2.1 Evolution of child care services

Any national development strategy that emphasises human development essentially begins with the welfare of children. Investments made in children’s health, nutrition and education help in reducing hunger and malnutrition, extending life expectancy, and lowering death rate and school dropout rate among them. Planners all over the world have recognised that access to minimum services for children is likely to ensure their optimal development and would help in shaping them into adults capable of contributing to economic and social development of the nation.

2.2 Child in India

India has around 350 million children who are below the age of six years. A majority of them are raised in families living in extreme conditions of poverty. Consequently, on important indicators of social development, India still ranks low. Infant mortality rate, one of the crucial indicators of child survival continues to be as high as 74 (1995); 30 percent new-borns are low birth weight babies; and about two-fifth of deaths occur in the age group 0 – 6 years. Further, we have not been able to adhere to the target to universal
primary education and control dropout rate at primary level that continues to be as high as 48.60 percent (1986-87).\(^5\)

Owing to the interlocking problems of the grinding poverty of families, children grown in uncongenial environment characterised by non availability of civic amenities, health care and lack of access to cognitive stimulation, skills and knowledge remain a problem in India. Several intervention programmes and services therefore, have emerged during the last few decades, in order to safeguard survival and development of disadvantaged children, both in the Government and voluntary sectors.

Independence ushered in a new era in the field of child welfare/development. It is marked with events, which bear testimony to the commitment that we have towards our children. Adequate provisions were made for the care and protection of children in the Constitution. In order to meet these obligations, welfare services have been provided at the national level as an integral part of the country’s development plans. The first three five-year Plans placed the major responsibility of child welfare services on voluntary organisations. The Central Social Welfare Board (CSWB) was set up as early as 1953 to promote child welfare/development programmes by providing assistance to voluntary organisations. Besides this, the then Department of Social Welfare initiated several programmes which provided health, nutrition and education interventions for child welfare and development.

The experience of implementing various programmes sector-wise, however, indicated that the impact of these on children remained at best marginal. The isolated and fragmented services failed in providing solutions to

Fig. 2. Child Population in India
1971-2001

Table 5. Projected child population by age group in India from 1996-2016
(Population ln'000)

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Year</th>
<th>Child population in the age group (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0-4</td>
</tr>
<tr>
<td>1.</td>
<td>1996</td>
<td>1,19,546</td>
</tr>
<tr>
<td>2.</td>
<td>2001</td>
<td>1,08,494</td>
</tr>
<tr>
<td>3.</td>
<td>2006</td>
<td>1,13,534</td>
</tr>
<tr>
<td>4.</td>
<td>2011</td>
<td>1,19,530</td>
</tr>
<tr>
<td>5.</td>
<td>2016</td>
<td>1,22,837</td>
</tr>
</tbody>
</table>

SOURCES: Census of India 1991, population projections for India and States, 1996-2016
**Fig. 2.2: Infant Mortality Rates**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rural</th>
<th>Urban</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>138</td>
<td>82</td>
<td>129</td>
</tr>
<tr>
<td>1976</td>
<td>139</td>
<td>80</td>
<td>129</td>
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<td>1979</td>
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<td>1981</td>
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<tr>
<td>1982</td>
<td>114</td>
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<td>1983</td>
<td>114</td>
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<td>1984</td>
<td>113</td>
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<td>1985</td>
<td>107</td>
<td>59</td>
<td>97</td>
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<td>1986</td>
<td>105</td>
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<td>96</td>
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<td>1987</td>
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<tr>
<td>1988</td>
<td>102</td>
<td>62</td>
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</tr>
<tr>
<td>1989</td>
<td>98</td>
<td>58</td>
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<tr>
<td>1990</td>
<td>86</td>
<td>50</td>
<td>80</td>
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<tr>
<td>1991*</td>
<td>87</td>
<td>53</td>
<td>80</td>
</tr>
<tr>
<td>1992*</td>
<td>85</td>
<td>53</td>
<td>79</td>
</tr>
<tr>
<td>1993*</td>
<td>82</td>
<td>45</td>
<td>74</td>
</tr>
<tr>
<td>1994*</td>
<td>80</td>
<td>52</td>
<td>74</td>
</tr>
<tr>
<td>1995*P</td>
<td>80</td>
<td>48</td>
<td>74</td>
</tr>
</tbody>
</table>

**SOURCE**: Office of the Registrar General, India, (Sample Registration System)

* Excludes Jammu & Kashmir and Mizoram
P Provisional
the problems of children. As pointed out by Pandit Jawahar Lal Nehru, the then Prime Minister of India “...........individual acts and services performed here and there........ never solve great and stupendous problems on a countrywide scale”.

