PERFORMANCE EVALUATION OF INTEGRATED CHILD DEVELOPMENT SERVICES IN HIMACHAL PRADESH: A STUDY OF KANGRA DISTRICT

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SYNOPSIS

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Performance Evaluation of Integrated Child Development Service in Himachal Pradesh: A Study of Kangra District

1. Introduction

Early childhood\(^1\) development is considered to be the most important phase in life which determines the quality of health, well-being, learning and behaviour across the life span. It is a period of great opportunity, but also of great vulnerability to negative influences and constitutes a unique phase for capitalizing on developmental forces to prevent or minimize disabilities and potential secondary conditions. The course that development takes in each person depends critically on the quality of stimulation, support and nurturance that the child experiences in his or her family, neighbourhood, and care environments. When these are deficient or unsupportive child development can be seriously mal-affected. Conclusive evidence shows however that with early and appropriate interventions that address the risk factors, growth, cognitive and social-emotional development can be modified in ways which improve health, well-being, and competence in the long-term. Despite the strength of the evidence for the greater effectiveness of investing in the early years, the response in terms of investments, has been slow particularly in the poorest countries. Improving care for young children is fundamental to achieving the Millennium Development Goals.\(^2\)

Children are the most important assets of a country because they will be tomorrow’s youth and provide the human potential required for a country’s development. The strength of the nation lies in having healthy, protected, 

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1 Early childhood is defined as the period from birth to eight years old. A time of remarkable brain growth, these years lay the foundation for subsequent learning and development. See http://www.unesco.org/new/en/education/themes/strengthening-education-systems/early-childhood/. Sometimes first six years constitutes early childhood.

educated and well-developed children who may grow up to be productive citizens of the country. It is estimated that around 40 per cent of children are vulnerable or experiencing difficult circumstances characterized by their specific social, economic and geo-political situations. All these children need special attention.

It is now globally acknowledged that investment in human resource development is a pre requisite for any nation. Early childhood, that is the first six years constitutes the most crucial period in life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative lifelong learning. The young child under 3 years is most vulnerable to the vicious cycles of malnutrition, disease/ infection and resultant disability all of which influence the present condition of a child at micro level and the future human resource development of the nation at the macro level.

India is in the curious position of having very high levels of malnutrition despite large stocks of food-grains resulting from increased agricultural productivity. Moreover, the country experienced rapid economic growth during the 1990s, but this was accompanied by very modest declines in child malnutrition. There are two factors responsible for this outcome. A significant proportion of the population remains unable to buy enough food. And the whole population is vulnerable to becoming malnourished due to exposure to diseases in particular diarrheal diseases and parasitic infections resulting from poor sanitation and living conditions and malnutrition in turn increases future susceptibility to disease. These synergies take a heavy toll in labour productivity and outlays on health care, as well as mortality.

To ameliorate the situation, the government of India has developed several major programs for increasing access to food. One approach is through price controls: for example, the Public Distribution System makes some staple foods

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such as food-grains and sugar available at controlled prices through “fair-price shops”. Another thrust has been through income support: such as a range of food-for-work programs and employment guarantee programs, where people are paid (often in foodgrains) for working on building or maintaining public infrastructure. A third approach has been to directly feed children: this includes mid-day meal programs for school-going children, and nutrition supplementation programs. By far the biggest nutrition supplementation program is the Integrated Child Development Services (ICDS)\(^5\).

The provision of “basic needs”\(^6\) forms an integral part of development. Growth alone has not always let to equitable development, and governments feel the need for direct intervention, especially in the fields of nutrition, health and education\(^7\). The ICDS is such a scheme. It is a national level scheme of the government of India providing a package of services to children below six years and to pregnant and nursing mothers, such as supplementary nutrition, immunization, health check-ups, referral services and pre-primary education. The scheme now covers almost all districts in the country; however this does not mean that all children below six years from poorer sections of society are covered by the scheme. There are still large areas left uncovered, especially in less densely populated areas or where population is more scattered and in undeclared slums\(^8\).

2. Demographic Profile of Children in India

India, with 1.21 billion people is the second most populous country in the world, while China is on the top with over 1.35 billion people. The figures shows

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\(^{5}\) Loc. cit., p. 1.

\(^{6}\) It influenced the programmes and policies of major multilateral and bilateral development agencies, and was the precursor to the human development approach. A traditional list of immediate “basic needs” is food (including water), shelter and clothing.


\(^{8}\) Once the population in a slum area grows beyond a certain limit, generally 10,000, it is recognised' or 'declared' as a slum by the local government, while slums with smaller populations are deprived of the benefits of certain schemes like the ICDS. See VandanaKhullar (March, 1998). “Integrated Child Development Services: A Critique of Evaluation Techniques”. *Economic and Political Weekly*. XXXIII(10). p. 537
that India represents almost 17.31 per cent of the world's population, which means one out of six people on this planet live in India. Every year, an estimated 26 millions of children are born in India which is nearly 4 million more than the population of Australia. It is significant that while an absolute increase of 181 million in the country’s population has been recorded during the decade 2001-2011, there is a reduction of 5.05 millions in the population of children aged 0-6 years during this period. The decline in male children is 2.06 million and in female children is 2.99 millions. The share of Children (0-6 years) in the total population has showed a decline of 2.8 points in 2011, compared to Census 2001.

### 3. Status Of Children In India

As India races towards achieving superpower Dom, its children are still far behind in terms of healthcare, education and other facilities. Children especially girls are faced with lack of educational opportunities, malnourishment, infant mortality and early marriages. According to the latest data collated by the National Health Survey 2005-06 the all India average for malnourished children is 47 per cent. Every second child under 5 years is malnourished. Even the prosperous states like Gujarat and Kerala there is rise in the number of malnourished children. Both states saw an increase of 2 per cent between 1991-2001. Other states for instance Madhya Pradesh registered a rise from 54 per cent in 1991 to 60 per cent in 2001.

Nearly three fourth of all infants between 6-35 months of age are anemic in the 19 states for which NFHS-3 data are available. Among all the children up to 3 years age over 1/3 are stunted and more than 1/6th are wasted. Two out of five children are underweight. This state of the youngest Indians point towards pervasive malnutrition. For most of these infants, malnutrition would have started in the womb itself. This is apparent from the data on married and pregnant

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women. An astounding 54 per cent of pregnant women and nearly the same proportion of married women were found anemic. In fact the Body Mass Index (ratio of weight to height- a measure of nutritional availability) of nearly 1/3rd of all women was below normal. What is alarming that the situation is worsening or at best not improving over the years. Comparison with NHFS-2 carried out five years ago shows that the proportion of wasted children has increased while underweight children are only marginally less. Similarly the proportion of anemic infants has marginally increased. The number of pregnant women who are anemic has jumped from about 49 per cent to over 54 per cent in these five years in these 19 states. The prevalence of anemia among infants has declined in several states but it has not improves or even worsened in AP, Assam, Karnataka, Kerala, Meghalaya, Orissa, Punjab and UP. In no state has the proportion fallen below 50 per cent. UP, Rajasthan, Punjab, Haryana, Karnataka, Gujarat and Assam all have shockingly high proportions of anemic infants-80 per cent or above. Incidentally nearly a third of married men in the eastern states of W. Bengal, Orissa, Assam and Meghalaya and in highly advanced Gujarat are anemic and have lower than normal BMI. Chattisgarh has the highest number of underweight children closely followed by Gujarat and Uttar Pradesh. However while the numbers have declined in the former, they are increasing in the latter two over the past five years.

