channels have only been utilized to a limited degree, and that many mothers' groups have ceased to function in recent years. This may be because women are unable to give much time to them unless there is an adequate income generating component.

Centre days and motivation days
Centre days have been conducted at least once during the last two or three years in most AWCs included in the prestudies. However, due to lack of funds both Centre days and Motivation days were cancelled in many places in 1996. Balmelahs have taken place in some selected centres.

These days of celebration have made the AWC more visible and recognized. On days when school children participate, great enthusiasm is generated both among the children and the parents. The state functionaries' impression was that Motivation Days and similar activities had succeeded in raising community awareness and mothers' appreciation of ICDS activities for their children (10). However, these days seem to be conducted in the same way year after year, and most villagers do not distinguish between the different days.

Audio-video programmes
The audio-visual materials and equipment have been very little utilized, and very few communities have had the chance to see the videos. One reason for not showing the video films is that reference is made to politicians from the former government. Another is lack of instruction on how to use the equipment. Because of lack of a driver, the vans could not be used for much of the time.

Posters, pamphlets and newsletters
Some years ago, more than 1000 posters were supplied for some of the AWCs. These posters mainly provided messages about maternal and child health and family welfare and not the pre-school activities. The posters were observed and remembered by many villagers. However, none have been produced in recent years.

The AWCs do not get the newsletter regularly. Even when the distribution functions, most AWWs don't share them with the mothers.

Mass media
Mass communication activities have declined greatly in recent years. With the exception of the beneficiaries, most persons get their information about the AWC on celebration days. Posters seem to have been far more effective than written material. Neither posters nor celebration days have been used to demonstrate what the children actually do at the AWC, missing an opportunity to illustrate the value and quality of the preschool activities.

Awareness of the AWC and its activities
Among 30 village leaders interviewed in the targeting prestudy (13), most knew that young children, pregnant women and lactating women were eligible for ICDS services.[19] In the participation prestudy (17), all community leaders knew that children and women are provided with supplementary feeding. Most also knew that ante-natal and post-natal health care is given to women. About three out of four village leaders knew of the pre-school activities and about half of them knew that children are immunized.

Almost all other local functionaries, such as school teachers, village health workers, village administrative officers, and postmasters knew of the nutrition and health services at the AWC, while two out of three knew of the pre-school activities.

Among the beneficiaries, the level of knowledge of the services at the AWC is high. Villagers know that a "Balwadi" functions in the village and renders service, particularly to pregnant and nursing mothers. They are also aware of an "ayah" (the helper) coming to the centre daily to prepare food for the children. The anganwadi worker is called "Balwadi teacher," yet the community members don't seem to perceive the activities that she is performing as "preschool education." Instead, they associate the AWC with a place where they children are safe, get food and are looked after. Few of the villagers had heard of the adolescent girls' schemes (17).

One prestudy (13) found signs that some communities are taking the AWC and its services more seriously. For example, the people complain about grievances to the CDPOs.[20]

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[19] However, only 44% of mothers in Chengalpattu, 63% in Pudukottai and 80% in Nilgiris knew that all preschool children were eligible for ICDS services; only 64% know about pregnant women's eligibility and 25% about lactating women's. Only 77% of pregnant women and 36% of lactating women themselves knew they were eligible.

[20] When asked if they agreed with the statement, "If the AWC shuts down there will be no loss to the village," only 17% agreed. The breakdown by district was 13% agreed in Chengalpattu, 22% in Nilgiris and 33% in Pudukottai.

Participation of the community
The community shows interest for the AWC by participating on centre days and motivation days. About half of the community has participated in cooking demonstrations (13). Those who know of what is going on at the AWC are those who participate. Similarly, many of those who know that help is needed do help.

The village leaders often assist the AWW solve problems. They monitor the activities at the AWC, particularly the food and health components, inform the people, and try to raise resources for the AWC. Teachers help the AWW to contact parents to enrol their children.

Many villagers have assisted in some way: they may bring children to AWC, sing with the children, keep the centre clean, or maintain the kitchen garden, depending on what they are asked to do.

In several communities the AWCs have been provided with a building free of charge. Some of these buildings belong to the Panchayat, some to individuals. Two of the 16 centres (17) had mobilized the community to collect funds to purchase sites and the AWC building. In other cases the community had decorated, white washed or donated material to the Centre.

Replicability

The concept behind Sida's approach toward financing ICDS in Tamil Nadu (at least beginning with Phase II) is that the additionalities are in fact a type of pilot test to be implemented on a larger scale in other ICDS projects in the state if and when they prove successful. However, since the food is the only thing the state pays for, all non-nutrition additionalities are actually more relevant to the national level. In a meeting with Ms. Binu Sen, a former Joint Secretary, Department of Women and Child Development, the Team was informed that GOI was aware of and studying several of the Sida innovations for possible testing at national level.

As detailed above, the additionalities are in some cases truly innovative, in some cases an expansion of approaches GOI is already pilot testing (e.g., adolescent girls schemes), and in some cases expanding what is already a part of ICDS but under-funded (improved AWC construction, distribution of drug kits).

The evaluation found evidence that many of the Sida additionalities appeared to be successful and in many cases were replicated by GTN in the non-Sida ICDS areas. In some cases, staff were able to incorporate lessons learned at no additional cost. Those which, at least to some extent, already have been replicated at state level (and in a few cases in other states or even at national level) include:

- afternoon feeding of sundal (not by ICDS, but by mothers)
- nutrition gardens
- cooking demonstrations
- improved preschool training
- training for community participation
- low cost teaching aids, and
- incentives/rewards to motivate AWWs.

It would appear that the factors which determine what will be replicated are: (1) proven success, (2) awareness-raising of this success, including through advocacy by the donor agency, (3) cost, and (4) priorities and policies of the governments and the administrative heads of the program.

The cost of replication of the Sida additionalities, based on Sida expenditures for recurrent costs and budgeted funds for capital costs, has been calculated.[21] The average one-time cost per project is 0.4 million SEK, 80% of which is for preschool-related costs. The annual recurring cost is 0.32 million SEK, 41% of which is for food and nutrition and 27% for administration. Given a five-year period of amortization, the one-year costs amount to 20% of the total. The total cost for replicating the Sida additionalities was 59% more than was spend on the non-Sida districts. To implement it throughout rural Tamil Nadu is estimated to incur a SEK 158 million one-time cost and an annual SEK 122 million recurrent cost. For districts with above 20% scheduled caste or scheduled tribe populations, the cost would be SEK 90 million and SEK 71 million respectively. If the TINP districts are left out, replication in the non-Sida ICDS districts would respectively cost SEK 9.8 million and 7.9 million annually. This would further drop to SEK 5.3 million and 4.2 million respectively if only poor districts are included. At this level (assuming a five-year amortization), this increase in cost represents 12.6% of the Department of Social Welfare and Noon Meals Programme annual budget. Since the Department budget has been increasing on average by 12.4% since 1992/3, the Team considers the Sida additionalities to be potentially replicable. Indeed, further replication is already planned by GTN.

Sustainability

Similar to the issue of replicability, sustainability will be related to issues such as cost and political priorities. There is little risk that ICDS per se will decline – to the contrary, it is now considered by GOI to be one of its most important social sector investments. Indeed, the proposal for the 1997/8–2001/2 five-year plan included a 600% increase compared to the previous one.

Joint Minister Sen pointed out that the Sida support is budgeted more closely to the existing program than support from some other donors, which makes it easier to maintain and replicate. The short-term perspective is perhaps not very positive, as GOI is prioritising universalisation. However, from 1985 to 1995, GOI expenditure on ICDS increased at a rate of 25% annually, and the number of projects funded increased at a rate of 11%, so quality concerns have been getting attention. As shown in the analysis above, the costs for maintaining the Sida additionalities are not beyond what the governments can afford in the longer term. Nevertheless, for widespread adoption it should be possible to use a model significantly cheaper than the one that has been pilot tested.

Conclusions

- Many previous evaluations have shown that ICDS has a positive effect on young child health and nutrition and some studies have also found that it improves health and nutrition of participating women. The present evaluation could not study impact but its findings suggest that a positive impact was likely.
- This evaluation has shown that ICDS is a programme that reaches the very poor. The establishment of mini-AWCs would allow it to do so even more effectively in the near future if the resources are available.
- Although this evaluation has identified a wide range of areas in which ICDS in the state could be improved, in the judgement of the Team much of this improvement can be made with a feasible level of effort in a reasonable amount of time, following the recommendations given here.
- The Sida approach of encouraging and funding innovation, but doing so in ways close to and compatible with existing government approaches appears to have succeeded in many ways. The team

[21] Not included were costs for AWW II, WILL, AWC repair and construction, and warm clothes. Adolescent girls schemes were costed according to the way they were run before the evaluation.

found evidence from many sources that some of these approaches have been replicated in part or completely by the community, by other donors such as the World Bank, by GTN, and even in some cases by GOI. Thus the impact of the Sida support has gone far beyond the three districts that directly benefited. Sida has a good reputation now both among other donors and the two governments and thus this model can continue to work in Tamil Nadu.

Recommendations

Sida support

Based on these conclusions, the Evaluation Team believes that an increase in the resources allocated by Sida to support ICDS would be justifiable. However, the team recommends that Sida consider providing support in a different way, horizontally to include certain components or additionalities throughout the ICDS program, rather than just to certain districts. This would extend what has proven to be a successful partnership in strengthening and making the program more innovative as well as increasing the likelihood that improvements and additionalities made will be sustainable.

This would also no longer require the GTN to maintain a separate administration to deal in a piecemeal way with different types of support to different districts. World Bank support currently being planned to replace TINP will be integrated with ICDS after some period of phasing in. This provides opportunities for increased efficiency and sustainability but would require increased communication among the three parties while the modalities were worked out. Since WB is supporting ICDS in several other states, working in an integrated way with them in Tamil Nadu may increase the chance that Sida support for innovative additionalities could rapidly lead to replication on a much larger scale.

Management strengthening

A Project Coordinator (at Director level) for ICDS should be appointed who is free of charge of any other scheme.

It is recommended that Sida continue providing support to program administration and management, but to do so on a functional basis. A review should be undertaken to redefine and rationalise administrative responsibilities, designing job descriptions that are more accountable and proactive. Options such as the following should be examined:

- Monitoring & Supervision Unit, headed by an officer at Deputy Director level, consisting of Programmer and support staff. An additional post for applied research and evaluation could be seconded from an outside agency if existing staff do not possess the requisite skills.
- Communications Unit, responsible for planning and implementing of communications and CP activities, with an officer at Deputy Director level with support staff.
- Preschool Unit, with expertise and experience in disability identification and management, with an officer at Deputy Director level and support staff.
- Training controller with an officer at Deputy Director level, supported by special team trainers.

One of these or some other officer should be assigned to review gender issues in all planning documents, training, monitoring, project reporting and evaluation.

A management training package is needed in order to develop management skills of the officers at the state and district levels, empowering them with necessary tools and techniques in planning and management. It should be based on a review of the management and accounting needs of the programme.

Decentralization of decision-making to district level should be given attention both by the state government and by Sida in any further support given to administrative strengthening or support of posts.

Quantitative and qualitative analysis of programme performance needs to be strengthened by developing a detailed list of measures of performance. This should be developed and used in giving promotions.

The system for professional growth of AWWs should include not just promotions but also opportunities for further education.

Programme planning

The new project proposal should utilize LFA, clearly spelling out immediate objectives that relate both to the quantity and quality of programme output and indicators for assessment set against them.

Once the overall programme plan is set up with specific time frames, each functional Deputy Director, as recommended in the new organisation structure, can prepare a detailed plan in his or her area of responsibility (in coordination with the district level staff) to formulate an Annual Action Plan. Time should be allocated so as to allow the district participatory planning exercise to be used in a conscious attempt to streamline the traditional hierarchical decision-making system.

The Deputy Director (Training) should ensure that all senior staff at state and district levels receive training in the use of planning tools and techniques. Training needs assessments could be done in participatory ways on a regular basis to fit the needs of the various functionaries.

A manual on planning methods specific to the programme should be developed and kept in-house for reference and guidance.

Management information system

The ICDS director could benefit from a direct line of communication to and from the workers at the "lowest" level. For example, all AWWs and supervisors could be given a set of post cards they can use to write anonymous messages directly to the Director about any matters they think require his or her attention. He or she should then explore ways of ensuring that feedback reaches all the way back to the AWW and ultimately the community.

Better refresher training and more effective supervision could reduce the levels of biased and incorrect figures moving through the system.

The ongoing emphasis on MIS should aim to redesign it along the following lines. It should:

- be computer based and ensure easy retrieval of relevant, adequate, and timely information at both the state and district levels
- be designed to generate cross checks, validation of data and processing logic to reduce errors
- identify relevant yet simple indicators relating to programme performance, expenditure, and stocks, leading to rationalisation of data to be collected at the AWC
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- carry out simple trend analysis over time at district level
- carry out comparisons of key indicators against targets and across districts
- train staff in understanding and using the system, and
- be designed to ensure feedback to each level, including the community.

Programme supervision and evaluation

A post should be created at state level within the monitoring and supervision unit for a person who is outside the implementing agency to increase the possibility of obtaining unbiased reports. At the district level, the statistical inspectors who are on deputation from the Statistics Department should play a more proactive role in supervision.

The performance of the supervisors should be reviewed and if necessary modified to be more participatory and technically supportive in the AWC activities.

Models should be tested whereby a community group such as women working groups do ICDS programme monitoring.

A baseline study should be conducted before launching the new programme to improve the prospects for conducting impact evaluation.

Needs assessments should always be done whenever initiating new programme components.

Coordination issues

Functionaries should more often be able to make exchange visits to other well-performing AWCs.

To enhance intersectoral convergence, committees should be set up at district and block level for planning and problem solving, chaired by the District Collector. These could be composed of representatives from the village Panchayats, project functionaries and other departments.

For coordination with the health sector, monthly coordination/planning meetings organized by the Joint Director (Health) involving district officials should be more regular.

To enhance the possibility of women's working groups taking over responsibility for the activities of the AWCs, groups that are already organised such as women's savings groups under Tamil Nadu Women Development project could be approached and offered tailor-made management training. Ways also need to be sought to more involve fathers in ICDS activities and decision-making.

Targeting

ICDS should be extended to the unserved low-income groups in the state through expanding into mini-AWCs where possible.

A review should be made of which AWCs no longer have a high enough attendance level to justify continuing them. Their resources and staff might better be made use of by shifting them to unserved hamlet areas.

Transport and construction

Mopeds may be needed by more supervisors than now have access to them, particularly if mini-AWCs are established, as this will expand the geographic area to be covered. In any new project agreement, the team recommends that greater attention be given to identifying further repair where needed and to the addition of toilets to all AWCs. If there is to be an expansion into mini-AWCs, a study may be required to identify a reasonable compromise regarding size and cost of such centres and to prepare a plan and costing for building them in areas where new buildings are necessary.

Nutrition

The sundal afternoon feeding for preschool children could be replaced with the nutritious flour. It would not be much extra trouble to just order more; indeed, the societies often have under-utilised production capacity. It is easy and fuel-efficient to prepare and appropriate in nutrient content. It is high enough in sugar that the children will no doubt accept it. Since it is given to the mothers as well, there

also should be no problem with children thinking it is weaning food only meant for babies. Indeed many of them probably consume part of their mother's share at home already.

Funds for fuel may be inadequate in areas where wood is scarce; considering the environmental disadvantages of using this fuel in certain areas, the possibility of providing pressure cookers or other types of stoves should be considered. Nilgiris has a special problem: at high altitudes water boils at lower temperatures and thus food takes longer to cook. This means that the fuel allowance there is inadequate for many AWWs and pressure cookers may be a particularly wise investment.

Increased cooperation should be sought with the horticultural sector to strengthen the nutrition garden component. The link between gardening, the use of these foods in supplementary feeding and giving attention to them in cooking demonstrations should be made more explicit. Low-cost, nutritious, locally available foods should be used in cooking demonstrations and recommended in nutrition education, especially to adolescent girls.

Since the areas in which gardens are difficult to grow are also the ones where they are most needed, in a future cooperation it might be useful to budget assistance to those which are unable to grow gardens without it. Perhaps an internal assessment could be done to see which centres require such support as irrigation or fencing (preferably live fencing, since it is more sustainable).

Since AWWs are receiving pay for it, it would seem justifiable to add some simple measure of nutrition garden quality to project supervision and monitoring. A good beginning would be number of crops under cultivation. Even during off-season, certain permanent varieties and papaya and drumstick trees will still be present.

Attention should shift from food to nutrition education as the way to further improve nutritional status of children and women. Growth monitoring represents an important opportunity to interact with mothers about their children's diet and health that could be better exploited. Major attention in discussions and home visits with pregnant and lactating mothers should be on encouraging exclusive breastfeeding for six months followed by the introduction of nutritious, hygienic complementary foods in gradually increasing amounts.

The practice of sustaining breastfeeding to two years and beyond is less common in Tamil Nadu than in any other state in the country. Bottle feeding has also made substantial inroads. Staff must receive up to date training on how to support women to breast feed; it cannot just be assumed that saying "breast is best" to mothers will solve the complex issues likely to be involved.

Health

Continued effort should be made in convergence though following up referrals and joint training wherever this makes sense.

A review should be done of constraints to improving coverage of prophylactic nutrients and drugs. Intermittent dosing should be attempted on a trial basis for iron, at least for less at-risk groups, to see if can increase programme effectiveness.

Health and nutrition education should get additional attention in the context of the improvements needed in overall project communication mentioned below. The whole community should be made aware of key childcare issues, including the goal that fathers take a more active role and responsibility.

Community participation/communication

More emphasis should be given to communication and CP. The recommendations provided here aim to increase community involvement and sense of ownership of the AWC.

AWWs to be employed in the future should be selected among women in the village of the AWC. Wherever possible, AWWs should be transferred to their own villages.

The mass media component needs to be strengthened. At the state level one staff should be deployed who is solely responsible and accountable for the communication component.

Actions need to be taken to use the existing video and film equipment. Videos and other materials produced should not have political references unless the programme is prepared to change them when government changes.

Posters and other material should be produced and used for promoting preschool and other ICDS activities and messages. The production and distribution of the newsletter "Chittkuruvi" should be re-evaluated.

Contacts between CDPOs and Panchayat should be established, and local committees involved as part of ongoing efforts at intersectoral convergence. Where they do not exist, such committees should be formed, including both elected and other members.

The community should be involved when a new AWC opens or new components are introduced. This should take the form of active participation in appraisals and needs assessments. ICDS functionaries should receive some training, including practical experience in doing participatory needs assessment.

Centre days and motivation days should be more lively, creative and vary in contents and approach from year to year. In Balmelahs or children's days, singing and dancing and other performances by the children should be included.

The impact of the new AWW training should be assessed within a year. Furthermore, experiences from pilot projects should be disseminated and made use of. Projects in Morapur Block, Dharmapur and in Kadampathur, Minjur (see Annex 6) are some examples.

Planning for and monitoring of CP should be an integral part of formal meetings, celebration days and home visits.

Preschool component

The Anganwadi Centre could be called a "ballarpalli" or school to focus on the preschool aspect.

Orientation should be given to the POs, CDPOs and supervisors so that rather than only playing inspectorial and administrative roles they can support the AWWs' preschool work.

Preschool methodology needs to be strengthened through completion of training. There is scope for more feed back on the impact of the training from the field so that the programmes can be modified and adapted to meet changing and varied needs. Inviting suggestions from the workers as to what training they would like would motivate fuller participation.

Indoor and outdoor play equipment and materials should be distributed again. AWWs' capacities to make their own from local materials should be strengthened. In addition to blocks, balls and toys, there is scope for greater use of natural and easily available materials like stones, leaves, old tyres, logs as balancing beams, etc. Trees growing near centres could be used more often for swings. Often the AWW is not aware she can use the help of craftspeople in the community to make toys and games. A review

should be done as to what materials AWWs could purchase directly, as supply procedures are slow and irregular.

The thematic approach should allow some local flexibility. Not just the intellect, but also the senses should be given attention. Each child's development should be a matter of concern and follow-up for the parents and the AWW.

Where there are alternative childcare centres and preschools, AWWs need to focus on educating the community that this the best way to prepare their children for a successful school experience rather than trying to start more formal learning approaches at too early of an age.

Exchange visits to other centres to discuss issues and find solutions would be a learning experience and strengthen morale. The resources in terms of government and NGO support, materials and craftspeople in the area could be compiled and given to the AWW. She needs to know what resources are available in the community and to feel that she can use this support.

A ready reference manual, as requested by the AWWs, could be prepared at training sessions, compiling songs, poems etc. This would also give much needed recognition to the AWWs whose material is used. At a later stage there could be some work on teaching mothers some simple methods for early stimulation of children below 2 years of age using mobiles, songs, and colours. It would be wise to ensure that each training course, no matter what its subject, briefly touches on all major components of the training, since some workers miss certain training courses and all may need some repetition.

Linkages with the following bodies are essential for strengthening the AWC's work with the preschool component:

- The community: Mothers should be motivated to attend the full day programme by rotation so that they observe all the activities. This would contribute to one of the original objectives of the ICDS, which was to improve the quality of care of the child in the home. Women's Groups should also be motivated to play a larger role. Older people should be invited to narrate stories, legends etc.
- There is scope for a greater participation by men, as they need better awareness of good parenting practices. If they too became concerned about the AWC and its preschool activities, this would help overcome economic and political constraints to improving it.
- The primary school: greater communication between the school and the AWC could help meet the needs of the students better, particularly once the ICDS improves in integrating children with disabilities into its activities.
- The mass media could be better used to improve awareness of the value of the preschool programme

Evaluation indicators should measure both the quantity and quality of preschool outputs, including things such as the following, a few of which could be incorporated in ongoing monitoring:

- Physical aspects including indoor and outdoor space, ventilation, lighting, cleanliness, wall displays;
- Play materials: variety, safety, durability, replicability, age appropriateness and accessibility to the children;
- Children**:** participation by all the children, their response, and progress;
- Methodology: whether the activities cater to all aspects of development and there is a balanced routine;
- AWWs' training, creativity, competence, nature and degree of planning and management, and involvement with the children and the community;

Disability

The main goal of training for the AWW should be to enable her to identify and work more effectively with the marginal disabilities already found in the children attending.

An Action Plan in a time frame should be drawn up for Integrated Early Childhood Education for the next 3 – 5 years stating objectives, implementation, monitoring and evaluation and key indicators be developed.

NGO support should be used to train field workers for quicker training transfer. The NGOs could also provide support in referral, as they are already working in this field. In all but one district in the state, the Spastic Society has identified nodal NGOs who have been trained.

All new workers, in all training sessions should receive a period of sensitization discussing programme integration issues including those related to disability.

To increase the acceptance and integration of these children, the linkage with the primary school should be strengthened.

ICDS should contribute toward improving community understanding of the causes of disability and thus attitudes toward it. A note or newsletter from the Directorate Social Welfare to the POs and CDPOs stating that integration of disability is an important objective would ensure greater efforts are made.

Helpers should receive some training in disability and other issues.

Mobile service for disabled children should be spread throughout the state. In the existing three Sida districts, this would serve 300–400 children a year. The audiovisual vans could be used for this at little extra cost.

Adolescent girls schemes

Before a long-term program starts, situation analyses should be made considering the socio-cultural context and the socio-economic situation for different target groups. Special attention should be given to the girls' and their parents' concerns regarding income generation, violence, and other problems that they perceive.

The objectives should be made clear; for example objectives such as encouraging girls "to go back to school" and "to postpone marriage" should be reviewed and discussed. A simple LFA should be the basis for designing any new program.

The community should be made aware of the program and should be informed about the progress as well as constraints. The parents should be included, particularly in programs with the aim of postponing marriage, as they most often are the decision-makers.

Training should be conducted in the village so that also girls living in isolated villages can participate. Such training should be limited in time and recognized by some kind of certificate.

Any training, including the new scheme, needs to be followed up to keep the knowledge alive as well as to give feed-back to the trainers for possible changes of the curriculum.

A closer, more institutionalised, cooperation between the AWC, local women's organizations, health and education functionaries, youth groups and other NGOs needs to be established. Setting up an inter-sectoral committee for this purpose should be discussed.

In a long-term perspective, the possibility to involve adolescent boys should be discussed, as well as a youth-to-youth approach. Experiences from similar projects, such as those carried out by the Chennai Branch of the Indian Family Planning Association, could serve as inspiration.

The Convention of the Rights of the Child may be used as a basis for information and training regarding sexual and reproductive rights, marriage etc.

WILL programme/recreational centres

If mini-AWCs are established in the next phase of Sida support, the need to link the WILL programme to ICDS in the hamlets will need to be reviewed.

The team recommends that a review of the effectiveness of the recreation centre approach now being tried should include an examination of the objectives and sustainability of this approach to ensure that it is practical.

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Annex 1

List of abbreviations used

ANC	Antenatal care
AWC	Anganwadi centre
AWW	Anganwadi worker
CDPO	Child Development Project Officers (block level)
CP	Community participation
DSW	Directorate of Social Welfare
GOI	Government of India
GTN	Government of Tamil Nadu
ICDS	Integrated Child Development Services
LFA	Logical framework analysis
MIS	Management information system
NGO	Non-governmental organization
NMP	Nutritious Meals Programme
PO	Project Officer (district level)
Rs	Rupees
SEK	Swedish Kronor
Sida	Swedish International Development Cooperation Agency
TINP	Tamil Nadu Integrated Nutrition Project
USAID	United States Agency for International Development
VHN	Village health nurses
VIPP	Visualization in participatory programmes
WILL	Women's Integrated Learning for Life
WB	World Bank

Annex 2

Objectives of the ICDS Scheme in Sida-financed districts

1. to improve the health and nutritional status of the children 6 months to 6 years of age, pregnant and nursing mothers and adolescent girls in the age group 11–18 years.
2. to reduce malnutrition, morbidity and mortality of children below 6 years.
3. to reduce the number of school drop-outs.
4. to reduce severe and moderate protein energy malnutrition in children.
5. to lay the foundation for physical, motor, language, cognitive, and socioeconomic development in children.
6. to provide a congenial atmosphere for creative expression.
7. to enhance the ability of mothers to provide care for their children.
8. to improve the efficiency of functionaries through training, participation, ensuring 100% enrolment of children in primary school.
9. improving and enhancing the health structure through additional resources.
10. elimination of micronutrient deficiency diseases in children and mothers.
11. referral of high risk pregnancy.
12. immunization of all children under six years of age and pregnant women.
13. improvement of antenatal, intranatal and postnatal services in co-ordination with the Health Department
14. to reduce the infant mortality rate by drug supplementation and strengthening the referral services.
15. to integrate disabled children into the mainstream.
16. to improve adolescent girls' knowledge and skills in nutrition and health, train them in vocational skills, enable them to become self-reliant; to postpone the marriage age.
17. to create community awareness of the various activities of the anganwadi centres by dissemination of information; to involve them actively in all the programmes.
18. promotion of kitchen gardens in the centres.
19. improvement of amenities in the anganwadis.
20. improve the efficiency of functionaries through provision of transport facilities.

Annex 3

Terms of reference, joint Sida/GOI/GTN evaluation

1. Background

The nationwide Integrated Child Development Services (ICDS) scheme aims at enhancing survival and development of children from the vulnerable sections of society and encompasses the main components of human resource development: health, nutrition and education. It intends to provide a package of services which vary for each of the following groups: children 6 months to three years of age, children 3–6 years of age, pregnant and nursing mothers, adolescent girls between 11–18 years of age, and women 18–45 years of age. The Directorate of Social Welfare and NMP (Nutritious Meals Programme), Government of Tamil Nadu (GTN) is the implementing agency of the ICDS in Tamil Nadu.

The main objectives of the ICDS activities:
The objectives of the ICDS activities in the three Sida-supported districts of Tamil Nadu have changed over time since the support started. (They were presented above as Annex 2)

Sida has supported ICDS activities in Chengalpattu District since 1988. From July 1993, this support was extended to the districts of Nilgiris and Puddukottai. The Sida support for the agreement period July 1993–June 1995 was 55 MSEK and for July 1995–June 1997 (proposed to be extended to June 1998), it is 60 MSEK. The cost for the ICDS scheme in these districts is almost equally shared among Sida, Government of India (GOI) and GTN. The Sida-supported ICDS covers a population of about 5 million out of nearly 7 million living in those districts.

The main objective of the Swedish support to ICDS is to improve the quality of certain activities and make ICDS a more comprehensive development programme by:

– encouraging innovative activities;
– integrating these activities among sectors;
– supporting special activities for girls and women;
– reinforcing the ICDS administration.

2. Purpose of the Evaluation

There has been no joint evaluation of the Sida-supported components of the ICDS. This evaluation is a joint undertaking and responsibility of the three parties, i.e., GOI, GTN, and Sida. The aim of the evaluation is:

- to describe the overall development of ICDS in the three districts in which Sida has supported it in Tamil Nadu, as well as each Sida-supported additionality;
- to assess the role of the Sida support, including financial implications, in improving the quality of ICDS in these areas and, where replicated, elsewhere;
- to provide recommendations to Sida on possible reorientation or adjustment of its support to ICDS.

3. The assignment

The evaluation shall consist of the following components.

3.1 Attainment of stated objectives

The programme attainments should be compared with the original stated objectives to determine the extent to which these were met, including the extent to which target groups have been reached. Reasons for any failures to meet these objectives should be analysed. The evaluators should determine if the program had other major outcomes unforseen in the original objectives, the reasons for these deviations, and delineate any implications for future programme planning.

3.2 Assessment of the usefulness of the Sida inputs

The evaluators shall analyse how the various Sida additionalities contributed to improvement of the quality of ICDS in the three districts, as well as some indication of the cost effectiveness of these activities. (Examples of these additionalities include support to salaries of 21 staff at state level and to AWW II, payment of incentives for nutrition gardens and community involvement activities such as demonstration days, various types of additional training, provision of toys and play materials, supplies of medicines, construction and repair of anganwadi centres, WILL (Women's Integrated Learning for Life) and support to the adolescent girls schemes.)

Special attention should be given to whether the various innovative aspects of the Sida-supported ICDS have led to improved sectoral integration; whether the targeting at district and lower levels has reached the socio-economically vulnerable groups in society; and whether programme efforts have led to increased benefits for girls and women.

3.3 Impact

Where possible, existing project monitoring data should be analysed to estimate the impact that the programme has had on relevant indicators (health, nutrition and educational outcomes) during the life of the programme, particularly in Chengalpattu where it has continued for a longer period of time. The results of any existing additional studies should be utilized to increase the depth that the evaluation can go into this question of impact. Wherever possible the prestudies should present information on ways in which project activities have led to the creation of networks, pressure groups or collectives, influenced decision makers, including policy decisions, and resulted in changes in attitudes, abilities and approaches on the part of project functionaries and the community itself. As far as possible, data should be presented by gender.

3.4 Cost analysis

The evaluators should examine from a broad perspective and describe how Sida funds were utilized and relate this to the outcomes, providing their judgements as to how cost-effective it has been and recommendations for improving this aspect in the future.

3.5 Organizational development

Describe any changes in the usual ICDS organizational development in Tamil Nadu at each level from state to block that may have resulted from the various kinds of Sida support, including covering salaries, training costs, changes in programme monitoring etc. Comment on how useful such changes have been and the extent to which any useful changes may be sustainable and/or replicable.

3.6 Effectiveness of implementation

The evaluators should review which program components have been implemented well and which have suffered from constraints. The factors responsible for both these strengths and constraints should be identified, including any related to administration or technical inputs, from either the Swedish or Indian

sides. Programme capacity to do internal monitoring and evaluation and to make use of such activities for programme improvement should be assessed. The process of change in project direction, emphasis and modus operandi should be described and the consequences for program effectiveness analysed.

3.7 Sustainability
The evaluators should identify any program elements that clearly are sustainable and any where this aspect is questionable. Possible implications for future program design should be discussed.

3.8 Replicability
The evaluators should identify the extent to which innovations resulting from or furthered by the Swedish support have already been replicated in non-Sida supported districts either in Tamil Nadu or in ICDS programs in other areas of the country. This should focus particularly on any innovations that will lower costs or increase cost effectiveness in situations where substantial external funds are not available.

4. Methods

4.1 Components
I. A subjective "lessons learned" *desk study* will be done by the main monitoring consultant in Sweden.

II. **Prestudies** will be done by various teams of Indian and/or Swedish consultants, to be funded by Sida. Reports from these studies will be made to the evaluation in advance of the period during which the evaluation is to be conducted.

A. Targeting of ICDS services: social, economic and gender aspects
1. Existing statistical data routinely gathered for project monitoring should be examined. The accuracy of these data should be determined and any existing persisting biases identified.
2. Written and oral policies for selecting beneficiaries should be documented and compared at national, state, district and block levels.
3. Qualitative studies should be conducted to determine the factors underlying successes and failures in targeting. For example, what factors influence whether or not extremely poor, low-caste or tribal mothers, children or adolescents are included? In some areas, does the AWC in effect provide low-cost childcare for lower middle class groups rather than reaching the poor? Is there ever an excess of girls or boys attending and if so what are the reasons for this?
4. Provide practical recommendations and advice for how any future Sida-supported ICDS projects can be designed to overcome any irregularities in targeting.

B. Review of the economic implications of the Sida support to ICDS
This review would take a broad look at macroeconomic issues and also a more detailed examination of cost-effectiveness issues, based mainly on examination of existing Government of Tamil Nadu records. A draft plan for this review is attached as Appendix 1.

C. Study of the adolescent girl schemes and ideas for new approaches
Practical studies are needed to provide recommendations for revamping or if necessary discontinuing these schemes which have so far not proven very successful. Girls who have already been through either scheme should be interviewed to find out ways in which they suggest that such programmes did or did not benefit them and how these programmes could be changed to be of greater usefulness in addressing the expressed objectives (return to school and delayed age of marriage). So far, only a small proportion of the target group is reached and the benefits to them appear small in their own eyes, particularly since participation in the schemes does not easily lead to employment.

D. Rapid appraisal of a random sample of anganwadi centres
Both structured observations and interviews of relevant actors should be done in a sample of about 20 centres. Attention should be focused on the Sida additionalities. The report should provide the team a good deal of fairly objective background material in a condensed form.

E. Community participation in ICDS
It is well known that ICDS will have a much greater impact in reaching its objectives when the community feels ownership and concern for the AWC and the work it is to be doing. The Sida funded program included several innovative approaches toward increasing community participation in ICDS. These included broader scale IEC, workshops to increase community support for ICDS, formation of AW women's groups, and the celebration of motivation day, centre day, project day and nutrition week. There may have been relevant information dissemination through films screened on ICDS, radio, ICDS newsletter, and use made of video equipment purchased through the project. This prestudy will be mainly a process evaluation to determine how widely and at what level of quality each of these components was implemented. However, as far as possible, evidence should be gathered from the field to document how much community participation has actually taken place. How involved and committed are the beneficiary groups and their communities and what could be done in the future to improve this aspect?

F. Impact of ICDS on health, nutritional and educational indicators
This review will examine existing records from the ICDS itself as well as data routinely gathered by other relevant government actors at the state and district levels. Data will be followed over time at block or district level as far back as possible. Data quality will be assessed and where it appears to be good, any clear changes in relevant indicators that have taken place will be examined. The timing of such changes will be examined to determine whether they may have resulted from program activities. Variables to be examined include any that are available and deemed useful (relevant and of adequate quality) regarding elementary school participation, continuation and performance, women's educational status, birth weight, weight for age of under-fives, vaccination coverage and other health indicators.

III. *The main evaluation* will utilize the prestudies and complementary information as well as their own site visits, interviews with key actors, etc. Additional issues that should receive attention beyond those covered in the prestudies are infrastructural development, contributions by the community, convergence of sectoral services in the anganwadi centre, and community participation. The evaluation team will come to their own conclusions, discuss their preliminary conclusions with representatives from all three parties, and write the final evaluation report which may be published at Sida's discretion.

4.2 Documents

The evaluation team will have access to all relevant documents in the possession of all three of the parties to the evaluation. They should review all major reports, plans and other materials produced by the parties and relevant documents on ICDS from other districts, national level, and other donor agencies.

4.3 Site visits

The evaluation team will have the right to visit any ICDS site or administrative location in the Sida-supported districts and to interview any staff working on the project at state or national levels, whether Indian or Swedish. All major actors at state, national and donor levels should be contacted, their opinions sought, and these given due attention by the evaluation team.

5. Composition of the evaluation team

GOI and GTN have each appointed one team member. Sida will appoint a team leader and other team members required to ensure that relevant areas of expertise are covered. These include public health; nutrition; education (including at the preschool level); program management, including financial aspects; monitoring and evaluation; and social science.

6. Time schedule

A) completed in November, 1996.

B) The prestudies will begin in May and first draft reports from them will be ready by August, 1997 when they should be provided to the evaluation team.

C) the evaluation should take place during a three week period in October, 1997, including seminar discussions in Madras and in Delhi before the evaluation team leaves each area.

7. Reporting

7.1 Rough drafts of major preliminary conclusions and recommendations should be provided in connection with the seminars held in Madras and Delhi before completion of the evaluation.

7.2 The draft report, in English, must be submitted to the three parties not later than one month after the conclusion of the evaluation. The three parties will have one month in which to comment on this draft. The final report, written according to established Sida regulations and guidelines for formal evaluation reporting, must be submitted no later than one month after the team has received these comments.