A high powered committee under the chairmanship of Shri Ganga Sharan Sinha recommended at that juncture that a comprehensive national policy for child welfare was necessary to take an integrated view of different needs of children and assign priorities. As a result of this, the National Policy for children was evolved and adopted in 1974. It describes the country’s children as a supremely important asset and enjoins on the State the responsibility of their nurture and solicitude.

2.3 Integrated Child Development Services Scheme

In 1974, India adopted the National Policy for children and constituted a National Children Board to ensure continued planning, monitoring and co-ordination of various welfare services for children. An in-depth assessment of prevailing programmes confirmed the need for a holistic programme to provide an integrated approach to child growth and development. It was decided that such a programme should have components of health, nutrition, pre-school and non-formal education on health and nutrition. Thus, in pursuance of the National Policy for children, the country’s largest programme was launched on the fateful day of 2 Oct. 1975 in 33 experimental blocks\(^6\) (4 – urban, 18 – rural, 11 – tribal). By the end of 1995-96, the scheme had spread over 5614 projects (Central – 5103, States – 511) covering nearly 5300 community development

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blocks and over 300 urban slums. ICDS caters for over 22 million beneficiaries, which include over 18 million children and nearly 4 million pregnant and lactating women from the poor socio-economic group. Nearly, 11 million children in the age group of 3-6 years participate in the pre-school education activities at various anganwadi centers. There are over 3 lakh trained anganwadi workers and an equal number of helpers in ICDS services delivery management. Undoubtedly, ICDS is the world’s largest programme and it attracts considerable attention of the scientific community all over the world.

2.3.1 The Philosophy and Approach

The concept of providing a package of services is based primarily on the consideration that the overall impact would be much greater if different services are delivered in an integrated manner, as the efficiency of a particular service depends upon the support it receives from the related services. For example the provision of supplementary nutrition is unlikely to improve the health of the child, if the child continues to be exposed to diarrhoea, infections or unprotected drinking water. ICDS therefore takes holistic view of the development of the child and attempts to improve both his/her prenatal and postnatal environment. Accordingly, besides children in their formative years (0-6 years), women between 15 to 45 years are also covered by the programme as these are child bearing years in the life of a women and her nutrition and health status has a bearing on the development of the child.
ICDS is thus the unique programme, encompassing the main components of human resource development, namely, health, nutrition and education. It is perhaps the only countrywide program in the world functioning on a large scale requiring multi-sectoral operations and inter-sectoral linkages for its implementation. Efforts are also made for the convergence of related schemes/programmes in ICDS projects such as Safe Drinking Water Supply, Functional Literacy for adult women, and Mobile Food and Nutrition Extension Units (MEU).

While selecting projects, priority is given to areas predominantly inhabited by backward tribes/scheduled castes drought prone areas and urban slums. Each project aims at total coverage of a compact area with a population of about one lakh each in rural and urban areas and about 35,000 in tribal areas. ICDS serves the target group through a network of Anganwadis (AWs). The Anganwadi (literally meaning a courtyard play centre) is the focal point for the delivery of services at the community level.

### 2.3.2 Beneficiaries

The programme beneficiaries are children below 6 years; pregnant and lactating mothers; women in the age group of 15–44 years and adolescent girls up to the age 18 years for non-formal education and training on health since 1991.

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7. Central Technical Committee-ICDS, Department of Women and Child Development, New Delhi, Monitoring, Motivation, Continuing Education, Evaluation, Research and Training and ICDS, Sachdev Y, Tandon BN, Krishnamurthy KS and Kapil U (Eds.).
2.3.3 Objectives

The main objectives of the scheme are to improve the nutrition and health status of the children aged between 0-6 years; to lay the foundation for proper psychological, physical and social development of the child to reduce the incidence of mortality, morbidity, malnutrition and school dropout; to achieve effective co-ordination of the policy and implementation among various departments to promote child development; to enhance the capacity of the mother to look after the health and nutrition of the child through proper nutrition and health education.

