CHAPTER I

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India is one of the few developing countries to have a national policy on children. With a view to helping lakhs of malnourished children and pregnant women belonging to the low income strata of the society, a centrally sponsored scheme - INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS) was launched on an experimental basis in 33 selected blocks on October 2, 1975, the 106th birth anniversary of Mahatma Gandhi. Now, under this scheme, there are about 2,424 Projects in 4,300 out of the total 5,092 blocks of the country. At present, there are 2,70,000 Anganwadi Centres in the country.

The scheme is implemented with an aim to provide facilities like supplementary nutrition, immunization, nutrition and health education to pregnant women, pre-school education to children in the age group of 3 to 6 years and other supportive services like water supply and sanitation.[1]

1.1 STATEMENT OF THE PROBLEM

High infant mortality rate, high levels of morbidity, high incidence of malnutrition and nutrition-related diseases, temporary or irreversible disabilities, low literacy rates - these are some of the prospects staring at the 110 million children under six years

of age in India.

Against such a grim background, the Government of India formulated a comprehensive child survival and development scheme drawing on the resources of the Centre, States, voluntary organisations and the communities themselves.

Since 1975-76, the Government has been actively implementing, improving and expanding a most ambitious and comprehensive scheme to increase the survival rate and enhance the health, nutrition and learning opportunities of pre-school children and their mothers.

There are various dimensions of ICDS but it is not possible to evaluate all these in a single study. Although in the past, a few attempts have been made to examine and evaluate the performance of some of the selected aspects of ICDS in Kolhapur, perhaps the answers to the following questions were not in their purview. Were the beneficiaries selected appropriate? What was the extent of benefit derived by the beneficiaries from the programme? What were the various procedural lacunae in the implementation of the programme?

In order to provide appropriate answers to these questions, a study entitled **A STUDY OF INTEGRATED CHILD DEVELOPMENT SCHEME IN KOLHAPUR** was undertaken. The present study deals with the implementation of ICDS programmes and policies for the development of children and

women at selected slum area in Kolhapur city of Maharashtra State.

1.2 HISTORY OF CHILD CARE SERVICES IN INDIA

In India of the past the joint family system was most prevalent and villages were self-sufficient. Life was comparatively simple, and usually the demands made on the individual in the family were familiar and not unbearable. The child was born in a family and grew, lived and died in the family. The destitute or handicapped children were generally protected by the community, as the Village Panchayat was considered to be the guardian of the village in all respects.

1.2.1 Child Welfare Services in the British Period

The Industrial Revolution in England affected Indian economy. The rapid spread of communication broke the village self-sufficiency. Due to peace and check of epidemics and famines the population of the country grew rapidly. The village industries were seriously affected due to keen competition with machine-made goods. The result was the growing poverty of the masses.

The number of destitute children grew in the village as the village Panchayat could no longer afford them protection due to paucity of funds. Many persons left for employment to the urban areas. The person migrated with his family; he had to live in slum areas, due

to low wages. The education provided to the children in the village was no more sufficient, but even after migration to the towns many people could not afford higher education due to poverty. Poverty was also the cause of under-nourishment and, many a time, of abundance of children borne by their parents.[2]

1.2.2 Acts Passed Before Independence for the Welfare of Children:

(i) *The Apprentices Act 1850 (The father or guardian can bind the poor orphan child between 10 and 18 for 7 years for learning some trade, craft etc.)*

(ii) *The Guardians and Wards Act of 1890 (Guardians for minors could be appointed under this Act)*

(iii) *Reformatory Schools Act 1897 (Youthful offenders upto 15 years not convicted for offences punishable with transportation or life imprisonment could be sent to these Schools)*

(iv) *Indian Merchant Shipping Act 1923 (Children under 14 years were not allowed to serve in ship)*

(v) *Child Marriage Restraint Act, 1929.*

(vi) *The Children Pledging of Labour Act, 1933 (No guardian could pledge a child for labour)*

(vii) *The Employment of Children Act, 1938 (Children were prohibited from employment in certain specified industries)*[3]

1.2.3 Some Non-government Organisations for the Welfare of Children

In mediaeval India, religious trusts had organised welfare services for destitute and delinquent children. The voluntary organisations also played a pioneering role in the development of child care services.