7.3 The team will participate as presenters and facilitators at seminars to be held about the outcome and recommendations of the final report not later than three months after this report is presented.

Appendix 1

A Review of fiscal and economic aspects of the ICDS-program in Tamil Nadu

This study will analyse the cost of the Sida-funded ICDS program in relation to the overall state budget for ICDS and the cost of ICDS in other districts. The study also will analyse the fiscal implications for the state of Tamil Nadu of scaling up various components of the Swedish ICDS program to other districts. The sub areas of the study shall be as follows:

A) Analysing the budgets of ICDS and other health programs

The study shall analyse the budget of ICDS in comparison with other health programmes and try to determine whether there is a reasonable relationship between the expenditure on ICDS and other health programmes. It would attempt to determine whether there has been an expansion of the ICDS budgets during the project period to take care of additional requirement, over time. The study will also attempt to determine the commitment of the state government through an analysis of sources of additional resources. The objective of the study is to find out if the Swedish support has resulted in additional funding support to ICDS.

B) Regarding ICDS as a pilot scheme

The ICDS project supported by Sweden was sanctioned as a pilot project with the objective of testing new innovative ideas which, if found effective, could be implemented on a larger scale subject to availability of funds for this purpose.

In the pilot project there is a need to analyse the fiscal implications of the larger implementation phase. There is thus a need to study the cost of the various components of the programme and estimate the budget implications of the larger implementation phase. The study should estimate the cost of implementing the programme in certain areas (for example the poorest areas) and the cost of implementing various components of the programme.

C) Studying what has already been replicated

Some of the Sida additionalities already seem to have been adopted in non-project areas. This can give some indication as to which components are most replicable and at what cost.

D) ICDS in Tamil Nadu, a variety of schemes

In Tamil Nadu, in some districts ICDS receives support from the World Bank (TINP-II), some under Sida, and others under General ICDS. The study would therefore attempt a comparative analysis of costs between Sida ICDS, the TINP Project and ICDS Projects under General Assistance.

The consultant

The study shall be carried out by an economist who is familiar with the state budgets of Tamil Nadu and has good knowledge of the ICDS programme in Tamil Nadu and good knowledge of the budgetary systems of the Government of India.

The study should take two weeks.

Annex 4

Organizational set up of ICDS, indicating the 21 posts financed by Sida

Chief Programme Coordinator (**Sida ICDS**)
Secretary; Social Welfare & NMP
Department, Govt. of Tamil Nadu

Project Co-ordinator (**Sida ICDS**) (**1**)
Director Social Welfare

Additional Director of Social Welfare

Joint Director (**Health**)

Deputy Director (**ICDS**)

Assistant Director (**Accounts Sida**) (**1**)

STATE LEVEL/DISTRICT LEVEL

Programmer (**1**) Programme Officers
Community Educator (**1**) Special Team Instructresses
Asst Engineer (**1**) Mobile Team Instructresses
Superintendents 2 (**2**) Supportive Ministerial Staff
Assistants (**5**)
Computer Operator (**1**)
Junior Asst (**1**)
Typists (**2**)
Drivers (**4**)
Office asst.(**1**)

PROJECT LEVEL

Child Development Programme Officers, CDPO
Supervisor Grade I
Supervisor Grade II
Anganwadi Worker I, II
Helpers

Annex 5

Partial schedule and list of persons met by Sida ICDS Evaluation Team

DELHI

7 .10. 97	World Bank	Mr Tony Measham
	Sida	Yasmin Zaveri
8 .10. 97	Min Human	Mrs Rekha Bhargava, Secretary
	Resources Dev	Mr Bhargava, Joint Secretary
		Presentation of prestudies for GOI and Sida
	UNICEF	Kamal Islam

MADRAS

09. 10 .97	Connemara Hotel	Presentation of prestudies for GTN
10. 10 .97	Connemara Hotel	Mrs Aloka Guha, Director, Spastic Society, Madras
10. 10 .97	DSW	Mrs Supriya Sahu, Additional Director, DSW
		Mr M P Vijaykumar, Director, DSW

13. 10. 97 Connemara Hotel
S Chenbagan, Special Team Trainer, Anna MGR Dist
V Glory Jayaseeli, Special Team Trainer, Anna MGR Dist
C Meena Mobile Team Instructor,Special Team Trainer, Anna MGR District
N Ragini Devi, Special Team Trainer, Chennai
D Kamaleshwari, CDPO, Chennai
S Susan Sundaravadani, Special Team Trainer,
Kancheepuram, Thiruvallur, Dist
Directorate of Social Welfare
Mrs Supriya Sahu, Additional Director, DSW
Mr MP Vijaykumar, Director, DSW
Dr. P. Srinivasan, Joint Director of Health
Dr. S. Murugan, ex Joint Director of Health

14. 10. 97	Spastic Society	Mrs Aloka Guha, Director
		24 Supervisors attending the training

DSW
Mr. Sivasubranamiam, Asst. Director Accts (Sida)
Ms. S. Valliammal, Asst. Director (NMP)
Mr. S. Kalyana Raman, Dept. Director (Special Programmes)
Ms. Usha, Programmer
90 Anganwadi Workers attending the Joy of Learning Training

15. 10 97	Adyar, Chennai	Mrs Elka Krausse, ex UNICEF
	Connemara Hotel	
	Geetha Krishnaveni, CDPO, Manmelkudi, Pudukottai Dist	
	R. Lalithamani, Supervisor I, Thirumayam Block, Pudukottai Dist	
	A. Saraswathy, Anganwadi Worker I, Arusumpathy Centre, Thirumayam Block, Pudukottai Dist	
	M. Salethi Selvi, Supervisor I, Avadayar Kovil , Pudukottai Dist	
	M. Indrani, Anganwadi Worker II, Kammankadu, Pudukottai Dist	
	D. Subbulakshmi, Supervisor II, Annavasal, Pudukottai Dist	
	A. Shummuya Sundaram, CDPO, Pannammaruvathy, Pudukottai Dist	
	DSW Meeting of physicians linked to urban ICDS projects	
16. 10. 97	Connemara Hotel	
	M.V. Sarojini, CDPO, Gudalur, Nilgiris Dist	
	S. Narghees, Anganwadi Worker I, Ooty, Nilgiris Dist	
	R. Vasanthy, Supervisor II, Ooty, Nilgiris Dist	
	H. Geetha, Supervisor I, Ooty, Nilgiris Dist	
	A. Gomathy, PO, Ooty, Nilgiris Dist	
	C. Rajamma, CDPO, Kotagiri, Nilgiris Dist	
	G. Rathnamala, Anganwadi Worker, Kotagiri, Nilgiris Dist	
	Directorate of Social Welfare	
	Mrs Supriya Sahu, Additional Director, DSW	
	Mr MP Vijaykumar, Director, DSW	
17. 10 97	Debriefing, Mrs Lakshmi Pranesh, Secretary	

DELHI

20.10.97	Meeting of the team	
	Debriefing Sida	Yasmin Zaveri
		Eva Joelsdotter-Berg
		Christer Holzberg
22.10.97	Meeting of the team	
23.10.97	Meeting of the team	
	Debriefing MHRD	Ms. Rekha Bhargava, Joint Secretary
		Mr. Bhargava,
		Yasmin Zaveri, Sida
24. 10. 97	Meeting of the team	

Annex 6

Community participation in Morapur Block

The UNICEF-assisted Community Participation Programme is being implemented on a pilot basis at Morapur ICDS in Dharmapuri District. The programme envisages a group-oriented approach to involve the people at large in community development. Women's groups are formed and involved in the programme in 85 out of 91 AWCs in the Block.

Women's groups are formed as a strategy and an opportunity for rural women to meet together, to work together and also find solutions to their common problems through united efforts. The group strategy offers rural women a chance to identify their rights and work for their common cause.

The main objectives here are to build confidence in themselves and to provide opportunities to manage their own approach toward meeting their needs.

The community response to the programme has been good. The project functionaries have given residential training to the presidents and secretaries and these women's groups. Along with them, the grassroot workers like AWWs and helpers are also given intensive training on community participation, mobilisation of resources, formation of women's groups, and their functions in neighbouring areas.

A workshop on community participation for trainees was also held in May, 1997 at Morapur and people from 35 villages spread throughout the block were involved and motivated. The study team visited Morapur and one of the women's groups at M. Vetrapatti village. The team discussed with group members and Morapur ICDS functionaries about their experience in community participation.

The salient features of the discussion were:

- Eleven groups are registered and provided with Rs. 1000/– each.
- The groups' officials are formally elected at a meeting in the presence of the panchayat president, school teachers and ICDS workers at a meeting. This selection is preceded by a process of electing leaders streetwise and wardwise and these leaders in turn elect the group officials for the villages.
- Each group will have membership between 20–60; they will meet twice a month and finalise resolutions.
- The sample group with a membership fee of Rs. 5/– has so far saved Rs. 6000/– under the thrift fund scheme.
- Members of the group have overcome their inhibitions and developed a certain orderliness in their activities.
- The interactions with other similar groups have given them good exposure to collective strength and access to a variety of knowledge on self-help and social development.

The group members at M. Vetrapatti have gained strength in standing up against social ills.

The members had organised dharma and succeeded in removing irregularities at the food ration shop in their village. They had also held a road roko to demand regular bus services to the village and succeeded in this effort.

The most impressive effort has been their drive against the local arak shop. However they could achieve only limited success due to local political pressure.

The members used to help local AWWs in their daily activities as well as during health camps. The local functionaries acknowledge their yeomen services during the recently held polio campaigns.

When referred to the ICDS activities and their significance, the members' responses were overwhelming: they seem to know very well each of the ICDS activities and they also spread ICDS messages to the community. They gratefully acknowledge the efforts of ICDS functionaries in improving their knowledge and awareness of women's rights and improvement.

Their knowledge of similar groups and their success in the neighbouring blocks (IFAD groups) is astonishing. But their point of contention in referring these IFAD groups here has been the liberal loans/subsidies given to IFAD groups.

While acknowledging the positive features of community participation and group formation, the members insist that they have to be recognised by way of assistance in improving their economic conditions. They believe that unless their economic conditions are improved they are no equals to their menfolk.

The group members argued that the training given to them, the regular follow-up by the ICDS functionaries in maintaining the group efforts, and the encouragement and assurance given to them by a variety of visitors have raised their hopes and expectations. The greatest felt need for them is an economic assistance by way of bank loans.

The president of the group even cautioned that unless the members are given loans – with or without subsidy – the group's sustainability is at stake. She argued for the necessity on the part of the government to repose faith in group members and to encourage them to sustain their tempo.

Another noted suggestion forwarded by the members is the need for recognition of services rendered by the president and secretary of the group. They felt that such honours would encourage the community to come forward for public services.

The members stressed the need for training for the male members of their households. They believe that this would go a long way toward achieving a better understanding between them and their husbands regarding their involvement in community services.

Annex 7

Prestudy on health, nutritional and educational indicators

This prestudy was designed to review existing records from the ICDS itself as well as data routinely gathered by other relevant government actors at the state and district levels. The timing of changes or trends in indicators was to be examined to determine whether these changes might have resulted from programme activities. Variables to be examined included any available and deemed useful (relevant and of adequate quality) regarding elementary school participation, continuation and performance; women's educational status; birth weight; weight for age of under-fives; vaccination coverage; and other health indicators.

Methods

As a first step, virtually all routinely gathered data from all blocks in the three districts were obtained directly from the blocks. This ensured that no central or district-level attempts could be made to alter the data in any way in connection with the evaluation. It was deemed unlikely that 47 separate blocks could be influenced in ways that would not be visible to the evaluators.

The second step was to carefully review these data and discuss them with staff at the various levels to determine which were of adequate quality and usefulness to warrant analysing them further. At this stage it became clear that there were no data related directly to the preschool activity. Even attendance at the preschool seemed unlikely to be the basis for AWW's marking attendance for that child for that day. A child who came for just a short time to get food would likely be recorded the same as one who stayed all day. No data were available on primary school attendance or women's education. The data on mortality and birth weight were not judged to be of adequate validity and completeness to warrant using them for evaluation purposes, so they were not coded. Data on each level of referral seemed of questionable completeness and relevance for evaluation purposes. (It is also not possible to discriminate based only on these data between a decline in disease prevalence and a decrease in the attention given to making and recording referrals.)

Data of adequate quality were then coded, graphed and examined on a block by block basis, resulting in a total of over 700 graphs with multiple variables on each graph. This allowed several large errors in record keeping to be uncovered, the causes determined, and corrections made in nearly all cases. It also allowed relationships among variables to be examined. In some cases this assisted in judging data quality, e.g. whether the data "behaved" as one would expect if they were free from major bias and error. In other cases, it allowed important questions to be examined, for example, whether nutritional status declined as the coverage of children weighed increased. (If so, this would suggest that the increase in coverage was reaching poorer children and this might be the explanation for any seeming "failure" of the programme to reduce levels of malnutrition. Conversely, "programme fatigue" might lead to poorer mothers no longer bringing their children and their dropping out could be the real explanation for seeming improvements made in nutritional status.)

Each block cumulates data by month starting in April each year. Therefore data were collected for March of each year. In a case like vaccination coverage, March gives the complete figure for the year. In the case of supplemental feeding coverage, the data used will only reflect that month and therefore are subject to any seasonal influences that may come to bear. However, this would not affect annual trends.

In the next step, data were combined to create separate graphs for Nilgiris (4 blocks), Pudukottai (13 blocks), Chengalpattu (called "Chengalpet" in the graphs) Phase I (8 blocks), and Chengalpattu Phase II

(22 blocks). Sida support began in Chengalpattu Phase I in 1989, in Chengalpattu Phase II in early 1992, and in Nilgiris and Pudukottai in late 1994. Data of reasonabe completeness became available starting in Chengalpattu Phase I in 1988, in Chengalpattu Phase II in 1991 and in the other districts in 1992. Thus March 1990 data must be examined to see any immediate impact that might be expected in Chengalpattu I (such as effects on enrolment or attendance in ICDS), and 1993 for Chengalpattu II. In Pudukottai and Nilgiris it is more difficult to decide which year to choose. Sida support began to flow in late 1994, so by March 1995 about a half-year's impact could be expected and this year was used in the analysis.

Finally, not all data were analysed, as this would have taken much more resources without providing much important new information relevant for evaluating the ICDS. For example, reasonably complete and probably reliable data are kept on all vaccinations, but only one was chosen as an illustration, measles.

Results and discussion

Data are presented on 14 variables in the form of eight graphs for each of the four areas, all of which are attached. They report on absolute values. This shows how numbers of people involved in the programs changed over time; numbers the AWW were aware existed in their catchment areas; numbers registered or enrolled; numbers who attended during the month of March in the various years; numbers who received various medical services via the AWC including measles vaccination and prophylactic iron, vitamin A (second dose during the year), and deworming medication; number weighed; number at different grades of malnutrition. These same data are presented in the tables below in terms of percentages.

One needs to examine both absolute numbers and percentages to get a clear picture of the changes that occurred. For example, in the early years of the programme, the AWWs became aware of more and more pregnant women, so even though the number receiving supplementary food increased dramatically, the percent enrolled may actually decline since it took more time to enrol the women they became aware of. Already in the early 1990s AWWs were well aware of how many children were in their areas, so the numbers are relatively stable throughout, though a general declining trend may be noted, perhaps reflecting a gradual decline in fertility.

Data for Chengalpattu I are the most unstable. This probably reflects the fact that several of these blocks are in the isolated interior of the district where it is difficult to fill posts. Thus data from many AWCs are no doubt lacking for certain periods of time.

Supplementary feeding

Table I presents the data on percentages enrolled and registered for supplementary food in the four classes of beneficiaries for the first year when data are available, the first year when any impact of Sida support is likely to show up (shaded), and 1997. Thus these data are related to programme inputs and coverage which is a process indicator reflecting on the quality of the programme.

Data quality generally seemed good. We know that there were disruptions in the programme that are not well reflected in some of the data, however.[22]

[22] After reducing or stopping purchases as noted above, the former Director of DSW then requested staff to hide the fact by falsifying data, that is indicating that everything was progressing at the same levels as before. This may explain why data for sundal feeding (bought with Sida funds) does not tally with data for supplemental feeding earlier in the day of the same group (bought with NMP funds).

Table I. Distribution of supplemental foods in Sida ICDS

District		Chengalpet I			Chengalpet II			Pudukottai			Nilgiris		
Year		88	90	97	91	93	97	92	95	97	92	95	97
Infants 6–24 months	%enrolled	71	45	85	49	66	76	34	96	103	72	86	86
	% fed of enrolled	61	88	84	58	69	83	62	97	88	30	90	67
Children 2–6 years	%enrolled	42	53	50	61	61	45	60	48	45	70	56	60
	% fed of enrolled	82	75	65	66	62	66	71	85	87	63	87	90
Sundal	% fed of enrolled	--	30*	90	--	107	135	75	93	10	--	91	101
Pregnant women	%enrolled	63	46	80	84	95	76	37	88	99	106	96	96
	% fed of enrolled	87	68	62	37	77	62	85	96	91	46	95	63
Lactating women	%enrolled												
	% fed of enrolled	67	62	51	35	80	77	88	95	92	54	93	79

* Data for 1992.

1. *Supplemental feeding, 6–24 months*. This age group is widely thought to be the one ICDS must reach to a greater extent if the program is to bring down levels of malnutrition, especially moderate malnutrition. ICDS does not maintain data on the number of eligible children of this specific age, but assuming they represent 25% of all children 0–6 years of age, the findings in Table I reveal that the first year of Sida support resulted in moderate to dramatic increases in enrolment and attendance in this group except for Chengalpattu Phase I. This provided a sound basis for the programme to have an impact on nutritional status of the entire 0–6 year old group, since impact is easier to achieve in younger children.

2. *Supplemental feeding, 2–6 years*. Coverage and attendance rates vary a great deal but there is no clear influence of the Sida support as might be expected. There is a tendency toward stagnation and decline in participation in 1997 compared with the years before that which is better visible from the graphs than the table. Since food for that group was less subject to disruptions than it was for all the other groups, this probably reflects the increased popularity of private and mission preschools which are attracting children away from ICDS, especially in the urban and semi-urban areas.

3. *Sundal feeding (afternoons for children 2–6)*. This was not meant to exist before Sida support came in, though it appears to have started in 1993 in Pudukottai and 1994 in Nilgiris. It went to very high levels a year after the Sida support started and has declined in 1997 to very low levels due to supply problems mentioned above. It may have contributed to improved nutritional status among the older children, for example by increasing daily meal frequency.

4. *Pregnant women, supplementary food*. Sida support appears to have led to increased enrolment and attendance in this group, something that could lead to increased birth weights if the women consume much of the food themselves. In Chengalpattu I, the increase in pregnant women identified took place faster than new registrations. This is probably because in the early years it took time for the AWWs to change over to the more liberal eligibility criteria ICDS has compared to TINP.

5. *Lactating women, supplementary food*. Sida support appeared to lead to increases in coverage except in Chengalpattu I where it could not keep pace with the rapid increase in numbers enrolled.

In summary, Sida support led overall to substantially improved coverage in the supplementary feeding component of ICDS in these three districts. This was not due to direct funding of these efforts, nor even specific efforts to support this component by Sida. The improvements are rather probably a reflection of other Sida inputs, including the increased staffing at state and field levels, the early work done on raising community awareness of the availability of the programme, especially to groups other than the 2–6 year olds who ICDS traditionally focused on, increased training and other measures to improve AWW performance.

Prophylaxis/prevention
Nutrient supplements and deworming pills are provided by GOI. Sida enables the purchase of extra supplies when it is clear that GOI supplies are inadequate. These data, as presented in Table II, are also related to coverage or quality of the programme.

Table II. Distribution coverage of prophylactic medications in Sida districts (% of group listed)

District	Chengalpet I			Chengalpet II			Pudukottai			Nilgiris		
Year	88	90	97	91	93	97	92	95	97	92	95	97
FST, pregnant women	63	45	84	40	54	69	60	100	92	62	98	61
FST, children 1–5 years	25	20	22	22	31	41	19	40	15	21	61	70
Vitamin A II, 6–72 mon	39	33	23	19	6	15	86	71	54	36	77	53
Deworming, 6–72 mon.	15	17	65	41	38	30	54	53	43	36	66	94
Measles vaccination	81	65	81	35	52	88	62	95	95	39	56	75

6. *FST (iron tablets[23]) for pregnant women*. Here again percentages can be misleading. ANC eligibility (AWWs' awareness of how many were in their catchment area) increased in the early years and sometimes decreased in recent years. This decrease was large for Chengalpattu I but not Chengalpattu II,

[23] Containing 60 mg iron and 0.5 mg folic acid.

likely due to lack of staff as mentioned above. Provision of iron to pregnant women made particularly impressive progress after the Sida support began in Pudukottai and Nilgiris. However, from mid-1996 to mid-1997, the Directors of DSW refused to purchase any drugs or nutrient supplements using Sida funds for ICDS. Therefore some decline in coverage in 1997 would be expected. That the opposite occurred in Chengalpattu could be either due to better GOI supplies or, as noted above, a deliberate attempt to cover up what was going on.

7. *FST for children 1–5*[24]. It is unusual for children this age to be supplied with prophylactic iron, though they often need it. It is likely that they do not like taking it and their parents may not like it if the children complain of side effects. Again, except for Chengalpattu I there seems to be an impact of Sida support but some reduction in coverage in 1997.

8. *Vitamin A, second semi-annual dose for children 6–72 months of age*. It is difficult to interpret these data. Presumably availability varies enormously over time and Sida funds made little difference, given bureaucratic inability to respond rapidly once shortfalls were known. In any case, if these data are accurate, Chengalpattu should examine why it is unable to achieve better coverage rates, given the performance of the other two districts. This is one of the kinds of questions that could have been raised years ago if these data were being collated and examined by programme managers.

9. *Deworming medication for children 6–71 months of age*. Presumably this simply cumulates the total number of doses given. In theory each child should receive it twice a year, but it was not in the past given in a campaign style and not recorded as first and second dose. So no doubt some children have received two doses each year and a greater than indicated percentage thus received none. It is popular and the main constraint is likely to be availability. Again the pattern is hard to analyse except to note that Nilgiris does the best job.

10. *Measles vaccination, children 0–1 years*. Increases occurred throughout this period in all areas but Chengalpattu I, starting from surprisingly low levels. Again, the anomalous increase in eligibility may largely be responsible. In the other areas some increase or instability was seen in the beginning, but figures seem stable in recent years, presumably reflecting better quality of data recording in those areas. Sida support made no direct effort to have an impact on this. ICDS plays only a supportive role but coverage levels might benefit from the AWC's increased reach out to the villages.

Nutritional status

These were the only data for which an inference of programme impact was reasonable. Of course other things besides the programme influenced nutrition, and this was not an experimental study with a control area, so conclusions drawn from Table III must be considered somewhat tentative. Furthermore, there are risks in utilizing service-based data to draw cause and effect conclusions (18). In India, malnutrition is graded according to the following system: Grade I: 75–90% median weight for age[25]; Grade II: 60–75%; Grade III: 50–60%; Grade IV: <50%. However, in Tamil Nadu, data are recorded with normal and Grade I combined and Grades III and IV combined.

11. *Growth monitoring*. One Sida monitoring report (9) mentions this as a problem area. However, the data in Table III show that coverage rates greatly increased a year after Sida support began and have continued to so do, now achieving satisfactory levels of about 92% of enrolled children 0–6 years old.

12. *Nutritional status*. The data in Table III attest to a remarkable success story. From the advent of Sida support, both severe and moderate malnutrition declined and have continued to do so. Particularly im-

[24] Containing 20 mg iron and 0.1 mg folic acid

[25] ICDS uses a modified Harvard Standard as recommended by the Indian Academy of Pediatrics.

pressive are the results from Pudukottai and Nilgiris. Examination of the graphs shows that this decline has been gradual but continuous. Severe malnutrition is now at levels of less than 1%.[26] While other nutrition programmes in India have also succeeded in bringing down levels of severe malnutrition, every Sida area shows a consistent gradually declining trend in levels of moderate malnutrition also.

Table III. Percentage of children 0–6 years old suffering from various grades of malnutrition

District	Chengalpet I			Chengalpet II			Pudukottai			Nilgiris		
Year	88	90	97	91	93	97	92	95	97	92	95	97
% 0–6 yr olds weighed	67	87	93	73	83	94	78	92	95	69	91	92
% Normal/Grade I	71	76	83	72	75	81	70	80	83	70	84	87
% Grade II	24	21	17	24	23	18	27	20	17	27	15	13
% Grade III & IV	4	2	0.1	3	3	0.8	2	0.8	0.2	3	0.2	0.2

Is it possible that these data have been manipulated, as have some other data included in the monitoring system? It is almost inconceivable that this could account for these changes. Nutritional data are too complex to be falsified by anyone except an expert at levels beyond those this project has had access to. The trends are too consistent over too many blocks and too many years. There simply has been too little continuity on the part of project management to succeed, even if they had the technical skills to know how to make falsified data look genuine.

Beneficiary-based data such as this can be misleading if coverage rates decline at the same time as nutritional status improves. Decreasing coverage tends to mean that mothers who are less conscientious, those who are too poor to give time to the project and to their children, and those who live in more isolated areas drop out from the program. Since their children also tend to be more malnourished, an artificial impression of improvement is generated. The present data show varying trends in coverage but only one single trend in nutritional status across all districts and over the whole time period: gradual improvement at a level that is feasible and yet signals that an effective intervention is in place.

Adolescent girls

13. *Participation in the adolescent girls schemes*. It is likely that the data gathered on this aspect are often a reflection of what the AWW thinks it is supposed to be rather than the true situation. This is because for most blocks and most years the number is exactly the same. One can at least deduct that girls who dropped out were not reflected in the data reported. Some blocks even appeared to continue reporting equal numbers attending after the project had been stopped. There is no basis for reporting percentages, but the numbers by year are reflected on the same graphs as the sundal feeding is reported on.

[26] Some part of this seeming problem of malnutrition may actually be related to infants who have AIDS as a result of vertical transmission from their mothers. Tamil Nadu has one of the highest documented levels of AIDS in the country (1).

Education

14. *Primary school attendance*. Data on education are not maintained by the ICDS programme but were obtained for Chengalpattu and Pudukottai from the education sector. It should be kept in mind that data on enrolment and retention are not very accurate, but tend to be inflated. For example, 18% of children listed as enrolled in school were actually long-term absentees and the State dropped them from its statistics first in 1996/7. In 1996/7, 95% of boys and 93% of girls age 6–11 were enrolled in school in the state (large gender differences appeared only after 14 years of age).

For the 1996/97 school year in Chengalpattu, 33,350 children were admitted from preschool into primary school. Of these, 279 left school, but in 88 of these cases it was to join another school and in 177 cases it was due to migration, so it was not known how many of them actually dropped out. Known dropouts were 14. Thus the true dropout rate, presumably for the first year of primary school, was between 14 and 191, or between 0.04% and 0.6%.

For Pudukottai, gender breakdowns were also available. For the 1996/97 school year, there were 6949 boys and 6705 girls eligible to enroll[27]. Of these, 64 boys (0.9%) and 72 girls (1.1%) left school, but records were not available as to how many of these were actual drop-outs. Thus those girls who survive to school age are not at that point substantially discriminated against with respect to school enrolment.

Conclusions

Supplemental feeding enrolment and attendance increased dramatically after Sida support was initiated for the crucial "non-traditional" groups of infants and pregnant and lactating mothers. However, declines in supplemental feeding enrolment and attendance are visible for 1997, as are declines in coverage of prophylactic nutrients and deworming tablets. Based on interviews with programme staff, there is little doubt that this is due to failure of the Director of DSW at that time (her tenure lasted through nearly all of 1996) to purchase agreed upon and budgeted components of the programme. This graphically illustrates that some kind of improvement in programme management and accountability must be built in to protect it from the whims of directors who will presumably come and go at regular intervals under the government system.

Nevertheless, this was a minor setback for a programme that in the years before had made major advances. Substantial improvements in vaccination coverage suggest that other areas of government services such as the health services were also making gains during this period.

Nutritional status gradually increased throughout the period studied in all districts. Was ICDS responsible for the impressive improvements noted in nutritional status? Given the fact that poverty is still relatively prevalent in the state, it is likely that these effects are due to welfare efforts rather than increased incomes, though each may have played a part. It is difficult to separate the effects of ICDS from the other improvements in social welfare going on at the same time throughout Tamil Nadu. But ICDS is probably the largest one aimed specifically at this age group. Also these data are not community-based but based on ICDS enrolment and weighing. Thus they probably reflect improvement due to ICDS at least to a large extent.

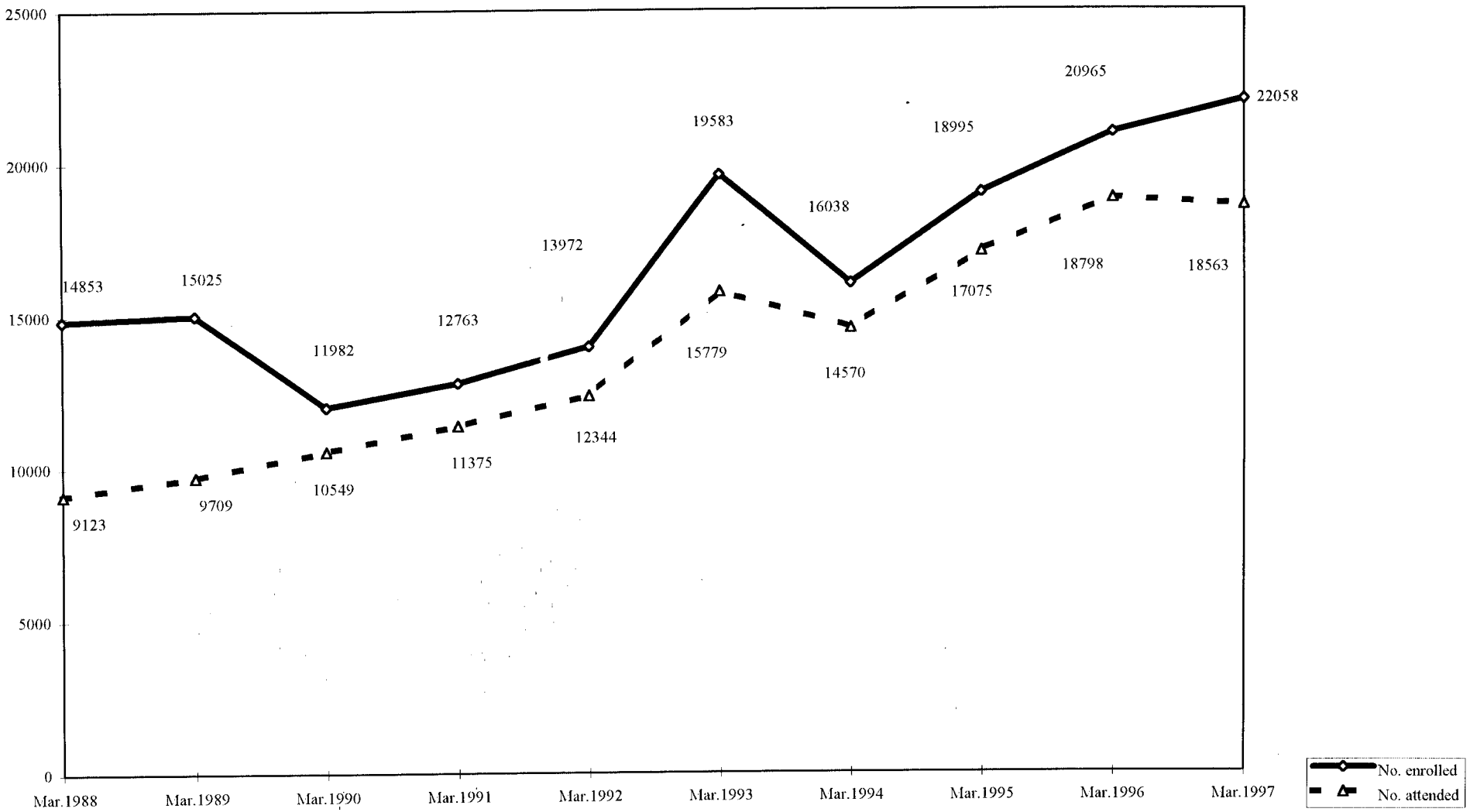
Did Sida support make a contribution? In the case of Chengalpattu, the improvement has been gradual throughout the period of Sida support. In the case of Nilgiris and Pudukottai, there were unusually large improvements within one year of the initiation of the Sida support, which more strongly suggests that something about the Sida support at least gave extra impetus to the processes responsible for this positive development. About half of the Sida support in Phase II has gone to the purchase of food and there is no doubt that this nutritious food, distributed to poor families, has played a major role in securing this

[27] Assuming that an equal number of girls as boys should have survived to this age, 3.5% of the girls were "missing."

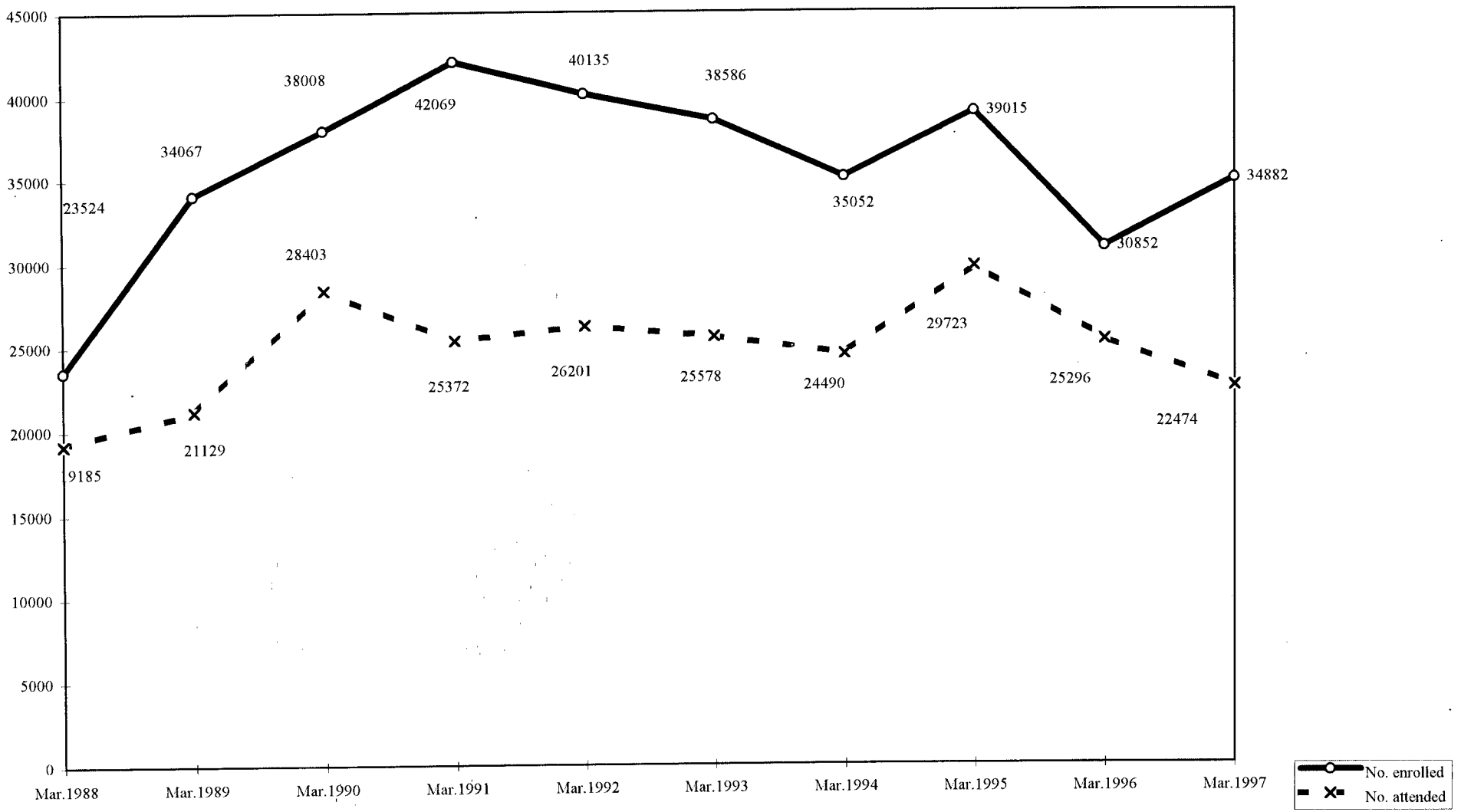
nutritional improvement. Since young child malnutrition is well known to have multiple causes and various levels, it is likely that Sida's support to other aspects of an already comprehensive programme also played a role.

It also seems likely that Sida support to ICDS preschool activities contributed to the high levels of school enrolment and continuation seen in the Sida districts, particularly among girls.