2.3.4 Services

A package of services provided to the beneficiaries includes supplementary nutrition, vitamin “A”, immunisation, health check-up, referral services, treatment of minor illness, non-formal health and nutrition education to women, pre-school education to children in the age group of 3-6 years and convergence of other supportive services like water supply, sanitation, etc.

This package of services is offered to the target community at a focal point ‘anganwadi centre’ (AWC) located within an easy and convenient reach. Anganwadi Worker (AWW) is the key community level functionary who receives a small honorarium and is specially trained for the job. The presence of the AWW in the community has synergistic effect as she liaises between health functionaries and the community.

Convergence with health functionaries helps better maternal and child health, enhance awareness regarding family planning services, treatment of morbidity and reduction of mortality. AWC serves as a central point for immunization, distribution of vitamin A, iron and folic acid and treatment of minor ailments and first aid. This is achieved by use of medical kit issued to AWC. AWC is also the venue for many health related activities carried out by auxiliary nurse-midwife (ANM) such as ante-natal care, motivation for family planning and referral of any child or women for medical attention.

Each AWC looks after a population of approximately 1000 in rural and urban areas and 700 in tribal areas. Presently, on an average there are 125-150 AWCs per project/ block. AWC being such an important place of ICDS activity; it will be better to define its norms of place, building, facilities etc. and ensure proper compliance by the village panchayat.

Supplementary nutrition

Six months to 6-year-old children belonging to low income families, pregnant and lactating mothers are encouraged to avail the facility of supplementary nutrition (SN) for 300 days in a year. The type of food varies from state to state. Usually, it consists of a hot meal cooked at AWC. It contains a combination of pulses, cereals, oil, vegetables and sugar. Some AWCs provide a ready-to-eat meal. Some agencies like CARE, World Food Programme (WFP) are implementing a ‘take-home’ strategy for 2-4 weeks at a time for children under 2 years and pregnant and lactating women. While the ‘take-home’ practice solves the problem of daily attendance and saves

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considerable time of the AWW, there is bound to be sharing of the food at home and the index beneficiary at best will get only a part of it. It will be interesting to note its long-term effect on AWC attendance for pre-school education and other activities. Cooking and serving food at AWC, eats into AWW time but then it also provides her with a good opportunity to develop a close rapport with the local women and indulge in non-formal education on health and nutrition. This is also a good opportunity for community mobilization and participation. A flexible approach to respond to local needs seems to be the answer.

Improper storage facilities, poor quality and erratic supplies, pilferages and other logistic problems in certain states and some parts of other states have also been noticed and require corrective steps.

Immunization

Primary health centers (PHC) and its infrastructure, carry out the immunization of infants and expectant mothers as per national schedule. AWW assists the functionaries in this activity. She helps in the organization of fixed day immunization sessions. She maintains records and follows up to ensure complete coverage.

Health check-ups and referral services

The health check-up activity includes health care of all children below 6 years, ante-natal care of pregnant women and post-natal care of lactating mothers. AWWs and PHC staff, work together and carry out regular check-ups, body weight recording, immunization, management of malnutrition, treatment of diarrhoea, deworming and other minor ailments. At AWC, children,
adolescent girls, pregnant women and lactating mothers are examined at regular intervals by the lady health visitor (LHV) and auxiliary nurse-midwife (ANM). Malnourished and sick children, who cannot be managed by the ANM/AWW are provided referral services through ICDS. All such cases are listed by the AWW and referred to the medical officer.

**Growth monitoring promotion (GMP)**

Growth monitoring is an accepted method to evaluate nutrition. It is an important tool to assess the impact of health and nutrition-related services. Children below the age of 3 years are weighed once a month and those over 3-6 years, are weighed every quarter. Fixed day immunization sessions or days when mothers visit AWC for collection of 'take home' rations for the younger children are used for growth monitoring activities. Growth is charted to detect growth delay or malnutrition, if any. Severely malnourished children are prescribed therapeutic supplementary nutrition and also referred to medical officer. This activity unfortunately has not been very successful due to many reasons, some of which are poor understanding of GMP by the AWW as well as the mother: erratic method of weight taking, non-availability of weighing machine/growth charts, paucity of time at the disposal of AWW and lack of knowledge about weight recording and interpretation.

The growth monitoring activity needs a great deal of time, training, supervision, skill and support. Unless these are forthcoming, it becomes just a wasteful time consuming ritual. 