The significant contributions were made by the following organisations:

i) Indian Council for Child Welfare
ii) The Indian Red Cross Society
iii) All India Women's Conference
iv) Balkanji-Bari
v) The Children's Aid Society, and
vi) The Kasturba Gandhi National Memorial Trust.

1.2.4 International Agencies

There are three main agencies dealing with child welfare.

1.2.4.1 World Health Organisation (WHO)

During the Conference in San Francisco in 1945, which created the charter and founded the United Nations Organisation, it was proposed to include the protection of health into the goals of the United Nations. The United Nations convened an International Health Conference in June, 1946 in New York, which approved the Constitution of the World Health Organisation. It is the first world-wide health agency, working as a specialised agency

of the United Nations. Its principal organs are the World Health Assembly, composed of representatives of all member-countries and meeting each year, Executive Board elected by the Assembly and the Secretariat under the Director-General.

The WHO's main objective is the attainment of the highest possible level of health for all people of the world. The major programmes of action include the promotion of maternal and infant hygiene, of nutritional diets, of environmental hygiene as well as campaigns against malaria, tuberculosis, yaws, typhus, trachoma and venereal diseases. Many of these health programmes are operated jointly with the UNICEF when they are aimed at the protection of children, mothers and youths, and with other organisations. It also takes an active part in the technical assistance programme of the United Nations.

> *India has been a member of the WHO ever since its inception in 1948. The Government of India's programmes of public health in which the WHO has co-operated cover such fields as: malaria, tuberculosis, venereal diseases, environmental sanitation, maternal and child health, nutrition, health education of the public, community development, professional and technical training especially for doctors and nurses, plague research, trachoma control, dental education and vital health statistics.*[4]

1.2.4.2 United Nations International Children's Emergency Fund (UNICEF)

Under its original title 'United Nations International Children's Emergency Fund' this agency was established in 1946 at the urgent request of the UNRRA Council in order to carry on child feeding and child welfare services that could not be discontinued without grave damage to millions of children, pregnant women, and nursing mothers. The United Nations Assembly adopted provisions stipulating that the UNICEF was to operate for the benefit and rehabilitation of children and adolescents in war-devastated countries which received the UNRRA assistance, and finally for child-health purposes where they were needed in general.

> *A UNICEF Area Office was established in India in February, 1949. The Fund provides basic medical equipment for rural health centres, associated hospitals and public health laboratories; teaching and demonstration equipments for the training of nurses, midwives, health visitors and Sanitary inspectors; insecticides, vaccines, drugs and antibiotics to initiate campaigns against disease; milk and other foods to combat malnutrition and transport to speed up the development of health programmes.*[5]

1.2.4.3 International Union for Child Welfare (IUCW)

The International Union for Child Welfare was established in 1920 with headquarters at Geneva. It

is a federation of national and international organisations which in 1959 counted on 68 members of various descriptions in 43 countries. The Union's activities derive from the Declaration of the Rights of the Child, commonly known as the 'Declaration of Geneva.

The purpose and activities of the Union are:

> *... to make known throughout the world the principles of the Geneva Declaration of the Rights of the Child, to relieve children in case of distress, to raise the standards of Child Welfare, and to contribute to the physical and moral development of the child.*[6]

1.3 CHILD DEVELOPMENT SERVICES AFTER INDEPENDENCE

After independence, the Government of India assumed greater responsibility towards the care and welfare of children. The policies relevant to children are being discussed in the Indian Constitution. The Constitutional provisions concerning children mainly relate to the provision of free and compulsory education for children between 6 and 14 years of age.

Many child welfare programmes launched under the Five Year Plans and the Planning Commission decided to give priority to the needs of children. So, special programmes to meet the needs of delinquent, handicapped, destitute and other groups of children were also undertaken. Some of these programmes were related to the

growth and development of children, especially children belonging to the pre-school age group of 0-6 years.

The details of the Child Welfare Services and Nutrition Programmes are given in the next topic.