4. Child Welfare In India

Child welfare has historically responded to the needs of dependent and neglected children with common sense, energy, and practicality and has been motivated by a sense of moral responsibility and compassion, like the charity movement that precede it. Lacking a tradition of scientific research, help relied on good intentions and high moral purpose.

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11 Ibid.
12 Ibid.
The social Welfare Services of the Government of India are intended to cater to the special needs of persons and groups who, by reason of some handicap, social, economic, physicals or mental are unable to avail themselves of the amenities and services provided by the community. These weaker sections include women, children, handicapped, aged and infirm, Scheduled Castes & Scheduled Tribes etc. Social welfare activities in the country find their inspiration in constitution which postulates the goal of welfare state. Article 38 of the Constitution enjoying that the steps shall strive to promote the welfare of the people by securing and protecting as effectively as it may, a social order in which, social, economic and political shall in form all the institutions of the national life. They also encourage the states to ensure that the health and strength of wonders, men and women and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age and strength, and that childhood and youth are protected against exploitation and against moral and material abandonment.14

No programme of social welfare can afford to ignore the child. Therefore, various services have been provided to the children at district from general social services. These include establishment of Balwadis, grants for organizing holidays groups for school going children of low income families, establishment of Ashram schools, rehabilitation of handicapped children, probation, services, care and protection for children, provision for both institutional and non-institutional services which include establishment of postal schools, children’s home to tackle the problem of juvenile delinquency.

4.i. **Constitutional provisions for children in India**

Several provisions in the Constitution of India impose on the State the primary responsibility of ensuring that all the needs of children are met and that their basic human rights are fully protected. Children enjoy equal rights as adults

as per Article 14 of the Constitution. Article 15(3) empowers the State to make special provisions for children. Article 21 A of the Constitution of India directs the State to provide free and compulsory education to all children within the ages of 6 and 14 in such manner as the State may by law determine. Article 23 prohibits trafficking of Human beings and forced labour. Article 24 on prohibition of the employment of children in factories etc, explicitly prevents children below the age of 14 years from being employed to work in any factory, mine or any other hazardous form of employment. Article 39(f) directs the State to ensure that children are given equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and guaranteed protection of childhood and youth against moral and material abandonment. Article 45 of the Constitution specifies that the State shall endeavour to provide early childhood care and education for all children until they complete the age of 6 years. Article 51A clause (k) lays down a duty that parents or guardians provide opportunities for education to their child/ward between the age of 6 and 14 years. Article 243 G read with schedule-11 provides for institutionalizing child care to raise the level of nutrition and the standard of living, as well as to improve public health and monitor the development and well-being of children in the Country.\textsuperscript{15}

4.ii. Union Laws Guaranteeing Rights and entitlement to Children

A fairly comprehensive legal regime exists in India to protect the rights of Children as encompassed in the Country’s Constitution. The age at which a person ceases to be a child varies under different laws in India. Under the Child Labour Prohibition and Regulation Act, 1986, a child is a person who has not completed 14 years of age. For the purposes of criminal responsibility, the age limit is 7 (not punishable) and above 7 years to 12 years punishable on the proof that the child understands the consequences of the act, under the Indian Penal Code. For purposes of protection against kidnapping, abduction and related

\textsuperscript{15} Government of India (2012), op.cit., pp. 8-9.
offences, it’s 16 years for boys and 18 for girls. For special treatment under the Juvenile Justice (Care and Protection of Children) Act 2011, the age is 18 for both boys and girls. And the Protection of Women from Domestic Violence Act 2005 defines a child as any person below the age of 18, and includes an adopted step- or foster child.\textsuperscript{16}

4.iii. National Policies and Programmes for Children

Further, the Nation is implementing a number of Child centric policies addressing the issues of Child Survival, Child Development and Child Protection. The important among them are\textsuperscript{17},

1. \textit{National Policy for Children 1974} is the first policy document concerning the needs and rights of children. It recognized children to be a supremely important asset to the country. The goal of the policy is to take the next step in ensuring the constitutional provisions for children and the UN Declaration of Rights are implemented. It outlines services the state should provide for the complete development of a child, before and after birth and throughout a child's period of growth for their full physical, mental and social development.

2. \textit{National Policy on Education, 1986} was called for "special emphasis on the removal of disparities and to equalize educational opportunity," especially for Indian women, Scheduled Tribes (ST) and the Scheduled Caste (SC) communities. To achieve these, the policy called for expanding scholarships, adult education, recruiting more teachers from the SCs, incentives for poor families to send their children to school regularly, development of new institutions and providing housing and services. The NPE called for a "child-centered approach" in primary education, and launched "Operation Blackboard" to improve primary schools nationwide.

\textsuperscript{16} Loc.cit., p. 9.

\textsuperscript{17} Ibid., pp. 10-11
3. **National Policy on child Labour, 1987** contains the action plan for tackling the problem of child labour. It envisaged a legislative action plan focusing and convergence of general development programmes for benefiting children wherever possible, and Project-based plan of action for launching of projects for the welfare of working children in areas of high concentration of child labour.

4. **National Nutrition policy, 1993,** was introduced to combat the problem of under-nutrition. It aims to address this problem by utilizing direct (short term) and indirect (long term) interventions in the area of food production and distribution, health and family welfare, education, rural and urban development, woman and child development etc.

5. **National Population Policy 2000:** The national population policy 2000 aims at improvement in the status of Indian children. It emphasized free and compulsory school education up to age 14, universal immunization of children against all vaccine preventable diseases, 100 per cent registration of birth, death, marriage and pregnancy, substantial reduction in the infant mortality rate and maternal mortality ratio etc.

6. **National Health Policy 2002:** The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance is given to ensuring a more equitable access to health services across the social and geographical expanse of the country.