Non-formal and pre-school education

Non-formal nutrition and health education given by the AWW, is aimed at empowerment of women in the age group of 15-44 years, to enable them to look after their own health and nutrition needs as well as that of their children and families. The education is imparted through participatory sessions at AWC, home visits and small group intimate discussions. Basic health and nutrition messages related to child care, infant care practices, utilization of health services, personal hygiene, environmental and family planning are the usual components covered by AWW.

Early childhood care and pre-school education is yet another important activity of the ICDS programme. This focuses on the total development of the child up to 6 years. It also promotes early stimulation of younger children (<3 years) through intervention with mothers. At this tender age, mother is the best teacher. In 1991, school dropouts and other adolescent girls in the age group of 11-18 years, were included in the ICDS orbit for health and nutrition education, literacy, recreation and skill formation. At present, this scheme is available in 507 projects only. The pre-school education has contributed a great deal in child development and has encouraged school enrolment and retention. In one of the studies conducted by the National Institute of Nutrition (NIN) under supervision of Central Technical Committee (CTC) ICDS, it was abundantly clear that ICDS beneficiaries achieve higher psychosocial scores. The younger children (36-47 months) benefited more than 48-72 months old children. The available syllabus appears to be inadequate to stimulate the older children.
entally. The possibility of introducing age specific curriculum needs to be explored\textsuperscript{12}.

There has been a debate about children below the age of 3 years (2-3 years) and their education at AWC. The pre-school education in ICDS is primarily aimed at 3-6 years age group while under 3 years are left to the mother to educate at home. Some workers feel that there should be some module of education for these children also. They say that as intellectual development does get established by 3.5-4 years, it is better if younger children aged 2-3 years are also given some education at AWC. No one will dispute the necessity to stimulate the younger children intellectually, though, many child psychologists may not agree to club them with the higher age group. Therefore, either AWW will be required to hold separate sessions for them or mother has to be trained to become a good teacher.

2.3.5 \textit{Central technical, committee (CTC)-ICDS}

A central committee (CTC) on health and nutrition, was constituted on 30 June, 1976 by the then Ministry of Social Welfare, Government of India, to provide technical and scientific assistance to the department of Women and Child Development. A central cell was established at New Delhi to assist the state health departments in monitoring the motivational and continuing education activities of the ICDS; evaluate the flow and availability of services and their impact through undertaking annual surveys and research studies and conduct the orientation and training courses for the medical officers and health functionaries of ICDS.

2.3.6 Monitoring of ICDS

The programme is characterised by a built-in monitoring system. The Department of Women and Child Development (DWCD), Ministry of Human Resources Development (MHRD) has the overall responsibility to collect and analyse periodic work reports and suggest strategies for timely interventions, thereby ensuring smooth and effective implementation of the programme. The Central Technical Committee (CTC) of the Department monitors and evaluates services related to health and nutrition. It also provides continuous education and training to health functionaries associated with ICDS\(^\text{13}\).

2.3.7 Innovative activities under ICDS

In order to meet the changing needs of the target populations resulting from socio-economic pressures some innovative activities are proposed to be included in the ICDS scheme. Adolescent girls in the age group 11-15 years, on a selective basis, would be imparted health and nutrition education in AWs and would be encouraged to assist the activities of the AWs. Suitable vocational training to 15-18 years old girls would be imparted and an attempt would be made to set up training cum production centres\(^\text{14}\).

With the increasing number of women joining the labour force, it has become imperative to provide institutional care for children in the age group 0-3 years. It is thus proposed that AWCs will have crèches attached to them. This is likely to spare young girl from taking care of siblings and would hopefully enhance primary school enrolment. Besides this, under the activities taken during the SAARC year of the girl child crèches are being opened by CSWB and ICCW

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in the states with low female literacy. These crèches will be located preferably in the primary schools or else at AWs.

Another activity being dovetailed with ICDS package is the scheme of Women’s Integrated Learning for Life (WILL) which aims at promoting literacy among women. These innovative activities are currently being tried in selected ICDS projects to see their feasibility before going on scale.

ICDS was conceived as a community based programme. It was envisaged that people’s participation would come forth readily in its implementation. However, contrary to the conception, it has acquired the profile of a Government programme and people accepts ICDS programme as a dole. Taking cognisance of the above, it has been proposed to assign a few ICDS projects to recognised voluntary agencies known for their ability to mobilise local resources and community participation. It is particularly feasible when these agencies spring up at the grassroots level and are in direct interaction with the target population – a function which may not be easily performed by functionaries of the Government.