1.3.1 Constitutional Provisions

Our Constitution has made the following Provisions:

i) In Article 15, provision has been made for making any special provisions for women and children by the State.

ii) In Article 24, it is provided that no child below the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment.

iii) In Article 39, it is provided that the state shall in particular, direct its policy towards securing that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter vocations unsuited to their age or strength and that children and youth are protected against exploitation and against moral and material abandonment.

iv) Under Article 45, it is stated that the state shall endeavour to provide within a period of ten years from the commencement of this

Constitution for free and compulsory education for all children until they complete the age of fourteen years.

v) *In Article 46, it is stated that the state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.*[7]

1.3.2 Child Welfare Services and Nutrition Programmes

1.3.2.1 Welfare Extension Projects (WEP) (1958):

The Central Social Welfare Board, in its survey of the voluntary field in India, found that most of the voluntary welfare organisations were concentrated in and around urban areas. The objective of the programme is to carry welfare services to women and children living in rural areas.

By the end of the First Five Year Plan, the Central Social Welfare Board had set up 292 Welfare Extension Projects with 1,150 centres covering 6,000 villages with a population of 5.5 million. At present the programme is located in community development blocks on a co-ordinated basis.[8]

BENEFITS

The programme is being run to act and serve maternity and child care services, first-aid and primary medical aid, Balwadis comprising crech and pre-school,

supplementary nutrition, craft training for women, and social education for women. The programme also attempts to secure participation and organises its activities through project centres which have trained resident staff.

PERFORMANCE OF THE PROGRAMME

The programme, however, aims at a very broad target group of children in the pre-school age. But with limited resources available for various activities, it will not be possible to make an appreciable impact. Often funds from the State Government are not released in time. The project implementation committee only consists of representatives of outside groups. So, it cannot involve the local leadership.

1.3.2.2 The Applied Nutrition Programme (ANP)(1963)

The Expanded Nutrition Programme was launched as a centrally sponsored programme by the Government of India with the idea of enhancing the production and consumption of protective foods in rural areas. Orissa and Andhra Pradesh were the first two states to take up the programme in 1960 which was then extended to Tamil Nadu in 1961 and Uttar Pradesh in 1962. In 1963, the programme was renamed as the Applied Nutrition Programme and an agreement was signed between the United Nations International Children's Emergency Fund (UNICEF), the

Food and Agricultural Orgnisation (FAO), the World Health Organisation (WHO) and the Government of India, to increase the coverage of the programme so as to include the entire country. The programme is now being implemented under the Department of Rural Development.[9]

OBJECTIVES

The main objectives of the Applied Nutrition Programme (ANP) as listed in the master plan of operation are -

(i) To develop progressively co-ordinated and comprehensive national education and training in applied nutrition and related subjects with the object of establishing an effective field services to improve local diets.

(ii) To provide progressively, facilities for the training or reorientation of tutorial staff required for the educational institutions and training centres participating in this programme as well as for training of managerial and supervisory personnel in the field service programme.

(iii) To provide facilities for a quick survey of the general nutrition problems including the present and potential production and supply of food in the areas selected for implementation

of the programme for the purpose of initiating the most effective strategy for the local conditions.

(iv) To upgrade and extend facilities for training selected groups of personnel engaged in the national community development programme in nutrition, production and preparation of suitable food and application of basic principles of personal, household and community hygiene in feeding infants and young children.

(v) To assist in the extension of the programme in community development blocks in the vicinity of training institutions for the purpose of demonstration and training.

1 To promote, through demonstration and education among village communities, sound and hygienic practices for the production, storage, preservation and use of protective foods.

2 To encourage practical application of such principles at block and village level, and

3 To stimulate self-help in this regard.

TARGET GROUPS

The programme aims at extending these services to the general population in rural areas. Feeding, however, is limited to the vulnerable groups, i.e., children in the age group of 0-6 years and pregnant and nursing mothers. Drought-prone and backward areas are given priority over the others.

PROGRAMME CONTENT

The Applied Nutrition Programme (ANP) is being implemented through rural development blocks. Essentially, the programme calls for organisation of poultry units, horticulture, kitchen gardens, community gardens and school gardens with the intention of bringing about greater awareness with regard to the production and consumption of protective foods. The feeding component is limited only to the vulnerable groups and was introduced basically as a form of practical demonstration for the beneficiaries. The activities may, however, vary from area to area, depending on the needs.