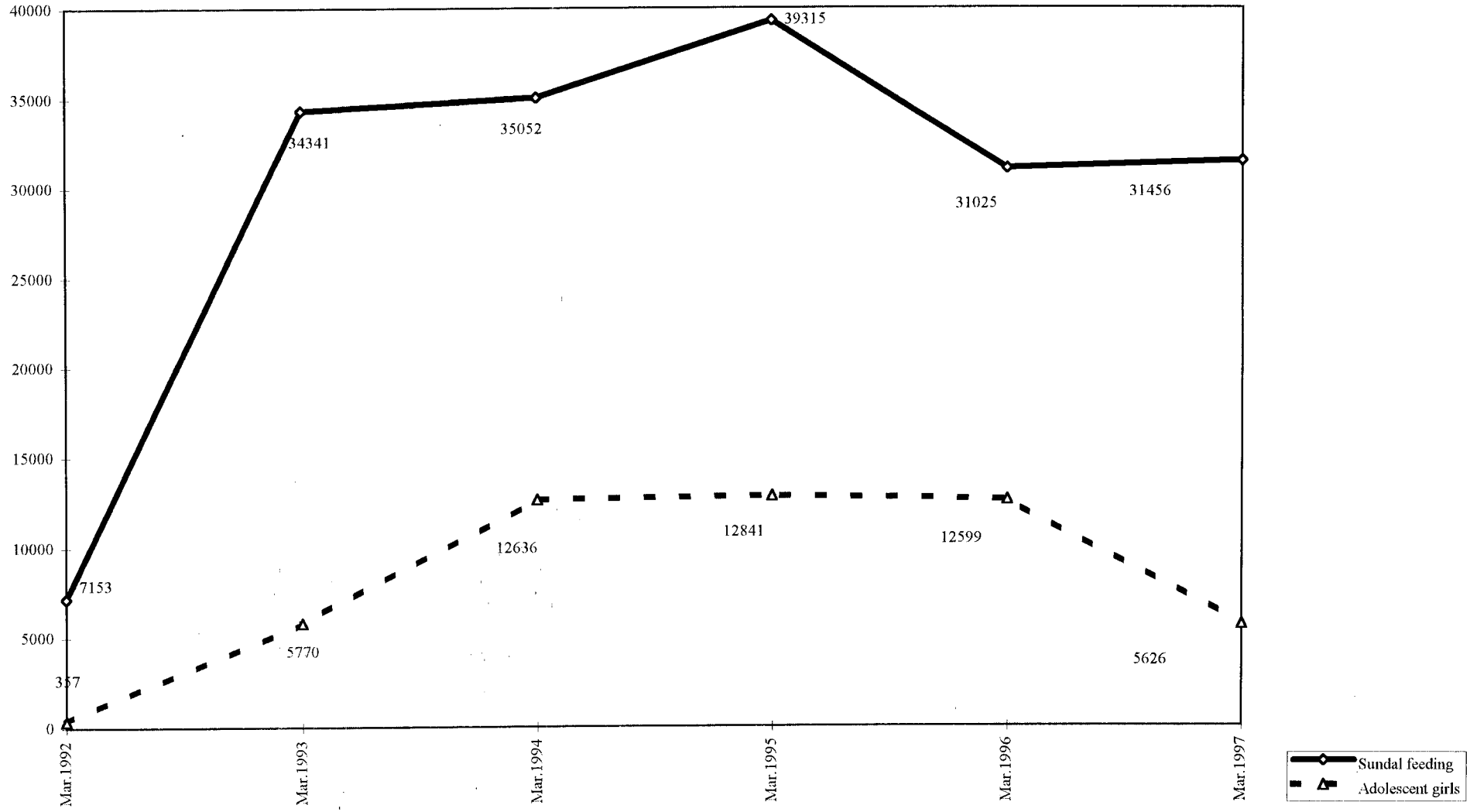
CHENGALPET - PHASE - I
Supplemental feeding (6-24 months)



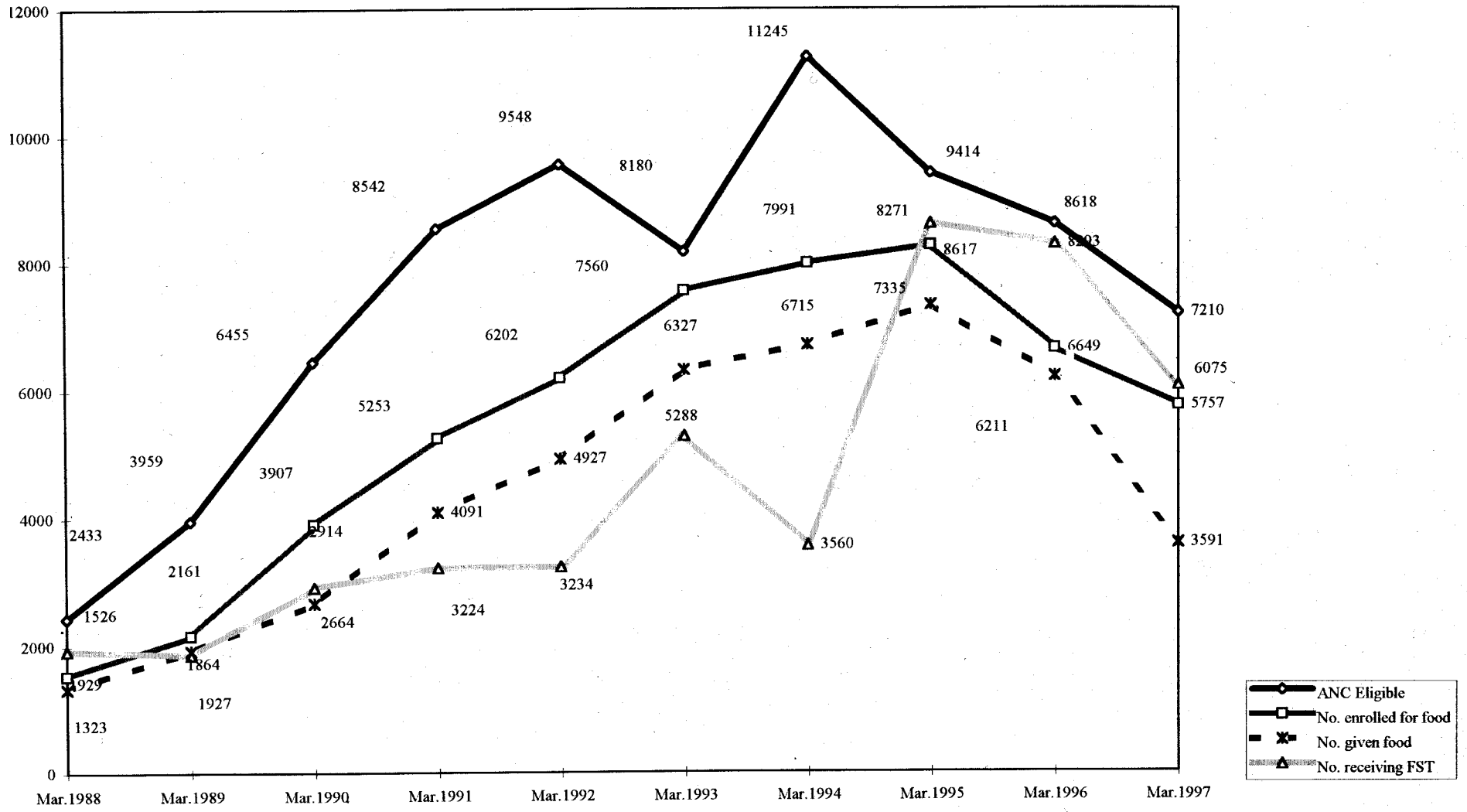
CHENGALPET - PHASE - I Districts
Noon meal enrolment and attendance (2-6 years)



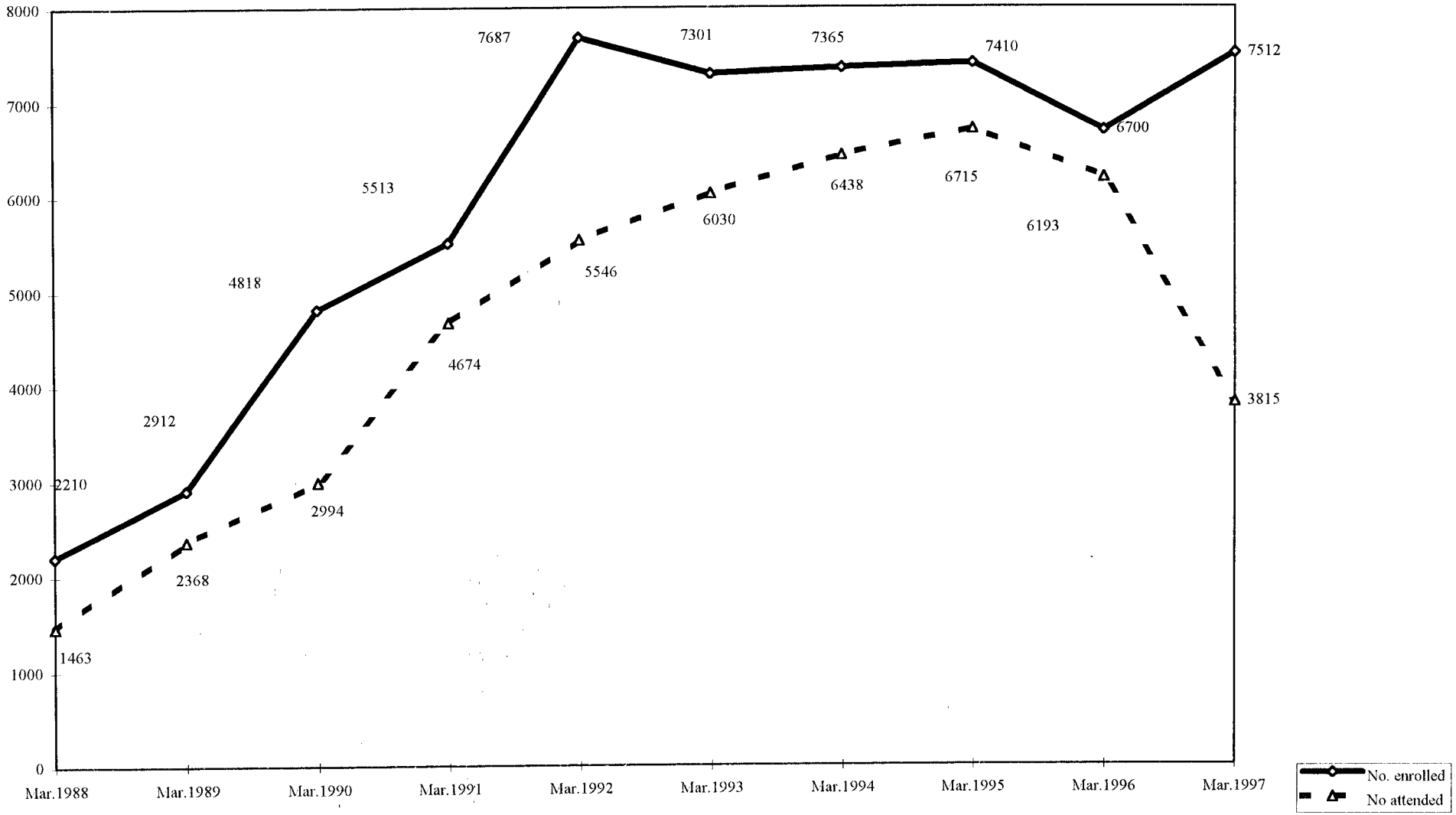
CHENGALPET - PHASE - I
Adolescent girls & sundal feeding



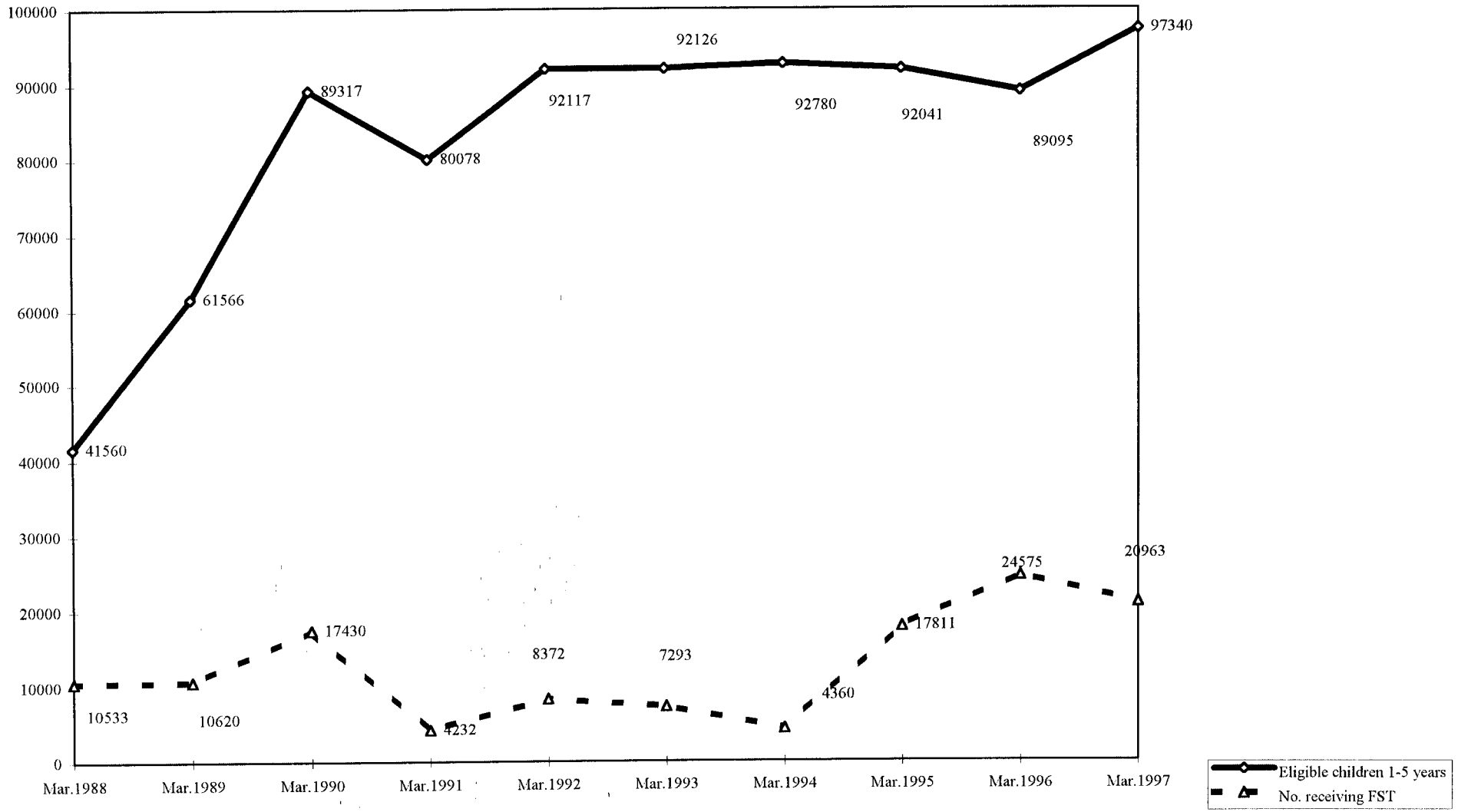
CHENGALPET - PHASE - I Districts
Nutritional supplementation, pregant women



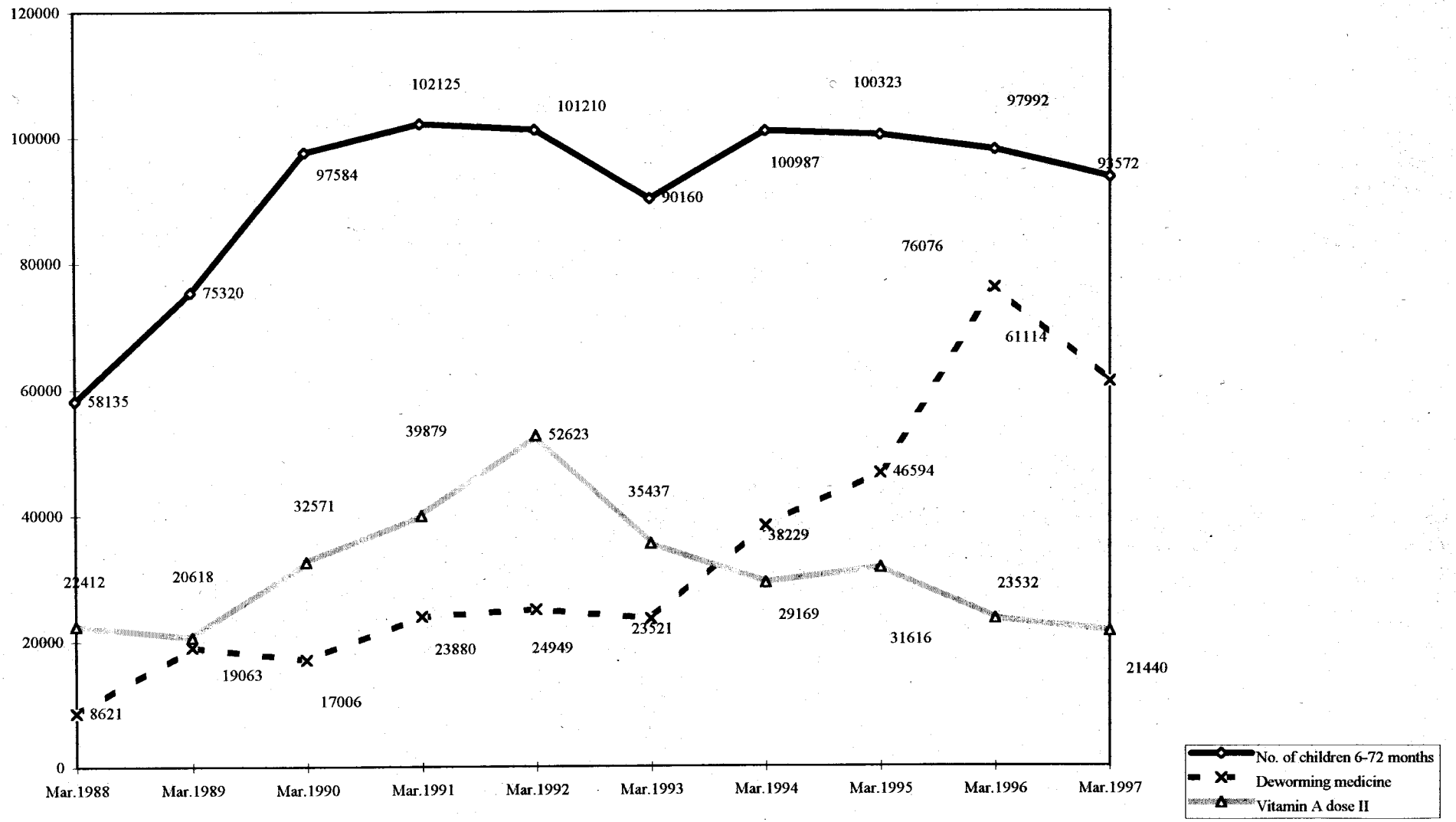
CHENGALPET - PHASE - I
Nutritional supplementation, lactating women



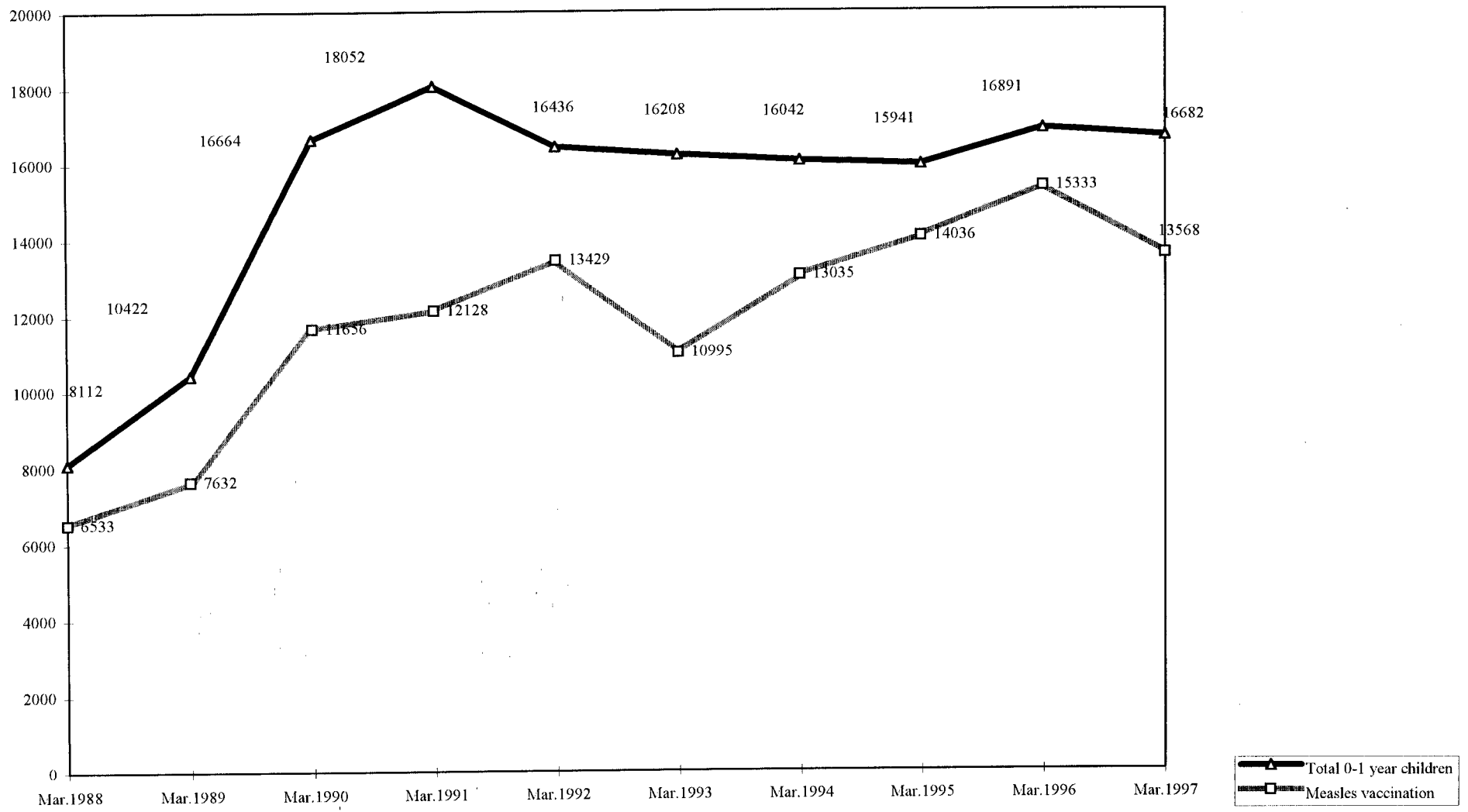
CHENGALPET - PHASE - I Districts
Provision for ferrous sulphpate tablets (FST) to children (1-5 years)



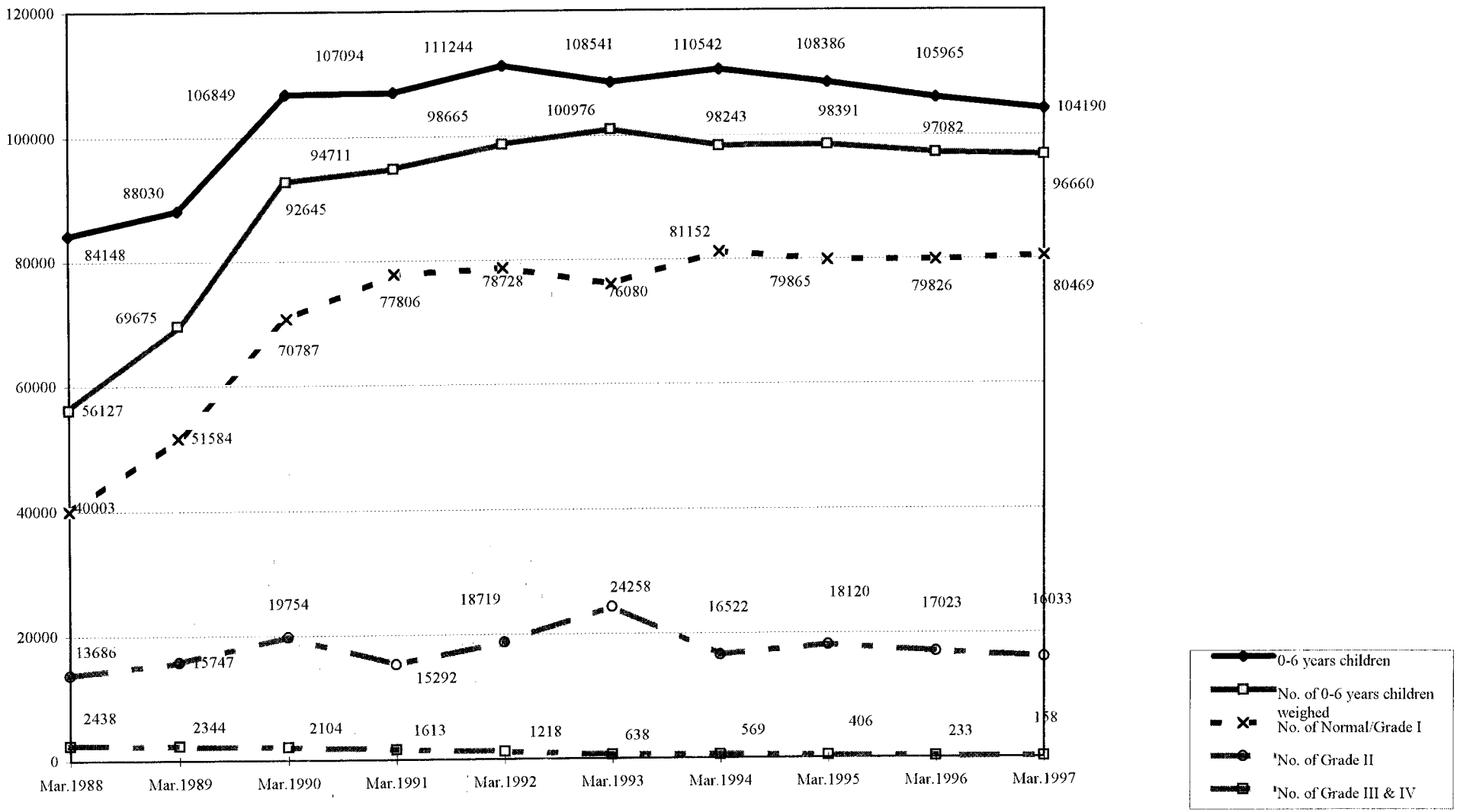
CHENGALPET - PHASE - I
Vitamin A & Deworming (6-72 months)



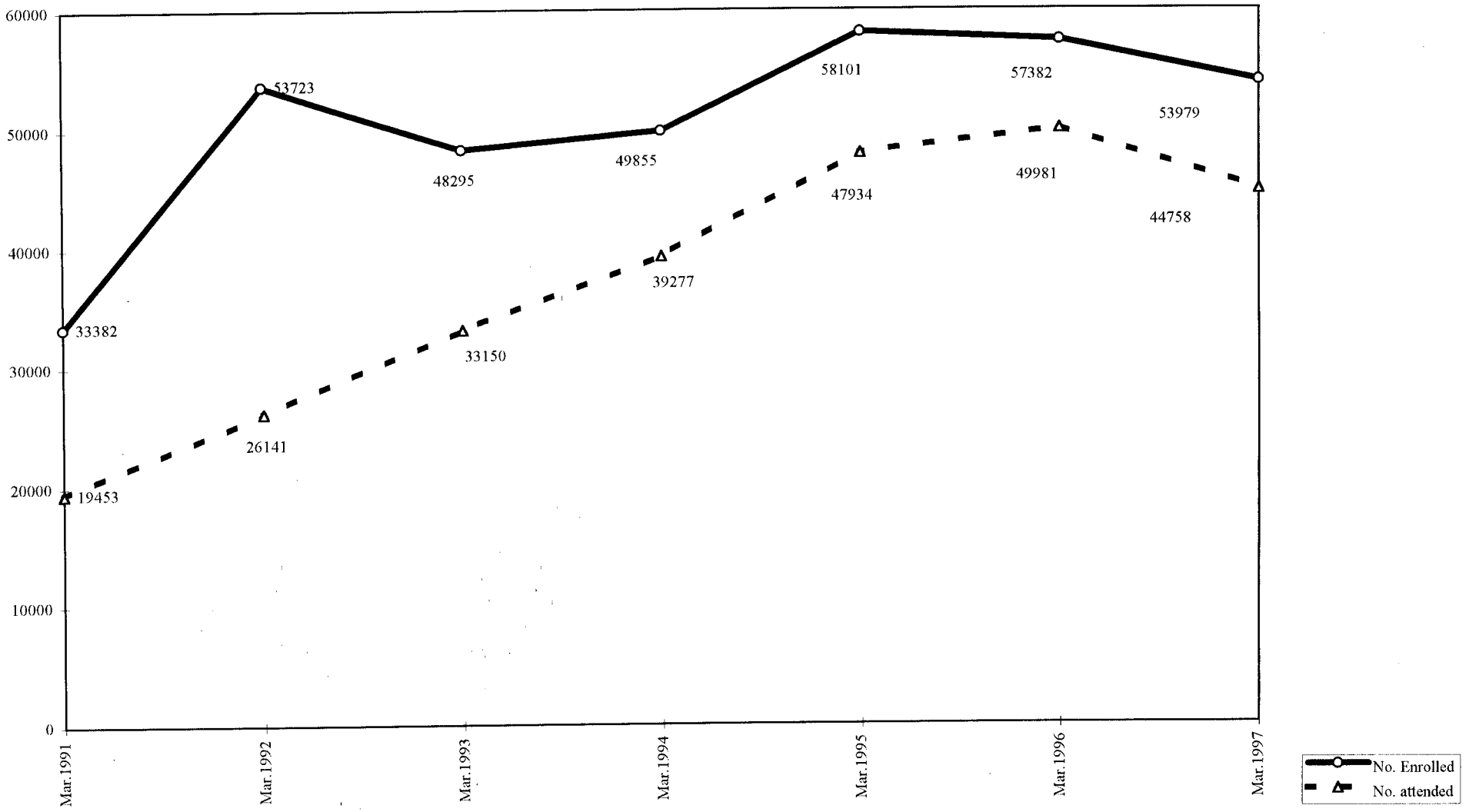
CHENGALPET - PHASE - I Districts
Total Children & Measles Vaccination (0-1 year)



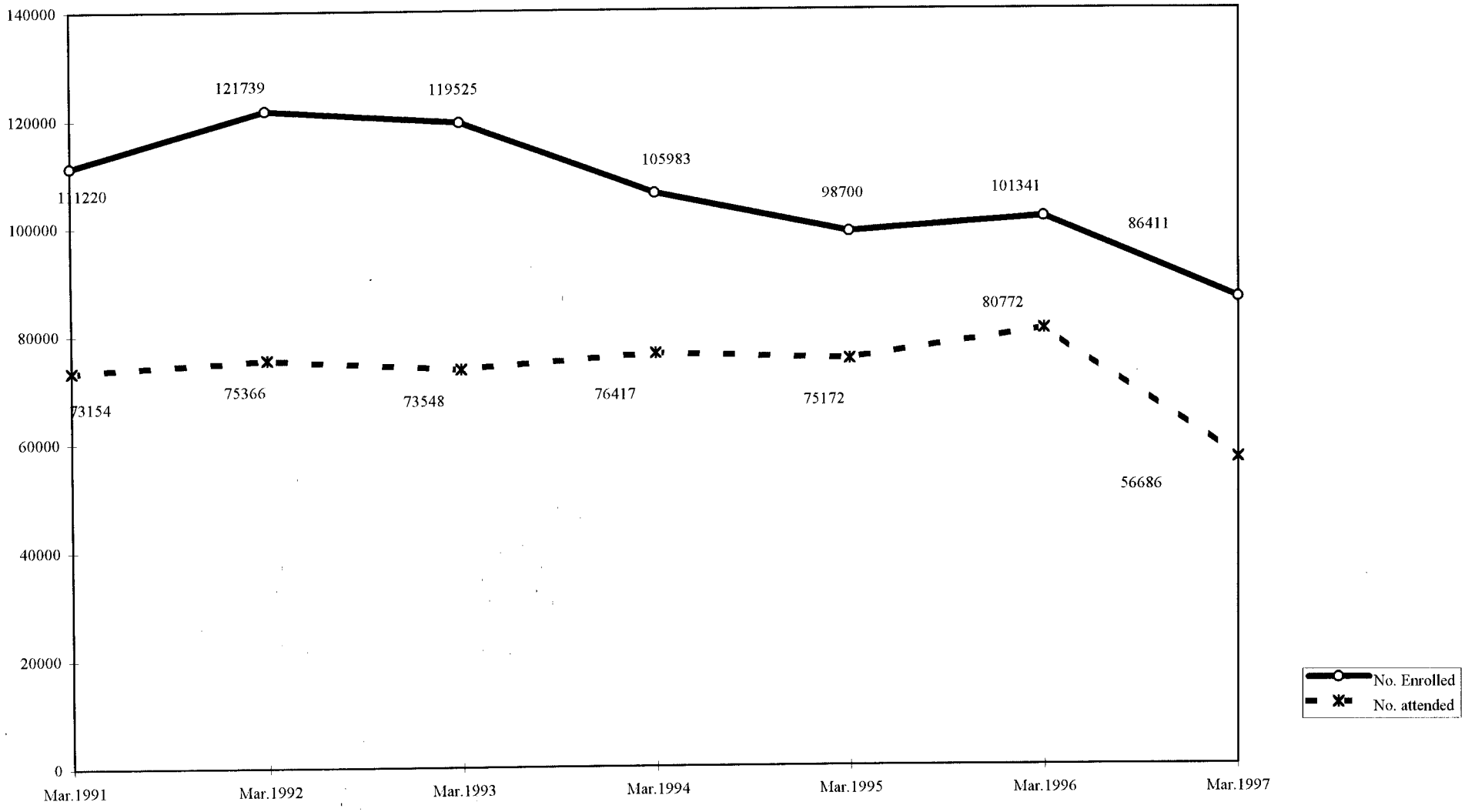
CHENGALPET - PHASE - I
Levels of malnutrition (0-6 years)



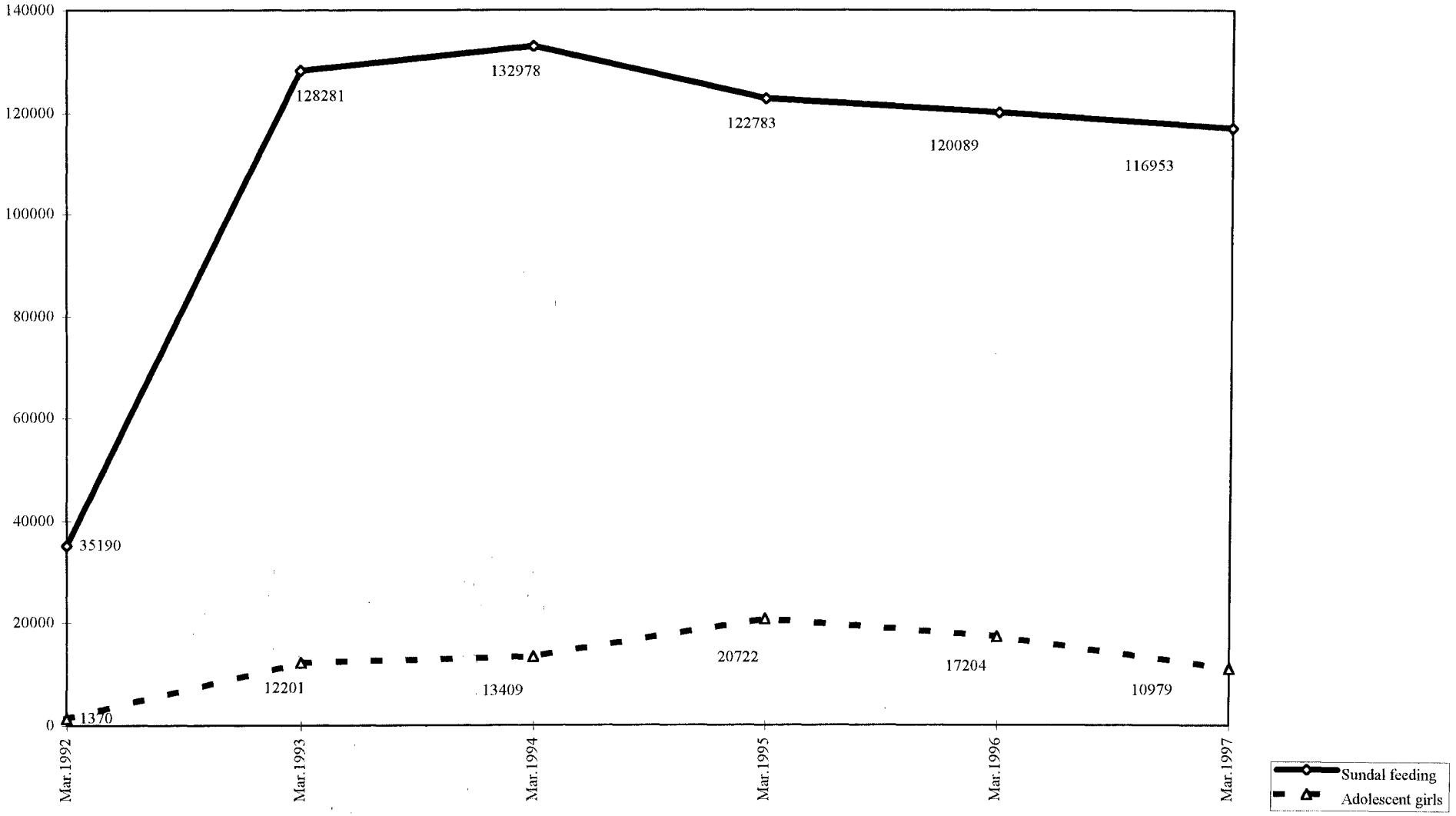
CHENGALPET - PHASE II
Supplemental feeding (6-24 months)



