

## Chapter-1

### INTRODUCTION

The levels of child nutrition in India show very dismal scenario. From NFHS-3 data it is found that near about 50% Indian children are underweight and anemic . This is a matter of utter disgrace that India falls under the category of most ‘undernourished’ countries. Though this is also to be noted that the entire South Asian region is depicting this trend of high range of malnutrition. In fact it is hard to believe that child malnutrition in India is remarkably lower than that of Sub-Saharan Africa (**Source: World Development Indicators 2007**).

In China even in the rural areas the average increase in height between 1992 and 2002 was 3 centimeters and needless to add that it was much higher in the urban areas. Even the adult health and height is attained lately in early –mid 20s in India while in western countries it is attained at the age of 18, which is a clear cut indication of poor nutrition. It is found that Indian women and also the Nepalese and Bangladeshi women are among the shortest in the world (**Source: Deaton, Height, “Health and Development”, Proceedings of the National Academies of Science, pp 13232-37, 2007**).

The decline in sex – ratio also remains a great enigma which is widely discussed by Prof. A.SEN (**Source: Dreze and Sen; India Development and Participation; Oxford University Press, 2002**). The NFHS anthropometric data shows that the speed of nutritional improvement has virtually stopped. It shows that there is no change in the percentage of women with low BMI, the percentage of underweight children remained same (nearly 50%) from 1998-99 to 2005-06. Interestingly there was notable decrease in the percentage of stunting children.

However, the mean levels of stunting of young children generally do not recover; the children grow at the same rate as the reference population, but are much shorter for their age. Gestation and the first year of life are critical periods of human brain development; it is thus not surprising that there is a correlation between low birth weight (LBW) and stunting early in life and later cognitive deficits .This points to the importance of intervening early to prevent stunting and its long-run consequences. It also suggests that the potential for interventions to prevent malnutrition is greatest during pregnancy and the first 24 months of life (*Bhutta and others 2008; Shrimpton and others 2001; World Bank 2006*).

The Integrated Child Development Services (ICDS) is the Flagship Scheme of the Department of Women and Child Development with an allocation of 90 per cent of the total plan outlay. New policy initiatives have also been taken for the setting up of the National Commission for Children, National Plan of Action for Children, National Nutrition Mission etc. Keeping in view the need for focused attention on the welfare and development of girl children, certain programmes like Kishori Shakti Yojana (KSY), Nutrition Programme for Adolescent Girl (NPAG), Balika Samriddhi Yojana (BSY) etc. are being implemented by this Department. Besides, new initiatives in the form of universalisation and expansion of ICDS, merger of Kishori Shakti Yojana (KSY) with National Programme for Adolescent Girls (NPAG), merger of the Scheme of Creches and Day Care Centres and the National Creche Fund etc. are being contemplated for evolving a holistic approach and effective implementation of various schemes and programmes for the benefit of the target groups.

In spite of all these programmes, the development in basic infrastructure and basic amenities/facilities is not perceptible especially in rural areas of the district <sup>of Darjeeling</sup>. The standard of living of the people is still very poor and the employment opportunities to the young people are

few and far between. A large proportion of population is still deprived of basic necessities of life. About 30 percent of the households are using water from unsafe sources. Besides, most of the villages have been identified as disadvantageous in respect of availability of water supply due to less service level, source depletion, and outlived design period of water supply schemes. The situation on sanitation front is even more alarming. Around two-third of the households (64 percent) do not have a toilet facility or have a pit type of toilet. Similarly, 60 percent of the households do not have any sewage and drainage facility.

## **OBJECTIVES OF THE STUDY**

The specific objectives of the evaluation study include the assessment /examination of the following:

1. The type of mechanism adopted and arrangements made for planning co-ordination, monitoring and implementation of the scheme.
2. The extent to which allocations, releases and utilization of funds were made as per the guidelines under various scheme.
3. To portray as to what extent the scheme has generated the needed benefits.
4. To analyze socio-economic and demographic characteristics of the beneficiaries of the scheme, so as to assess the extent to which the guidelines for identifying the beneficiaries/villages have been followed.
5. To identify the problems in the implementation of the scheme and the reasons for tardy implementation, if any.

## **REVIEW OF LITERATURE**

“There is a surprising degree of continuity in public policy, as evident in literally thousands of case studies of disparate policy sectors in a multitude of countries showing that most policies made by governments are in some way a continuation of past policies and practices. Most analyses attribute continuity in policy making to the fact that the same set of actors is typically involved in the policy process over a long period of time. Only when a policy monopoly is broken by the emergence of new members or subsystems would one expect a policy to change in any significant sense of the term.” (Howlett and Ramesh 1995, *Studying Public Policy*, Oxford University Press, pp 184-185.)