2.3.8 Implementation of ICDS Programme

ICDS is implemented through the State Government with one hundred percent financial assistance from the Central Government for inputs other than supplementary nutrition. The expenditure of the feeding programme is met by the State Governments from their own funds under the Minimum Needs Programme. Over the years, there has been substantial increase in the funds allocated for ICDS scheme in the central budget, which have increased from Rs. 337.6 million in 1983-84 to Rs. 5,876.4 million in 1996-97 (Fig.2.6).

The UNICEF have evinced keen interest and participated in the programme of child development in India. They are eager to participate in the
successful implementation of the present programme as well envisages the implementation of a co-ordinated strategy for the development of the child. Some of the areas of UNICEF participation are consultancy service, training, supplies, equipment, monitoring, research and evaluation.

The administrative set up of ICDS is well conceived and is uniform throughout the country (Fig. 2.7). However, operational flexibility is accorded to the States in the implementation of the programme resulting in variation in its organisational pattern. There are variations in the administrative pattern at the district and project levels in different States. Available research information confirms that the scheme proposes active involvement of ICDS functionaries in programme planning. Though desired, it is not being practised and in most projects administration tends to be more centralised at the Directorate level (Murthy, 1989; Bhowmick, 1990).

To implement ICDS programme, the Department of Women and Child Development works in close collaboration with other technical departments, ministries and international organisations. It utilises all the existing resources and services provided at the State, block and district levels, and has close functional linkages with many allied schemes of the Government of India and State Governments, Union Territories Administration. The horizontal and vertical co-ordination machinery therefore, has been set up at all levels of management for effective convergence of the services in ICDS package and of the allied schemes.

At the central level, there are forums like Committee of Direction for ICDS programme: Central Technical Committee on Health and Nutrition: Apex Body for ICDS Training programme and Technical Advisory Committee in the Planning Commission. In each State/UT, an inter-departmental
committee under the Secretary of the concerned department co-ordinates the implementation of the programme. At the district level, a co-ordination committee functions under the chairmanship of the District Collector.

At the block, project and village levels, the co-ordination mechanism is informal, voluntary and yet more functional in nature. Stress is given on establishing close functional ties among BDO, MO and CDPO, and between the rest of health and non-health staff of ICDS to avoid duplication of efforts and resources, and to optimise on time, money, energy and technical knowledge. At the village level, efforts are also made to have liaison between the Anganwadi and other local organisations like Mahila mandals, Panchayats, co-operatives, schools etc.

The Administrative Unit for the location of an ICDS project is a community development block, covering a population of one lakh spread over 100 villages in Urban and Rural areas and a population of 35,000 spread over 500 villages in tribal areas. The focal point for the delivery of ICDS services in each project is an Anganwadi (AW) located in a village. As per the scheme, there are 100 AWs in each rural and urban project and 50 AWs in the tribal project. But in practice, the number of Anganwadis differ from project to project on the basis of population, topography, communication and other logistic consideration.

The project team of ICDS functionaries comprises a Child Development Project Officer, three to five supervisors and one AWW for each AW, to provide a package of identified integrated services to the same set of beneficiaries simultaneously to have the desired impact. For the delivery of health component, ICDS project staff is supported by the staff of PHC, i.e.,

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Medical Officer (MO), Health Assistants (HAs), Multipurpose Health Workers (MPWs) etc.,

An Anganwadi worker is normally a woman from the local community. She is an honorary worker in charge of an Anganwadi and gets an honorarium of Rs.750 per month. She is assisted by an Anganwadi Helper in organising supplementary nutrition feeding and non formal pre-school education activities. The Helper is also a local village woman and is paid an honorarium of Rs.500 per month. A supervisor provides guidance and support to AWWs in providing different services of the scheme. She/he has 20 – 25 Anganwadis under her charge in each rural and urban project and about 17 AWs in each tribal project. A CDPO is the administrative head and is in charge of the project. He/she is responsible for management and delivery of services, and has to arrange procurement of material and equipment from the State Government and supply it to AWs. The information related to work reporting is compiled by CDPO for further submission to the State and Centre.