PERFORMANCE OF THE PROGRAMME

> *This Programme failed to generate the desired awareness for improved diets and failed to make an impact on production and consumption. The radiating effect of the programme through demonstration was not achieved. The programme suffered from non-availability and lock of irrigation,*

delays in implementation and lack of economic viability of the gardens. Panchayati Raj institutions had limited participation. Mahila Mandals were not successful at places. Participation of local centres was not adequate. The training, monitoring and supervision methods were defective and not well-planned and well-perceived.[10]

1.3.2.3 The Vitamin 'A' Prophylaxis Programme (VAPP)(1970)

The Vitamin 'A' prophylaxis programme was launched by Ministry of Health and Family Welfare.

OBJECTIVES

The programme aims at reducing the incidence of blindness occuring due to a nutritional deficiency of Vitamin 'A'.

TARGET GROUPS

Children in the age group of 1-5 years form the target group for prophylaxis.

PROGRAMME CONTENTS

Oral prophylactic doses of 200,000 1.U. of Vitamin 'A' suspension in oil are provided to all the beneficiaries once every six months.

PERFORMANCE OF PROGRAMME

The surveys carried out in various parts of the country have revealed that at least 20 to 30 per cent of the children in the pre-school age group

have eye manifestations as a result of Vitamin 'A' deficiency. It has been estimated that no less than 12,000 to 14,000 children go blind in the country every year as a result of Vitamin 'A' deficiency. Therefore, efforts have to be made to cover all children in the age group 1-5 years in the ICDS Project areas by this programme of oral administration of Vitamin 'A' concentrate.[11]

1.3.2.4 The Special Nutrition Programmes (SNP)(1971)

The Special Nutrition Programme was launched as a 'Creche Feeding Programme' by the Government of India.

OBJECTIVES

The primary objectives of the Special Nutrition Programme are as follows:

(i) Improvement of the health and nutritional status of children (0-6 years), pregnant and nursing mothers.

(ii) Reduction of infant and child mortality and morbidity rates through well co-ordinated health and nutrition services.

(iii) Improvement of the mother's capacity to cater to the needs of the child through adequate health and nutrition education.

TARGET GROUPS

Infants and children in the 0-6 years age group, expectant and nursing mothers from urban slums, tribal and backward areas form the major target groups of the Special Nutrition Programme.

PROGRAMME CONTENT

A nutritive supplement as per the following specifications is provided to the beneficiaries through feeding centres set up for the purpose.

Beneficiaries	Nutritional Supplement
Children 0-1 years	200 calories & 8-10 gm protein
Children 1-6 years	300 calories & 10-12 gm protein
Pregnant and Nursing mothers	500 calories & 20-25 gm protein

Supplementary food is provided to the beneficiaries for 250-300 days in a year. The nature of food supplements used may vary from area to area depending upon local availability. Reconstituted skimmed milk, corn-soya milk, balahar in various forms, Khichri made from cereal-pulse mixtures, vitaminised bread produced by Modern Bakers Ltd., and a variety of other food items have been used for feeding from time to time. Supplements in the form of multivitamin tablets, iron and folic

acid tablets and prophylactic oral doses of vitamin 'A' are also given to the beneficiaries. Periodical health check-ups, immunization, and health and nutrition education are also included under the programme.[12]

PERFORMANCE OF THE PROGRAMME

It is felt that administrative arrangements made for the supervision of the programme are inadequate. Programme contents such as health check-ups need to be followed adequately. The organisers and helpers are getting small honorarium and are not happy. Children of 0-3 years are not fed properly. There are not sufficient facilities for sheltered accommodation and cooking.

1.3.2.5 Family and Child Welfare Projects (FCWP)(1964)

The Family and Child Welfare Programme was prepared by the Central Social Welfare Board. The Ministry of Social Welfare of the Government of India was made responsible for running the programme. The United Nations International Children's Emergency Fund assisted the programme. The Central Social Welfare Board is entrusted with the actual implementation of the programme. At the State level the programme is to be supervised by State Social Welfare Advisory Boards.

OBJECTIVES OF THE PROGRAMME

(i) To provide integrated basic social services to children.

(ii) To offer basic training to women and young girls in home craft, health education, nutrition and child-care as well as essential health and maternity services for women.

(iii) To assist women in the villages through Mahila Mandals and other agencies to obtain supplementary work and income.