7. **National Charter for children (NCC), 2003** highlights the Constitutional provisions towards the cause of the children and the role of civil society, communities and families and their obligations in fulfilling children’s basic needs. Well-being of special groups such as children of BPL families, street children, girl child, child-care programmes, and educational
programmes for prevention from exploitation find special mention in the NCC. It secures for every child its inherent right to be a child and enjoy a healthy and happy childhood, to address the root causes that negate the healthy growth and development of children, and to awaken the conscience of the community in the wider societal context to protect children from all forms of abuse, while strengthening the family, society and the Nation. The Charter provides that the State and community shall undertake all possible measures to ensure and protect the survival, life and liberty of all children. For empowering adolescent, the Charter states that the State and community shall take all steps to provide the necessary education and skills to adolescent children so as to equip them to become economically productive citizens.

8. National Plan of Action for Children (NPA), 2005 was adopted by Government of India in the pursuit of well-being of children. NPA has a significant number of key areas of thrust out of which the one’s relating to child protection are: Complete abolition of female foeticide, female infanticide and child marriage and ensuring the survival, development and protection of the girl child, Addressing and upholding the rights of children in difficult circumstances, Securing for all children legal and social protection from all kinds of abuse, exploitation and neglect.

4.iv. Various Schemes/Programmes

The various Schemes / Programmes are implemented by different Central Ministries, following the guidance of the national policies. They are aiming to tackle the issues relating to the overall welfare of children work independently as well as hand in hand. The State/ UT Governments also execute numerous programmes from time to time for improving the lot of children. The various schemes and programmes are:

1. Integrated Child Development Service Scheme
2. Integrated Child Protection Scheme
5. Rajiv Gandhi ManavSeva Awards for Service to Children.
7. Nutrition Programme For Adolescent Girls
8. Early Childhood education for 3-6 age group children.
9. Welfare of working children in need of Care and Protection
10. Childline services
12. UJJAWALA : A Comprehensive Scheme for Prevention of trafficking and Resue, Rehabilitation and Re-integration of Victims of Trafficking and Commercial Sexual Exploitation
13. SarvaShikshaAbhiyan
14. National Rural Health Mission
15. Rajiv Gandhi Scheme for empowerment of Adolescent Girls – SABLA.
16. DhanaLakshami – Conditional Cash Transfer for Girl Child with insurance cover
17. National Commission for Protection of Child Rights

5. Child Welfare in Himachal Pradesh

The Social Justice and Empowerment Department of the State is engaged in socio-economic and educational uplift of scheduled castes, scheduled tribes, other backward classes, inirms, handicapped, orphans, children, widows, destitute, poor children and women etc.18

In pursuance of the National Policy for Children and India’s commitment to provisions enshrined in the Directive Principles of the Constitution, Integrated Child Development Services Programme, on experiment basis, was introduced in 33 projects including one in Pooh of Kinnaur district throughout the country on

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Integrated Child Development Services (ICDS) programme, is being implemented in all Developmental Blocks of the State through 78 ICDS projects. ICDS services are being provided to children and pregnant/lactating mothers through 18,354 and 256 Mini Anganwadi Centres in the State. The department is providing supplementary nutrition, nutrition and health education’ immunization, health check-ups referred services and non-formal pre-school education to the masses of the state.

As per Census 2011 the child population (0-6 age group) of Himachal Pradesh is 763864 out of which 400681 are males and 36183 are females. The child population constitutes 11.14 per cent of total population of Himachal Pradesh. Kangra has the highest child population, while Lahaul and Spiti has the lowest child population in Himachal Pradesh. Mandi followed by Shimla and Chamba ranks 2nd, 3rd and 4th respectively in child population. In terms of both male and female it has been observed that Kangra tops the list followed by Mandi, Shimla and Chamba.

5.i. Integrated Child Development Services (ICDS) in Himachal Pradesh

In pursuance of the National Policy for Children and India’s commitment to provisions enshrined in the Directive Principles of the Constitution, Integrated Child Development Services Programme, on experiment basis, was introduced in 33 projects including one in Pooh of Kinnaur district throughout the country on 2nd October 1975. During Sixth and Seventh Plan period, more projects were sanctioned to the State. In 1995-96 during universalization phase of the scheme, the Government of India sanctioned 29 new ICDS projects. Four new ICDS projects, namely, Shimla (urban), Haroli, Tauni Devi and Sulah were sanctioned during 2005-06. Thereafter, during 2009-10, two new projects at Dharamshala

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and Nankhari were sanctioned. Today the scheme is operating in 78 ICDS projects. Out these 70 projects come in the definition of Rural Projects, one in Urban Projects and remaining 7 in Tribal Projects.²¹

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ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations. Prior to 2005-06, 100 per cent financial assistance for inputs other than supplementary nutrition, which the States were to provided out of their own resources, was being provided by the Government of India. Since many States were not providing adequately for supplementary nutrition in view of resource constraints, it was decided in 2005-06 to support to States up to 50 per cent of the financial norms or to support 50 per cent of expenditure incurred by them on supplementary nutrition, whichever is less.²³

From the financial year 2009-10, Government of India has modified the funding pattern of ICDS between Centre and States. The sharing pattern of supplementary nutrition in respect of North-eastern States between Centre and States has been changed from 50:50 to 90:10 ratio. So far as other States and UTs, the existing sharing pattern of 50:50 continues. However, for all other components of ICDS, the ratio has been modified to 90:10 (100 per cent Central Assistance earlier).²⁴

²³ http://wcd.nic.in/icds.htm
²⁴ Ibid.
The programme approaches a holistic child health comprising health, nutrition, and education components for pregnant women, lactating mothers, and children less than six years of age. The programme is implemented through a network of community-level Anganwadi Centres. The range of services targeted at young children and their mothers for growth monitoring, immunization, health check-ups and supplementary feeding, as well as nutrition and health education to improve the childcare and feeding practices that mothers adopt. Pre-school education is provided to children between three and six years of age.\(^{25}\)

5.i.(a) Objectives of the Scheme

The broad objectives of the ICDS Scheme are\(^ {26}\):

i) To improve the nutritional and health status of children in the age group 0-6 years.

ii) To lay the foundations for proper psychological, physical and social development of children.

iii) To reduce the incidence of mortality, morbidity, malnutrition and school drop-out.

iv) To achieve effective coordinated policy and its implementation amongst the various departments to promote child development; and

v) To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

5.i.(b) Services

The above objectives are sought to be achieved through a package of services comprising:

i) supplementary nutrition,
ii) immunization,
iii) health check-up,
iv) referral services,
v) pre-school non-formal education and
vi) nutrition & health education.

The concept of providing a package of services is based primarily on the consideration that the overall impact will be much larger if the different services develop in an integrated manner as the efficacy of a particular service depends upon the support it receives from related services.27

6. Review of Literature

A literature review is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic. Knowledge of existing and up-to-date relevant literature related to the studies and their critical and comprehensive review helps a researcher to formulate research project on scientific lines. It guides the investigator to solve the researchable issues of the study. Literature review acts as a searchlight to guide the course of prospective research activity. Keeping in view this logical thinking, here an effort has been made to make analytical review of the relevant literature.