2.3.9 ICDS – Growth and Development

The ICDS programme was launched on October 2, 1975, the 106th birth anniversary of Mahatma Gandhi, the father of the nation. Started on an experimental basis in 33 blocks, the programme by June 1995 covered 3663 of a total of 5239 community development blocks in the country. In addition, there are 260 ICDS projects in urban areas. Over 6.5 lakh persons are involved in promoting basic health care and pre-school education activities under the scheme.16

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Table 2.3 The various services under ICDS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Beneficiary</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Children 0-5 years</td>
<td>Immunisation, health check up, supplementary nutrition and referral services</td>
</tr>
<tr>
<td>2</td>
<td>Children 3-5 years</td>
<td>Non-formal pre-school education</td>
</tr>
<tr>
<td>3</td>
<td>Nursing and expectant mothers</td>
<td>Supplementary nutrition: Health check up (expectant mothers), immunisation against tetanus (expectant mothers)</td>
</tr>
<tr>
<td>4</td>
<td>Women 15-45 years</td>
<td>Nutrition and health education</td>
</tr>
</tbody>
</table>

However, the scheme has been considerably expanded in the subsequent years. Accordingly as on 1995, there were 5614 projects sanctioned. This points to the significance of the scheme. Every year the Government is taking steps to enhance the scheme. The location-wise break-up of the scheme, the central expenditure on the scheme, vertical growth of the scheme and the services under the scheme are furnished in the following figures.

2.3.10 Training

This is organized for ICDS functionaries through periodic courses. An effective uniform syllabus for various categories of functionaries has been prepared by the CTC in consultation with experts. The teaching programmes are aimed to provide a comprehensive training package. This has the following advantages. It helps in establishing a culture of holistic approach for delivery of essential services to mother and child; develops better inter-personal relationship and better understanding of each other’s role and difficulties; is time saving and cost effective as the trainees will not be called upon repeatedly to the training venues and develops a team spirit for better service delivery.
FIG. 2.3. EXPANSION OF ICDS PROJECTS
(MARCH 1975-76 - 1995-96)

No. of Projects sanctioned

YEAR

Source: Statistics on children in India, National Institute of Public Co-operation and Child Development. Page 205
FIG. 2.4  CENTRAL EXPENDITURE ON ICDS (1983-1997)

(Rs. in crores)

Year

* Estimated
FIG. 2.5 LOCATIONWISE BREAK-UP OF ICDS PROJECTS

Total No. of Projects = 5614

FIG. 2.6 SERVICES UNDER ICDS

- **CHILDREN (0-12 MONTHS)**
  - Health Check-up
  - Immunisation
  - Supplementary Nutrition

- **CHILDREN (1-3 YEARS)**
  - Referral Services

- **CHILDREN (3-6 YEARS)**
  - Non Formal Pre-School Education
  - Nutrition and Health Education

- **Adolescent Girl (11-18 years)**
- **Pregnant Women**
- **Nursing Mother**
- **All Women 15 - 45 years**

Source: India, Ministry of H.R.D., Dept. of Women & Child Development.
The schedules are made available with the consultants who organize various courses. However, the training schedule is flexible and the consultants are given a free hand to make suitable changes in content depending upon local needs. The types of training courses are one day introductory course; two day regular course; one day refresher course; one day health seminar for medical officers on maternal care and child development; one day course for community; short orientation session during monthly district level conferences organized by Chief District Adviser (CDA) on monitoring, motivating and continuing education; short orientation session in child survival and safe motherhood (CSSM) and short orientation session during training courses organized by nodal department of ICDS.

Besides, the training activity followed by CTC-ICDS, on-the-job training is also imparted by the supervisors and Child Development Project Officers (CDPO).

It has been commented by many workers\textsuperscript{17} that on-the-job supervision and training is disproportionately titled towards register-maintenance instead of quality assessment, support and education.

2.3.11 Survey, evaluation and research

ICDS is the only national health programme which has a built-in 'External Investigative' survey, evaluation and research component from its very inception. The senior faculty members from the departments of preventive and social medicine and paediatrics of various medical colleges and institutions form the core of the component. They are designated as 'ICDS honorary consultants'. They help in the training and evaluation activities. Initially, there were only 19 consultants. Presently, there are over 190. Their contribution is

\textsuperscript{17} Gupta DB, Gumber A and Banarjee A. Strengthening ICDS programme. Key findings from pilot study. \textit{MARGIN} 1998;30(2):77-106.
extremely cost effective and observation unbiased and objective. The evaluation is done in the form of multicentric annual surveys or unicentric research projects. In 1993, research activities were decentralized and 4 research regions were identified. The main objectives of this strategy\textsuperscript{18} were to identify regional research issues, optimize improve upon supervision and co-ordination and better cost-effectiveness.