It is obvious that the determinants of maternal and infant health are closely related, there are very few works where the issue of maternal and infant health is considered jointly (Winikoff, 1988 ;Winikoff, Beverly. 1988. “Women’s Health: An Alternative Perspective for Choosing Interventions.” *Studies in Family Planning* 4 (19):197–214.);(Conway and Deb, Conway Karen and Partha Deb. 2005. “Is Prenatal Care Really Ineffective? Or, Is the

**Devil in the Distribution?" Journal of Health Economics 3 (24):489–513).**

It is sometimes argued that spending pattern has no role in malnutrition as since 1991 the Indians are spending a lot but at the same time it failed to curb the number of malnourished children! On the contrary on poor and rural households, spending does play a role in improving infant health for those groups. **[Goldman and Grossman (1982), Goldman, Fred and Michael Grossman, 1982. "The Impact of Public Health Policy: The Case of Community Health Centers." NBER Working Paper No. 1020].** find that health care spending and public policy programs in the US do have a significant impact on infant mortality, and argue that this impact runs through improvements in health of mothers, rather than the use of prenatal care per se. The evidence also shows that infant and child mortality and morbidity are determined by poverty and unemployment rate **[Bhalotra, 2007 Bhalotra, Sonia. 2007. "Spending to Save? State Health Expenditure and Infant Mortality in India." University of Bristol Working Paper No. 07/169.; Currie and Grogger, 2000), (Currie, Janet and Jeffrey Grogger. 2000. "Medicaid Expansions and Welfare Contractions: Offsetting Effects on Prenatal Care and Infant Health?" NBER Working Paper No. 7667.]**, parental

education, urban residence, and maternal health in general [*Buckley, 2003 Buckley, Cynthia. 2003. "Children at Risk: Infant and Child Health in Central Asia." William Davidson Working Paper No. 523.; Chou et al., 2007). Chou, Shin-Yi, Jin-Tan Liu, Michael Grossman, and Theodore J. Joyce. 2007. "Parental Education and Child Health: Evidence from a Natural Experiment in Taiwan." NBER Working Paper No. 13466.*]

It is common in health economics research to find little or no effect of prenatal care on infant health, which may be due to two reasons – endogeneity and heterogeneity. Mothers anticipating poor birth outcomes are more likely to seek more prenatal care and seek it earlier while still having poorer than average outcomes. Authors that use exogenous variation in prenatal care, such as “natural experiment”, find positive and significant impact of prenatal care use on birth outcomes [*Evans and Lien, Evans, William N. and Diana S. Lien. 2005. "The Benefits of Prenatal Care: Evidence From the PAT Bus Strike." Journal of Econometrics 125:207–239. 2005). Conway and Deb Conway, Karen and Partha Deb. 2005. "Is Prenatal Care Really Ineffective? Or, Is the Devil in the Distribution?" Journal of Health Economics 3 (24):489–513.(2005)*] in addition to addressing

the issue of endogeneity explore the possible heterogeneity in the impact of prenatal care on birth outcomes.

Looking at all births simultaneously may obscure the effect of prenatal care on “normal” births. Some of the births result in poor outcomes due to bad maternal behavior or poor fetus condition to begin with and cannot be remedied by any prenatal care intervention. Therefore, lack of significant impact of prenatal care on infant health may be explained by data that do not distinguish between “normal” and “problematic” pregnancies. Thus, Conway and Deb (2005) found that prenatal care has a substantial effect on “normal” pregnancies.



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## **SOURCES OF DATA AND**

### **METHODOLOGY**

As the district of Darjeeling remained like a hot cauldron of political and social unrest people was very suspicious and over cautious while responding questions. In fact most of the respondents were reluctant to talk to us. Which was the biggest constraint of the study?

Moreover due to financial constraints the dependence on secondary data has to be accommodated. The main source of secondary data was the project level MPR (Monthly Project Report). For Growth monitoring data the AWC level had to be explored. While the office of the DPO served the final information. The office of the Director was also visited for State level data. Both primary and secondary data were collected through instruments structured at different levels. The secondary data was obtained through the District, Block and Village level questionnaires. Information was collected about financial and physical performance and adequacy of the implementation mechanism for the schemes. Detailed discussions were held with the officials at various levels to gather information on the implementation of the scheme. The primary data was collected through

field surveys from beneficiaries as well as non-beneficiaries of the scheme.

The schedules covered a host of areas starting with the socio-economic characteristics of the beneficiaries, level of awareness about the schemes, eligibility criterion, procedures, problems encountered, utilization of the funds and impact of the scheme, etc. Information collected from the non-beneficiaries included their socio-economic status, knowledge of the schemes and experiences with the implementation of the scheme.

The experiences of the beneficiaries and non-beneficiaries were collected with a view to identify and analyze the possible shortcomings in the implementation of the scheme.