Gupta and Rohde (2004)28 discussed about the negative consequences on child health due to malnutrition. He gave the solution by the need to understand the distinction between hunger and malnutrition. As according to the oxford dictionary hunger is an uneasy sensation caused by want of food. But malnutrition is much more severe situation. He quote that malnutrition is not necessarily non availability and accessibility of food but lack of breast feeding during the first two years mainly the first 6months also leads to malnutrition. He suggested spending

27 http://wcd.nic.in/icds.htm
infant and young child nutrition to improve their health for enhancing their development.

Chatterjee (2006)\textsuperscript{29} demonstrate that adequate child care encourages school going among children and tackle social barriers such as caste. Employment to women as crèche teachers helps them forge that causes a child to be hurt killed. The term child abuse refers to as physical, emotional or mental harm inflicted on children of all ages. Another form of child abuse is sexual abuse that exp. The children should be provided with the food, clothing warmth so that they are shattered.

Chowdhury (2006)\textsuperscript{30} in her paper entitled, “ICDS: India’s Response to Early Child Development”, opined that ICDS has reached a stage where it has become essential to harmonize the expansion of the programme and its content enrichment, in order to accelerate the, implementation in achieving the core objectives of the programme especially to reduce the child malnutrition and help reduction in mortality rates. The trend in reduction in malnutrition as observed between NFHS-I & NFHS-II is not significantly positive towards achieving the MDGs by the end of 2015. In order to accelerate the pace of reduction in prevalence of child malnutrition, a concerted effort is required during the 11th Plan in some of key areas.Addressing issues like prevention and management of malnutrition (especially severe cases), poormaternal and adolescent nutrition, lack of nutrition and health education, and inadequate communityparticipation in the programme, continues to be a major challenge during the Eleventh Plan.During the 11\textsuperscript{th}Five Year Plan, the overall objective for ‘ICDS could beStrengthening ICDS for Reduction of Child Malnutrition’. In order to have a faster and sustained achievement of child and women nutritional goals, a paradigm shift is required to reform the ICDS in respect of overall programme management. During the Eleventh Plan,while we rededicate ourselves topromoting early childhood care

for survival and development of the children, an attempt would be made to restructure the ICDS programme implementation framework to suit the current nutritional needs of the women & children and to strengthen the existing service delivery mechanism.

Mehrotra (2006)\(^{31}\) focused that the rate of child nutrition are higher in India, Pakistan and Bangladesh as in sub-saharan countries of Africa. The focus of all interventions has to be on improving the health status of women in general and the target of most inventions is on the first three years of life as in the case of infants. The universal school feeding programmes will ensure to save the cost of at least one square meal for its children belonging to poor families and there is a need of rapid action to the access to safe drinking water and sanitation facility to the entire population.

Gautam (2006)\(^{32}\) has emphasized that children constitute one third of the country’s population and children are the human resources and assets of a country. So development of children has to be priority item in the country’s development agenda. Various policies and legislations have also been introduced in India to ensure protection of children and improvement in their status like Rajiv Gandhi National Creche Scheme, ShishuGreh Scheme and Scheme for Working Children in need or Care and protection. The country is on the threshold bonds with other women and for the promotion of allover community development. Child care is essential to make children to attend school the older siblings, particularly girls, can also take care for their young sisters and others if the crèche is located in school compound. This will encourage children to go school. The little exposure to learning through play, learning, through play way method, earning from others and exploring the world outside can be helpful in blooming the poor children having few opportunities.


Gragnolati, et.al. (2006)\textsuperscript{33} in a study concluded that ICDS has great potential to improve the nutritional status of India’s children is undeniable, but it needs to overcome some challenges if this potential is to be realized. Three major mismatches between what an effective nutrition interventions should do and what ICDS is currently doing are preventing the programme from achieving better results. Consequently, despite its national infrastructure, ICDS is not making the expected contribution to reducing the prevalence of malnutrition in India. It might be more beneficial to focus energies on improving service delivery within existing AWCs projects, rather than just on expanding coverage. There are some possible alternatives to the current overall implementation strategy adopted by ICDS that, while still firmly rooted within the broad programmatic approach and overarching aims of the intervention, may help to resolve some of these issues. To conclude, greater clarity and focus are needed if the ICDS programme is to make a substantial dent in the problem of persistent undernutrition in India. In particular, the three mismatches identified earlier need to be resolved so that a nutrition intervention is implemented that (a) provides the most effective services to address the most important determinants of malnutrition; (b) reaches younger children and the most vulnerable segments of the population; and (c) is well targeted to areas where the prevalence of under nutrition is highest.

Sinha (2006)\textsuperscript{34} in her paper generalizes that ICDS programme in India reaching nit to most neglected sections of the population. She suppressed the need of its scansion to include every child, pregnant and nursing mothers and adolescent girls. It is also important to set clear goals so that achievements can be assessed and work can give direction. The recommendation such as keeping Anganwadi centers open for whole day, setting up crèches for younger children, providing take-home rations for less than three years of age etc. The vision of good health and wellbeing of mot children must be recognized as an


overwhelming priority. Clear vision along political commitment in this regard could play a key role towards the development country.

Nayak and Saxena (2006)\textsuperscript{35} in their article expose the apathy of the state governments of Bihar and Jharkhand towards this scheme, particularly in terms of coverage, financial procedures and practices adopted in the appointment of personnel. While they limiting their discussion of the implementation of sanctioned ICDS projects, they found that the problems appear at several levels. Further, to the operationalization of these projects, financial allocations need to be effectively utilized, vacancies need to be filled and staff needs to be trained and given vision. Very importantly, the programme needs to be given priority and effectively supervised. In its objectives and original structure, the ICDS set out to achieve laudable goals. Since 2001, the vision of the scheme has been strengthened by the interim orders of the Supreme Court. The poor administrative arrangements for implementation of ICDS in Bihar and Jharkhand are especially unfortunate, given the fact that many other poor states have managed to get the scheme off the ground. Procedural corrections are critically required for positive change.

Chandra and Reddy (2007)\textsuperscript{36} argued that the main trap for engaged in the industries like state mine is the structure of employment and segmented nature of work. The adult workers especially female workers who are engaged in industry has reinforced the child workers. The technical advancement tends to reduce child labour as machines do the routine and repetitive work efficiently and the people, often children and it demand for more highly skilled workers like adults in the slate industry because of diversification in designing slates has reduced drastically but the demand for more raw material for designing slate phenomenally increased the involvement of children in the slate mines. If the change in income of the


parent could be made then the practice of child labour will ultimately end the child labour.

Reddy (2007)\textsuperscript{37} generalized the child labour as the byproduct of our social economic conditions. In the pretext of socio-economic conditions the evil can be aired rather than be eliminated. The ban on child labour can cause harm to the real of the families of the working children. Formal education should be given to the children indulge in some work as a form of evening or night school. Thus, it is a society need India and indispensable in a society like India and complete abolition.