(iv) To promote cultural, educational, and recreational activities for women and children.

PERFORMANCE OF THE PROGRAMME

The Programme of Family and Child Welfare Projects was reviewed by an evaluation committee. The committee felt that the objectives of the scheme should be broad based and they should be broken into operational coverage of services. There was no arrangement of referral services of children in need of special care. There was no systematic supply of nutrition in the centres. Not all the centres provided nutrition education to mothers too.

There were delays in release of funds by Central Social Welfare Board. There was no special provision for medical services under the programme. There was also no effective system for monitoring the progress of the scheme.[13]

1.3.2.6 The Mid-day Meals Programme (MDM)(1982)

As per the recommendations of School Health Committee, Mid-day Meals Programme (MDM) was initiated

as a centrally sponsored scheme.

OBJECTIVES

The Mid-day Meals Programme (MDM) has two general objectives - nutritional and educational. These may be specified as follows:

(i) Provision of a free meal to school-going children with the aim of bridging the gap between the dietary intake at home and the Recommended Daily Allowance.

(ii) Improving schools' attendance and reducing the number of drop-outs by offering an extra incentive of a free meal at school.

TARGET GROUPS

Under the programme, an attempt is being made to offer school-going children between 6 and 11 years from the weaker sections of society.

PROGRAMME CONTENT

The programme provides for the supply of one meal containing about 80 gm of food-grains and 7 gm of oil with a nutritive content of approximately 300 calories and 8-12 gm protein for a period of at least 180 days.

PERFORMANCE OF THE PROGRAMME

It was pointed out that at the end of the Sixth Plan about 20 million beneficiaries got the proper

nutrition support while the actual coverage was about 13 million. But the programme failed to make community conscious of balanced nutrition by bringing change in the food and dietary habits. It was also pointed out that there was weak supply of food items.[14]

1.3.2.7 The Goitre-control Programme (GCP)(1963)

This programme was launched at the end of the Second Five Year Plan under the Ministry of Health and Family Welfare.

OBJECTIVES

The programme aimed at controlling the incidence of endemic goitre in the country.

TARGET GROUPS

The target groups of this programme are the populace residing in endemic goitre-prone regions of the country where the water supply has an unusually low iodine content.

PROGRAMME CONTENT:

The programme consists of three basic components, viz.,

(i) Surveys for identification of endemic goitre-prone areas.

(ii) Production and supply of iodised salt to the populace in the identified areas.

(iii) Assessment of the impact of the programme by means of surveys conducted for the purpose, after five years of continuous supply of iodised salt.

Two central goitre survey teams have been set-up under the Directorate General of Health Services, Ministry of Health and Family Welfare. These teams have surveyed the entire sub-Himalayan belt as well as certain areas in Central India. Salt iodised to the extent of 23 PPM is supplied in these areas at the usual price of edible common salt.

PERFORMANCE OF THE PROGRAMME

> *The programme could not achieve significant success in controlling the incidence of endemic goitre. The total estimate was of nearly 40 million sufferers from some degree of goitre residing in endemic goitre-prone area. But only 15 million beneficiaries have been covered under this programme. It is pointed out that there is no improvement in the production and distribution of iodised salt.*[15]

1.3.2.8 The Programme for Prevention of Nutritional Anaemia (PNA)(1978)

Surveys indicate that 50 per cent pre-school children and 30-50 per cent women in the later stages of pregnancy have haemoglobin levels below 10 per cent. Consequently, this programme was launched by the Ministry of Health and Family Welfare.

OBJECTIVES

The programme aims at the reduction of the incidence of nutritional anaemia among population groups in India.

TARGET GROUPS

Pre-school children and expectant mothers during the latter half period of pregnancy from the target groups for this programme.

PROGRAMME CONTENT

Iron and folic acid supplements to the extent of 60 mg of iron as ferrous sulphate or ferrous fumarate and 500 micro gm folic acid are provided to expectant mothers and 20 mg iron and 100 micro gm folic acid are given to pre-schoolers for a period of approximately 100 days consecutively.