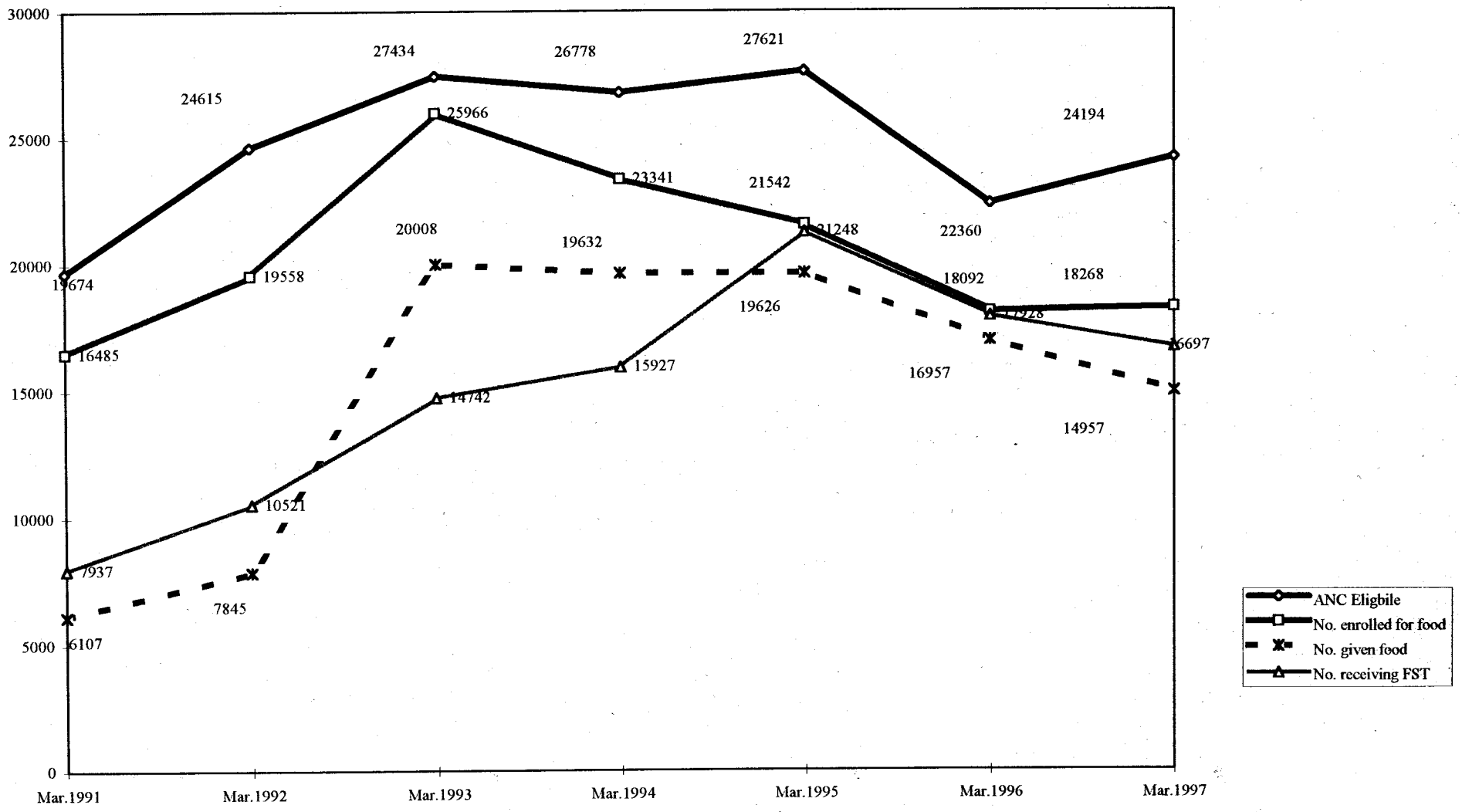
CHENGALPET - PHASE II Districts
Noon meal enrolment and attendance (2-6 years)



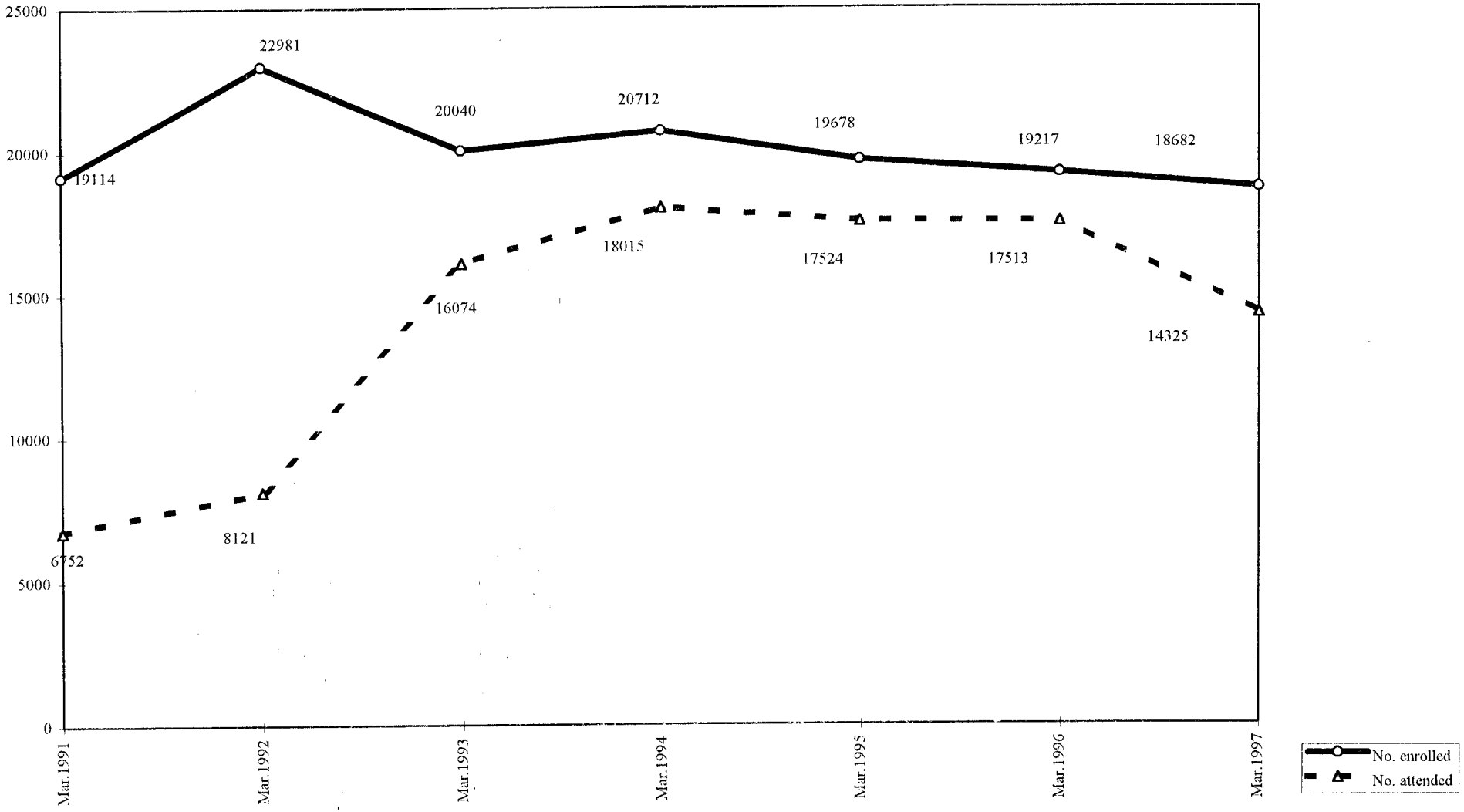
CHENGALPET - PHASE - II
Adolescent girls & sundal feeding



CHENGALPET - PHASE II Districts
Nutritional Supplementation, pregnant women

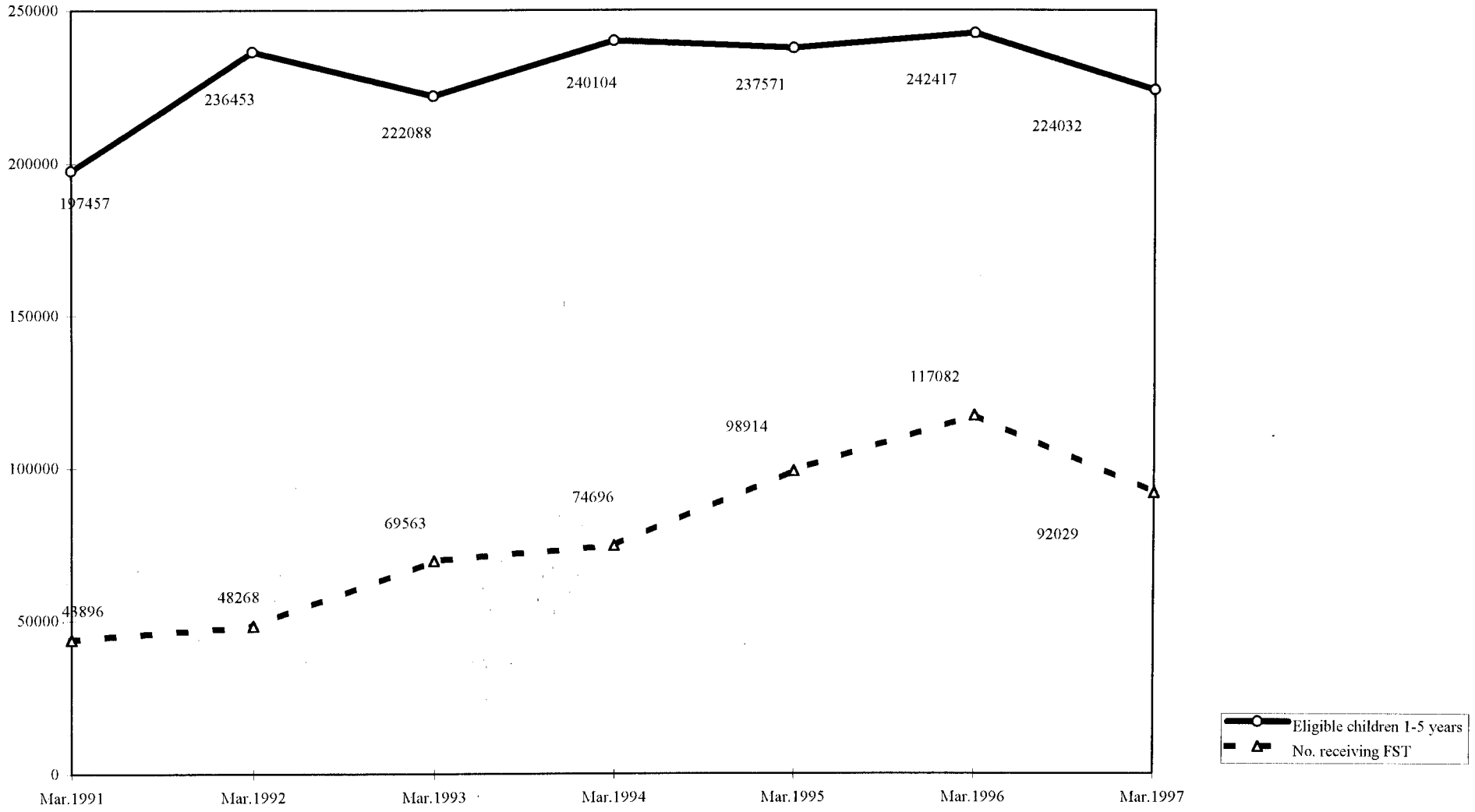


CHENGALPET - PHASE II
Nutritional Supplementation, lactating women

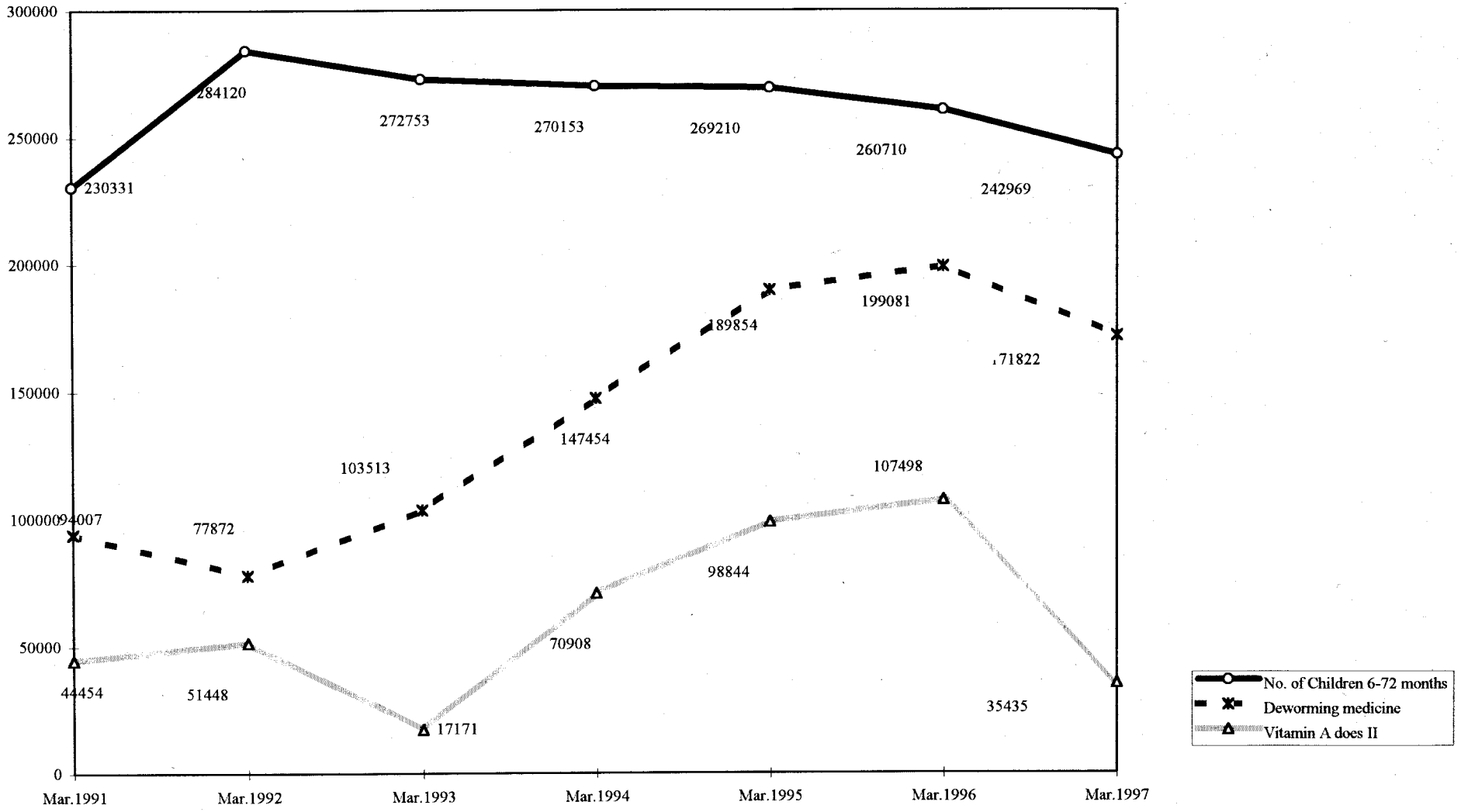


CHENGALPET - PHASE II

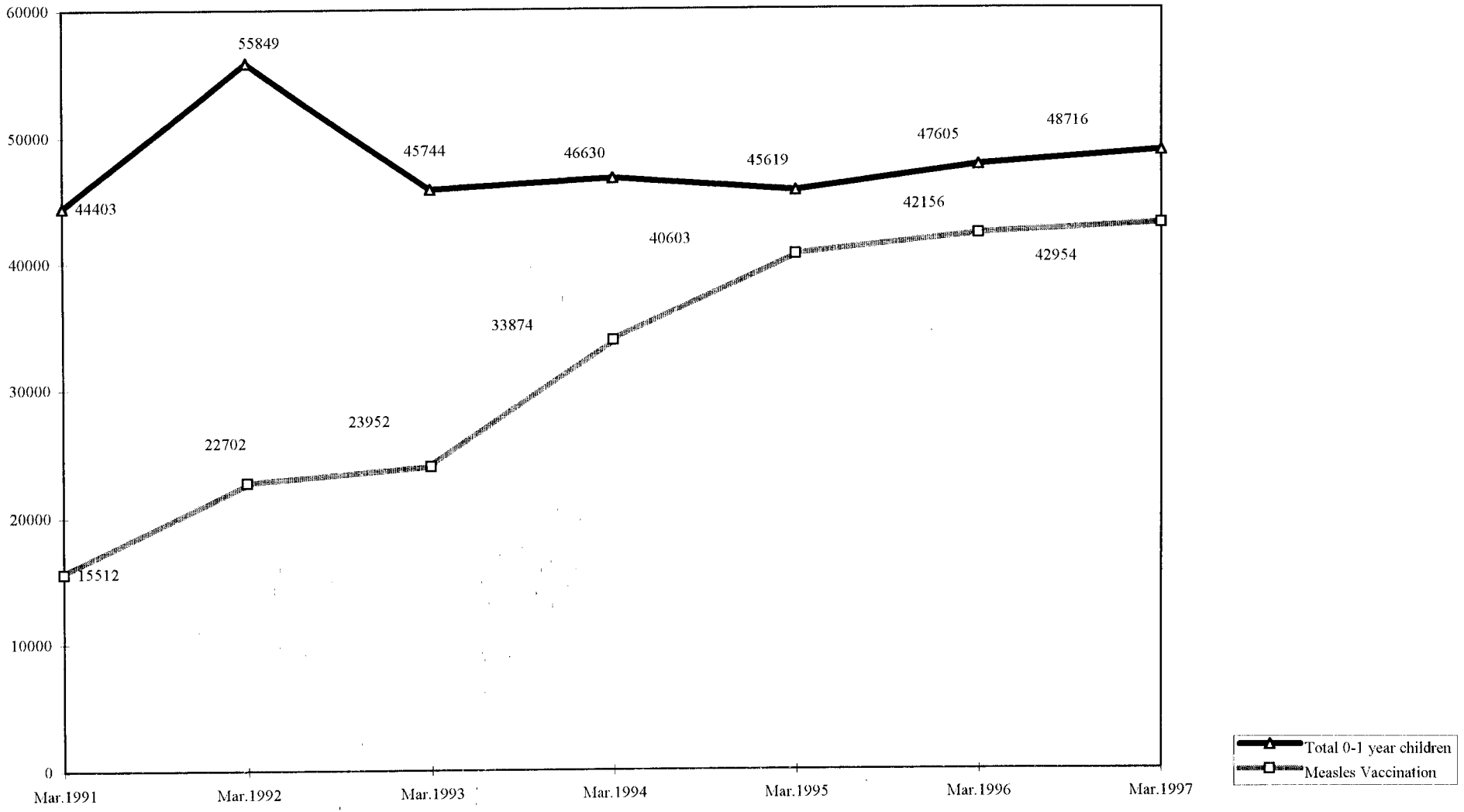
Provision of ferrous sulphpate tablets (FST) to children (1-5 years)



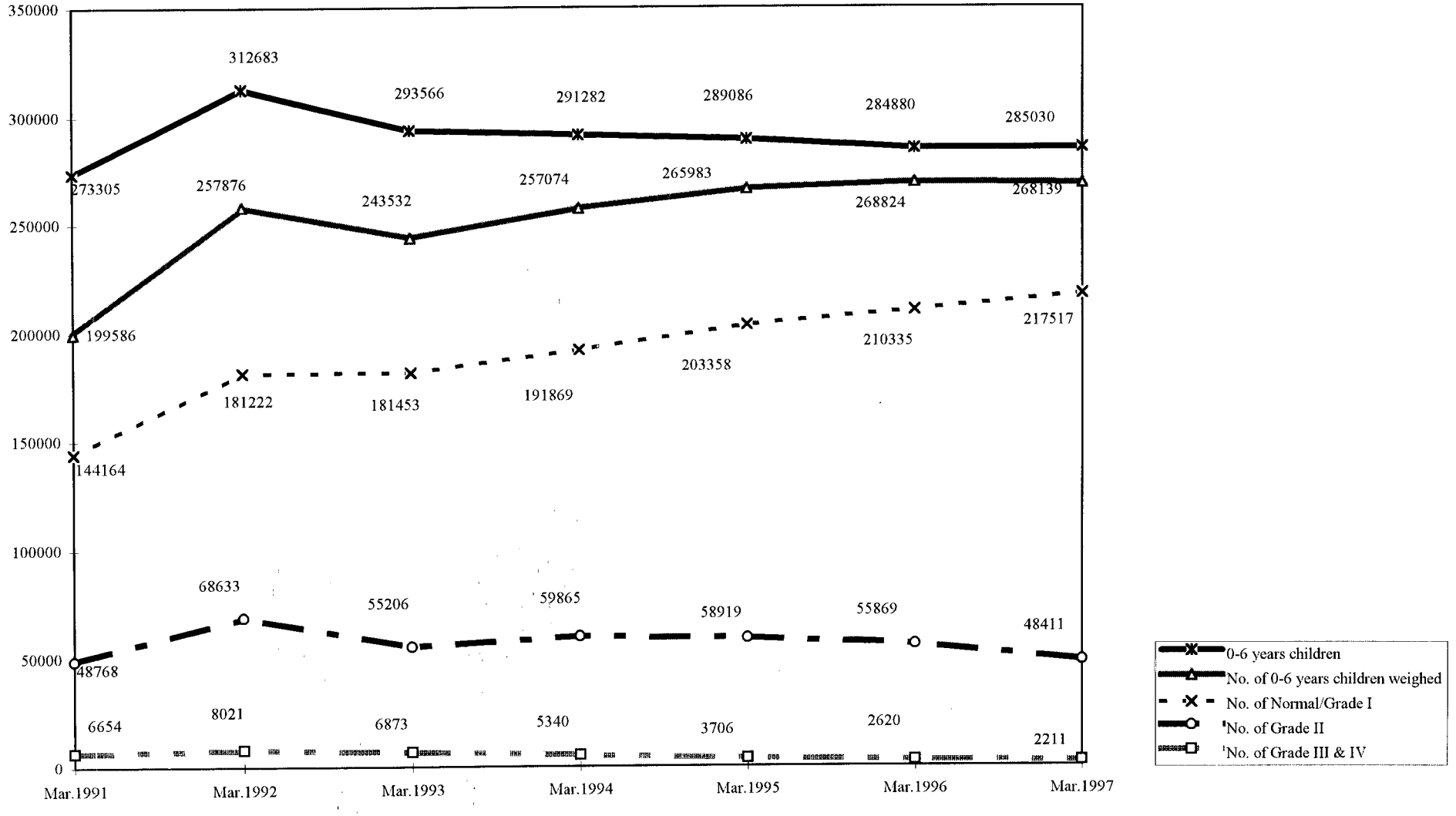
CHENGALPET - PHASE II
Vitamin A & Deworming (6-72 months)



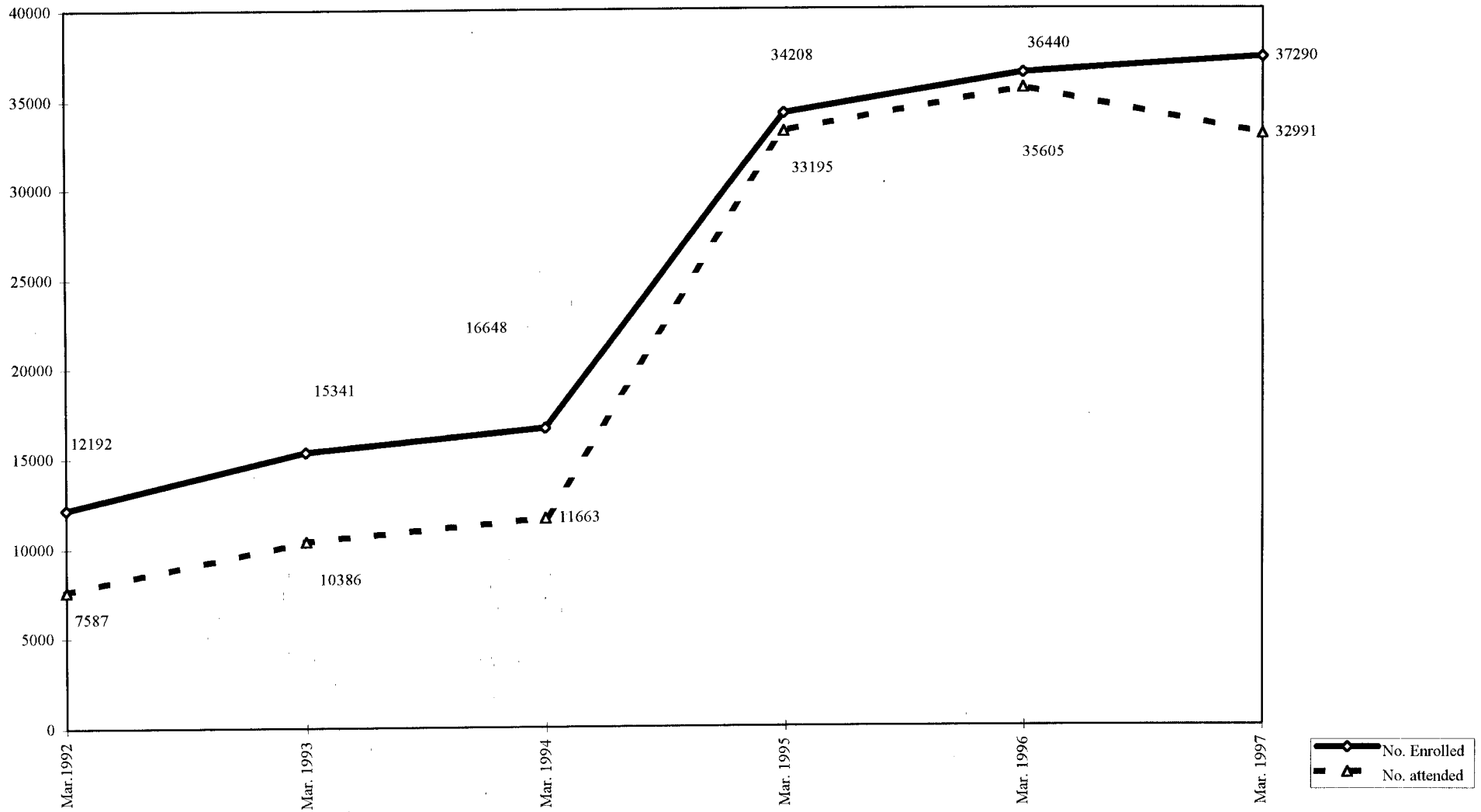
CHENGALPET - PHASE II Districts
Total Children & Measles Vaccination (0-1 year)



CHENGALPET - PHASE II
Levels of malnutrition (0-6 years)

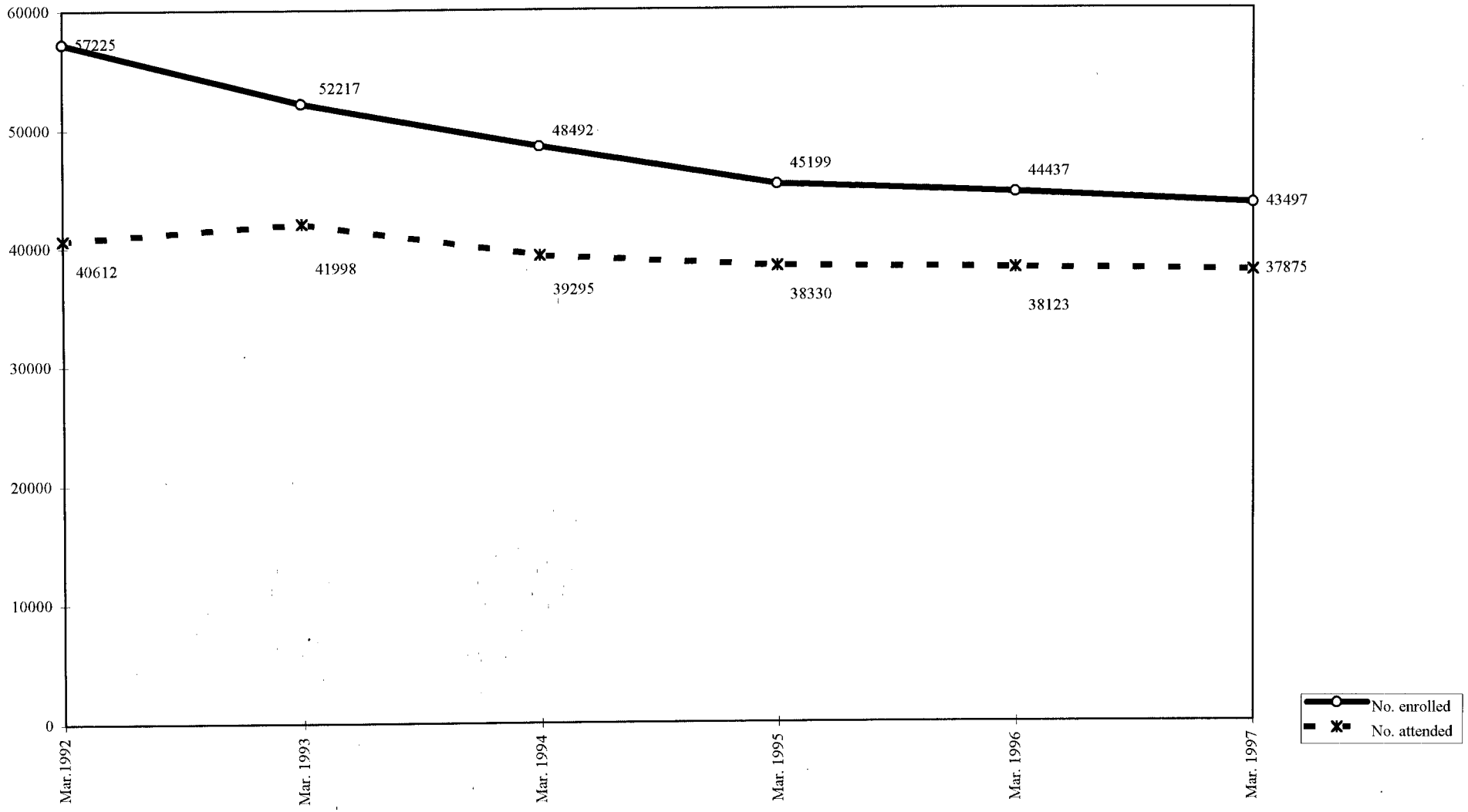


PUDUKKOTTAI
Supplemental feeding (6-24 months)



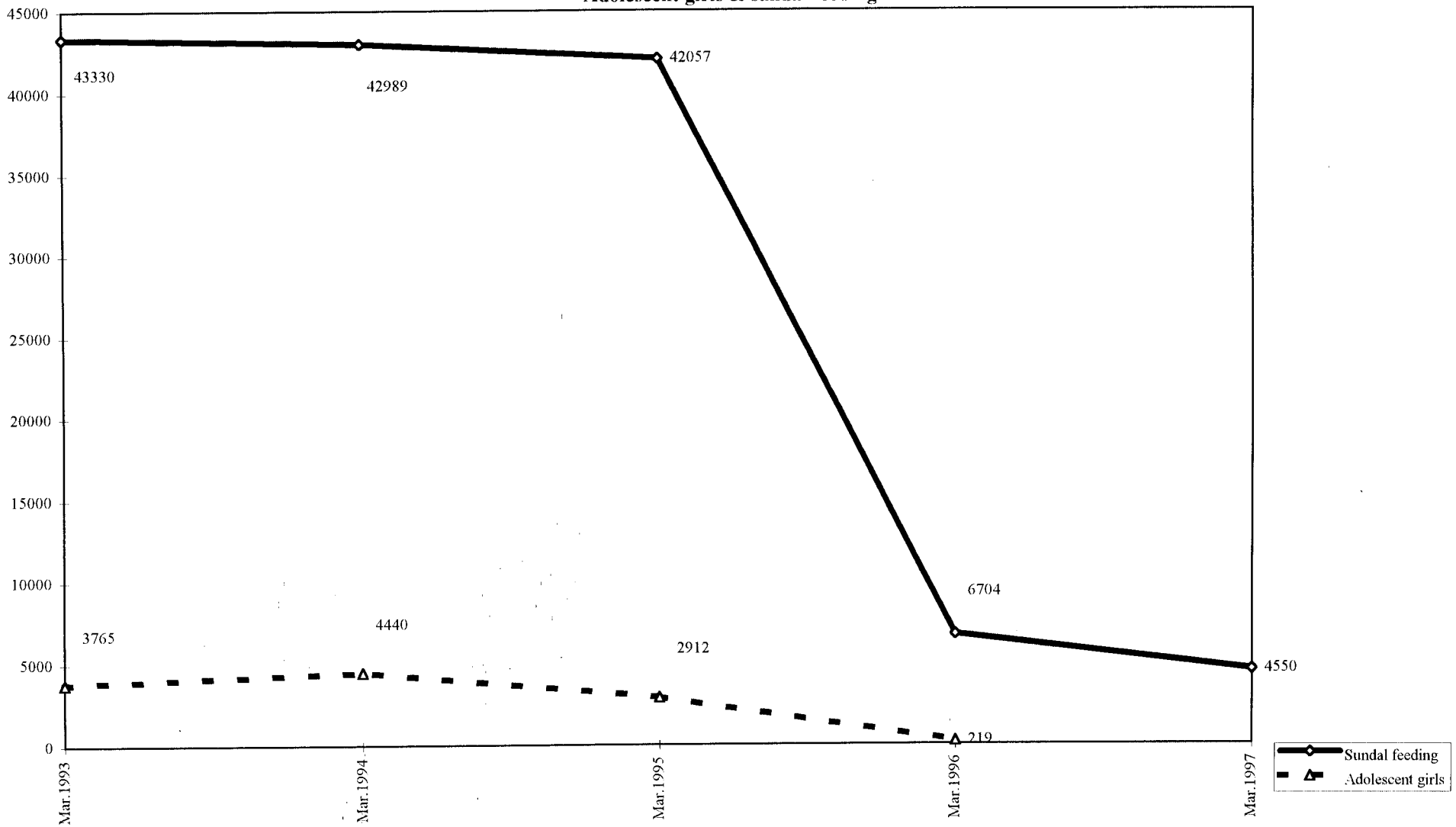
PUDUKKOTTAI

Noon meal enrolment and attendance (2-6 years)