Sirinivasan and Bedi (2009)\textsuperscript{38} provides a brief review of the pattern of daughter elimination in Tamil Nadu and then goes on to focus on the role played by the government’s Girl Child Protection Scheme in particular, in shaping sex ratios influencing daughter elimination has declined sharply between the late 1990s and 2003. In Tamil Nadu, daughter elimination in the form of female infanticide first gain public attention in the mid-1980s. Initially it was felt that the practice was limited to certain groups and certain geographical areas but subsequent several researched.

Acharya and Paul (2009)\textsuperscript{39} revealed that the child labourers are rescued by immense media coverage and this method has been used for rescuing the labourers but the task of rehabilitation of the children by states is not success. Majority of these children either return to work or being sent to remand homes whose conditions are not very conducive to their welfare and development. By taking the study of Mumbai it further explains that the state of Maharashtra told the Member that Maharastra would be free from the evil of child labour by 2010 but it has not yet, rather the government is still in process of framing its own rules and regulations in this regard and not following Central Government rules. In


\textsuperscript{39} Akash Acharya and Mcnamee Paul (September, 2009), “In Name of Child”, Economic and Political Weekly, XLIV(38).
March 2009 the Supreme Court (in M.C. Mehta vs. Union of India case) had directed that child labourer should be compensated and an adult member of the family should be helped by giving employment so that the evil could be eliminated and the overall development of the children could be sidle.

Gairola and Chauhan (2009) in their article observed that healthy society raises children to be responsible citizens rather than mere consumers. It is probably impossible to completely shield children from marketing messages. The ice by the parents and help by the government in this regard can stop children by local targeting. Children need counseling, time and lot of patience by their parents to make them to understand the ill effects of certain food commodities available in the market, by stressing the need of a supportive family system so that children do not fall prey to advertisement and marketing gimmicks very easily.

Programme Evaluation Organization (2011) of Planning Commission has conducted an evaluation study to assess the gaps and impact of implementation of ICDS programme in achieving its aims and objectives. The study has been conducted in 100 districts of 35 States and UTs and has covered 19,500 households. The study concluded that the performance of ICDS programme has been found to be mixed in selected sample states. There is wide divergence between official statistics on nutritional status, registered beneficiaries and number of days food/ supplementary nutrition served vis-a-vis ground-reality with regard to these indicators. Around half of the total eligible children are currently enrolled in anganwadicentres and the effective coverage as per norms is only 41% of those registered for the ICDS benefits. Anganwadi workers are over-burdened, under-paid and mostly unskilled, which affects the implementation of the scheme. Inadequate infrastructure to deliver the six designated services under the ICDS at majority of anganwadicentres have adversely affected the service delivery.

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40 Yogesh Gairola and Amita Chauhan (January – March, 2009), *Think India Quarterly*, 12(1).
Arokiasamy et.al. (2011)\(^{42}\), in their paper, makes a systematic effort to assess the performance of the family welfare programmes vis-à-vis the trends in expenditure. A comparative analysis of evidence during the pre- and post-RCH policy regimes revealed that expenditure on family welfare programme has more than doubled during the post-RCH policy regime. However, some variable patterns are noted in expenditure allocations. First, the with the pre-RCH period, the progress in the post-RCH period in these two programme outcome indicators is virtually stalled for India and the three selected states. State comparisons indicated much slower progress in Maharashtra than in Tamil Nadu and Uttar Pradesh. The RCH programme approach did not suggest evidence of significant and anticipated effect on any of the selected programme indicators, particularly in medium and less developed states of Maharashtra and Uttar Pradesh, respectively. There appears to be less integration between different programmes that is supposed to be coming into force when they are implemented under one category. It is evidentially clear that in the absence of suitable mechanism to operationalize RCH approach under the integrated banner of family welfare programme, the exponential increase in expenditure alone cannot lead to commensurate a positive impact on key performance and outcome indicators.

Arokiasamy and Goli (2012)\(^{43}\) examining the direct relevance of the landholding-patriarchy hypothesis to the dynamics of sex discrimination and family-building strategies in rural India, This paper presents evidence that indicates the child sex ratio varies greatly when stratified by size of household landholdings. Among many structural factors, the landholding size emerges as an influential determinant of the sex ratio imbalance in rural India. The key effect of landholding is consistently established across categories of the principal socio-economic determinants of sex ratio imbalance. The CSR consistently increased

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with the size of household landholding. The SRB for last and last two births increased steeply with the size of landholding, as an outcome of both the strong preference for sons to maintain the large-sized landholdings and the greater economic utility assigned to boys in household agricultural activities. Women in large landholding families do not have much socio-economic freedom or decision-making powers. Among states where land distribution is more uniform (for example, Kerala), the sex ratio is favourable to females. In contrast, the results for Gujarat, Punjab and Haryana substantiate the pattern of skewed distribution in household landholdings and sex ratio. Madhya Pradesh, Chhattisgarh and West Bengal fall in a third category, where traditionally women were allowed to participate in decision-making.

Maitra and Ray (2013), their paper entitled, Child Health in West Bengal: Comparision with other Regions in India’, analyzed four interrelated child health indicators in West Bengal – child malnourishment (measured by the rates of stunting and wasting), prenatal, infant, and child mortality rates. It also provided evidence on how these rates vary with the gender of the child, parental education, and the wealth status of households. The paper concluded that the state of child health in West Bengal is no better or worse than the rest of India as a whole. It is a better performing state than the other states in east India. However, West Bengal, in common with several other states, lags behind south India. Second, West Bengal shares the paradoxical result that while there has been an improvement in children’s height for weight that measures stunting, there has been deterioration in children’s weight for age that measures wasting. Third, the study disaggregates the child health statistics in West Bengal by gender of the child, parental wealth, and education. It finds strong and positive parental education and wealth effects on child health in West Bengal. This points to the positive role that improving awareness through parental education can play in improving child health. Fourth, West Bengal’s neonatal and infant mortality rates are among the lowest in India. It is interesting that West Bengal’s record on infant

44 PushkarMaitra, Ranjan Ray (December 7, 2013). “Child Health in West Bengal Comparison with Other Regions in India”, Economic & Political Weekly.XLVIII(49), pp. 50-58.
and child mortality stacks up quite well when compared with that of south India, which has a lead on child health. However, during the period in this study, 1998-99 to 2005-06, the mortality rates in West Bengal did not share the steady improvement recorded in many other parts of India. Clearly, there is room for improvement in this and other aspects. Finally, and quite significantly, while parental education has a strong and positive effect on reducing infant mortality, the wealth effect is weak and insignificant. This suggests that the mortality rates are unlikely to decline if policymakers simply rely on increasing household affluence. One needs direct policy intervention in the form of more parental education, especially mother’s education, for improving the dismal mortality statistics that prevail in West Bengal and the rest of India.

