PEO Study No.95

REPORT ON THE STATE OF PREPAREDNESS OF THE INTEGRATED CHILD DEVELOPMENT SERVICES PROJECTS - 1978

1. The Study

Child welfare was accorded the highest priority among the programmes for social welfare during the Fifth Five Year Plan. A National Children's Board was set up in 1974 and a resolution on the National Policy for Children, which stressed the importance of programmes beamed to the development of children, was adopted in the same year. The blueprint for the Integrated Child Development Services (ICDS) Scheme was prepared in 1975 by the then Ministry of Education and Social Welfare. The ICDS Scheme was included in the Social Welfare Sector with the objectives of (1) improving the nutritional and health status of children in the age group 0-6, (2) laying the foundations for the overall development of the child, (3) reducing the incidence of mortality, morbidity, mal-nutrition and school dropout, (4) achieving effective co-ordination of policy and implementation among various departments to promote child development and (5) enhancing the capability of the mother to look after the normal health and nutritional needs of the child. The scheme was intended to deliver an integrated package of services consisting of supplementary nutrition, immunisation, health check-up, referral services, nutrition and health education and non-formal education. Apart from the normal funds provided by the State Governments for child welfare, the scheme was envisaged to receive resources through Special Nutrition Programme (SNP)/CARE/WFP/UNICEF assistance and Central assistance (through the State Governments). The hierarchical organisational structure of the Scheme consisted of the Ministry of Social Welfare which was vested with the budgetary control and administration of the Scheme at the Centre, the Secretary of the Department of Social Welfare at the State level, the District Social Welfare Officer (in his absence the District Development officer/District Planning Officer) at the district level and a Child Development Project officer (CDPO) at the block level. The Anganwadi in each village manned by an Anganwadi worker was the focal point for the delivery of various services under the Scheme. Co-ordination Committees were also envisaged to be set up at different levels.

At the instance of the Planning Commission, the Programme Evaluation Organisation took up an evaluation study of the Scheme in July, 1976, the field work of which was completed in two phases. The first phase, aimed at (Baseline Survey) understanding the state of preparedness for implementation of the Scheme, was completed in October, 1976 and the Repeat Round, aimed at assessing the impact of the working of the projects, was conducted during 1977-78. The present report relates to First Round of the Survey.

2. Objectives

i) To examine the availability of basic data at the project level;

ii) To study the broad characteristics of the ICDS projects in relation to feasibility of operation;

iii) To review the extent to which infrastructure was built up for the delivery of health, nutrition and education services in the Scheme;

iv) To assess the flow and utilization of finances and the flow of supplies to the projects;

v) To examine the extent to which placement and training of staff was accomplished; and;

vi) To assess the involvement and participation of the Community in the initial stages of the project and administrative co-ordination.

3. Sample Size/Criteria for Selection of Sample

Out of a total of 33 ICDS projects, 29 projects (17 rural, 8 tribal and 4 urban) were purposively selected on the basis of the availability of PEO units from 19 out of 22 States and the Union Territory of Delhi. Six Anganwadis were selected from each project on a stratified random basis, the criterion of stratification being the distance of the Anganwadi villages from the Project Headquarters. One village was chosen from within a distance of 5 kms. of the Project Headquarters; 3 from the radius of 5 to 10 kms, and the

remaining 2 from a distance beyond 10 kms. Three of the 6 selected villages were from areas where both Anganwadi and Auxilliary Nurse and Midwife (ANM) Centre were functioning, whereas the remaining 3 represented the village that had an Auganwadi but no ANM centre.

4. **Reference Period**

The survey was conducted between July and October, 1976 and the data were collected for the year 1975-76.

5. **Main Findings**

1. A great deal of effort had indisputably been put into taking the ICDS projects off the ground. The Anganwadi workers (AWWs) were appointed and trained in large number. There was increasing awareness of the potentials of the projects. A start was made in monitoring and various agencies were assigned definite tasks. All this notwithstanding, serious deficiencies had crept in during the first year of the implementation of the Projects.

2. The project authorities did not have the required understanding of the priorities among different components of the Scheme i.e. health, nutrition and education. The last component received undue emphasis. Pre-primary education for a thin segment of target population of 3 to 5 years was the main activity.

3. Co-ordination between the implementing agencies was not satisfactory. The role of the health staff in implementing the Scheme was not clearly understood, nor was their attitude towards the programme suited to its co-ordinated functioning along with other agencies. The composition of the Co-ordination Committees was predominantly official and male dominated. These Committees were constituted with considerable time lag.

4. Surveys and household enumeration had been so haphazard that the characteristics of the target groups - their size, composition etc. - were not yet determined. Consequently, programme planning in terms of the area requirements like staff, equipments, materials, finances etc. suffered.

5. Involvement of women, which was an essential component for the success of the programme, was conspicuously absent. Accommodation for the Anganwadis was generally of poor quality.

6. Owing to the lack of critical equipments like weighing scales and printed growth charts, the children eligible for supplementary nutrition and special health care could not be identified. The most inaccessible and vulnerable group of children, i.e. the below three years, who required the maximum attention in terms of health & nutritional services could not be reached yet.

7. Release of funds and appointment of health staff were preceptibly slow and halting. The AWWs who were pivotal to the programme implementation were not health oriented. Despite being an essential precondition, separate funds were not earmarked by the State Governments for supplementary nutrition in the ICDS project areas.

8. Most capital items, except the weighing machines and refrigerators were received. However, there was considerable lacunae in the supply of essential medicines, vaccines required for immunisation work, etc.

9. The nutrition programme relied heavily on WFP or CARE food, contrary to the concept of the Scheme. Lack of basic data on the size and composition of target population was a major deficiency in the feeding programme. Prevalent food delivery system did not ensure nutrition for the `below threes', nutritionally-at-risk and pregnant and lactating women.

10. The prevalent monitoring system provided a great deal of information. However, in the absence of realistic time schedule and sequencing of supplies and delivery of services to the target groups, the system missed the needed information on health infrastructure, nutrition, education, drinking water supply etc.

6. **Major Suggestions**

1. In view of the flaws in the prevalent food delivery system, it is suggested that a sound food delivery system needs to be developed.

2. Depending upon the severity and incidence of childhood disease, it is suggested to work out a differential sequencing of immunisation schedule.

3. Health and Nutrition Education needs to be developed and the various activities under the ICDS should receive right type of attention.