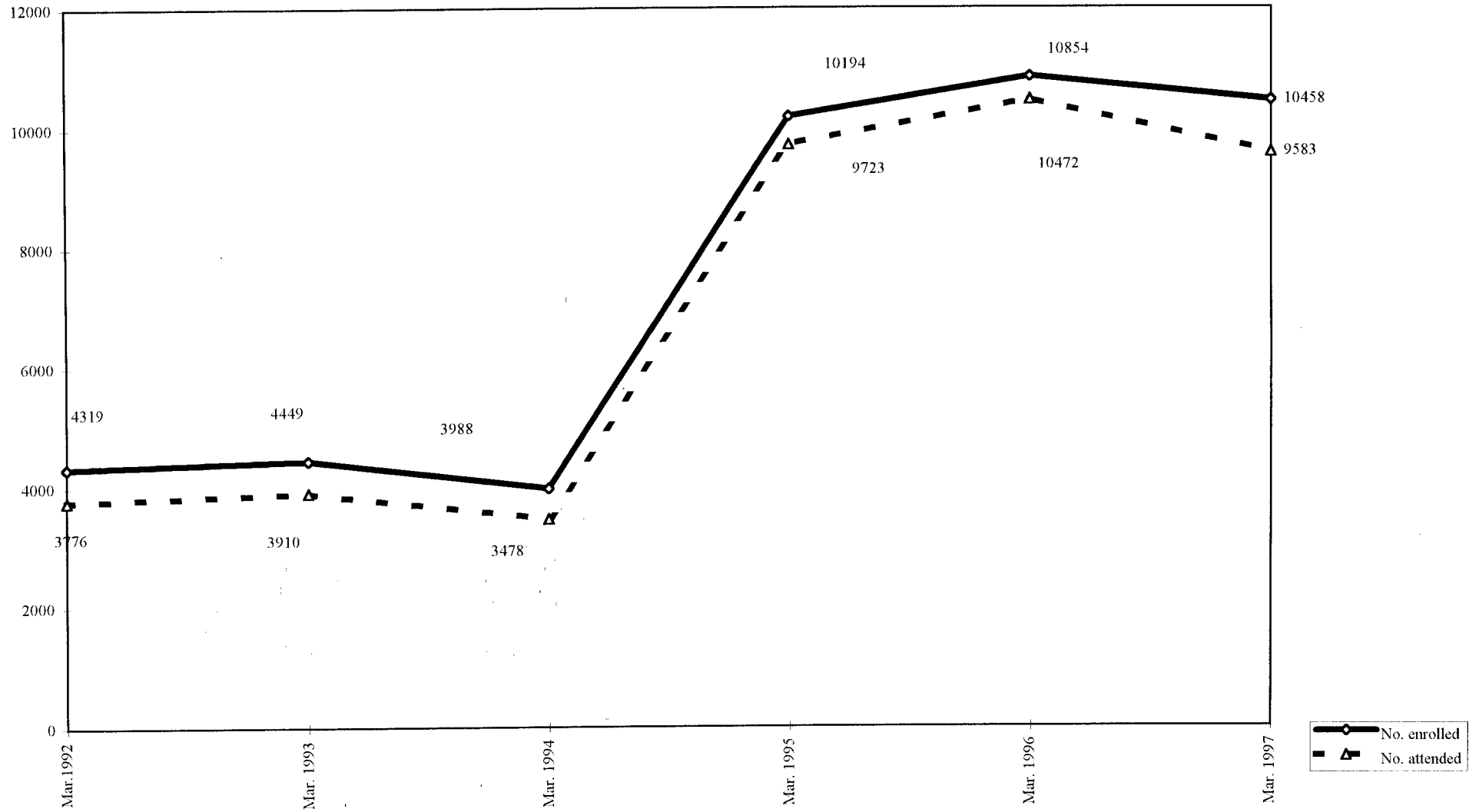
PUDUKKOTTAI

Adolescent girls & sundal feeding



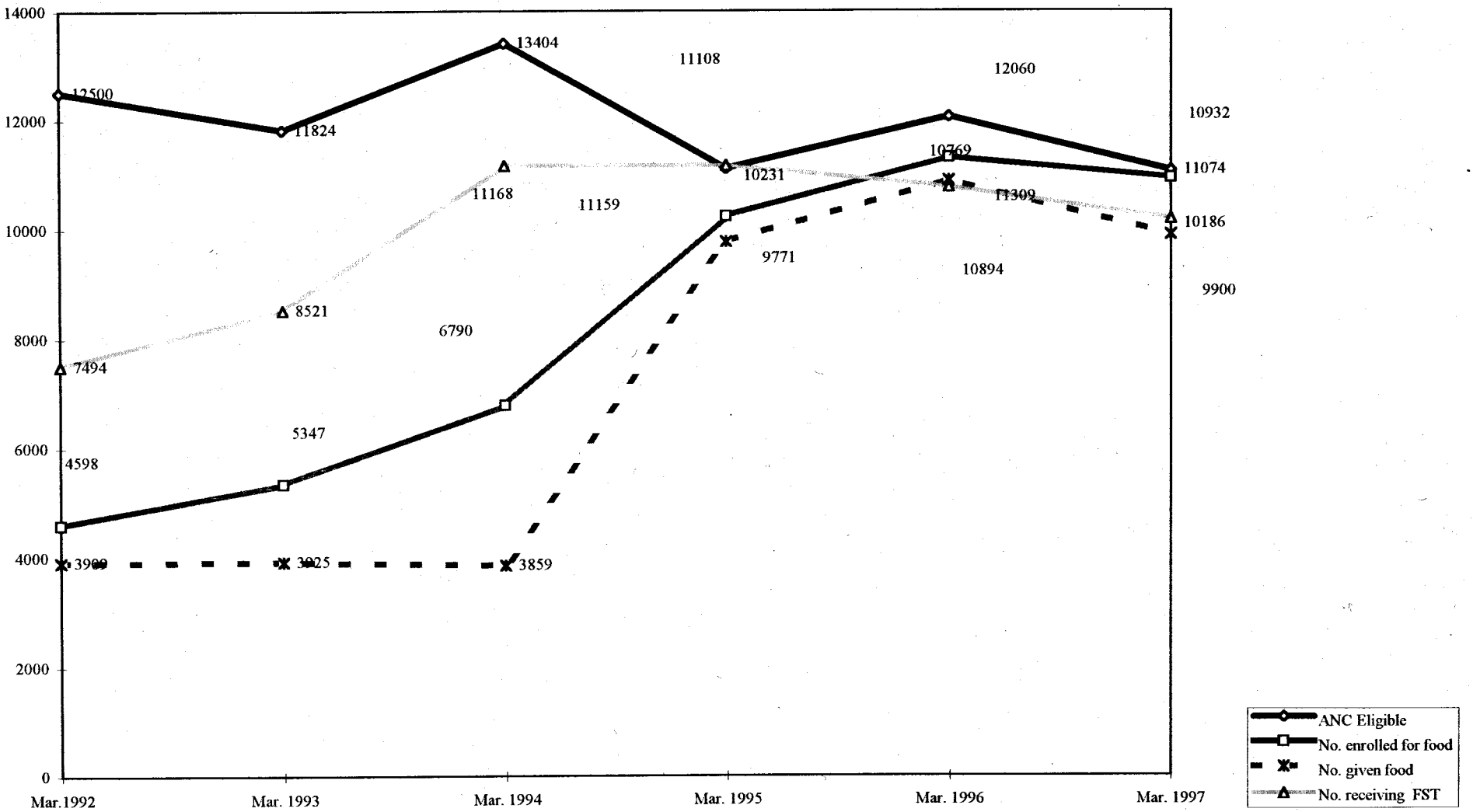
PUDUKKOTTAI

Nutritional supplementation, lactating women



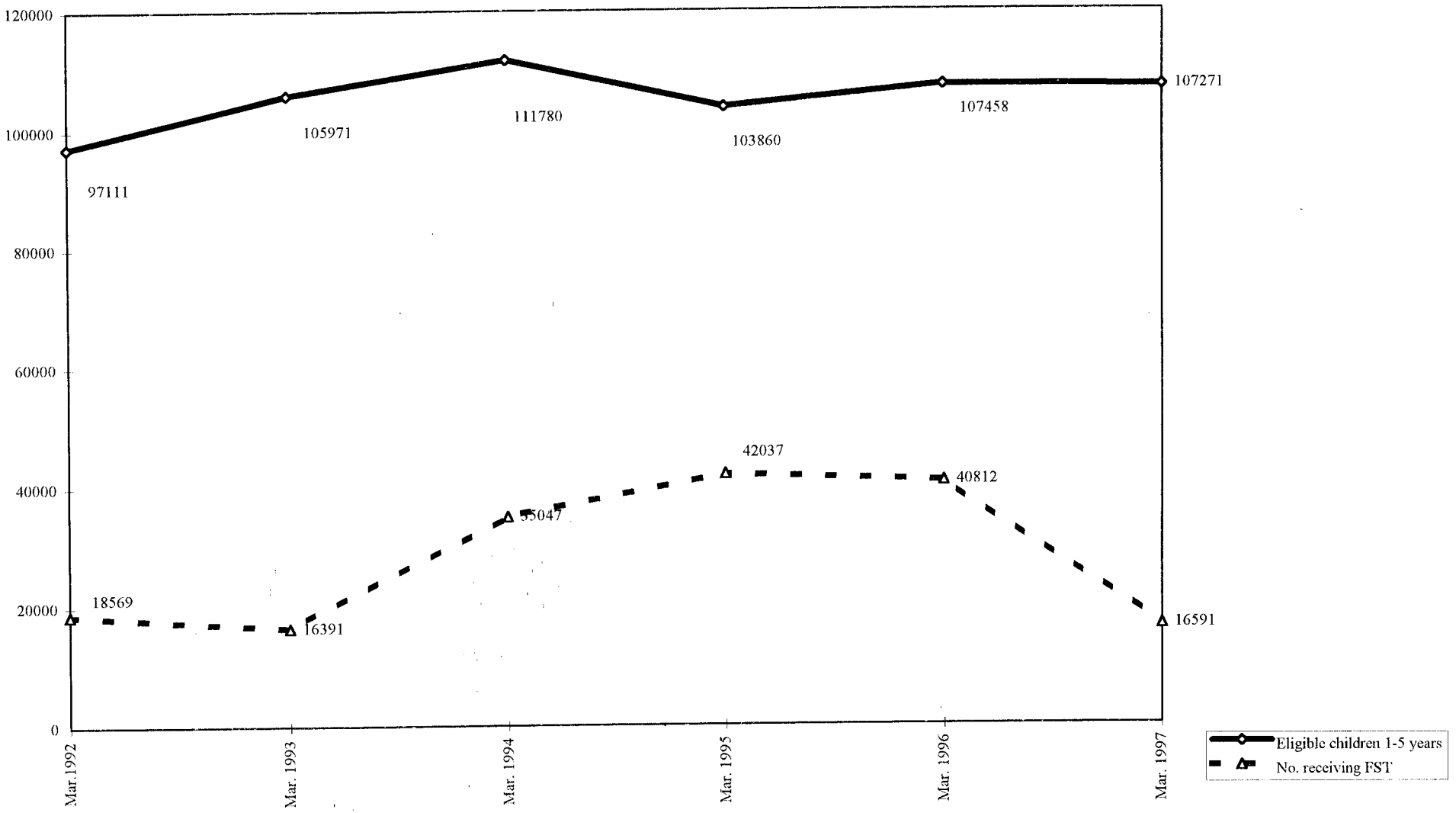
PUDUKKOTTAI

Nutritional supplementation, pregant women



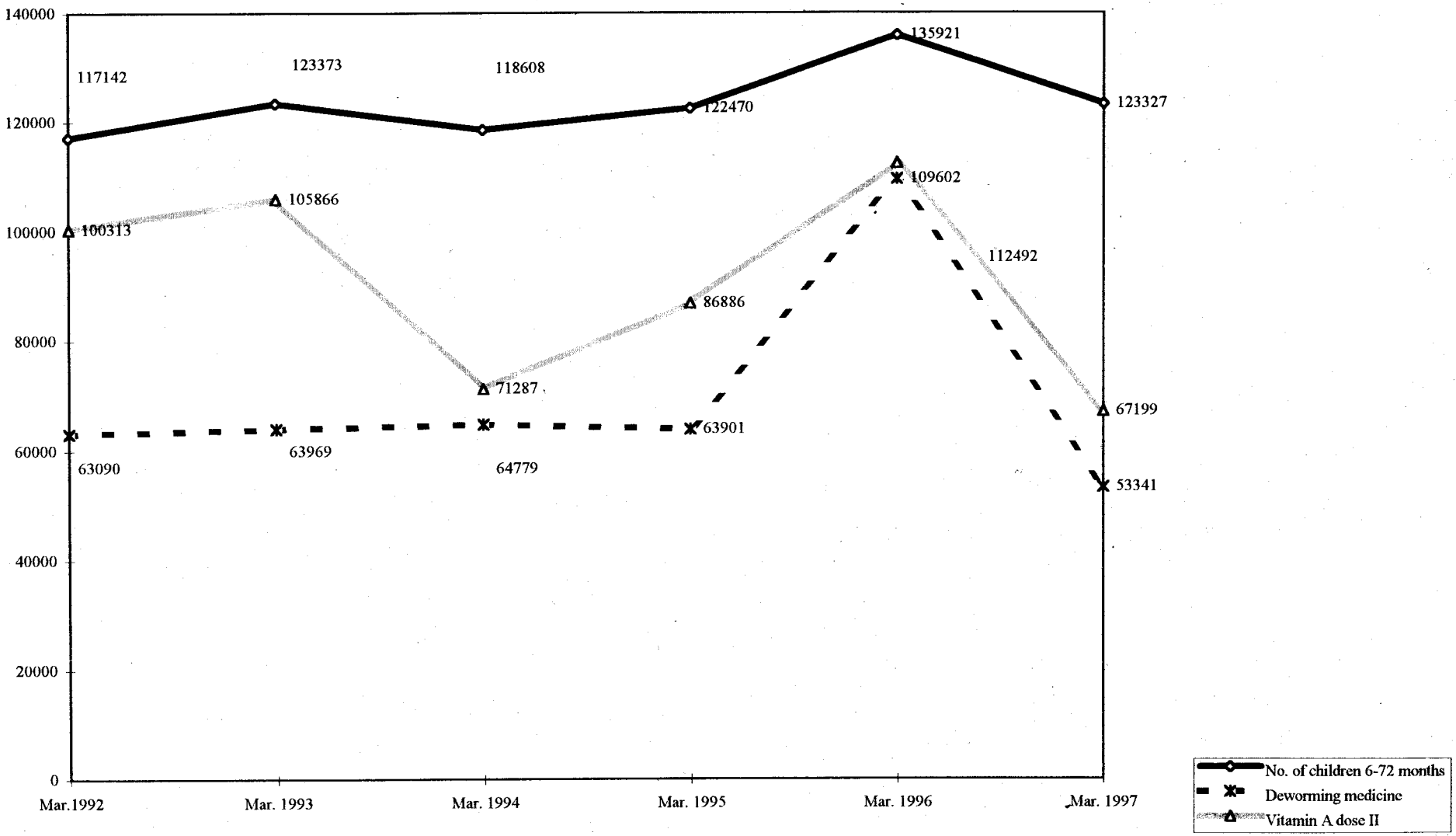
PUDUKKOTTAI

Provision of ferrous sulphate tablets (FST) to children (1-5 years)



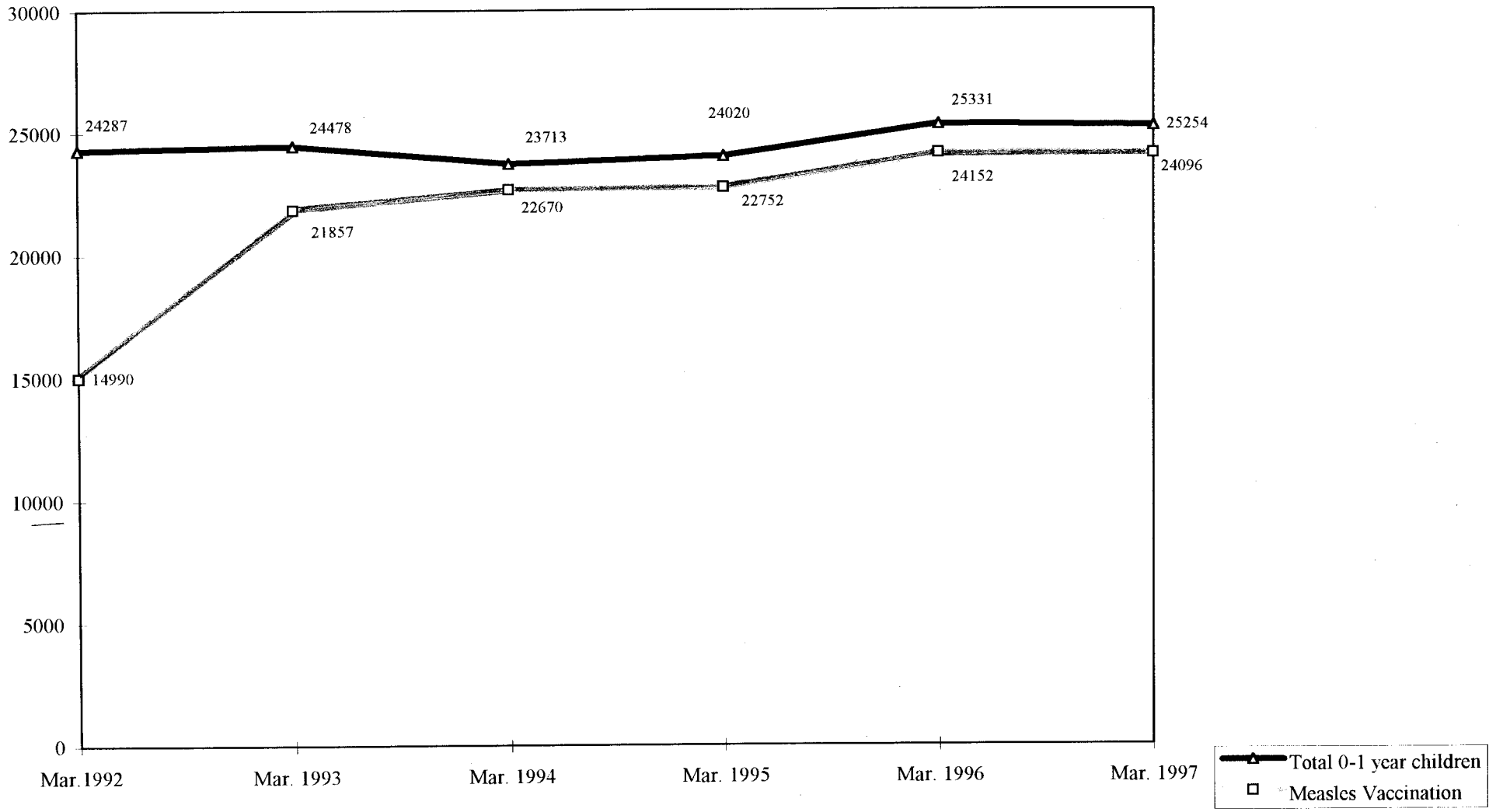
PUDUKKOTTAI

Vitamin A & Deworming (6-72 months)



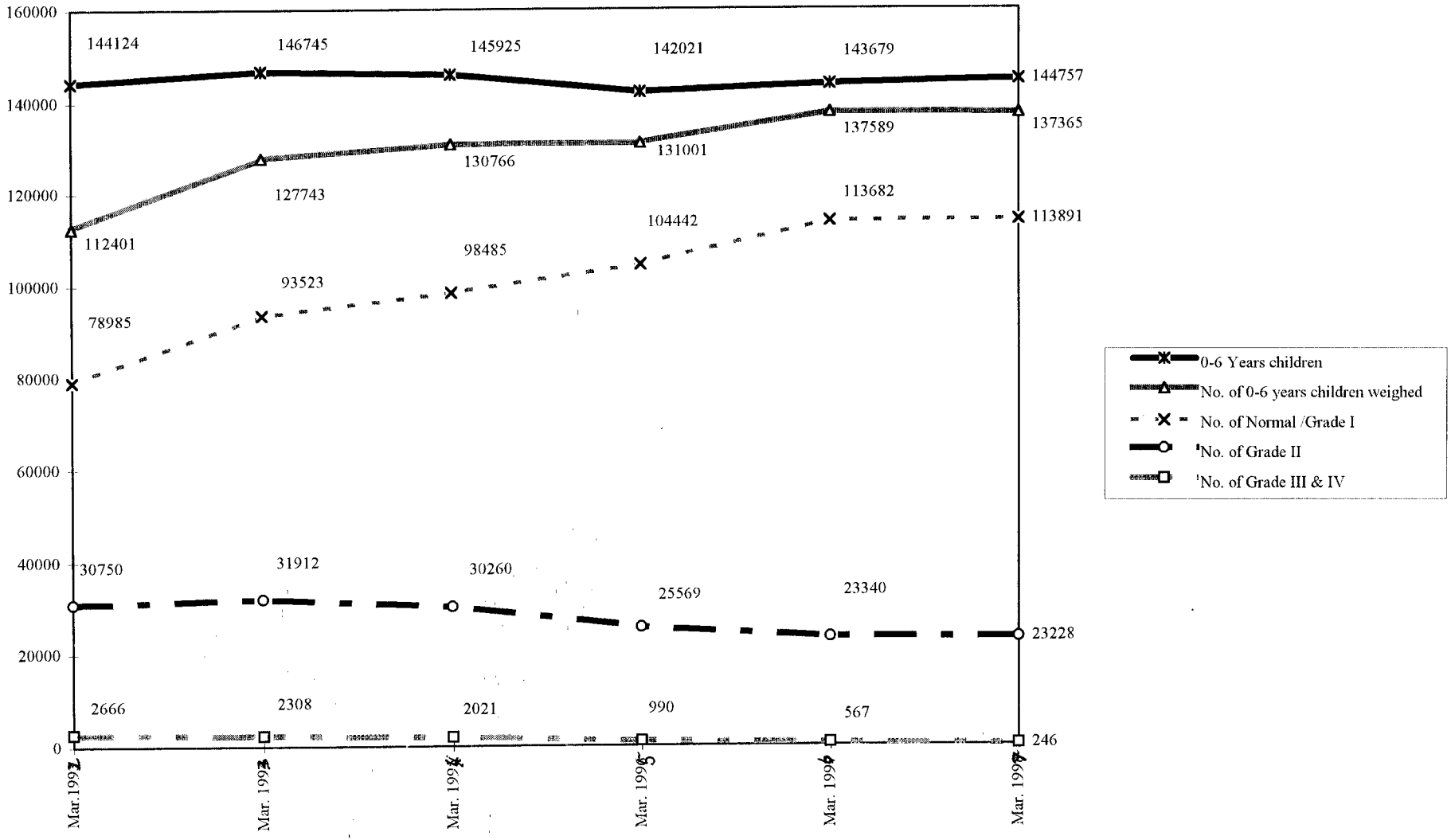
PUDUKKOTTAI

Total Children & Measles Vaccination (0-1 year)

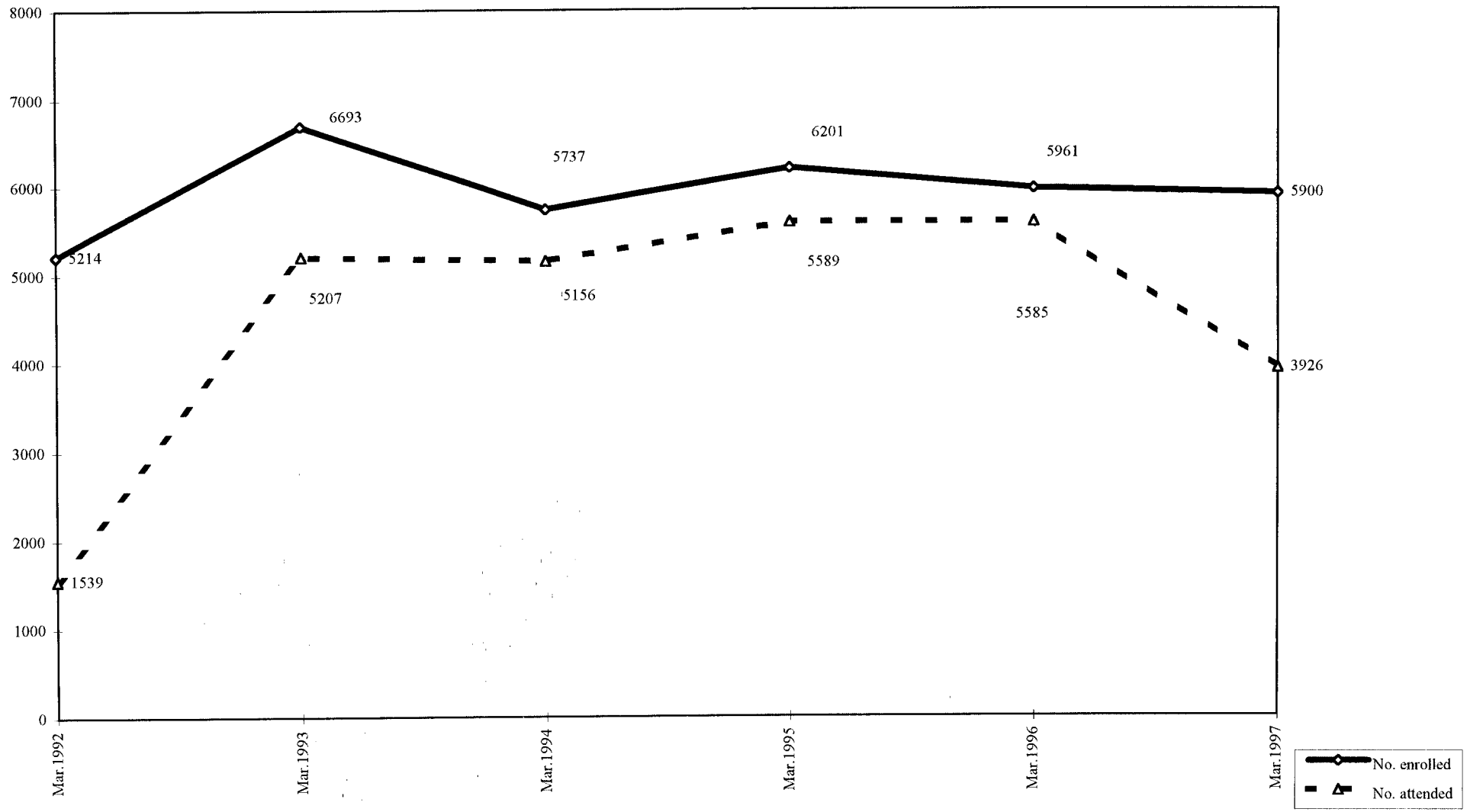


PUDUKKOTTAI

Levels of malnutrition (0-6 years)

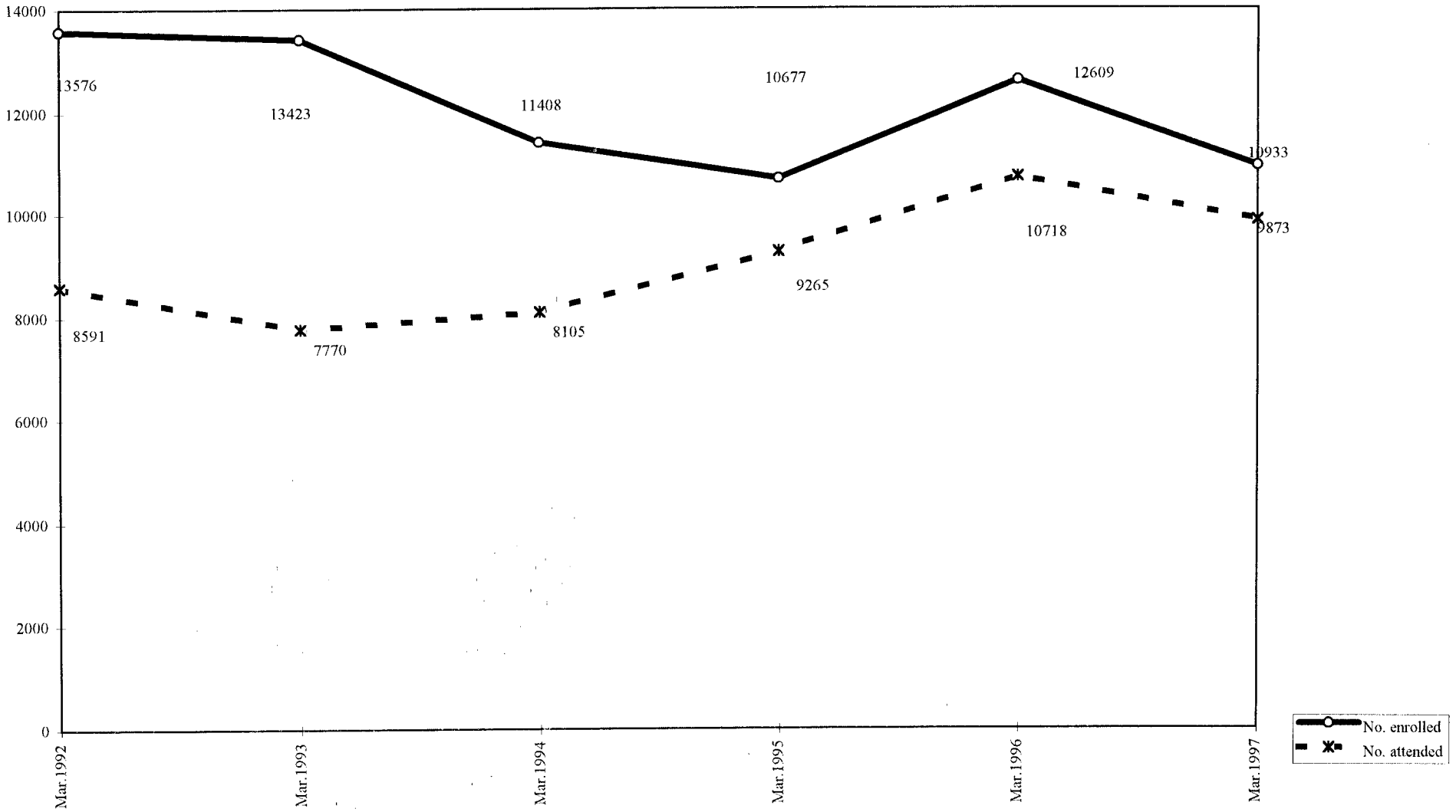


NILGIRIS
Supplemntal feeding (6-24 months)



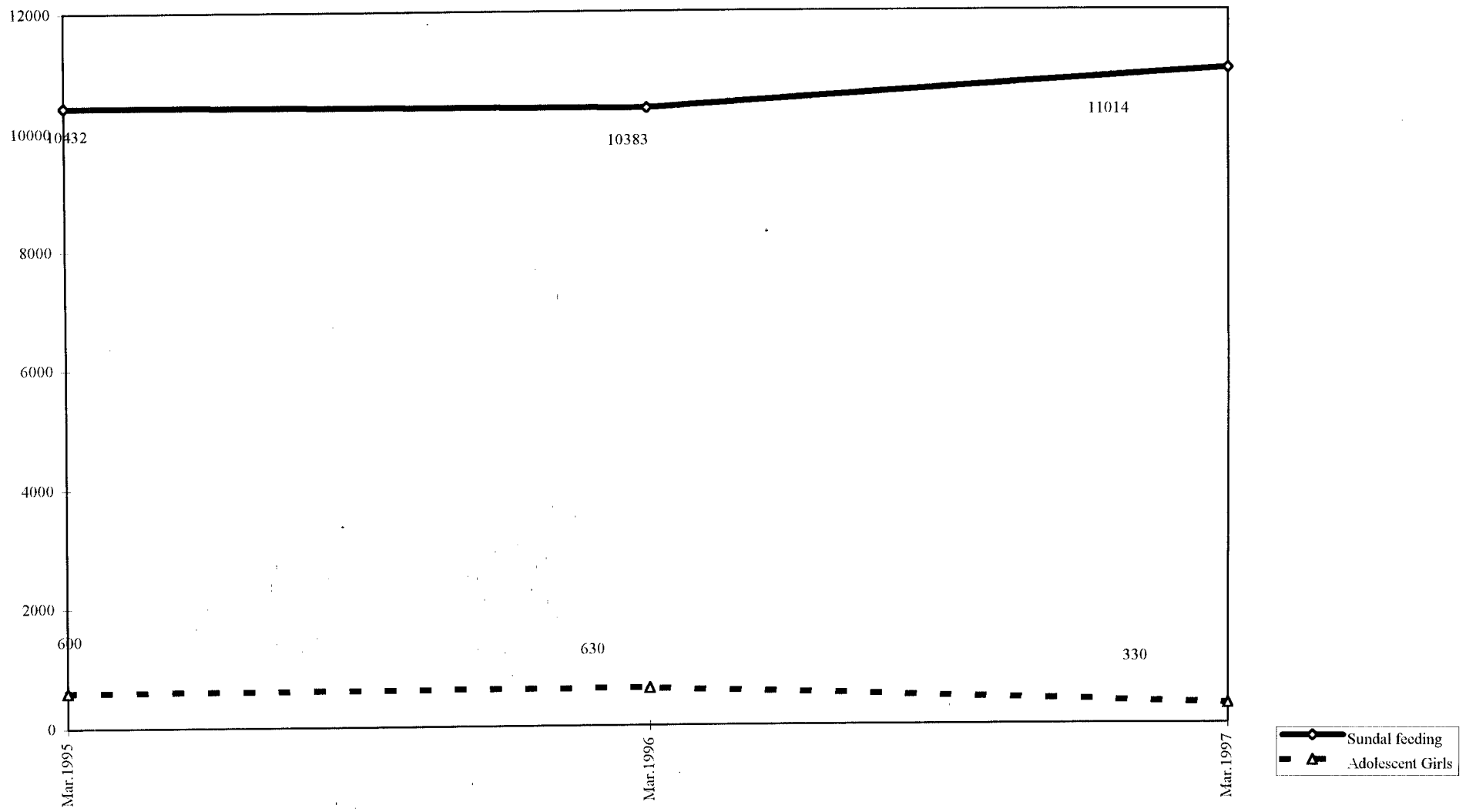
NILGIRIS

Noon meal enrolment and attenance (2-6 year)