Panagariya (2013) in his paper revealed that child malnutrition estimates based on a flawed measurement methodology. The central problem with the current methodology is the use of common height and weight standards around the world to determine malnourishment, regardless of differences that may arise from genetic, environmental, cultural and geographical factors. Though medical literature recognizes the importance of these factors, the World Health Organization (WHO) totally ignores them when recommending globally uniform height and weight cut-off points against which children are compared to determine whether they suffer from stunting (low height for age) or underweight (low weight for age) problems. Further, the paper concluded that evidence also does not support the view that a lower incidence of child malnutrition in Sub-Saharan Africa reflects its smaller “catch-up” deficit. African mothers exhibit far higher maternal mortality than Indian mothers. The argument that higher maternal mortality ratios in Sub-Saharan Africa can be reconciled with its higher nutrition levels once we recognize its poor medical infrastructure turns out to be empirically invalid. Direct evidence on adult nutrition does not support the view that African adults have been historically better nourished than Indian adults. Genetic differences between the Indian and Sub-Saharan African populations is

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the only plausible explanation of the observed differences in malnutrition rates. The common impression that India has not made much progress in child nutrition despite economic progress also turns out to be false. Whether we go by indicators of stunting or underweight, progress in child malnutrition, consistent with that in other vital statistics such as life expectancy, infant and child mortality rates, and maternal mortality ratio, has been made. The proportions of stunted and underweight children have been steadily declining and the average height and weight steadily rising since the late 1970s when data on these measures began to be collected.

Ao and Lhungdim (2014)\(^{46}\) in their paper entitled, “Re-Estimating Malnourishment and Inequality among Children in North-east India” have tried to re-estimates the prevalence of child malnutrition among the under-five age group in eight north-east states using the composite index of anthropometric failure method as proposed by P Svedberg, using the National Family Health Survey-3 data. The study highlights that children’s characteristics do influence their nutritional status, but the mother’s characteristics, such as education or BMI, have a stronger relationship with child nutritional status. There is also a strong relationship indicated between wealth index and malnutrition, and a substantial poor-rich gap in all domains of malnutrition with a disproportionate burden of child malnutrition on the poor. Also interesting is the finding that suggests no significant association between macroeconomic growth and child malnutrition. Economic development per se would not ensure good nutritional status of the children unless it is through inclusive growth. Unless there is proper monitoring and coordination at the household and community levels, there would be no improvement in child nutritional status. Among the eight states in the region, Meghalaya has been a surprise by being the state with the highest percentage of child malnutrition (in all measures – underweight, stunting, wasted and CIAF), but at the same time as having lowest inequality in child malnutrition across all socio-economic groups

Aguayo, Singh and Badgaiyan (2014)\textsuperscript{47} in their study made an attempt to present a child under-nutrition index (CUI) that captures the multidimensional nature of child under-nutrition in India and reflects which states face the greatest nutrition risk, to present a child nutrition score (CNS) that captures the performance of Indian states in delivering proven essential nutrition interventions for infants and young children; and to assess the links between under-nutrition risk and nutrition performance as measured by the CUI and the CNS, respectively. Both the index and the score use data from India’s NFHS-3. Their study clearly indicates that levels of child under-nutrition in India are strongly associated with the performance of states in delivering proven nutrition interventions for children. Almost without exception, the higher the state’s CNS – measuring the overall coverage of essential nutrition interventions for children – the lower the state’s CUI. What is relevant to policy is the fact that the CNS tends to be significantly lower among the most vulnerable children and population groups. CNS is lower in the states with higher proportions of people surviving below the poverty line, among children from the poorest wealth quintiles, those who belong to SC/ST families, and/or those who live in rural areas. Further, they found that in India child under-nutrition levels are lower where the economic growth dividend has been directed to reduce poverty and the proportion of children surviving in households below a minimum standard of living; and improve the coverage and equity of proven essential nutrition interventions, particularly for the most vulnerable children. Therefore, the challenge ahead for India is to ensure that national nutrition policies and social transfers are aimed at reducing inequalities and the disproportionate impact of under-nutrition among the poorest and most vulnerable groups in society and that nutrition intervention are delivered through effective governance systems that privilege evidence-based and cost-effective interventions.

Borooah, Diwakar and Sabharwal (2014)\(^{48}\) found that the ICDS programme, which addresses the issues of early education, malnutrition, and morbidity, is an imaginative response by the Indian government to the multifaceted challenge of providing for the health and development of children and their mothers. In its implementation, however, the programme embodies several inequalities. Although the ICDS policy stipulates that there should be one AWC per 1,000 persons (and 700 persons in tribal areas), the coverage is much better in wealthier states. The second type of inequality is in the distribution of AWCs within states. The third type of inequality is locational inequality within a village. Mander and Kumaran (2006) have observed that, in mixed-caste villages, the ICDS centre is never located in the SC or ST hamlet. The fourth type of inequality is based on excluding – or, more accurately, restricting – persons from certain groups from using ICDS. First, leavening the accounts of exclusion, there might be enlightened and progressive persons involved in the delivery of ICDS who actively promote the usage of these services by SC and ST mothers. Second, there might be the perception among upper-caste Hindu mothers that the quality of ICDS is poor, in particular, in supplementary nutrition and preschool education. Recognizing the importance of these services, they would prefer to obtain them elsewhere. So, while the AWC might, as a symbol of caste power, be located in the “main” village where the upper castes reside, it would be used relatively lightly by upper-caste mothers.

Khera (2015)\(^{49}\) in her paper studied the two children’s schemes in four districts in and reports how they perform and identifies areas for further action. The level of functionality achieved in the ICDS in Odisha is remarkable because as recently as 2009, when anganwadis opened, the main activity was providing supplementary nutrition (Government of India 2011a). A study in 2009 in seven districts found that the “Take Home Ration under Supplementary Nutrition” was not being implemented, and in 2010, a total of 35.8% of the children were undernourished.


Nutrition Programme is found to be the only activity that is going on everywhere. The gains in the implementation of ICDS are largely on account of creative policymaking in the field of child nutrition in Odisha. Simple measures such as providing uniforms for the ANM, AWW, AWH and ASHA as well as anganwadi children helps create an environment of seriousness associated with, say, schooling or at health centres. Another example is decentralized procurement for items required for Supplementary Nutrition Programme (SNP). Instead of routing funds through the CDPO’s office, the money goes straight into a joint account operated by the AWW and a GP member. This has freed AWWs from the tyranny of CDPOs, a common complaint elsewhere. Along with decentralized devolution of funds, the state has also introduced a model of decentralized procurement for THR. The most interesting initiative as far as nutrition is concerned, of course, has been the introduction of eggs as THR. It is more nutritious than chhatua and given that its shelf life is longer than most other foods with comparable nutritive value, it can be given as THR.