Initially I was permitted by the Director to visit four Projects two from Darjeeling Sadar Subdivision and two from Kalimpong subdivision. Later they allowed me to visit all the projects in the hill area. Further, the Projects were divided into two groups of high and low performance, based on the information on key indicators of performance of the AWWs. 6 projects from each of the two groups was selected on random basis in the district. Accordingly, 12 projects were selected from the district. Details about the ICDS were collected from the offices of the District Magistrate and concerned Block

Development Officers. The information regarding the Integrated Child Development Scheme was also collected from the offices of the Programme Officers, Child Development Project Officers and Anganwadi Centers. From each selected I.C.D.S. projects a sample of 5-6 beneficiaries was selected on random basis from the selected beneficiaries who were covered under ICDS. In case there were more than one Anganwadi Centres (AWCs) in a village, only one AWC per village was selected. Besides, detailed interviews were conducted with the officials involved with the implementation of these schemes at State, District and Block level. A check list was also prepared to collect the qualitative information from the beneficiaries, and officials/offices. As the list of non-beneficiaries for any of the schemes was not readily available, therefore, effort was made to collect list of non-beneficiaries with the help of knowledgeable persons of the villages, but even the villagers were not aware of any such person.

## **FIELD WORK & METHODOLOGY**

The Data collection started from April 2000 and continued till July, 2010. Data was collected by two teams and each team consisted of five field investigators, a supervisor-cum-editor and a field coordinator. Each field investigator was assigned to collect information for a particular scheme. Before the field work, all the team members received training for six days, which consisted of instructions in interviewing techniques and field procedures for the survey, review of each item in the questionnaire, mock interviews between participants in the classroom and practice interviews in the field. Besides the main training, one day training was specially arranged for supervisors. The supervisors were trained to hold formal discussions with the officials involved with the implementation of the schemes and record their observations regarding the implementation of the schemes, impact assessment and possible reasons for tardy implementation. Senior officials coordinated the data collection activities and also had formal discussions with the officials involved with the implementation/execution of schemes. During the course of field work, information was collected from 12 ICDS Centers and 80 mothers of beneficiary children.

To collect primary data the Blocks (CDBs) in Darjeeling were grouped as high and low categories on the basis of data of key indicators of development. A block from each of the categories was randomly chosen. Data was retrieved from district and block offices. From each chosen block, 3 - 5 villages were selected on random basis. From the chosen villages the information were collected from the beneficiaries covered under ICDS in the villages. Moreover, from each chosen village, one key respondent was also interviewed. When there were more than one Anganwadi Centers in a village, only one of them was selected. From the selected centers, beneficiaries were selected and the mothers were interviewed. The officers at state, district and block level were also interviewed. This helped to do the qualitative analysis. Secondary data on the financial progress, planning, implementation and monitoring was collected from the implementing agencies of the scheme.

## ***TIME PERIOD***

The reference period of the study for selection of beneficiaries, collection of field data was 2000-01 to 2009-10. However, while making analysis, the data on physical/financial targets vis-à-vis achievements for the years upto 2006-07, was also utilised. Though due to sudden outbursts of bandhs/strikes in the hill area it was too difficult to stick to the schedule all the time.

## **RESEARCH QUESTIONS:**

- Whether health check-ups were done regularly or not?
- How much effective were the referral services?
- Were the medical kit available to all the AWCs ?
- Was the quality of nutritional items satisfactory or not ?
- What was the impact of supplies on the functioning of the AWCs ?
- How effective was the growth monitoring and promotion during the study period?
- How far the nutrition and health education was imparted?
- What was the real picture of the Pre-School Education (PSE) imparted?

## **CHILD UNDERNUTRITION & MALNUTRITION: SOME PERSPECTIVE ON "KERALA MODEL"**

It is obvious that West Bengal is lagging behind the national level of malnutrition lately. In this context it would be helpful to look at the management style of a very successful state in this field. This is an approach which is quite unique and mention worthy.

Undernutrition and malnutrition occur largely due to inappropriate family practices related to diet, health care and hygiene / sanitation. Focusing on the family as a unit for behavioural changes communication is an advantage because through the family approach, it is possible to reach the children (especially the 0-3 age group), the adolescents, the antenatal and postnatal mother and the elderly who are the target groups for the programme.

- The primary focus would be to strengthen family practices related to Infant and young child feeding (exclusive breastfeeding, appropriate complementary feeding)
- Sick childcare with appropriate medical treatment and nutrition management
- Prevention of illnesses through immunization and hygiene / sanitation
- Appropriate cooking and dietary practices in the family
- Appropriate use of nutritional supplements and micronutrient supplements
- Diarrhoea management through ORT to be promoted within the family.

This will be done through specially selected and trained Family Nutrition Volunteers who will visit these families regularly and provide continuing support. The Family Counsellor will be selected from among experienced persons in the field within the community. They will be trained in nutrition topics and counselling skills and she will be supported and guided by the local AWW and by the Panchayat level Nutrition counsellor (ICDS Supervisor/ Nutrition Experts) The Nutrition Volunteer will identify all families with children 0-6 years, with antenatal mothers, nursing mothers, adolescent girls, and elderly persons. She will repeatedly visit these families and provide counselling and care for specific nutrition and health problems and issues faced and she will encourage and motivate the families for adopting / strengthening appropriate family practices.