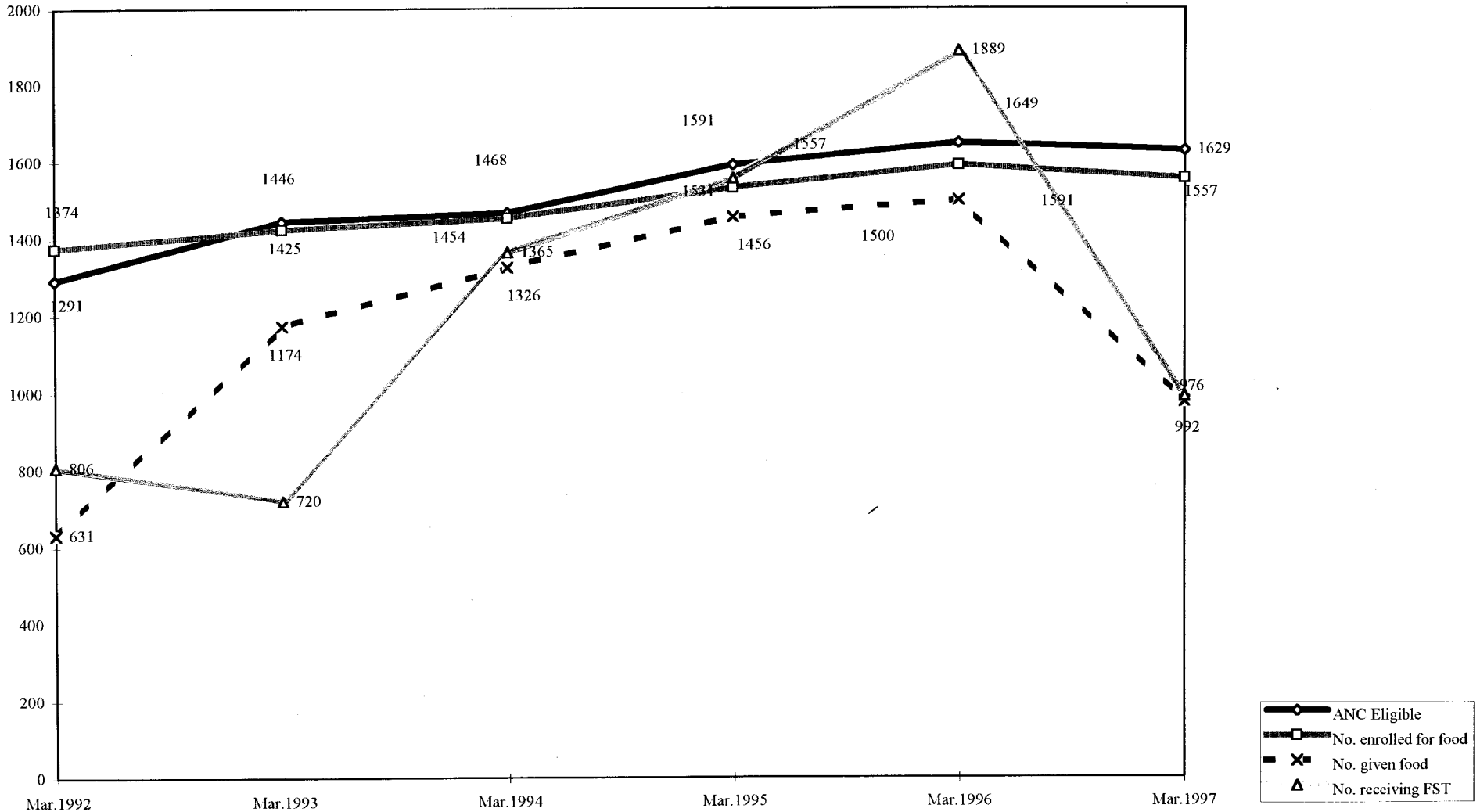
NILGIRIS

Adolescent girls & sundal feeding



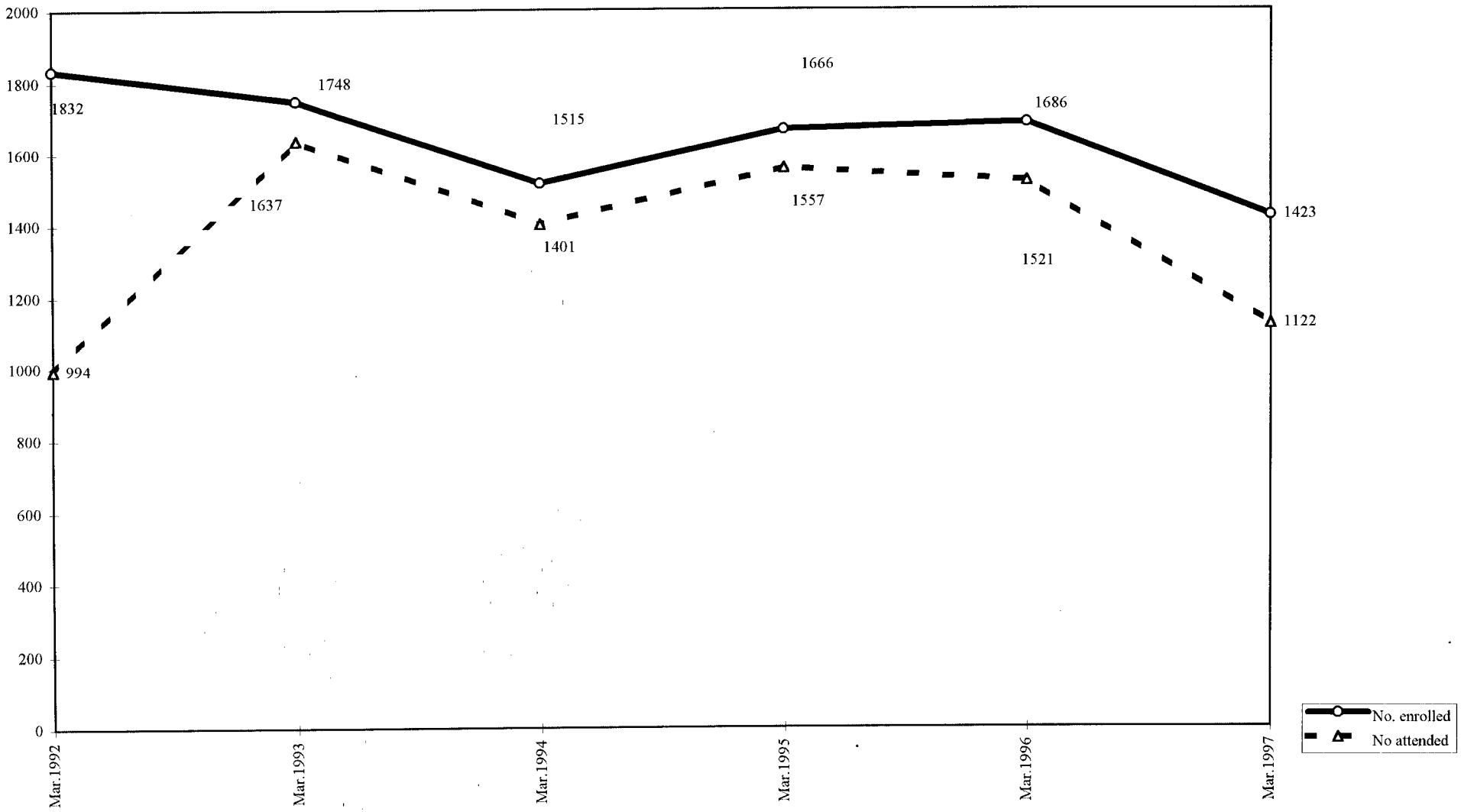
NILGIRIS

Nutritional supplementation, pregnant women



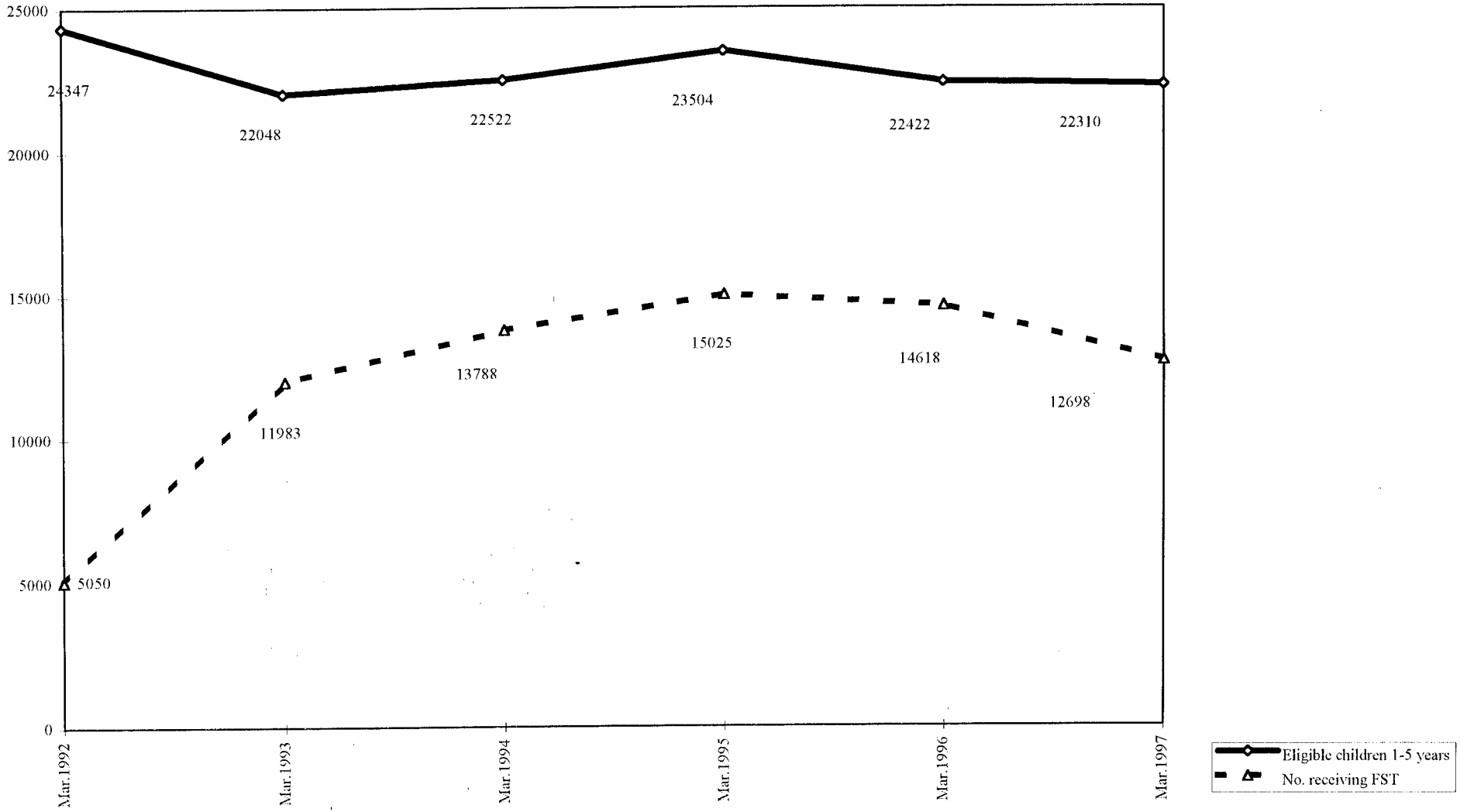
NILGIRIS

Nutritional Supplementation, lactating women



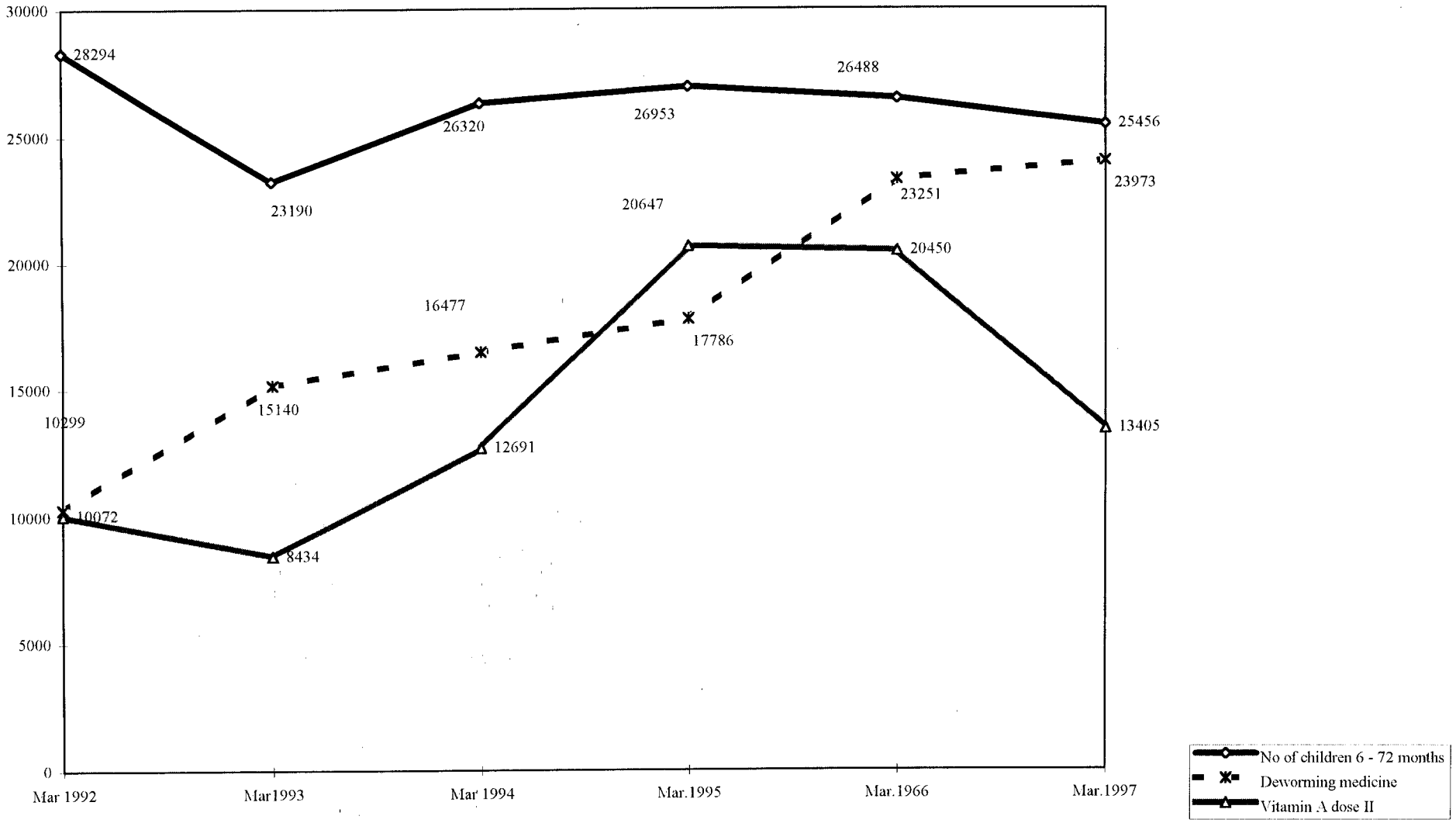
NILGIRIS

Provision for ferrous sulphate tablets (FST) to children (1-5 years)



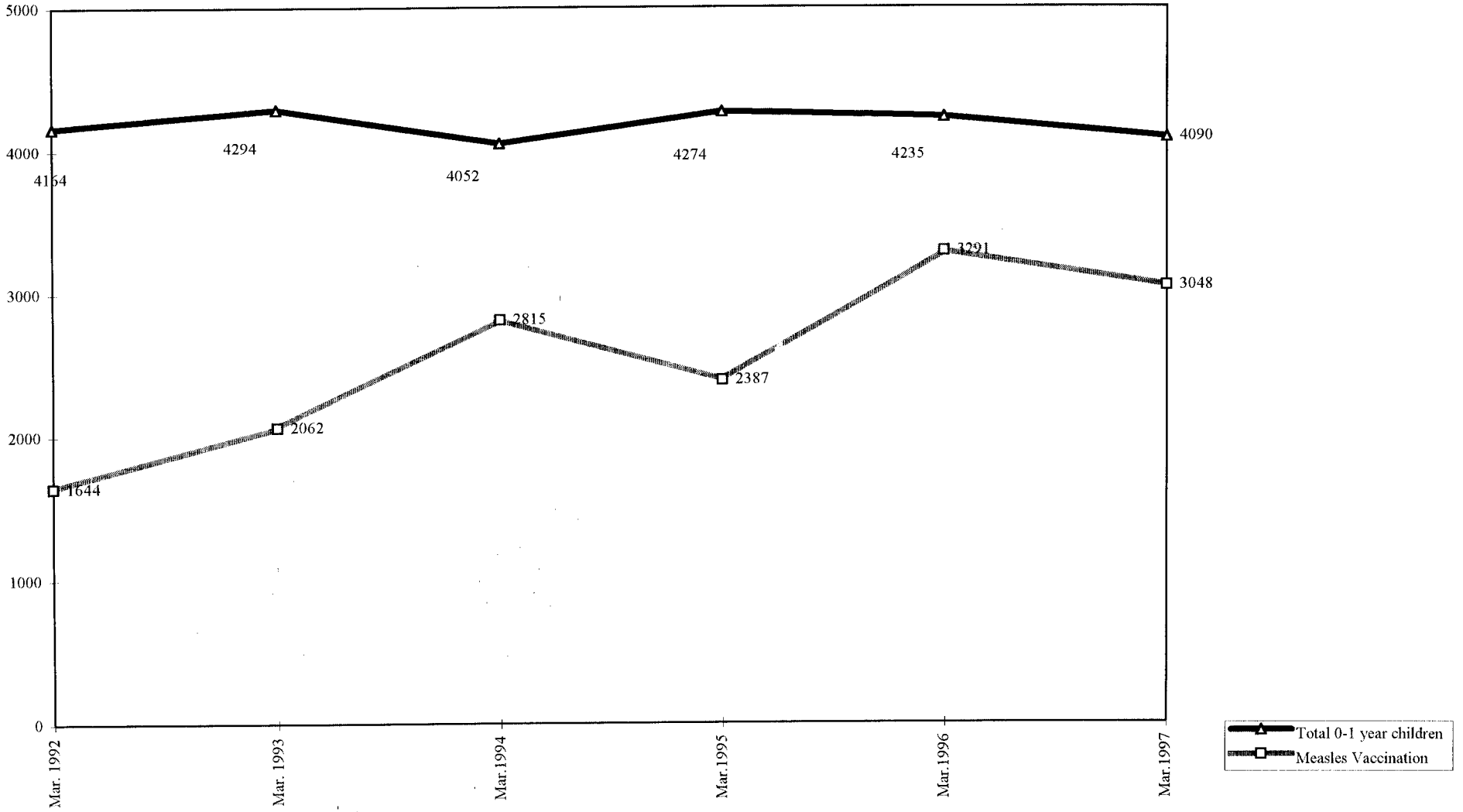
NILGIRIS

Vitamin A & Deworming (6-72 months)



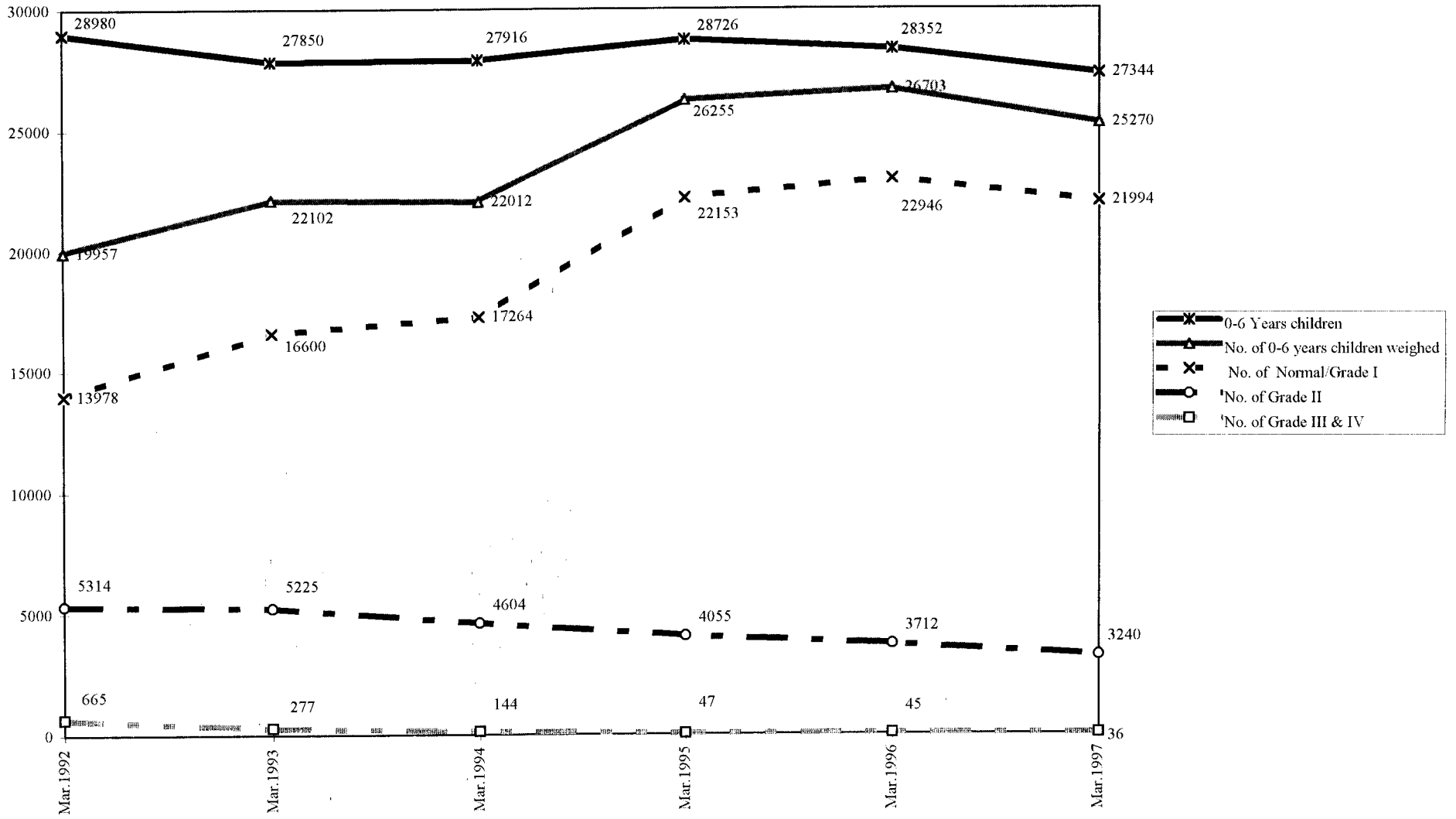
NILGIRIS

Total children & Measles Vaccination (0-1 year)



NILGIRIS

Levels of malnutrition (0-6 years)



Innovative ways to reach out to women and children: A review of the Sida-supported ICDS Project in Tamil Nadu, India

By

Dr. Ted Greiner, Team Leader, Health and Nutrition Specialist
Ms. Eva Klingberg, Disability Specialist
Ms. Lakshmi Krishnamurthy, Preschool Specialist
Prof. K. Ramakrishnan, Management Specialist
Ms. Anita Dighe, Adolescent Specialist

Executive summary

Sida support to the ICDS in Tamil Nadu has provided 167 million SEK over a period of 11 years; since Phase II began in 1994, this has included all costs for innovative "additionalities" in what are now four districts with a population of over five million. The Sida contribution has constituted about 32% of what has been spent on ICDS during this period. The total cost for the nutrition component, about US$10 per beneficiary per year, is within the range expected to lead to about a 1% reduction in malnutrition rates per year, and project statistics suggest this is occurring. The present review sought to focus mainly on developments that have occurred since the 1997 evaluation.

Since July, 1997, the project is in an unpaid extension period. Most components have been progressing well, yet utilisation of funds has been slow due to delays in government orders after Sida agreed to the extension. This meant that little procurement has been done. In addition, there has still been little progress on civil works in Nilgiris. Consequently another extension until the end of the 1998/99 budget year at the end of March 1999 has been requested.

Progress on the management side has included reductions in vacancies and the training backlog, a more "staff-friendly" transfer policy, and decentralisation of certain functions to block level CDPOs.

There still has been no progress in developing a system of functional administration at state level. Officials with adequate seniority need to be delegated required authority to be able to take full responsibility for certain key functions, including an overall state training plan, communication, and disability.

Partly due to increased computing capacity at state level, the MIS is improving, with improved annual reporting as a result. While plans are on to reduce the number of registers the AWWs keep, it is not yet clear if this lead to much of a decrease in her book keeping burden. The team recommends that ICDS at state and national levels examine whether data on immunisation and vital statistics need to be passed upward from AWC level. Since they are not population-based, they are not useful at higher levels. Instead, some few qualitative indicators should be developed related to child development, preschool activities, and eventually perhaps adolescent girls' activities.

While increasing based on public demand, the ICDS in Tamil Nadu is still inadequate. There is no provision for mini-anganwadi centres (at 500, requiring only half the population base of regular ones), and we found only a few examples of innovative efforts being made to reach the hamlets where most of the scheduled castes live.

The project is losing its opportunity of utilising the Sida support to strengthen its communication component. Production of posters for the AWCs, a staff newsletter with pages for each district and perhaps columns for blocks, and greater utilization of the video equipment and vans could make a difference.

It is a big challenge to change the traditional hierarchical approach to preschool teaching in the ICDS. The Joy of Learning training that has been completed among all staff except the helpers who are now receiving it seems to be going a long way toward meeting this need. The team was very positive toward its innovative approach and the way it was being implemented in the AWCs we visited, even if they may have been "model centres" in most cases. There is a need to provide toys that are locally made from more natural materials like wooden blocks and soft toys. These and books should be provided in large enough quantities and without risk that the AWW will be blamed if they are damaged.

In the long run it would be desirable to develop a system whereby some of training is more "horizontal" to break down the stiff hierarchical attitudes among the staff as well. For example, sometimes AWWs could be trainers of other AWWs; sometimes different categories of staff could be trained together.

Statistics for the health component stayed fairly stable, though it suffered from lack of procurement of medicine kits and supplemental nutrient supplies. It may be time for the ICDS to begin working out ways in which it can make a contribution to improved hygiene and sanitation, first by washing the children's hands with soap after defecation and before all meals. Future planning should consider the addition of hand pumps near the AWC where they are lacking and latrines for the children and staff, as long as provision is made at the same time for keeping them clean.

The project has done well in maintaining access to sathu during the project period and the noon meal food has not suffered from disruption. The afternoon sundal has however been disrupted for months and only just been ordered. The project needs to examine whether the new policy of requiring on-site feeding for infants 6–24 months is often leading to gap in project contact with their mothers at this time when growth monitoring and promotion are crucial.

The nutrition gardens continue to be a most successful component of the project. The noon meals are undoubtedly more nutritious, educational, and appealing due to additions from the gardens. Greater attention should be given to nutrition education, in particular focusing on the importance of vitamin A, not just for young children, but also for women. Certain foods such as papaya, mango, and orange vegetables thus deserve more attention within the gardening project.

Growth monitoring proceeds better in Tamil Nadu than in most places. But there is still a need to ensure that all workers know about taring (setting the scales at zero) and that record keeping is more closely examined, as many mistakes and perhaps even falsification can occur otherwise.

Seasonal changes in nutritional status can now be seen at district level thanks to monthly plotting of trends. This suggests that the most dangerous times may be when mothers have heavy burdens of work away from home. This is especially the case when their infants are young and are given diluted cow's milk. Exclusive breastfeeding for six months, even without the addition of water or herbal concoctions would go a long way toward further improving the levels of moderate malnutrition still prevalent in these districts.

Coverage levels of vitamin A and iron are in some cases satisfactory, but in others still not high enough to make a public health impact. Thought should be given to advising women to themselves purchase and consume one iron tablet a week throughout the years when they are menstruating.

Tamil Nadu seems to have embarked on a risky policy of not requiring iodised salt. The ICDS should at least ensure that all its AWCs use only iodised salt. A message of the importance of this for children's mental development and intelligence should be communicated through the project to the communities.

Some 50,000 adolescent girls have been given two-day workshops on issues related to their health and their rights. These have clearly been positive and much needed experiences for them and need to be followed up. Less than half the girls have been covered so far, and efforts need to be made to attempt to reach all. NGOs might be better able to provide information about rights, however, than male lawyers who tend to rely on the lecture method. Attention should also be given to how to reach the adolescent boys with information and activities designed to change patriarchal attitudes and other factors associated with the apparent high incidence of rape in the villages.

The WILL centres are a positive post-literacy initiative. However, it is unclear how they can reach the majority of the women and how it can be ensured that poorer groups are not only included but can play leadership roles. Furthermore, the use of sewing machines and trainers for possible income generation seems to have limited hopes for success. Other things that might be more promising include making such things for the ICDS program as leaf plates, soft toys and wooden blocks. Multiple sets of books, focusing more on fiction, need to be provided so that women can loan them home.

Some AWWs and staff above AWW level have been trained in disability management. Yet very few disabled children have been identified in these districts and fewer still are included in the preschools. This failure may have to do with not having adequately identified from the beginning the objective of this component and training for it. The team suggests that the ICDS should not undertake any responsibility for rehabilitation of disabled children, as this only places stress on the workers who have neither time, training nor support for doing so. Rather the ICDS could make invaluable contributions toward (a) early identification of disabled children, (b) communication of information to the communities on the true causes of disability and thereby attempt to improve attitudes towards these children, and (c) inclusion of these children in the preschools, perhaps involving them only in a limited number of activities appropriate for them.

Background

India's Integrated Child Development Services, begun in 1975, has expanded to the point where it is undoubtedly the largest welfare project in the world. It pursues an approach that would seem to be a prescription for bureaucratic constraints, run jointly by national and state governments and crossing into the "territories" of several sectors. Nevertheless it has maintained a spirit of innovation and continues to evolve at both state and national levels.

The Swedish International Development Cooperation Agency (Sida) has supported the ICDS in Tamil Nadu since 1989. Though it began in only eight blocks (each block has a population of about 100,000–150,000), by 1994, in Phase II of the support, it expanded to cover 47 blocks in four districts, now called Kancheepuram, Tiruvallur[28], Pududottai and Nilgiris. Since then, it has also focused only on innovative additionalities, developing and testing new approaches on a large enough scale that they could be replicated by other states at relatively low cost and low risk of failure. There are a total of 4670 Anganwadi Centres (AWCs) in these districts, an increase of 174 from a year ago, mainly in response to community demand.

The Sida support was based on two agreements for a total of 167 million SEK, the second of which ended on June 30, 1997. Unfunded extensions have been granted twice by Sida and now extend through December 1998. In preparation for the annual review, now scheduled for December 1998, Sida hired a group of consultants to review project progress according to the terms of reference attached as Appendix A.

The team spent the period between October 21 and November 3, 1998 in Tamil Nadu. We are grateful for the hospitality we were shown by staff at all levels throughout the state. We received full cooperation from the Directorate of Social Welfare (DSW), the ICDS implementing agency, as well as others who we interviewed, including UNICEF, the World Bank, and the Spastics Society. Interviews were held with individuals and in small groups; group discussions were held with personnel from all four districts; extensive field visits were made by the team within Kancheepuram, Tiruvallur, and Pudukottai, sometimes the entire group, sometimes in pairs and sometimes individually, allowing a large number of anganwade centres (AWCs) to be visited, activities viewed, staff and beneficiaries interviewed, and registers and other monitoring information examined. Key project documents were supplied to the team by Sida and DSW.

[28] These two districts were previously combined into Chengalpattu and still only have a single contingent of district-level staff for ICDS. For this reason, ICDS data are still reported on for Chengalpattu as a single district.

Some of the activities viewed were going on in their routine way. Others were no doubt prepared for our visits, in particular the AWCs we were taken to.[29] Nevertheless, a review of these centres was still useful. It showed us what is possible when the AWCs run well. And the problems and shortcomings we came across and write about below are almost certainly found in large numbers in the less well-functioning centres.

Sida support to ICDS in Tamil Nadu was evaluated in 1997. This report reviews project activities for each major component mainly since that time, often discussed under subcomponent headings. For longer sections on subcomponents, the discussion is divided into subheadings according to progress, constraints and problems, and recommendations.

Civil works

Of the 80 AWCs to be built with Sida funds in Pudukottai, nearly all are complete and completion of the rest is expected before the project ends in December. Work on the 60 allocated to Nilgiris has been greatly delayed and is only just getting started. At the same time, in Chengalpattu 68 ICDS preschools are held in the open (under a tree) due to the lack of any facility. Progress in carrying out repairs under Sida support is also delayed. There is a risk that these opportunities of support from Sida are lost unless progress is extremely rapid during the remaining project period. Although some patchy progress is being made, more attention needs to be paid to how the Sida buildings will be maintained and repaired after Sida withdraws.

The smokeless stoves never seem to work. In part this may relate to a failure to regularly clean the soot from the chimneys. Also, the people who build them are not familiar with new ideas on how to do so, and include some features from traditional ones that may spoil them in terms of the cooking pot filling the hole entirely and creating a good current of air up the chimney.

Management, finance and administration

Utilisation of funds

Progress
As on September 30, 1998 nearly 90 % of the allotment for Phase II has been spent. The balance remaining as on 30.9.'98 is reported as Indian rupees (Rs.) 51,500,000. This amount may not be spent entirely before 31.12.98 even if in the remaining months the pace of activities with respect to training, procurement of medicines, supply of growth charts etc. (the activities which can absorb considerable resources in a short time) kept at a much higher level than has been possible in the past. Hence we were told that DSW has asked for one last extension of the programme till the end of 31.3.99, which is also the end of the financial year for the Government of Tamil Nadu (GoTN).

Constraints and Problems
From 1995–1997 there were frequent changes in project leadership; three different Directors were in position in the span of 18 months; the present Director and the recently transferred Additional Director took charge in May '97. Also, action on project extension was initiated on 1.7.97 but the Swedish embassy's concurrence got converted into an enabling Government Order (GO) through GoI and GoTN only by late November '97. The second extension request made on 30.3.98 resulted in a GO only on

[29] An examination of the visitor's registers showed that most had recently been visited by a supervisor and many even a CDPO before we arrived.

11.9.98. Thus only 62% of the unspent balance of about Rs. 137,000,000 available on 1.7.97 has been spent by 30.6.98.

Recommendations
The team recommends that Sida comes to an agreement with MHFW/GOI on use of remaining funds, but the DSW should present evidence that there will not again be a delayed GO and details on how this time the entire remaining amount really will be utilised completely by the deadline.

Staffing

Progress
Several improvements in management were evident to the team and very much welcomed. The pay for anganwadi workers (AWWs) has been increased, as has the level of reimbursement provided during training and for transport of the food to the AWC from the block offices. There was also an increase in the amount given for making low-cost materials for the preschool.

The vacancy situation in the three Sida-supported districts has greatly improved in the past couple years as detailed below. The training backlog has also been reduced.

	Sanctioned	**Vacancies**		**Untrained**
		1996	1998	
Project officer (district level)	3	3	0	0
CDPO (block level)	47	23	7	24
Supervisor I (block level)	54	12	6	9
Supervisor II (sector level)	208	78	8	32
Anganwadi workers	4730	"-	59	448
Anganwadi helper	5928	"-	64	1383

During the period June 97–September 98, ICDS got the attention by an Additional Director almost full time, besides the committed involvement of the Director, DSW. Excepting for the post of Assistant Engineer (Sida funded) intended to hasten the process of building AWCs, all other posts are filled at the State Level. However at the District and Project level some vacancies in the administrative positions do exist and the respective block-level Child Development Project Officers (CDPOs) did point out their difficulties on account of this.

One Joint Director (Health), one Deputy Director, a Programme Officer (state cell) and a programmer (the current incumbent seems to be more than that) assist the Director exclusively for ICDS-related functions. At the district level, the PO is assisted by a Grade I Supervisor, a Statistical Inspector (SI) and three or four special trainers. At the block level, 3 or 4 supervisors assist the CDPO. Besides these programme-directed staff, administrative staff at every level take care of the routine accounting and other administrative functions.

Constraints and problems
The rapid progress in recruitment has added to the training challenge. About half the CDPOs in place are untrained. The backlog of untrained AWWs and helpers amount to nearly 450 and 1400 respectively.

Recommendations
The team encourages project management to continue the ongoing process of decentralisation as well as further devolution of responsibility and accountability to administrative and technical staff at various

levels. Even more transparency and flexibility in management routines will bring a breath of fresh air and set an example for other states.

Decentralised administration

Interruptions in supplies of supplementary food ("sathu," used for children under two and women beneficiaries) used to occur commonly for two reasons. First, the aggregate order quantity computed from the requirements indicated by the field officers was often arbitrarily reduced by the DSW under the assumption that field officers were padding the requirements. This led to arbitrary allocation to the field, resulting sometimes in the genuine requirements also not being met. The centralised payment of bills also led to long delays in receipt of funds by the women's co-operatives producing the sathu and they sometimes had to stop production for want of funds.

One of the major steps taken by the DSW since the 1997 evaluation was to delegate to the CDPOs the responsibility to order the sathu and to pay for it directly. The CDPOs pay within one week of delivery and t his has eliminated interruptions in supplies to the blocks. Because the CDPOs order exactly what they need, there is also a substantial overall reduction in the amount of sathu being ordered, thus saving the state money. Currently CDPOs also draw funds independently from the local Government Treasury for training programmes. Such steps have also boosted their morale and confidence.

Organisational climate

Progress

The work culture in the DSW is quite different from what one encounters in other government departments. The enabling attitude of the present Director seems to have motivated not only the field functionaries, but even the administrative and technical staff such as the Statistical Inspectors (SIs). All the typists in the State office have become computer-competent and enthusiastically respond to new initiatives proposed.

Transfers have always been a thorny issue in government departments. The initiatives of the present administration ensure that an employee will not be transferred before the completion of three years in a post. Three preferences are allowed for the place of posting; the seniority norms are strictly adhered to; and above all the whole process was made transparent by displaying notices in all the offices. This seems to have removed the threat of transfers being used as a punishment or reward. Another welcome step is the plan to train the CDPOs in management and human relations concepts.

Constraints and Problems

Though improving, the management style is still hierarchical. Some staff say that creativity and initiative are more likely to lead to criticism than to be rewarded.

The AWWs and helpers, not having official jobs, do not enjoy any paid vacations. Helpers actually work seven days a week, even on holidays, to ensure that feeding at least takes place daily.

The administration concedes that the training programme is not based on any long-range plan (although one may be developed in connection with the new World Bank nation-wide support to ICDS training), nor has its effectiveness been critically evaluated. Some field level initiatives in this direction have been taken. While the gesture is to be appreciated, the methodology of assessment must be strengthened to gain useful insights.

The Assistant Director (Accounts) funded by Sida is looking after the accounts for non-Sida areas too. As a consequence, new initiatives of financial planning are lacking and management control functions such as continuous monitoring of expenditure as against allotment to alert the programme managers for possible consequences of deviations seem to suffer.

Travel expense claims of several CDPOs have been pending settlement for a long time at the state level. The gains of the major reforms must not be allowed to be undermined by the disgruntlement which can occur when personal finances are affected even if to small extent.

The AWWs complained that the norms of reimbursing their expenses to transport the sathu from the block office to the AWC and the fuel expenses for preparing the noon meal, the sathu, the sundal (boiled chick peas given to preschool children in the afternoons), and boiling eggs once a week led to their being out of pocket by anywhere from Rs.40 to Rs.80 a month. Considering that the AWW gets less than Rs.1000 a month, this out of pocket expense is a burden causing resentment. Since jobs are scarce and the AWWs are still not organised into any powerful trade unions, the resentment has not taken any serious form of action. The Directorate of Social Welfare (DSW) and the Government of India (GoI) seem to be aware of these issues.

Currently one gets a feeling that individuals are looked upon as "CDPO-Madam," "SI Sir" or "Ayah" (the helper) rather than individuals with a name and unique personality. Of course cultural practices are not changed overnight, but a human-services delivery programme – particularly one which is devoted to children and women – may be the most appropriate place to experiment with a people-centred management and work environment in which all are addressed by their names.

Interactions with CDPOs did create an impression that they are molded more as administrators bound by rule books than as pro-active managers evolving solutions to the field problems with the participation of other functionaries and the community. For example CDPOs were concerned that bicycles given to only a portion of the AWWs is creating resentment among those who were not given one. Therefore CDPOs want all AWWs to be given bicycles. No matter how rational or well justified the original decisions may have been, if they had been taken in discussion with the relevant groups, the resentment would probably be less. Even alternative solutions such as rotating the bicycle among the AWWs every quarter or six months might have emerged from such discussion.

Recommendations

Efforts should be made to relieve helpers from their feeding duties on weekends. Since such detailed records are maintained on food, perhaps adolescent girls or other groups could take this on.

The last review mission recommended that management structure be reorganised into functional units with specific responsibilities. Competence development is the most important aspect of the Sida-assisted component of the programme. Hence there is definitely a need for a state-level official to be responsible for the development, phased implementation, evaluation and refinement of training programmes throughout the state. Identification of competent NGOs and individuals to provide inputs to the training programmes may not be feasible or even desirable to leave entirely to the block level.

The person assigned may also be given the opportunity to be exposed to programmes by leading institutes of management or training organisations. Well-designed sample studies to assess the impact of training on the attitudes and behavioural changes of the participants must also be under taken. The responsibility should include financial planning and monitoring too so that a situation does not arise whereby the training budget has to be spent in a very short period of time. Similarly, the communication component might progress more satisfactorily if program and budgetary responsibility were devolved to a single officer at state level who could liaise with the Joint Director, Health for example regarding the technical content of health and nutrition messages.

It may be desirable to conduct the proposed management training programmes for mixed groups of CDPOs and supervisors, so that barriers of hierarchy are broken, the functionaries become aware of the communication gaps between different levels, and they work towards the evolution of better teamwork. The

spirit of being open to innovative ways of solving perceived problems and learning from the mistakes must in itself be encouraged for field functionaries to become pro-active managers.

Management information system

Quantitative Indicators or Outcome Evaluation

Progress

Since the 1997 evaluation there has been significant improvement in the manner in which comprehensive data collected at the Anganwadi level is consolidated and analysed for the purposes of monitoring.

The computers provided by Sida for state level appear to have been put to good use. The quality of annual reporting has improved, with some process and impact (nutritional status) data being included. Excellent graphs are presented by district that show how nutritional status varies from month to month, thus revealing seasonal changes. Several improvements have also occurred at CDPO level. Maps are now on the walls showing where the AWCs are and noting how many severely malnourished children are at each. The CDPOs are also supposed to plot the numbers of severely malnourished over time.