7. Selection Of Problem

As India races towards achieving superpower, its children are still far behind in terms of healthcare, education and other facilities. Children, especially, girls are faced with lack of educational opportunities, malnourishment, infant mortality and early marriages. Every second child under 5 years is malnourished. Child malnutrition is, mostly, the result of high levels of exposure to infection and in appropriate infant and young child feeding and caring practices, and has its origins almost entirely during the first years of life. To prevent recurrence and to overcome the effects of chronic malnutrition, these children need extra attention both during the early rehabilitation phase and over the longer term.

Integrated Child Development Scheme is one of the best expressions of India’s commitment for children. It is, today, the largest and unique and integrated programme of the world for early child development, converging interventions for health, nutritional well-being, psycho-social and cognitive development linked to
other sectoral operations for safe drinking water, environmental sanitation and women’s development. As the government is investing huge sum of money in this programme, it is important that it will provide better services to the society.

Many scholars had attempted to study the schemes of child welfare and development at the national level. But, in Himachal Pradesh very little work was initiated to study Integrated Child Development scheme. The present study will be initiated to fill this gap. As the success of any programme depends on the effective implementation and its impact on the target group, hence, it is important to study the implementation and impact of ICDS. It is in this background that the present study will be proposed.

8. Importance of the Study

As the ICDS is one of the major concerns of India’s commitment to child development and welfare, the present study will be conducted to evaluate the implementation and impact of ICDS in Himachal Pradesh in general and in Kangra district in particular. The present study will be important as it will contribute, theoretically and empirically, to a better understanding of the issues involved in designing child welfare programme. It would be critical in designing not only appropriate policies for child welfare but also for women development. Moreover, the present study will be a great help to planner, policy makers and administrators in making efforts to streamline the process of implementation of ICDS. And also it will provide the real picture of implementation and impact of ICDS in Himachal Pradesh.

9. Scope of the Study

The scope of the present study will be confined to analyze the implementation and impact of Integrated Child Development Services in Himachal Pradesh in general and in Kangra district in particular. The study will
be based on the responses obtained from the Anaganwadi Workers/ helpers, officials and ICDS beneficiaries.

10. Objectives of the Study

The present study will be conducted to achieve following objectives.
1. To examine the child welfare programmes at the National and State Level.
2. To examine the organizational setup for the implementation of ICDS.
3. To study the implementation of ICDS in Kangra district of Himachal Pradesh.
4. To study the impact of ICDS on the beneficiaries in Kangra district.
5. To find out the constraints in the effective implementation of ICDS.
6. To suggest measures that would help in enhancing the effectiveness and streamlining the implementation process of ICDS.

11. Hypotheses of The Study

To achieve aforementioned objectives, following hypotheses will be tested during the study.
1. Integrated Child Development Services has not been implemented as per its spirit.
2. There is a lack of participation of people in the ICDS in the Kangra district.
3. There is a lack of awareness among the people about the ICDS in Kangra district.
4. Integrated child development services has helped to improve health status of the children.
5. There is lack of proper monitoring and supervision of Anganwadi centres.
12. Research Methodology

The application of appropriate methods and adoption of scientific form of mind is an essential requirement for any systematic study. The methodology for the present study will be as under:

1.2.i.(a) Sampling Design

A sample design is a definite plan for obtaining a sample from a given population. It refers to the technique or the procedure the researcher would adopt in selecting items for the sample. For the collection of relevant first hand data in the present study multistage random-cum-purposive sampling technique will be used. At the first stage one district will be selected, at the second stage five blocks will be selected, at the third stage Anganwadicentres will be selected and at the fourth stage respondents will be selected.

Selection of Universe

i. Selection of District

At the first stage, one district will be selected to represent Himachal Pradesh. To choose a representative district all the districts will be arranged on the basis of three indicators. These indicators will be: total anganwadicentres, population of 0-3 years child, beneficiaries of ICDS (lactating and pregnant mothers), 3-6 years boys and girls beneficiaries.

All the twelve districts will be given ranks from 1 to 12. The ranks will ranged from 1 to 12. 1st rank will be given to the highest number and thus in descending order 12 to the lowest number. Then ranks will be converted into scores. Maximum scores of 12 will be assigned to 1st ranks, 11 to 2nd ranks, 10 to 3rd ranks and so on. After this, individual scores will be added to get the total scores with respect to each district separately. Thereafter, final ranking of the district will be made. The district that attained first ranks will be selected for the study on the basis of highest number of score. (see Table 1).
## Table - 1

### Procedure for the Selection of District

<table>
<thead>
<tr>
<th>Selection of District</th>
<th>Total AWC</th>
<th>Child Population</th>
<th>Beneficiaries</th>
<th>Total Score</th>
<th>Re-ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AWC</td>
<td>Rank</td>
<td>Score</td>
<td>0-3 years</td>
<td>Rank</td>
</tr>
<tr>
<td>Bilaspur</td>
<td>1111</td>
<td>9</td>
<td>4</td>
<td>16219</td>
<td>10</td>
</tr>
<tr>
<td>Chamba</td>
<td>1495</td>
<td>4</td>
<td>9</td>
<td>25658</td>
<td>5</td>
</tr>
<tr>
<td>Hamirpur</td>
<td>1351</td>
<td>7</td>
<td>6</td>
<td>17090</td>
<td>8</td>
</tr>
<tr>
<td>Kangra</td>
<td>4225</td>
<td>1</td>
<td>12</td>
<td>54742</td>
<td>1</td>
</tr>
<tr>
<td>Kinnaur</td>
<td>234</td>
<td>11</td>
<td>2</td>
<td>3105</td>
<td>11</td>
</tr>
<tr>
<td>Kullu</td>
<td>1095</td>
<td>10</td>
<td>3</td>
<td>16848</td>
<td>9</td>
</tr>
<tr>
<td>Lahaul spiti</td>
<td>123</td>
<td>12</td>
<td>1</td>
<td>897</td>
<td>12</td>
</tr>
<tr>
<td>Mandi</td>
<td>3004</td>
<td>2</td>
<td>11</td>
<td>40915</td>
<td>2</td>
</tr>
<tr>
<td>Shimla</td>
<td>2152</td>
<td>3</td>
<td>10</td>
<td>29482</td>
<td>3</td>
</tr>
<tr>
<td>Sirmaur</td>
<td>1485</td>
<td>5</td>
<td>8</td>
<td>24317</td>
<td>4</td>
</tr>
<tr>
<td>Solan</td>
<td>1281</td>
<td>8</td>
<td>5</td>
<td>22172</td>
<td>6</td>
</tr>
<tr>
<td>Una</td>
<td>1364</td>
<td>6</td>
<td>7</td>
<td>20390</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Directorate of Women and Child Development, Department of Social Justice and Empowerment, Government of Himachal Pradesh, Shimla
Selection of Blocks