The evaluation components has conducted till today 23 annual surveys and a large number of multicentric and unicentric research studies.

The results were published in the book form in 1995. This research document is an excel studies confirm that the programme has done well on the whole. The nutritional status of children, their coverage by immunization, vitamin A and iron and folic acid has improved. Their psychosocial development and scholastic performance are better than non-ICDS areas\textsuperscript{19-22}. Their KAP about health and nutrition is also better. However, there are some areas where progress is slow while in certain other areas a 'plateau' effect is visible. These areas require an innovative approach and a new strategy. The poor logistic support, irregular supply of SN, medical kits and other essential commodities; discrepancies between sanctioned and positioned staff; indifferent training of AWWs and other ICDS functionaries; unequitable workload distribution; AWWs’ inappropriate time-budgeting; inadequate


understanding by the functionaries of the priorities of different service
components; lack of community participation, etc. are some of the factors
responsible for variations in the programme performance. Considering the size
and area of the vast country, democratic set up of our governance and so many
variables like different cultures, customs, surface transport, literacy, etc.,
various hues and complexions in ICDS spectrum is to be expected and it should
not surprise anyone.

The weaknesses of ICDS have been commented upon in detail during
1997 at CTC’s annual convention and a number of corrective measures were
also proposed. Many other workers\textsuperscript{23} have also made a number of suggestions
from time to time. Some of these recommendations are: Community
involvement in the planning stage; seeking help of the village elders and other
NGOs in the area; better training of AWW and other functionaries; better
micro-level supervision; more rational workload distribution among ICDS
community level functionaries and realistic community expectations from
them. A great concern has been expressed by everyone in the field of child
development that ICDS has a relatively lesser effect on children below 3 years.
Obviously more concerted efforts are required to reach them and draw them out
to AWC.

Another trust area is closer co-ordination and better convergence of
various departments and agencies involved in mother and child development.
No doubt, ICDS has bettered the convergence; still there is lot of potential in
this aspect. CARE India and some other agencies have encouraged the concept

\textsuperscript{23} Kennedy E and Slack A. The integrated child development services (ICDS) in India. Lessons
learned and Implications for Future Policies. International Food Policy Research Institute,
of observance of a special day in 10-15 days where the community actively participates and interacts with ICDS and health personnel.

2.3.12 Conclusions

ICDS scheme is the world's largest mother and child development programme. Launched in 1975 in 33 projects, it has spread over more than 5600 projects. It has improved the KAP and ICDS mothers in health and nutrition; scholastic performance and psychosocial development of ICDS children, their immunization and nutritional status. It has also enhanced their coverage by ICDS services. This positive impact is visible in urban slums, tribal and rural areas though in varying degrees. ICDS's weaker links have been identified and are being strengthened. Given a good leadership and a dedicated team to handle and co-ordinate its various activities, ICDS performance is expected to improve further in time to come.

The organisational set-up of ICDS in the country is given in Fig. 2.7.
FIG. 2.7 ORGANISATIONAL SET-UP OF ICDS

DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT
MINISTRY OF HUMAN RESOURCE DEVELOPMENT, GOVT. OF INDIA
DIRECTOR (CHILD DEV) DEPUTY SECRETARY (TRG.)

STATE

DEPTT. OF SOCIAL WELFARE/HEALTH/RURAL DEV./COMMUNITY DEV./
TRIBAL WELFARE/WOMEN & CHILD WELFARE
DIRECTOR NODAL DEPTT.

DISTRICT

DISTRICT WELFARE OFFICER / PROGRAMME OFFICER

BLOCK

BLOCK DEV. OFFICER → CHILD DEV. OFFICER
PROJECT OFFICER → MEDICAL OFFICER

SECTOR

BLOCK MUKHYA SEVIKA → SUPERVISOR → HEALTH ASSTT.
(FEMALE)

VILLAGE

ANGANWADI WORKER

ADULT EDUCATION INSTRUCTOR

AUXILIARY NURSE MIDWIFE

TRADITIONAL BIRTH ATTENDANT

HEALTH GUIDE