Preliminary steps taken so far in computerising the district level data have made it possible for key parameters such as proportion of children weighed, malnourished or receiving the designated services and many others (altogether 87 parameters) to be monitored on a monthly basis. Efforts are on to streamline many other aspects of the information gathering and processing routines, which are expected to strengthen the MIS. The feasibility of providing each district and later each block with a computer is being examined. Such steps may enable the CDPOs to monitor each AWC's performance more effectively.

Constraints and Problems

While improving, more progress could be made in increasing staff awareness at all levels of how to use monitoring information available to them.

Any information system is only as good as the data fed in from the field. In a situation where documents automatically capturing a transaction (such as a sales invoice or a delivery slip) do not exist and the aggregate information is dependent on what is reported from below, it is extremely important to ensure that what is reported is correct. As described in the nutrition section below, there are many pitfalls that the supervisors need to be aware of to avoid faulty data on the prevalence of malnutrition.

In order for the AWW to discharge her many other responsibilities effectively, her administrative and record-keeping workload should be kept to the minimum. Though it has been reported that the number of registers she is expected to maintain has been brought down to 7 from over 20 in the past, this has been achieved mainly by combining registers rather than reducing the amount of information to be recorded.

The AWW is currently expected to report every month the number of beneficiaries who were eligible, who were enrolled and who were actually provided the service for different categories of beneficiaries (viz. 6 month–2 year old children; 2–6 year old children; anti-natal care women; post-natal care women; and old age pensioners getting the noon meal).

The AWW is also asked to maintain daily records of:

a) The opening stocks, consumption, and closing stocks for the sathu as well as the supplies intended for the noon meal; and
b) The details of expenditures on vegetables, condiments and fuel for which a cash allowance is provided. Considering the small amount of funds allocated for these in comparison to other expenses of the pro-

gramme, it does not seem appropriate to expect such meticulous records at the AWC level on a daily basis.

Recommendations
Functionaries at the block and district levels should be sensitised to the need for ongoing internal evaluation through sample checks of key information reported by the AWWs. The field functionaries and all those involved in facilitating monitoring must be exposed to evaluation methodologies.

Before finalising the changes involved in introducing the seven registers, it might be advisable to test their use in a few AWCs. Some requirements for new and more detailed record keeping need to be reviewed carefully to ensure that the information is really needed and it will not add unduly to the AWW and others' record-keeping burdens. This includes records on amounts spent on minor items.

Given that the eligible population changes every month is marginal (in case migration in and out of the community is there) the AWW may need to report only the actual number of beneficiaries. The data collected every year via the household survey could be used at the block and district levels to estimate through computation the changes in eligible population over time. With the introduction of computers at the district and block levels, such computations can easily be programmed. While it may be a good idea for the AWW to collect and record information on health services such as immunisation and on vital statistics such as births and deaths, this is for the purposes of assisting the health sector in their own record keeping. No purpose is served in having it reported upwards to block and state levels. These statistics do not cover the entire population and thus cannot be used anyway for consolidation at higher demographic levels. Leaving them out would reduce the number of parameters reported upwards from 87 to 63.

The monthly indent for the food and supplies do give details of opening stocks, and consumption during the month. These can be spot checked occasionally to practice what may be termed as management by exception. That is, the trend of consumption by the different AWCs in relation to the attendance reported may be monitored to detect any possible irregularities.

A good management information system should develop macro indicators such as the per capita cost for each category of beneficiary. It should also be possible to obtain the components of the cost per beneficiary such as the direct cost of the food, delivery cost at the AWC level and overheads. Such macro parameters may enable the programme to be designed more cost effectively. The introduction of computers for the MIS activity will facilitate this process.

Qualitative Indicators or Process Evaluation
The traditional target-oriented and register-checking supervisory styles in the government do not change overnight even when the top administration wants more qualitative assessment. Thus the state administration's initiative to emphasise the qualitative aspects of the interventions through the question, "What has been the contribution by the field functionary during her visits to the AWCs"? is still to yield significant results. The management's response to some functionaries who question this approach has been to "provide guidance and clarify doubts." More efforts to sensitise the field functionaries to the concept of process evaluation and intervention in the future training programmes will be useful.

Project coverage

Progress
The following table presents the latest data on project coverage and is complemented by data in Appendix B.

Population of 0–6 years old children covered by ICDS

	Chengalpet K + T	*Pudukottai*	*Nilgiris*	*Total*
Population, 0–6 years	400,000	141,000	28,000	569,000
No. fed 6 mon–2 years	46,700	28,400	600	75,700
No. fed, 2–6 years	93,900	37,200	8,900	140,000
% of 0–6 population fed	38.5	50.8	35.2	41.3
No. of AWCs	2146	1292	360	4798
No. 6–24 mon. fed per AWC	22	22	2	16
No 2–6 yrs. fed per AWC	44	29	25	29

Constraints and problems

The ICDS programme does not lay down criteria by which beneficiaries are to be selected for the services. However the broad guideline is that about 40% of the population will be covered. This figure is the approximate proportion of population below poverty line. However the performance reports at all levels – AW upwards to the state level – do not clearly indicate the percentage of population touched by the programme. Proportion of children fed among those enrolled is indicated and such proportions are generally upwards of 70%. Computations based on the assumption that about 12% of the total population will be 6 months – 6 years, indicate that for the three Sida districts together about 41% of the population of 6 months–6 years old children are covered by the programme. Such computation for ANC & PNC mothers could not be done for want of data at the district level, though it is possible to do so since AW level data exist.

Given that nearly 60% are not covered by the programme, and that very few of the AWCs are located in hamlets or colonies with predominantly scheduled caste (SC) or scheduled tribe (ST) populations, it is possible that those who need the programme most do not have effective access to it. Even the Government commitment that 20% of the funds of all externally assisted programmes must directly benefit the SC population may not have been met. By and large colonies do not have enough families to warrant the starting of an AWC there according to the norms. The children of the colony are eligible to attend the AWC, but often the AWC is inaccessible to them, because of an intervening road or too great a distance.

One AWC we visited was in a colony but there was very low attendance; a nearby street of some 30 non-SC/ST families did not like sending their children there, especially as the food was cooked by a SC woman. It appears that caste barriers have been crossed to the extent that SC/ST children are allowed to attend an AWC in the main village, but main village children will not go to a colony AWC.

Little thought has yet been given on how children living in unserved colonies and hamlets could be brought to the AWCs or how the services could be taken to them. Some efforts of collecting details of uncovered population and the distance at which they are located form the existing AWCs have been in progress. But they have not been put together and a mapping exercise conducted to facilitate expansion or substitution.

Recommendations

Several ideas need to be explored for reaching the unreached colonies. One CDPO had taken her own initiative and was asking AWW IIs in centres with low attendance to spend time delivering services to near-by colonies.

Moving the AWCs to the colonies may not be a viable solution, since the attendance may be too low. Starting mini-AWCs wherever possible would be an important first step.

To deal with the double problem of depleting numbers at AWCs and the non-coverage of small colonies and hamlets, a cycle-cart could be provided to a selected, willing person from each colony. He could then bring in the children to the AWC and take them back home. As an incentive he could be allowed to use in cart in the in-between period and in the evenings.

Project costs

For the Sida component of the project, it can be roughly estimated that the cost has been 68 SEK or Rs. 270 per beneficiary per year, using the method shown in Appendix B. This can be compared with rough estimates of 209 Rs. for GOI and 335 for GTN, thus bringing the overall Sida contribution to about 32% of the total during the 11 years that the support persisted.

Inter-sectoral co-operation

Progress

Efforts have been made to enhance the extent and quality of collaboration with other departments delivering a variety of services to the community. Since September 97, joint meetings of health workers and ICDS workers, are reported to have been held to ensure that follow up on malnourished children or pregnant and lactating mothers is more effective.

The Rural Development Department managing the Employment Assurance Scheme, has earmarked funds specifically for the construction of AWCs. Maintenance and improvement of centres are carried out with community-Government joint efforts under new schemes such as Namakku Namey ("We for ourselves"). Government at village level (the Panchayats) come forward to utilise resources to strengthen the centres in various ways. Thus the picture of better collaboration among various arms of the government towards the objective of strengthening the ICDS programme is emerging.

Constraints and Problems

In spite of the efforts to achieve convergence of various services delivered at the village level, the basic problems such as lack of medical doctors at the rural Primary Health Centres leave the follow up of malnourished children at an unsatisfactory level. The poorest people are most likely to have malnourished children and least can afford transport costs for longer referral distances. Inadequate resources at the disposal of Panchayats and lack of any administrative control by them over the government functionaries in Tamil Nadu are barriers to satisfactory levels of convergence being achieved.

Recommendations

Creating awareness among the community members, particularly among the women, through WILL and programmes for the adolescent girls will go a long way to bring about convergence through community pressure. In some states there is a budget that the CDPO has control over which can be used to pay for transport for referrals in the most needy cases.

Communication

Progress

The AWWs, supervisors, and trainers provide a great deal of face to face communication to mothers through counselling during home visiting (often more frequent for those with severely malnourished children), discussions with pregnant and lactating women when they come to pick up their weekly food, monthly meetings with women's groups, discussions with WILL groups, the eligible couples workshops,

and the adolescent girls training. All told, this represents a powerful communication tool for improving health and nutrition in Tamil Nadu.

In the Sida districts, the various Centre Days, Motivation Days, Nutrition Week, etc. add to this and appear to be going on according to schedule. Many CDPOs have added to this some kind of activity for World Breastfeeding Week during the first week of August each year. One CDPO visited had made an effort to obtain from DSW posters for the walls of all her AWCs.

Constraints and problems

The video cassette recorders and video vans are still not being used much. Indeed, Pudukottai would prefer not even to have one. No communication materials appear to be in production. The walls of most AWCs have only things made by the staff and children, not posters conveying any messages. The development and implementation of a plan for mass communication is one of the opportunities offered by Sida support that has been missed.

Recommendations

Refresher and other training for AWWs should emphasise which messages they need to be conveying to mothers in their home visiting and talks with mahila mandals. In its discussions with ICDS personnel at all levels, the present team has made a number of suggestions for improving these messages.

Like some other states ICDS in Tamil Nadu apparently has a bimonthly newsletter. This is a good way to provide ideas, inspiration and information as well as a forum for publicising success stories. There could be a separate page or column for each district. The team believes this would contribute to making the staff of that block feel they are a team. It could provide a much-needed form of horizontal communication. This would be a more effective and sustainable way of rewarding good work by staff at all levels than the current practice of giving monetary awards to a very few. Also important is to include stories (not just for children), puzzles, new play/educational activities, poems written by AWWs and other staff, and down-to-earth informative articles on child development.

The World Breastfeeding Week theme in 1999 is on breastfeeding and education. This would be a good opportunity to promote six months of exclusive breastfeeding (no water or other fluids) within the ICDS for its effect on infant development and increasing children's intelligence. One way of ensuring that breastfeeding remains the norm is not to give children bottle-feeding dolls to play with. Indeed, some women's groups in Brazil produce breastfeeding dolls for sale both domestically and internationally – perhaps an income-generating idea for some group in Tamil Nadu?

The preschool

Background

There is a growing realisation in India that no lasting development is possible without paying attention to and tapping the potential of the young. The teaching learning transaction in primary school is being made more locally relevant, thought provoking and exciting. A good example is the Sida-assisted Lok Jumbish in Rajasthan.

There is increasing awareness, concerted action by civil society, and a perceptible awakening of political will regarding preschool and primary education. Community organisations are being facilitated, based on the understanding that "effective" participation by the people can lead to a development that is not only sustainable but self-propelling as well. Gender inequalities are beginning to be addressed in primary school, but not yet in the preschool context.

ICDS first started in Tamil Nadu in 1976 and for a long time was synonymous with "Feeding Programme." The preschool component was a limping along incidental. Now changes have been occurring rapidly – many since the 1997 evaluation.

Progress

The AWCs we visited were full of activity, with the AWW singing and playing games with the children. Her eyes were as bright as the children's. The noise and bustle made one feel that perhaps the preschool component was no longer a poor cousin but had achieved respectability. Here are some events we witnessed in the AWCs we visited that typify these changes:

- C "Teacher, there is something white on your face", giggled one child and others giggled with her. The teacher (AWW) wiped her face and laughed. "It is the coconut I just ate." This easy camaraderie is something rarely seen in previous years.
- C The AWW is running around, playing with the children. Though called "Teacher," she has thrown off her cloak of mentor and elder.
- C All the children are singing together without being led or directed by the AWW. (One child singing illustrates what has been taught; all children singing illustrates what has been learned!)
- C Children are sitting in small groups playing with toys, fitting in shapes or matching colours in a manner that shows this is not a first-time activity for them.
- C The AWW sits in a circle on the floor with the children, playing games, singing songs.

The ability to understand and empathise, to be "child-friendly," may not be the general norm. It may be only the best of the AWCs we saw, though not necessarily the "best" in terms of winning the "Best AWC" prize. But, even if we saw only showpieces, this still gave an indication of what is possible.

Constraints and problems

Having said this, there are still a few areas where change can bring about a more child-centred and child friendly environment. AWWs tend to give more direction than necessary. Continuous direction prevents a child from knowing her/his own mind. The child needs "space," mental more than physical, to try out different things, experiment, find out for herself, and thereby gain confidence. These years from 3–6 are a crucial period for this aspect of a child's development.

Even just letting children handle toys and teaching aids is minimally done in many AWCs. The fear that children will break/spoil things is ever present in the AWW's mind. Constant correcting of the child increases fear and dependence, reduces self-confidence and growth. In her anxiety that the child should "learn," the AWW is pre-empting the trial and error process of learning. We saw very few instances of AWWs praising children. The AWW herself has hardly any acquaintance with praise and is perhaps therefore unable to appreciate the importance of a pat on the back for increasing self-esteem in the child.

In her anxiety, show that she has been "teaching," the AWW often brings forward the 2 or 3 children who can "perform" well. While this boosts the self-esteem of these chosen few, there are some 20 odd kids at the AWC, whose self-esteem is invisibly being eroded.

There is a rigid hierarchical relationship between the CDPOs, Supervisors, AWWs and Helpers – a relationship which is not only inimical to the health of the programme, but which also firmly implants the concept of "hierarchy" in the minds of the children. These children are among the most underprivileged in the country. Their life experiences outside the AWC clearly and loudly affirms this fact. Their experience in the AWC and later in school has to alter this perception, not reinforce it, if these children are ever to believe that change is possible.

In many (though not all) AWCs, the charts, other teaching aids, and blackboard are beyond the children's reach. In some AWCs the bottom half of the wall is painted black, which is therefore within the child's reach, but more often than not, there is no chalk available for children to scribble with.

The selection of the best AWC, we feel, promotes values that negate the preschool aspect of the ICDS. We were told that the most important criteria are that there is enough space inside and outside the AWC to accommodate play and other equipment; that there is good attendance; that there is community participation (interpreted as donation of such things as plates and tumblers); attendance of mothers at project activities; good rapport with children; punctuality and regularity; obedience to the superior; and adherence to the time-table set by the PO. Where is the space for the AWW to be innovative and creative? Moreover, the best AWW is usually from the best AWC.

The actual prize given – plastic tables and chairs – can also be called into question. These are thought to make the AWC more attractive. There may not be enough space in the AWC for the children to freely move about with chairs and tables scattered about like an obstacle race. Even stacked up (as they usually must be) the furniture occupies much space.

A major problem (as seen by the ICDS Staff) is that attendance in AWCs is going down. Quite a few private preschools have sprung up. These schools even run buses for picking up children and charge roughly Rs 50 per month for school and transport. Children also have uniforms, which attracts parents; for them it is like a normal school. Often, English is also taught in these private preschools. Parents send boys to them more often than girls.

Recommendations

AWCs run from 9 a.m. to 4 p.m. and at least 1 to 2 hours could be given to free play – where toys, games, books are left around and children do what they want.

There needs to be a change in the way supervision is given to the AWW. She is scolded/fined if anything is broken/torn/lost. Only when fear is removed from the AWW's mind, will she, in turn, allow the children freedom from fear, exercise for their curiosity, and a chance to experiment and grow. Only when she is praised will she praise her children.

Monitoring and evaluation formats need to be revamped so that the whole process of overseeing ongoing work is supportive rather than admonitory. Qualitative indicators of behavioural change that can be identified/captured through observation need to be identified and tested such as the following:

(1) Are the children speaking more or the AWW?

(2) How often does the AWW give a pat on the back?

(3) How often does the AWW scold children?

(4) Does the AWW allow free play – for how long?

(5) Is the AWW sitting in a circle with the children?

(6) Is the AWW calling children by name? Is she calling the helper by name? Are children calling the Helper by name?

A substantial part of creating a fear-free environment is obliterating hierarchical differences and promoting a sense of equality. If the AWW calls the helper "Ayah," the children do so too. This term clearly indicates the lower status of the helper. The AWWs are often called "Grade I and Grade II" by the Supervisors. An AWW can be "Akka" (Elder Sister); the Helper, the AWW, the Supervisors can all call each other by name. Otherwise, the child, from the bottom rung of the ladder, is internalising the inexorable workings of hierarchies.

All charts, toys etc. should be within reach of children. While singing and indoor games were being appreciated by girls, boys in some AWCs wanted more outdoor games, e.g. with balls. Girls too should be encouraged to join the boys in such games.

Criteria for selecting the best AWC should focus on all-round development of the child. Rather than giving plastic chairs and tables, multiple sets of toys and books could be given so that the AWW need not be afraid to let children handle them. Local carpenters (or women's income-generating groups) could be located and given orders for wooden blocks and other toys for AWCs, according to designs supplied by the ICDS.

Training

Progress

Training in Tamil Nadu has moved into the fast track during the past year, the results of which can be seen in the field. The situation with respect to basic training was detailed above. Here are the statistics related to the Joy of Learning Training in the Sida assisted areas:

Type of Participants	No.	No. of batches	When	Type	Duration In Days	By Whom
Trainers	82	3	95–97	Res.	10	THREAD
Special Team	9					
Mobile Team	12					
CDPOs	93	3	Sept. '97	Res.	5	Master Trainers
Supervisors						
Grade I	90	3	Sept '98	Res.	5	MTs
Grade II	240	8	Sept '98	Res.	5	MTs
AWWs	4310	225	Oct–Feb '98.	Res.	5	Sup. Gr. I
Helpers			on going	Non Res.	5	Sup. Gr. II

THREAD, an NGO from Orissa, prepared the original training manuals on preschool activities, community participation, health, nutrition, etc. These were painstakingly put together and are thorough in the information they give and the methodologies they recommend. The Master Trainers have translated these manuals into Tamil and adapted them to the local culture. Inspired by THREAD, there is some emphasis on the relationship between different levels of staff, especially regarding support to those on the lower rung of the ladder; also about how the AWW can gain more respect in the village.

The Joy of Learning training had not yet been completed at AWW level at the time of the 1997 evaluation, so there was no way of knowing what effect it had in the field. During our field visits it appeared that the training had infused both AWWs and children with a new energy.

In a "Joy of Learning" training camp for helpers, the Special Team Trainer is low-key. The helpers joke and laugh with her. They are playing many of the same games that will later be played with children at the AWCs. The helpers have themselves become children again; as did the AWWs, when they underwent this training.

Becoming less inhibited, opening up, having fun, running around, playing, singing, dancing during their own training has enabled the AWWs and helpers to do the same for the children. Many can make up games, songs, and teaching aids. It is essential that this be developed in those working directly with children. They need the imagination to improvise on the spot, so that they have a continuous repertoire to call upon. Creativity has made them feel good, and this feeling is shared with the children.

Immediately after the training, different categories of staff evaluated it. By and large, they were exhilarated by the experience they had gone through. We did see some of the AWWs carrying on activities

that had not been included in their training. However, it is too early to comment on how and in what ways AWWs take their training experiences further.

Constraints and problems

The Master Trainers have really had a surfeit of training and yet some aspects like community participation that need in-depth understanding and internalisation have not been given enough time. Due to the rush to finish while Sida funds are available, training courses follow one upon another with little respite for reflection in-between.

The more "concrete" activities learnt in the training e.g. games for physical development or songs for language development, are easier to implement than aspects like "working as a team," or "giving support" which involve behavioural changes, and take time to internalise and practice. Follow-up and refresher training need to stress this aspect of ICDS implementation.

Training has been done for different levels of staff at different times. The content of the training is the same, but there is no inter-level training. There is a risk that this affirms hierarchy.

Training in disability, income-generating activities, property rights, sexual harassment, etc. imparted to ICDS staff, WILL participants and adolescent girls, will soon be forgotten if information is not translated into action. And action is not possible/effective unless the whole group acts as a pressure group.

Recommendations

A tremendous amount of training, often innovative, has been carried out in the Sida ICDS. But changing behaviour and attitudes takes time for the AWWs but even for the trainers themselves. There has to be 'space' for this "process" to take place. Trainers need to reflect on the training, get feedback and change it accordingly before proceeding further.

A fear-free environment needs to be created throughout the whole system. An environment of fear and distrust affects that final relationship in the chain – that between the AWW and the child. No child blossoms in fear.

If might help if horizontal training could be done. A selection of effective AWWs could be formed into a team and given the necessary skills to train other AWWs. "If she can do it, so can I" is a strong motivation to learn.

Most of the training is impersonal – great deal of information is given but little or no experiential component, i.e. touching a personal, emotional chord within the participants. This is needed if empathy is to be created for those they will be working with. At a disability training session, we asked the AWWs to recount how they are discriminated against because they are women. Several incidents when they had felt humiliated or oppressed were related. Didn't these instances show that that they, as women, were disabled? The AWWs immediately made the connection between the two types of disability – both of which are socially produced and can be socially prevented/cured.

Training is one of the most important interventions in making the ICDS a success. It cannot be driven by the exigencies of meeting targets or spending funds. Training is a process and needs 'space' if it is to be effective.

Health

Progress

Immunisation coverage has reached quite high levels in these districts, nearly 100% in Nilgiris, about 95% in Pudukottai, and about 93% in Chengalpattu for the financial and record keeping year that

ended on March 31, 1998. As an example of the important role-played by ICDS, approximately 40% of the polio immunisations take place through the ICDS. Coverage for deworming treatment among children 6 months to 6 years of age was recorded as 90%, 44% and 61% in the three districts respectively.

Medicine kits were supplied in April and May 1997, but have not been procured again since then. Thus many AWCs are completely lacking in drugs. Some have paracetamol, which is supplied separately through another channel, some have left over items that have no expiry date such as cotton and bandages, and some have a partial supply left of a few items which have not yet expired and for which demand was not so great.

The AWWs are being trained and used for increasing numbers of health sector initiatives including control of filaria, guinea worm, TB, HIV, etc. The AWC visitors' books showed that they had received regular visits from ANMs and supervisors. ICDS staff felt they received good cooperation from all health sector staff with the exception of doctors, which in the majority of the blocks were often thought to be uninterested in ICDS and often did not attend joint meetings. Joint training is being planned for.

The Eligible Couples workshops continue providing a day of special information, much related to the small family ideal, to 25 couples, mainly newlyweds, per year per block. As is true for other ICDS components, it is unclear how the beneficiaries are chosen, who are excluded and why.

Constraints and problems

Except for Nilgiris, coverage for deworming was still unsatisfactory, probably in part because it is not well followed up and partly because of supply failures. The project delays already mentioned were confounded by a government order changing the procurement procedure. This also resulted in a lack of medicine kits and health cards. Procurement is proceeding at the present time.

According to the 1997 Annual Report, only 1% of the AWCs had toilet facilities. It was reported to us that these toilets are in any case not used. This is because provision has not been made for having them cleaned. Many preschool children are not yet completely toilet trained, and the helpers are forced to clean up after them without always having access to adequate facilities for this. Indeed, the floors and immediate surroundings of the AWC may be a source of parasite and diseases transmission from child to child.

While some level of basic hygiene is maintained in the AWC, it could be improved. Children's hands are supposed to be washed before they eat, but when this was observed, no soap was used (necessary if hand-washing is to have much effect in reducing parasite and other disease transmission). Indeed, hand washing soap is not provided to the AWCs.

Clean drinking water is said to be provided to the children, though many AWCs do not have hand pumps near by. Many have separate drinking cups for each child at meals. But the children dip their cups into the common water pot when they want more water, dirtying it from the bottom of their cups that have been on the floor.

Recommendations

In some states, the CDPO has a budget to use for severely malnourished children and others when referrals are made and the family cannot afford the transport cost.

Deworming should be done on a campaign basis 2–3 times a year to achieve an optimal effect, even advising entire families to do so simultaneously. This would reduce reinfection rates. One idea is to deworm all children who are eligible to receive prophylactic vitamin A a few weeks beforehand, increasing the absorption of the vitamin A. Then deworming record keeping could be done in a similar way, as dose I and dose II.

But deworming is only a short-term partial solution for the larger problem of parasitism linked to poor sanitation and hygiene. The ICDS program needs to give serious thought to how to develop cost-effective approaches toward achieving long-term solutions to the problem as well. At the very least, AWWs should be provided with soap and see to it that all the children learn in a rote way to wash their hands with soap after bowel movements and before eating. The reasons for it should be explained to mothers and other family members attending and if partaking of the food, they should be asked to join in the hand washing. Many AWCs do not have easy access to clean water, so the installation of hand pumps near by (routine when AWCs are built in some states) would be a useful contribution in many places.

Joint training is a huge undertaking and how long each course should last must be given careful thought, as this has implications for how long it will take people away from work and monopolise the attention of the trainers. If doctors are to be attracted to participate, the duration must be short and the curriculum problem-based, that is, designed to deal with specific problems rather than only providing general information.

Nutrition

Supplementary feeding

Progress
The mid-day meal for the preschool children, provided as part of the State Noon Meals Programme, has continued without disruption. Earlier the basic rice and dal were complemented once every two weeks with one egg but this year it was increased to one a week. It is fed hard-boiled to the children before the regular meal is served. This is likely to have very positive nutritional impact among the poorest groups who rarely can afford to eat animal foods. It is also a clever way to provide such food at very low risk of salmonella and other infections which otherwise would be likely in the relatively poor hygienic environment. In response to earlier problems with quality, there has apparently been built up a reasonably good follow up of the quality of these eggs.

In the Sida districts vegetables from the AWC garden are added in addition to those few that can be purchased with the allotment provided for that purpose (which is used to buy carrots and other vegetables that do not grow in the gardens). This is a big advantage compared to other states for the following reasons: (1) the vegetables increase the nutritional value of the diet, (2) children learn better to each vegetables when they see others their age eating them, (3) vegetables help prevent the noon meal from becoming too monotonous. Making the food more varied, eye appealing, and appetizing also results in children leaving less food uneaten on their plates.

Weekly take-home food (sathu, the high energy flour which is also used as complementary food) of pregnant and lactating women has also continued basically without disruptions as described below.

Complementary feeding

Progress
The sathu is still produced by the 26 women's societies. Disruptions in food distribution, though common earlier, have in rural areas not occurred in the past year and in urban areas in the past two years. One reason for this improvement is the decentralised purchased described above. They are also responsible for regularly sending samples for quality testing.

There has been a policy change requiring on-site feeding for all children. That is, even the children not attending preschool (6 month–2 years old) must come to the centre at around 9 am to get the food. Apparently the policy is that the child will then be allowed to take the rest home if he cannot finish all of it,

which is quite likely in the case of the younger ones. This policy is thought to improve targeting, as only those who need it will go to the trouble of coming to the centre for it. It also saves a lot of staff time compared with distributing it to people's homes every day as was commonly done earlier (and is still done in TINP). It also will reduce sharing of the food with others in the family.

Coverage rates of beneficiaries fed continue to be quite high except for sathu in Nilgiris. Here are the data for September 1998:

	Chengalpattu	*Pudukottai*	*Nilgiris*
Antenatal mothers	85%	84%	72%
Postnatal mothers	85%	82%	70%
6–24 months	78%	79%	65%
2–5 years (noon meal)	84%	84%	92%

Constraints and problems
The new policy of requiring the consumption of complementary foods on-site has resulted in a drop in participation rates among the 6–24 month age group. There is a risk that most of this drop-off is taking place among the infants aged 6–12 months, given the traditional hesitancy to give solid foods to children at this age. This could lead to a gap in their contact with the AWC just at the age when nutritional status is declining most.

The CDPOs who we asked were not sending sathu for regular testing and when they did, the response from the laboratory was so delayed that there would be little chance to react if anything was found to be wrong with it.

Recommendations
It should be ensured that all staff understand that the younger infants do not need to consume all the food given to them on-site, but merely need to pick up the food daily rather than having it delivered to their homes. A review should be done of participation rates among children 6–12 months to see if they have fallen to unacceptably low levels. One idea might be to offer the mother a ball of sathu for herself up until one year of age at the same time as her infant under one year old receives one. This might make it feel more worth her while to come to the centre and allow contact with her and messages to her to continue unabated during this crucial period.

Vigilance must continue to be maintained regarding the quality of the sathu, as the societies that produce it do not themselves have the technical capacity to apply modern food quality control testing methods.

Sundal feeding

Children are able to stay later at the AWCs in the Sida districts, which is probably beneficial for children of working mothers. This is achieved in part by providing them with sundal (boiled chick peas) when they wake up from their mid-day naps. This is important, as young children need a high frequency of meals and without this extra snack their overall food intake might decline due to the longer days at the centre. The method for procuring sundal was changed some months before the evaluation and this resulted in disruption of supply. It is still disrupted, but purchasing is now in progress.

Bureaucratic rigidity is apparently the main reason for the failure to find any solution for the problems related to procurement of sundal. However, it appears to be popular and will no doubt continue to be provided part of the time as long as external funds are available. When there is no sundal, some children go home earlier and some of those living near the AWC get some food at home and return to the AWC. For the others, lack of an afternoon meal may actually damage their overall nutritional status, as

the frequency of their meals might decline and their stomachs are too small for them to make up for it by eating a larger meal once they get home even if available at that time.

Nutrition gardens

According to the 1997 Annual Report to Sida, 4185, 93% of the then existing AWCs, had nutrition gardens. In Chengalpattu alone they produced about three tons of vegetables and fruits. The AWW receives 50 Rs per month while she is actively maintaining the AWC garden. In addition, 50 Rs per year is provided for purchase of seeds and seedlings. Purchasing is done by the CDPO, apparently usually on the advice of district horticultural authorities. The gardens viewed during field visits, though often small, were of high quality, including the fencing. They contained mainly lady's fingers, green leaves of various kinds (including drum stick trees), eggplant, tomatoes and fruit tree saplings: papaya, guava and pomegranate. Certain foods such as papaya, mango, and orange vegetables deserve more attention within the gardening project because of their greater vitamin A value.

Some AWWs say they provide vegetables nearly daily but many certainly do not have access to them from the nutrition garden during dry times of the year. Where records were checked in one block in Pudukottai (a relatively arid block), about half the gardens were not functioning for about 4 months a year due to lack of water. The AWW keeps a fictitious record of how she spends the money on her garden[30] and a record of how much produce she harvests, questionable record keeping burdens.

Growth monitoring

Growth monitoring is done quite regularly in the Sida districts. A high proportion of all the children in the catchment area are weighed, not just those enrolled in the AWC. Some AWWs we observed did a good job on all aspects. Generally, all hung the Salter or bar scale from a rope at face level, avoiding the problem of parallax when reading it.

Growth charts have not been supplied for over a year (and for nearly two years in some places). It appeared to be common that AWWs did not tare (zero) their scales. Indeed, even higher level staff did not appreciate the need for doing this. We came across two cases in which serious, systematic weighing errors of more than one kg for all children were resulting from this simple mistake.

Close examination of the registers of child growth uncovered several irregularities that were pointed out to the accompanying staff. In one place the weights recorded in the register were virtually the same at the same age (and all "normal") for a series of over one hundred children in a row. Such uniformity is not possible biologically even in an industrialised country. In another centre, entries had been made in a new handwriting for all children for the past two months showing uniform and surprisingly high growth, again placing all the children in the "normal" range. Perhaps a supervisor wanted the situation to look good in preparation for a possible visit from the review mission.

Supervisors should check whether scales are tared. When weights show systematically that nearly all children are malnourished or are normal, failure to zero the scale could be the reason. Supervisors and CDPOs should be observant for evidence of data falsification as described above.

Trends in nutritional status

The project-generated data are more representative than purely service-based data since weighing is apparently done of all children in the AWC catchment area. AWWs are supposed to include even children in the hamlets who are not enrolled. Nevertheless, these data probably leave out many children

[30] The 50 Rs/month is intended by Sida as a salary supplement, pay for the extra time she has to spend in the centre. Presumably there is an accounting reason for asking her to keep fictitious records showing that it is instead spent for fertiliser, seed, etc.

living in the more isolated of the 50,000 hamlets found in Tamil Nadu. Thus ICDS data likely underestimate the overall levels of malnutrition. If so, this will be revealed when the data from the National Family Health Survey become available in a few months.

Among the children being weighed, nutritional status is gradually improving. Levels of severe malnutrition are 1% in Pudukottai and 0.1–0.2% in the other districts. Moderate (grade II malnutrition) is 17.5% in Chengalpattu, 16% in Pudukottai and 12% in Nilgiris. These figures are 3–4% lower than they were in 1994. This is in line with a recent international estimation that when $5–$15 are spent per capita per year on nutrition projects, malnutrition will decline by 1–1.5% per year.[31]

In Viralimalai Block of Pudukottai, it was noted that growth charts of large numbers of children revealed that malnutrition started earlier than was seen elsewhere, often well before four months of age. It turned out that mothers give diluted cow's milk to their children when they left for work. This is a dangerous practice for several reasons: (1) Milk rapidly becomes contaminated with high levels of bacteria (even if it is pasteurised which in the present case is unlikely), as do any utensils or containers it comes in contact with. This is more dangerous the younger the baby is, as the immune system is immature in the first months of life. (2) Unprocessed cow milk damages the gut during the first months of life, causing occult bleeding and an increased risk of anaemia. (3) Cow milk, especially when unprocessed, increases the risk of an allergic reaction in infancy. Infection, allergy or simply intolerance can cause colic-like symptoms, likely to lead to the use of sugar to calm the baby and herbal remedies that may harm the liver of young infants.

A review was done with several Pudukottai staff of all factors they could think of that were likely to have a seasonal effect on nutritional status. The results fit with the seasonal trend shown by the data, suggesting that the seasonal factor which most affects nutritional status there is not harvest times or times when disease prevalences are highest, but times of heavy labour demand when mothers have to work away from home.

For each district, the state authorities might plot monthly levels of malnutrition, including each new year on the same graph. This will show whether seasonal trends occur regularly each year and this in turn may allow deductions to be drawn about the relative importance of some of the causes. It will also reveal whether secular change is occurring. At block level, plotting trends could be tried as planned but may not work well. Fluctuations due simply to "background noise" may be too great to allow reasonable interpretations of the data to be made. Inexperienced staff may try to take measures based on what they think are changes but in fact are simply expected random variation; false "responses" will then seem to occur in the expected or unexpected directions, gradually causing confusion.

In promoting exclusive breastfeeding, ICDS staff should be aware that some women have difficulty following this advice due to the need to return to work during the early months of life. The ICDS should join in the effort to advocate for an increased period of paid leave for working women and provide it to their own staff. Also, men should be made aware of the importance of exclusive breastfeeding and the need for them to provide increased support to reduce the work burden of the mother during the first six months after birth.

[31] The cost analysis above suggested that the total annual expenditure from Sida and the two governments has been on the order of Rs. 800 or $20 per capita during the past decade. However, ICDS is not only a nutrition program. The amount spent on food and other directly relevant inputs may be about half of this. Also, an unknown proportion of the weights are taken on children in the catchment area who are not benefiting directly from the program.

Nutrient supplementation

The following coverage rates were achieved among children 6 months–6 years of age during budget year 1997/98:

	Vitamin A, Dose I	*Dose II*	*Iron tablets*
Chengalpattu	25%	46%	37%
Pudukottai	34%	--	25%
Nilgiris	95%	68%	51%

For pregnant women, iron tablet coverage was 87% for Chengalpattu, 61% for Pudukottai and 97% for Nilgiris.

Procurement delays were also responsible for the fact that Sida funds being available to overcome any shortfall in availability of GOI supplies for vitamin A, iron, and deworming had little impact. These supplies simply are not purchased and thus coverage is dependent almost solely on GOI supply availability.

The poor levels vitamin A and iron tablet coverage achieved in Chengalpattu and Pudukottai should be a matter of serious concern for district and state level ICDS and health authorities. At such low levels of coverage these programs are a waste of resources. Only when coverage reaches above about 65% are the most needy reached and impact likely to be achieved. Similar to the argument made regarding deworming, distribution of nutrient supplements should be considered a short-term measure. Dietary improvement needs to be given more attention by ensuring that AWWs and mothers know which among the foods they can afford contain the highest levels of vitamin A.[32]

One group of women were asked about iron tablets when they were pregnant. It appeared that most of them had heard of it. Few received it from the formal health services, but others had bought it themselves. The fact that maternal death rates are relatively higher than infant death rates in Tamil Nadu (376 MMR versus 54 IMR) suggests that maternal nutrition needs to be given more attention. Again, the focus should not just be on pharmaceutical solutions, but dietary ones as well.[33]

Giving women small amounts[34] of vitamin A throughout pregnancy may reduce maternal death rates by over 40%. The only feasible way to provide this is through the diet. Besides adding this message to nutrition education, the project might want to consider whether vitamin A could be added to the sathu given to the mothers and young children.