At the second stage five blocks will be selected. The selection of blocks will be made after ranking all the blocks of the selected district on the basis of three indicators. These indicators and the procedure of ranking will be the same as in case of selection of district. There are 15 blocks in the Kangra district. All the 15 blocks will be given ranks from 1 to 15. The ranks will be ranged from 1 to 15. 1st rank will be given to the highest number and thus in descending order 15th to the lowest number. Then ranks will be converted into scores. A maximum score of 15 will be assigned to 1st rank, 14 to 2nd rank and so on. After this, individuals scores will be added to get the total points with respect to each block separately. Thereafter, final ranking of the block will be made. The blocks that will attain first five ranks will be selected. These five blocks Dehra, Fatehpur, Indora, Nurpur and Paragpur will be selected on the basis of highest number of score. (see Table no. 2).
At the third stage, an aganwadi centre will be selected from the five selected blocks of Kangra district. Ten Anganwadies will be selected from each block.

Table 2

<table>
<thead>
<tr>
<th>Block</th>
<th>Total AWC</th>
<th>0-3 Years</th>
<th>3-6 Years</th>
<th>Child Population</th>
<th>Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AWC</td>
<td>Rank</td>
<td>Score</td>
<td>AWC</td>
<td>Rank</td>
</tr>
<tr>
<td>Baijnath</td>
<td>278</td>
<td>8</td>
<td>7</td>
<td>3050</td>
<td>9</td>
</tr>
<tr>
<td>Bhawarna</td>
<td>230</td>
<td>13</td>
<td>3</td>
<td>2930</td>
<td>12</td>
</tr>
<tr>
<td>Dehra</td>
<td>387</td>
<td>1</td>
<td>15</td>
<td>5178</td>
<td>1</td>
</tr>
<tr>
<td>Dhamshala</td>
<td>182</td>
<td>14</td>
<td>2</td>
<td>2278</td>
<td>15</td>
</tr>
<tr>
<td>Fatehpur</td>
<td>278</td>
<td>9</td>
<td>8</td>
<td>4427</td>
<td>5</td>
</tr>
<tr>
<td>Indora</td>
<td>314</td>
<td>5</td>
<td>11</td>
<td>4769</td>
<td>3</td>
</tr>
<tr>
<td>Kangra</td>
<td>295</td>
<td>6</td>
<td>10</td>
<td>3342</td>
<td>8</td>
</tr>
<tr>
<td>Lamba Gaon</td>
<td>276</td>
<td>10</td>
<td>6</td>
<td>2997</td>
<td>10</td>
</tr>
<tr>
<td>Nagorta Suryan</td>
<td>325</td>
<td>4</td>
<td>12</td>
<td>4223</td>
<td>6</td>
</tr>
<tr>
<td>Nagrota Bagwan</td>
<td>254</td>
<td>11</td>
<td>5</td>
<td>2971</td>
<td>11</td>
</tr>
<tr>
<td>Nurpur</td>
<td>349</td>
<td>3</td>
<td>13</td>
<td>4898</td>
<td>2</td>
</tr>
<tr>
<td>Phachrukhi</td>
<td>169</td>
<td>15</td>
<td>1</td>
<td>2407</td>
<td>14</td>
</tr>
<tr>
<td>Pragpur</td>
<td>364</td>
<td>2</td>
<td>14</td>
<td>4043</td>
<td>7</td>
</tr>
<tr>
<td>Rait</td>
<td>282</td>
<td>7</td>
<td>9</td>
<td>4455</td>
<td>4</td>
</tr>
<tr>
<td>Sulah</td>
<td>240</td>
<td>12</td>
<td>4</td>
<td>2774</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Directorate of Women and Child Development, Department of Social Justice and Empowerment, Government of Himachal Pradesh, Shimla
These anganwadicentre will be selected on the basis of highest number of beneficiaries.

Thus after selecting block 50 AnganwadiCentres (10 from each block) will be selected. A total 360 respondents will be selected for the present study. The respondent will include 100anaganwadi worker and helper (2 from each anganwadicentre), 10 officials (CDPO/ACDPO and supervisor) (2 from each block) and 250 ICDS beneficiaries, (five from each anganwadicentres) (see Table no. 3)

Table 3
Selection of AngawadiCentres and Respondents

<table>
<thead>
<tr>
<th>Selected Blocks</th>
<th>Total number of AnganwadiCentres</th>
<th>Sample Anganwadies (Ten from each block)</th>
<th>Respondents</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dehra</td>
<td>387</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Fatehpur</td>
<td>278</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Indora</td>
<td>314</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Nurpur</td>
<td>349</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Pragpur</td>
<td>364</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1692</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
<td><strong>250</strong></td>
</tr>
</tbody>
</table>
Thus total sample will be consist 360 respondents (see Table no. 4)

Table No.4
Sample for Study

<table>
<thead>
<tr>
<th>Sample Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anganwadi Worker/helper</td>
<td>100</td>
</tr>
<tr>
<td>ICDS Beneficiaries</td>
<td>250</td>
</tr>
<tr>
<td>CDPO/ACDPO and Super wiseer</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>360</strong></td>
</tr>
</tbody>
</table>

1.2.i. **Methodology for Data Collection**

With a view to achieving the objectives and testing the hypotheses, the present study will be based on the primary as well as secondary data. The methodology of data collection will be as under:

1.2.i.(a) **Collection of Primary Data**

In the present study, primary data will be collected through a sample survey by administering the interview schedules. For this, well-designed schedules will be prepared and administered to the respondents selected through sampling method.

1.2.i.(b) **Collection of Secondary Data**

In the present study secondary data will be obtained from the office records of the Department of women and Child welfare, Department of Economics and statistics, Planning Department of Government of Himachal Pradesh, Block office. It will include annual progress reports, economic surveys, annual administrative reports, etc. The secondary data will also be collected from the various books, research papers, journals and internet sites.
SCHEME OF CHAPTERIZATION

The tentative chapterization of the present study will be as under:

**Chapter I**  Introduction

**Chapter II**  Integrated Child Development Services in Himachal Pradesh

**Chapter III**  Organizational Setup for the Implementation of ICDS in Himachal Pradesh.

**Chapter IV**  Socio-Economic Profile of Sample Respondents

**Chapter V**  An Evaluation of Implementation of ICDS in Kangra District of Himachal Pradesh.

**Chapter VI**  An Evaluation of Impact of ICDS on the Beneficiaries in Kangra District of Himachal Pradesh

**Chapter VII**  Conclusions and Suggestions
BIBLIOGRAPHY

Books


**Journal and Article**


Gairola, Yogesh and Chauhan, Amita (January – March, 2009), Think India Quarterly, Vol. 12, No. 1.


**Government Documents**