Providing 100 iron tablets to women during pregnancy is good, but not enough. Women begin losing iron monthly in menstruation from puberty and from that time they should take an iron tablet once a week until menopause. Such a small "physiological" dose can do no harm and yet is nearly as effective as the daily dose. Weekly doses also cause little if any side effects. Weekly iron tablets cost so little that

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[32] The following animal foods are the best source when they can be afforded: liver, very small fish (because the liver is not removed before eating it), milk (if the cream is present) and eggs. Next best is yellow fruits and vegetables, especially mango and carrots, but also papaya and pumpkin if they are dark orange in colour. Finally, green leaves, especially if lightly fried in a little oil, as this increases the absorption.

[33] Project messages should focus not on foods which are iron-rich (meat, fish were affordable, greens and legumes), but mainly on vitamin C, which increases iron absorption from the entire meal if eaten near meal-time. The best source is fruit, especially guava and certain wild fruits.

[34] Large doses of vitamin A, as are given to the children, cannot be given to pregnant women, as it could be teratogenic. However, in many countries a large dose is now given to women during the month or so after delivery when they could not possibly be pregnant again.

the project need not buy them; the nutrition education message should aim to convince adolescent girls and pre-menopausal women to buy them for themselves. Messages should also mention the need to store these tablets away from young children, as they are toxic and even deadly if consumed like candy.

Iodised salt

Tamil Nadu had a law intended to insure that only iodised salt was consumed by its population. Apparently this was repealed to save money, due to the perception that iodine deficiency is present only in a small part of the state. This is dangerous way of thinking, as it will make it harder to ensure that people who need it get the iodised salt. Even where iodine deficiency is mild, iodised salt may bring various benefits, including increasing IQ's by an average of 13 points.

Some adolescent girls appeared to have goitres, small and diffuse but visible. Yet iodised salt was either not available or rarely purchased from local shops that were visited in the villages. Where available, it often (though not always) cost more than non-iodised salt. The AWCs, far from promoting iodised salt, are "iodine-free zones." None of the centres visited were using iodised salt. Many had salt with labels that read "for preservation purposes only." This is probably salt sold in states that have iodised salt laws and is a way for the manufacturers to circumvent the law. Others had salt that was fortified with iron and the staff confused this with iodine. Still others received non-iodised salt from Tamil Nadu Civil Supplies. It states on its label that it is fortified with iron but testing revealed it contained no iodine. Awareness on this issue appeared to be quite low among the AWWs, adolescent girls, and WILL participants.

The Joint Director for Health might want to discuss what was revealed on the field trip with relevant state health authorities. If the state believes that saving money by not iodising the salt is a wise strategy, then at least they should do a study of urinary iodine excretion to identify which areas do need it. State level IDD policy cannot be based on simple observation for visible goitre prevalence. Then of course they must figure out some way to get the salt to those areas that do need it, an impossible task, given the chaotic nature of the salt market. Indeed, non-iodised salt from Tamil Nadu is likely to sold in high-IDD areas of other states – a clear case in which national policy should take precedence – universal salt iodisation should be a national law. If any non-iodised salt is to be available on the market "for preservation purposes," it should state in large letters in local languages (not only English): "unfit for human consumption." The ICDS program should be ensuring that all the salt it uses is iodised and should provide enough information to its staff about this issue that they can educate parents about it. If people are too poor to afford it, they should be told that at least women who are pregnant or planning to become pregnant should consume it. This message should be powerfully conveyed in the Eligible Couples Workshops. Supervisors could be provided with test kits to ensure that the salt used in the centres really does contain iodine and report improperly labelled salt to health inspectors.

Adolescent girls programme

Progress

The earlier programme for adolescent girls that was implemented from 1991 onwards was revamped. In the modified programme, not only girls who dropped out of school but also school-going girls 13–17 years old are included. This is appropriate, because schools do not teach certain basic facts of life relating to health, nutrition, personal hygiene, correct age at marriage, etc.

Around 25 girls per village attend a two-day orientation programme. Two villages are combined, bringing together around 50 girls per camp. As of September 1998, the number of camps conducted as well as of girls who attended these camps, were as follows:

District	*No. of A.G. Camps*	*No. of adolescent girls attending*
Nilgiris	68	3380
Pudukottai	235	14477
Chengalpattu	666	32350

The plan is to conduct 2248 such camps. Only another 360 will be conducted by the end of the year. Thus even with a three-month extension it is difficult to see how this project can be completed.

Undeniably, these camps have responded to a felt need of the adolescent girls. From the feedback received from them by the project staff through post cards, from our observations of such camps and from group discussions with adolescent girls, it was apparent that these camps were highly appreciated by them. As was poignantly expressed by some of the girls, "the orientation camps relieved the monotony of our daily lives."

Besides this, getting together constitutes an essential first step in breaking the isolation that gets socially structured into the lives of young women in Tamil Nadu. The camps provide an opportunity for horizontal interaction and communication, enhancing self-confidence and self-esteem.

Constraints and Problems

The content and the methodology of the orientation camps need strengthening. Presently, the training methodology is not participatory enough. There is a tendency on the part of the lawyers and doctors to lecture to the girls. Also, too many topics are covered during the two days. The printed booklet that is given to each girl attending the camp, while fulfilling an important information objective, needs to be looked at critically and revised.

Presently, there is a tendency to invite "expert" lawyers for the training sessions. Our field visit revealed the inadequacy of such experts to respond to the queries raised by the adolescent girls.

Recommendations

The initial training should be personally relevant to the adolescent girls, aiming to develop their personalities and to empower them. Also, there have to be constant initiatives in keeping interest and motivation alive. If possible, they should be provided opportunities to meet on a more regular basis; the AWC could be made available to them after four pm. They could be engaged in organising balmelahs and other ICDS activities.

The content of the booklet should be built on their everyday life experiences. It needs to be interactive and interesting enough to sustain their curiosity and interest in eliciting further information on issues that interest and concern them. Activists belonging to NGOs that are engaged in legal literacy work might provide better resource support than the mainly male "expert" lawyers.

Efforts would have to be specially made to ensure that the illiterate girls (presumably belonging to the SC/ST communities) are not excluded from these orientation camps. Also, rather than selecting only 25 girls from a village, efforts could be made to be all-inclusive and involve as many adolescent girls as possible.

Most of the girls we met were literate and were keen to get books and magazines to read. While just getting together is important, a library might help in keeping the group together. Some of the girls wanted to continue their education. They should be helped to access post-literacy and continuing education offered under the Adult Education Programme as well as correspondence courses and distance education programmes.

While recognising the importance of such orientation camps for adolescent girls, the field staff also felt that efforts should now be made to reach out to the adolescent boys as well. This could aim to deal with the common patriarchal values and the subordinate status of girls within families. The suggestion of organising youth clubs for adolescent girls and boys separately in the beginning and after some time, organising joint activities to promote healthy interaction between them, was received favourably by the field staff. It was thought that this might be one strategy to reduce the high incidence of rape of adolescent girls that goes largely unreported in the villages.

The other strategy, it was felt, would be for the adolescent girls and their mothers to act as a pressure group to ensure that justice is done to victims of rape. Such groups could also take up issues which personally affect their lives such as, not sitting separately when they have their menstruation, or ensuring that they undertake periodic outings together, which would enable them to gain courage from one another and build up their self-confidence.

A question was raised whether any restructured programme for the adolescent girls or a new programme for the adolescent boys, would mean "dumping" such a programme on the AWW, which would be resented by her as yet another additional responsibility. The project staff should thus redefine their roles; the supervisors be more supportive; means of eliciting more support from the community should be sought; and linkages should be established with some of the existing government programmes.

Finally, it would be useful to explore the possibility of involving groups of adolescent girls in some research work relating to the ICDS programme, along with say, students from Schools of Social Work or from any discipline of Social Sciences. Such micro studies, participatory in nature, could examine such questions as:

Are the women leading the women's groups and WILL recreation centres from upper classes?

Attitudes toward disability; gender differences in terms of treatment and marriageability

Developing qualitative indicators for following up the preschool activities and adolescent girls programs

Who sends their children to private preschools and why?

Why boys are more commonly sent to private preschools and how they fare compared to their sisters. How do the boys and their sisters feel about such discrimination?

The WILL programme

Progress

The earlier WILL programme overlapped with the Adult Literacy Programme, creating some confusion in the field. Hence, it was decided to modify the programme with emphasis on post-literacy, vocational and recreational facilities for women. On a pilot basis, 4 AWCs in each block were selected and materials for recreation and vocational training for women were provided. By the end of September 1998, 188 such AWCs were functioning in Sida districts.

The WILL programme offers women a "space" to come together, take part in recreational programmes, as well as engage in some other meaningful activities. Adolescent girls seemed to outnumber older women and participated enthusiastically in WILL activities.

Constraints and Problems

WILL is a classic case of the project not planning in any way to reach the groups who most need it. In one "colony" we visited, five girls said they had gone to the WILL centre and were told to go to another

centre which was further away. The women who ran the WILL programme and made all the decisions belonged to landlord families. They may well be benevolent, in the name of women's solidarity. But for example, the leaders did not like us raising the question of minimum wages for women, because the bulk of the membership were agricultural labourers working on the leaders' farms. This matriarchal shift (Awe women are all one") can insidiously lead to firmly keeping poor women exactly where they are now.

The WILL centres are provided with sewing machines. While these are useful in learning to stitch the family's clothes, previous experience throughout India shows that it rarely becomes viable as an income-generating activity. Moreover, sewing machines reinforce gender stereotypes. Other things they make, including baskets and decorative pieces, are again not saleable enough to be called an income generating activity.

Books have been provided at the WILL centre but generally these are not taken out of cupboards for fear of being damaged or lost. Nor are women allowed to take them home.

Recommendations

There are many other ways of generating income. One suggestion is the making of soft toys and wooden blocks for ICDS preschools. These would not only bring in income but involve the women more directly in pre-school activities and provide better quality toys than some of the plastic ones now purchased. If this proved successful with the relatively easy to reach ICDS market, then the production unit could look to other markets. Much depends on the training and successful models do exist.

Another potential income-generating activity is the making of leaf plates, which then can be supplied to the ICDS programme for the noon meal. These leaf plates are easy to make and after the meal either fed to cows and goats or composted. Additionally, water and labour in dish washing would be saved.

Providing multiple copies of books might overcome the fear of damaging them. It would be worthwhile providing more fiction and magazines that would be more interesting than the largely dry non-fiction mainly included so far.

The WILL programme could be strengthened by forming women's groups and turning them into savings and credit groups, combining this with their role as development watchdogs. They could also be developed into women's organisations that oversee AWC, primary health care centre and primary school functioning. They could act as pressure groups for improving village infrastructure, fighting for minimum wages, and so on. No matter how positive this project may be, they are expensive and the ICDS needs to consider seriously how to make them more replicable and sustainable.

Disability management

Background information

Terminology

There are a number of technical expressions often used in discussions on disability topics:

- Prevention deals with nutrition, health, and sanitation.
- Early detection means observing signs of deviation, to take notice of in a child's development.
- Early intervention means physical rehabilitation to lessen the impact of the impairment.
- Impairment: Limitation of anatomical, physiological and physical functions
- Disability: Inability to function as a normal person because of impairment.
- Handicap: The result of the disability, which hinders the person to function in accordance with his or her age, sex, education, social status and vocational skills.

– Disability management is ICDS terminology describing how to manage improvements in the situation of children with disabilities.
– Social inclusion is closely related to the older expression, "social integration."

Children with disabilities
The expected number of persons with disabilities is 5% of the population, about 1% being children below 6 years of age. While it can be expected that the most severe cases have died, only a very small number are registered at the AWCs. The following table, incomplete and based on interviews with personnel from the districts, is at least indicative of the current situation.

Children 0–6 years old with disabilities

	Chengalpattu	*Pudukottai*	*Nilgiris*
Total population	3,540,000	1,419,000	330,000
No estimated to have disabilities	35,400	14,190	3,300
No. identified with disabilities	1,200	89	24
No. attending ICDS preschools	35	—	19

There ought to be at least one child with a disability at each AWC. In Chengalpattu, SPASTN has rehabilitated 1 200 children and trained over 500 AWWs during the 1990s. Why are only 30 children with disabilities in school and 35 in preschool? What are the obstacles? Is it the workload of the AWW? Is it reluctance from personnel when the referral system is not yet well developed? Is it parents' protective habits or maybe guilt that prohibits them from letting the child go? Negative attitudes of villagers can be still another reason.

Networking in each district
A State Plan of Action on Rehabilitation of Children with Disabilities exists for Tamil Nadu, in which there will be one NGO in each of the 29 districts as a nodal organisation. The NGOs will train personnel from various backgrounds in disability issues and also rehabilitate children. So far, there are 20 nodal NGOs trained and in action. However, they are new in the rehabilitation field and cover rehabilitation services only in a limited number of villages. The Government's rehabilitation offices provide some services such as distributing disability equipment and pensions.

In Kancheepuram and Tiruvallore, the Spastic Society of Tamil Nadu (SPASTN) manage many activities including training centres, subcentres, home visits and a mobile team. In contrast, there are limited resources in Pudukottai, where Rural Education for Community Organisation (RECO) work in 30 villages. In Nilgiris there seems to be only Symirna Rehabilitation Centre where children can come for training.

RECO has 2 persons trained by SPASTN for 42 days. Its task is the training of 2202 workers. Within current resources, it will take them at least another 6 years to complete this task. Meanwhile there will be limited time to practice rehabilitation on children with disabilities.

Why include disability management in ICDS projects?
The Governments of India and Tamil Nadu both emphasise the rights of persons with disabilities to be included in development schemes of the country. Prevention of disabilities is already a part of ICDS activities. The very name of ICDS suggests it focuses on child development, which makes it a natural place to look for any early signs of developmental failure.

Much work is still needed to spread knowledge about disability. Knowledge about the causes and effects of disabilities and also on how to prevent them is expected to lessen the need for traditional, sometimes more negative, explanations for its occurrence. The parents and the child need a more positive and

supportive attitude from the community. Hopefully, knowledge also will give parents an understanding of the needs of children with disabilities, so that more children are sent to preschool like all other children. By stimulation from other children, the child will become motivated and hopefully imitate and take action that will improve his or her situation.

Training

Progress
Since 1995, Sida has supported training in disability issues within the ICDS projects. Professional support in training of personnel has come from SPASTN. The goals of the training are prevention, early detection and early intervention/physical rehabilitation of children with disabilities.

The training has taken place from 1995 to 1997. Due to employee transfers and vacancies, the actual number of trained personnel currently stationed in the four Sida districts is not available. However the numbers trained are as follows:

Number of persons trained in disabilities (untrained)

Staff trained	*Duration*	*Chengalpattu*	*Pudukottai*	*Nilgiris*
CDPO	10 days?	31	13	4
Supervisors I	1 month	41	13	4
Supervisors II	1 month	128	66	14
AWWs	15 days	800 (2786)	60 (1201)	– (313)

Obviously personnel learned a lot in the training. Especially physiotherapy has made a strong impact on the personnel and is more or less assumed to be obligatory when integrating a child in preschool

The World Bank has also added disability issues to its projects. Special training instructors have been trained for six (6) days at Trivandrum Medical College Child Development Centre on early detection of disabilities. Added to that, instructors will have a short course at SPASTN's training centre in Chennai. The cascade method will be made use of. Personnel at block, sector and grass root levels will get 10 days training each. At this moment there is no attempt in this training to go into either rehabilitation or inclusion in preschool.

Constraints and problems

It seems as if neither development objectives nor project objectives are set in accordance with the objectives of the ICDS projects. When that is done, training objectives and curricula can be made. At present, the training of personnel follows the goals set for the State plan of Tamil Nadu on Rehabilitation of Children with Disabilities, taken in 1995. ICDS projects have other goals and therefore its disability training objectives ought to reflect that fact.

Physical rehabilitation is not a task of ICDS. Therefore, such knowledge, imparted through the SPASTN training, has not been made use of. Indeed, by creating unrealistic and unrealisable expectations, a hesitancy to give any attention to disability has been created. ICDS staff understandably do not feel they have the time or expertise to get involved in this and it is not their mandate to do so.

Social stimulation of children by including even those with disabilities in preschool activities is well in line with the ICDS objectives. Unfortunately, this aspect has not yet been implemented. Achieving a change in attitudes towards persons with disabilities requires an interaction between facts and "seeing is believing". Knowledge on prevention and early detection are being included in other ICDS activities like women's groups, adolescent girls scheme, eligible couples meetings, and immunisation days. In addition, inclusion of children with disabilities would have a strong visual impact on attitudes.

Each district has 4 special training instructors, who implement all training given to ICDS staff. One would think that, after 42 days of training by SPASTN, they would train Supervisors I and II who, in turn, would train all AWWs. Instead, all training given has been done by SPASTN or one of its nodal organisations (RECO). Training of personnel has thus been both unnecessarily costly and time consuming so far. Unfortunately, in the training given, knowledge on inclusion of children with disabilities in preschool is completely left out.

Recommendations

It seems as if "attitudinal changes towards persons with disability" would be a suitable development objective for ICDS. Without better knowledge on causes and effects of disabilities, it will be difficult to improve the situation for those persons. The project objective could be "Disabled children are included in preschool." These two goals will interact and support each other. One disabled child included in each AWC could be a short-term goal. When the goals are set, then the implementation becomes easier. It is, however, advisable to present and discuss new goals on disability management among personnel at all levels to ensure good results.

Trained staff should be reminded that the methodologies used in their training also could be made use of when presenting the same knowledge to various groups in the villages.

Other resources like medical colleges can be made use of when training special training instructors.

Special schools for specific disabilities are present in some districts. The experienced personnel ought to be made use of. Some might be interested in advising ICDS personnel in physical therapy and/or in suitable preschool activities. Preferably they should be selected from the newly introduced manual on Joy of Learning. There are two relevant kinds of activities:

a. Compensatory training to compensate for the impairment e.g. games where lip reading can be practised for deaf children and senses training for blind children.

b. Selected suitable games, where the child can participate in one way or the other despite the fact that he or she has impairment.

In order to make disability management more cost effective it ought to be linked with other project inputs, e.g. the design of new buildings and latrines, transport to and from preschool, and the new preschool methodology, which ought to include disability issues in its manual.

Training strategy

One way of making training cost efficient is to look at factors such as the following:

- Who have the needs: the child, the parents, AWW, supervisor, village groups, health workers?
- What shall be included and why? The different categories have different needs, which ought to be reflected in the objectives of disability management.
- How? The methodology is of greatest importance. The training should be done in the same way, as it will be performed when the trainee becomes a trainer, e.g. when the AWW presents causes of disabilities to various interest groups.
- What? Knowledge needs vary from person to person, and group to group. Irrelevant knowledge is costly and will soon be forgotten. Motivation makes learning easy. Also, knowledge which is put into use will become reinforced and last longer. Therefore, training should be needs based and divided into various steps. Some ought to convey common knowledge, and some ought to be more related to the disability.

A logical framework analysis (LFA) done by two trained CDPOs and two untrained Supervisors I, showed that they were aware of the hidden obstacles and had ideas on how to overcome them. (See Appendix C.) This knowledge among the personnel should be made use of, when revising the curricula for training of the personnel.

Parts of the LFA model maybe a useful tool in the training. By using the "problem tree" and the "objectives tree," the participants will become aware of obstacles and how to overcome them. A strategy for disability training in new districts is presented in Appendix D.

Disability manager

So far, the objectives of disability management have been unclear. There is not only confusion but also reluctance, as no expertise and guidance is available. A trained staff member is needed at Director level to be responsible for disability issues. He or she could see to it that the respective supervisors are designated to support AWWs in inclusion of disabled children in preschool.

Mapping resources and networking

It is advisable to do mapping of all existing resources for each Sida district. The two districts farther from Madras will not have a well-developed referral system in the foreseeable future. Limited amounts of medical rehabilitation need to take place. However, there are many competent persons in the health sector, e.g. village nurses, medical officers, paediatricians, that can give qualified support.

Communication

During the mission, a few examples were observed where excellent inclusion in preschool at an early age has resulted in an acceptance among villagers. There are already many films on rehabilitation but apparently no films on village children with disabilities describing their experience in preschool and acceptance in the village. These examples ought to be made use of either in role-plays or by making instructive short films to be presented to village groups or in training of mothers and personnel.

Inclusion

Much of the preparatory work has already been done. The last step – to include children with disabilities in preschool – ought to be taken soon. There are no specialists in "inclusion of children with disabilities in preschool," so the "trial and error"-method has to be used. Therefore, the following is recommended:

Support should be given to the AWW from parents of the child and Supervisor II.

- Together they should decide upon the attendance in preschool, i.e. how often and for how long should the child stay.
- A few activities can be selected from the Joy of Learning manual that would seem to suit the child.
- A new date for meeting should be set at for example 3 months.
- The child goes to preschool in accordance with what has been decided at the meeting.
- At the new meeting, decide whether the selected activities were suitable or not. Notes can be kept so that this new knowledge can be made use of when more children are included in preschool.
- New selections can be made among the activities in the manual and a new date for a meeting set.

Appendix A

Terms of reference for the follow up/monitoring of the Sida supported ICDS project in Tamil Nadu, October–November 1998

Background

The Government of India has been implementing the Integrated Child Development Services (ICDS) Programme aiming at improving the health of children and women in the poorest segments of the society. It covers over 15 million children and 3 million pregnant women with an integrated package of health, nutrition and education services.

Sida has supported the ICDS project in Tamil Nadu since 1989 presently covering 4 districts and aiming at elaborating a comprehensive development project. The main objective of the support has been to improve the quality of certain activities viz. staff training, supplementary feeding, preschool, community participation, adolescent girls training, nutrition gardening, improved communication and materials, construction of anganwadi centres and administrative support.

The Phase II, July 1993 – June 1997, was extended by one year i.e., up to June 30, 1998 without additional funds. During the extended period an extensive evaluation of the Sida-supported ICDS project took place. Thereafter the project submitted a modified proposal which attempts to revamp some components like preschool training, adolescent girls programme, WILL programme and the disability component. As there was an unutilised balance from the extension period, the project has further been extended six months i.e. up to December 1998.

The total Sida contribution during Phase II, including extension is total 115 MSEK (55 million for July 1993 – June 1995 and 60 million for July 1995 – December 1998).

Purpose of the Mission

To review the ongoing activities in relation to the stated objectives, plans, expected results and budget set out in the Project Document of Phase II, the modified proposal for the extension period, the Progress Report and the Evaluation Report.

The report from this mission and the project's progress report will form the basis for the Annual Review planned to take place in November–December 1998.

To give recommendations on the plan of activities and the scope of strengthening the services.

To give recommendations on the scope and rate of expansion of the project, taking account of quality control.

Tasks of the Mission

Based on the overall objectives of the programme, the Project Document (July 1995 – June 1998) and the state of development of indicators and monitoring routines, the team shall discuss and review the following key issues and/or other areas which the team would consider important to focus upon:

- study and review the Project Document and the Plan of Action including the budget and any other relevant documents,
- review the progress of the programme and its expansion, in particular the initiatives taken as specified in the modified proposal of the extension period,

- assess if the project has addressed gender concerns at various levels of project implementation and gender sensitivity of the project staff,
- examine any new information on the health and nutritional status of the children,
- review the involvement of the community in the functioning and strengthening of the programme,
- review the extent to which the recommendations of the joint GOI/GTN/Sida evaluation have been followed,
- recommend areas and issues to follow up in the Annual Review.

In addition to the above, the team shall also specifically review the following areas of the project:

Management
- the financial situation in relation to the project components and the budget,
- routine flow of funds from state to district and below, information flow and transparency,
- the process of monitoring, reporting and indicator development (quantitative/qualitative) in relation to the project activities,
- the organisational and administrative setup (MIS) at state, district and block levels and its functional basis; to what extent decentralization efforts have been implemented,
- staffing situation, vacancies and transfers,
- competence development of staff, at all levels,
- intersectoral coordination with the health, the education and the horticultural departments and with women's organisations, youth groups, NGOs etc.

Training
- assess the training inputs (content, methodology, material, resource persons, duration etc.) made, especially regarding the preschool, the disability component, adolescent girls and the WILL programme,
- describe changes that occurred as a result of the training regarding the services provided, the functionaries and the service utilisation,
- monitoring and recording of the training provided and its follow up at all levels.

Preschool
- process of monitoring and evaluating the preschool activities,
- describe changes in staff performance as a result of introducing the "joy of learning"
- integration of children with disability
- parental/community involvement and its effects

Adolescent Girls' Scheme
- progress and results after restructuring and redesigning the scheme,
- validity and correlation of the objectives and activities in relation to the need,
- parental/community involvement and its effect,
- monitoring and documenting the program

WILL Programme
– progress and results after restructuring and redesigning the programme,

– purpose/objectives and status of performance, and whether the programme reaches the illiterate women in the most remote areas of the Sida-ICDS,

– cost-effectiveness and sustainability

Method of work
The basic documents for the mission are:

- Project Document covering the period July 1995 – June 1997
- Modified Proposal for the extension period, July 1997 – December 1998
- Progress Report
- Report from the Joint GOI/GTN/Sida Evaluation

Emphasis of the assignment should be made on the team providing the project functionaries/staff advice and assistance in dialogues on critical issues related to the project proposal for future implementation and best practices.

Before making the field visits, the team shall be briefed by Ministry of Human Resource Development (MHRD)/ GOI, GTN in Chennai, the Swedish Embassy in New Delhi and Sida, Stockholm. They shall discuss with the project functionaries and make field visits in selected districts and interact with the project personnel at all levels. By the end of the mission, the team shall debrief the GTN in Chennai and MHRD/GOI, the Swedish Embassy in New Delhi and Sida, Stockholm.

Participants
The team should be gender sensitive and preferably gender balanced; have experience from work in India; and be knowledgeable in monitoring and reporting techniques. The team members shall comprise of both Indian and Swedish consultants. The consultants should include specialists on the issues of management (financial and delegation of project planning and implementation), adolescent health, and the integration of disabled children in preschool.

Reporting
Observations and recommendations made by the team shall be presented to the Swedish Embassy/Sida in a draft report by the end of the mission in India. The draft report shall be concise in format and not exceed 40 pages including the annexes. In addition, it shall include an executive summary and the terms of reference. Comments, if any, on the draft report shall be given by GOI, Sida and the project functionaries within two weeks of receiving the draft report.

The final version of the report shall be submitted to Sida within a week after receiving the comments on the draft report.

Time Plan
October–November 1998 – 3 weeks

Appendix B

Sida average annual per capita expenditures on the Tamil Nadu

The overall amount allocated to this project was 167 million SEK from 1989–1998. The number of beneficiaries in each category changed a great deal during that period, but the total number of beneficiary-years can be estimated from the data provided in the 1997 evaluation and this year's monitoring data from the project. It should be kept in mind that the services provided differed enormously from one type of beneficiary to another. Much of the overall funding did go to aspects that benefited all categories, such as civil works, administrative support, staff training, etc.

The following tables provide the basis for calculating beneficiary-years. The data come from March of each year.

Children 6 months to 2 years (1000s)

dis/yr	1988	89	90	91	92	93	94	95	96	97	98
Che.	9	10	11	31	38	49	54	65	69	63	49
Pud.	0	0	0	0	8	10	12	33	36	33	36
Nil.	0	0	0	0	2	5	5	6	6	4	3
Tot.	9	10	11	31	48	64	73	104	111	103	88

Children 2–6 years (1000s)

dis/yr	1988	89	90	91	92	93	94	95	96	97	98
Che.	9	21	28	98	102	99	101	105	106	79	96
Pud.	0	0	0	0	41	42	39	38	38	38	37
Nil.	0	0	0	0	9	8	8	9	11	10	10
Tot.	9	21	28	98	152	149	148	152	155	127	143

Adolescent girls (1000s)

dis/yr	1988	89	90	91	92	93	94	95	96	97	98
Che.	0	0	0	0	2	18	26	33	30	17	32
Pud.	0	0	0	0	0	4	4	3	0	0	14
Nil.	0	0	0	0	0	0	0	1	1	0	3
Tot.	0	0	0	0	2	22	30	37	31	17	50

Pregnant women (1000s)

dis/yr	1988	89	90	91	92	93	94	95	96	97	98
Che.	1	2	3	10	13	26	26	27	24	19	22
Pud.	0	0	0	0	4	4	4	10	11	10	9
Nil.	0	0	0	0	1	1	1	1	2	1	1
Tot.	1	2	3	10	18	31	31	38	37	30	32

Lactating women (1000s)

dis/yr	1988	89	90	91	92	93	94	95	96	97	98
Che.	1	2	3	11	14	22	25	24	24	18	21
Pud.	0	0	0	0	4	4	3	10	10	10	10
Nil.	0	0	0	0	1	2	1	2	2	1	1
Tot.	1	2	3	11	19	28	29	36	36	29	32
Grand Total	20	35	45	150	239	294	303	360	370	306	343

Adding up the grand totals for each of the 11 years gives a total of 2,465,000 beneficiaries. Dividing by 11 gives an average of 224,090 beneficiaries per year. Dividing this into the total Sida contribution during these years of 167 million SEK, also divided by 11, gives an average annual contribution of 68 SEK per beneficiary per year. At today's exchange rate this would be worth about 340 Rs. But in reality it was substantially less than this averaged over the 11 years, as the value of the Indian Rupee compared to the Swedish Crown has depreciated a great deal during these years – a reasonable average for the period might be 270 Rs, at the 1993 exchange rate of about 4 Rs/SEK rather than today's 5.

Also at around 1993, the World Bank estimated that GOI invested 1 million Rs per block and state governments about 1.7 million. Assuming that the average number of beneficiaries was the same as the above divided by 47 (the number of blocks receiving Sida support), this would amount to per capita annual contributions of about Rs. 209 from GOI and 357 from GTN. Thus the Sida contribution would have come to about 32% of the total spent.

Appendix C

Participatory Planning by Staff on Disability Management, using the Logical Framework Approach

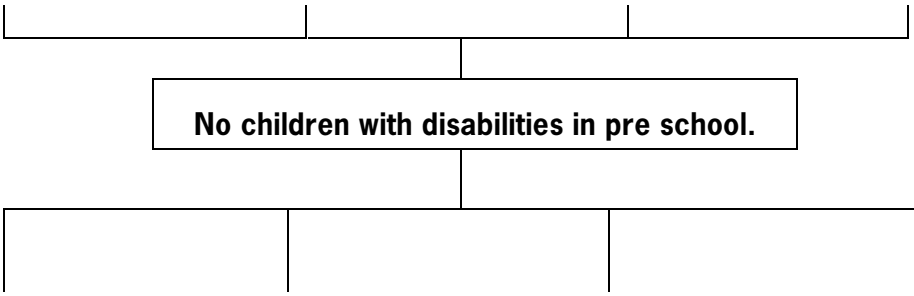
In 1995 implementation on disability management began but very little has taken place. Something in the planning had failed. To explore a better way of planning, four staff members were asked to use the Logical Framework Approach (LFA). It is in the interest of the project to find out how personnel look upon disability management, its obstacles and solutions. The following is a summarised presentation on the outcome of the planning session. The plan focuses on two parts: (a) the ICDS projects, and (b) the children with disabilities and their parents.

1. The Problem Tree

Only negative statements are listed

effects

ICDS	Family	Child	Village
– Not reaching the unreached	– Economic loss to the family	– Lack of attending to basic needs	– Not support the worker
– No change of attitudes among other children in pre school	– Emotional burden	– Psycho-social problems	– Don't know how to avoid disability
– No chance to make friends with the child		– Neg. development	– Don't know how to behave towards persons with disabilities
		– No schooling	
		– No adjustment and behavioural problem	
		– Denying the child education	



No children with disabilities in pre school.

causes

ICDS	Parents	Child	Village
– No support from ICDS and others	– No acceptance	– Low self esteem	– Non acceptance
– No knowledge on disability, no training	– Grief and guilt	– Fear of being teased	– Other children will imitate
– No change of attitude even with trained worker	– Can not carry the child to pre school		– Lack of knowledge of results from rehabilitation
– Age limitation in pre school	– Social stigma		– No knowledge on causes and effects of disability and needs of these children
– Extra work	– Fear from society		
– No special equipment for training and playing	– No knowledge of rehabilitation		
	– Lack of knowledge on the need of the child		

2. Objectives tree

The negative statements are made into positive and desirable conditions.

ICDS

– Support from all ICDS functionaries above AWW

– Age relaxation for child with disabilities if they are not able to attend school

– More understanding from worker and children towards children with disabilities

– Training in disability management

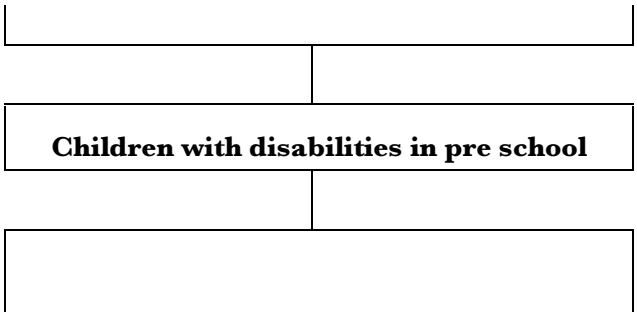
Village

– Acceptance

– Awareness building – knowledge on prevention and early detection

– Prevention further incidences of disability.

– Community participation on transport, play- and teaching materials



Parents

– Knowledge on causes and effects of disability

– Knowledge of the child's needs

– Knowledge of rehabilitation

– Acceptance in the family

– Relief from guilt

– Can concentrate on their other work

– Improved economy

Child

– Social stimulation

– Progress in physical development

– Increased self-confidence

– Schooling readiness

3. Definition of Main Project Elements

The following sketch will illustrate the outcome of the problem tree and the objectives tree.

Development objective:	**Indicator:**
Change of attitudes in persons with disabilities	x no incidences of community participation/centre
Project objectives:	**Indicator:**
Children with disabilities in pre school	one child with disabilities in each centre
Outputs:	**Indicators:**
– ICDS staff trained in prevention and early detection	– x no. AWW trained
– ICDS activities included disability issues	– x no. activities, which have included disability issues/centre
– Parents have learned about the child's needs	– x no. parents train/stimulate the child at home
– Children get pre school readiness	– x no. children with disabilities attending school

Comments

This experiment shows that personnel are often aware of reasons for obstacles that occur; that knowledge ought to be made use of when planning and implementing a project. The LFA method can be used both in the planning procedure at all levels and also in the training of personnel. When introducing disability management, the LFA method will involve the participants more in the objectives and the expected outcome of the training.

Appendix D

Disability management in new districts – an approach for discussion

In districts that have not had any training in disability management, networking is a must. Medical as well as pedagogical knowledge ought to be made use of in the respective district. This means that medical colleges, NGOs and special schools for children with disabilities will be involved in the training of personnel.

Training should be need based and thus cost effective. The following training strategy could be followed:

Step 1. All ICDS personnel trained in prevention and early detection (5 days).
Step 2. Selected staff members attend a disability-specific cause (5 days).

Positive side effects: Immediately after the training the new knowledge will be put to use. Motivation and support from all parties involved will ensure good results.

Step 1. Awareness building on disability issues
Objectives: Change of Attitudes towards Persons with Disabilities.
Awareness building on disability issues.
Contents: Prevention and early detection of disabilities.
Participants: Training should go to all personnel. Preferably, different categories can be mixed.
Teachers: Special training instructors and trainers
Method: By using appropriate methodology in the training the same methodology can be used in practice. Lectures should be avoided.
Output: AWW shall be able to give people – e.g. villagers, interest groups – an understanding on causes and effects of disabilities, how to avoid disabilities and also learn about the needs of children with disabilities, so as to lessen the sometimes negative attitudes towards these persons. Duration: 5 days Place: non-residential

Step 2. Disability specific training
Objectives: Inclusion of children with disabilities in preschool.
Support to mothers and the AWWs respectively.
Contents: Activities are selected to suit the participating children. There is also a need for selecting activities on compensatory training, that is, activities/games that will train/compensate the impairment, e.g. games are chosen so that the deaf child is "trained" to lip-read and a blind child how to make good use of the other senses.
Participants: AWW, Supervisor II, the mother and the child. Six sets makes 24 participants, which makes a good variety of problems occurred, which have to be dealt with.
Teachers: Special teachers for this specific disability and assistants to take care of the children when mothers need to participate without being disturbed.
Methods: Practical use of the manual for "Joy of Learning". Activities are selected according to the kind of impairments occurring among the participants and the need of the respective child.
Exchange of experiences in homogenous and mixed groups respectively are of great value.
Some counselling will occur.
Output: More children will be allowed into preschool by their parents
Mothers will become confident in the AWW and vice versa.

Also mothers will make friends with other mothers and children with other children, who have the same kind of disability

AWW and Supervisor II will learn about activities suitable for children with this kind of disability. Duration: 5 days alt. 2 + 2 days Place: Special school; Residential

– After a year or so these participants will be well equipped to participate in training of other AWW, Supervisors II and mothers (or preferably parents). Their "speciality" will be inclusion, which at the moment not many in ICDS have practical experience of.

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SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
S-105 25 Stockholm, Sweden
Tel: +46 (0)8-698 50 00. Fax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se