PERFORMANCE OF THE PROGRAMME

The programme has failed to achieve its objectives in reducing the incidence of nutritional anaemia. Only 12.5 million beneficiaries have been covered up till 1977-78. It is proposed to be increased to 28 million during the Sixth Plan.[16]

1.3.2.9 The Balwadi Nutrition Programme (BNP)(1971)

This programme, supported by the Ministry of Social Welfare, was started and is being implemented

through four national level voluntary agencies, i.e., the Central Social Welfare Board, the Indian Council of Child Welfare, the Bharatiya Adimjati Sevak Sangh and the Harijan Sevak Sangh.

OBJECTIVES

The basic objectives of the BNP may be listed as -

(i) Provision of educational facilities for pre-school children.

(ii) Provision of a nutritional supplement to pre-schoolers with the intention of alleviating their nutritional status.

TARGET GROUPS

Children in the age group of 3-6 years from low income families are the main target groups of the BNP.

PROGRAMME CONTENT

The programme provides for the organisation of small Balwadis (day-care centres) in rural areas. Provision is also made for the supply of one meal with a nutritive content of approximately 300 calories and 8 to 12 gm of protein to the children attending the Balwadi.[17]

PERFORMANCE OF PROGRAMME

Nearly 2.3 lakh children have been already covered under this scheme. Though the programme is fully funded by the Central Government, it fails to provide supplementary nutrition to children in Balwadi in order to meet one-fourth of their daily calorie requirement. Children of 3 to 6 years are not fed properly. It is also felt that selection of the beneficiaries is wrong and administrative arrangements of the programme are not adequate.

1.3.2.10 Demonstration Projects for Integrated Child Welfare Services (DPCWS)(1963)

This programme was launched to provide better service to women and children in rural areas. So, a few demonstration projects in rural areas were established where services in the field of health, nutrition, education, training and welfare could be provided to meet the total needs of children on a comprehensive and integrated basis. The scheme suggested the coverage of all children in the age group of 0-16 years in selected units with a population of 15,000 children or 5,000 families.

BENEFITS

While achieving objectives of this programme, it was felt that the age group of 0-6 years was the

most vulnerable among the children who should be given priority. The children in this group were looked after in the field of health, nutrition, and education more than the children above 10 years.

PERFCRMANCE OF THE PROGRAMME

> *The programme was not possible to reach all the children in the age group of 0-16 years for a variety of reasons. The programme did not provide any services for mothers. The initial enthusiasm shown by participating agencies was not sustained due to financial constraints.*[18]

Thus the performances of selected services and nutrition programmes relevant to child development have indicated that child care programmes have not been able to make much impact on the problems of children in this country. Various problems concerning children are still of fairly large dimensions. The incidence of mortality, morbidity and malnutrition among children continues to be alarmingly high.

The past experience has indicated that child care programmes with inadequate coverage and very limited inputs cannot make much dent on the problems of children. None of the health, nutrition, education and other social welfare measures adopted in the past has been as effective as the situation demands.

The eight inter-ministerial teams were constituted by the Planning Commission who studied the field situation in depth and proposed a scheme for Integrated Child Care Services for pre-school children covering supplementary nutrition feeding, immunization, health care including referral services, nutrition education of mothers, pre-school education and recreation, family planning and provision of safe drinking water. And the enunciation of the National Policy for Children in August, 1974, discussed later, was an important landmark in the evolution of the Integrated Child Development Services Scheme (ICDS).[19]

1.4 INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME AND ITS CONTENTS (ICDS)(1975)

OBJECTIVES

The objectives of the Integrated Child Development Services Scheme (ICDS) are:

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

(ii) Laying foundations for proper psychological, physical and social development of the child.

(iii) Reduction of the incidence of mortality, morbidity, malnutrition and school drop-outs among children.

(iv) Effective coordination of policy and implementation amongst various departments in order to promote child development.

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

TARGET GROUPS

Children of 0-6 years of age, nursing and expectant mothers as well as other women between 15-45 years of age constitute the target group of the scheme.

PROGRAMME CONTENTS

The scheme offers an integrated package of services for the beneficiaries. Since the impact of one service is, inevitably, dependent on other supportive services, such an integrated package would help to improve the overall impact of the scheme.

The following package has been identified for inclusion in the scheme:

(i) Supplementary nutrition
(ii) Immunization
(iii) Health check-up
(iv) Referral services
(v) Nutrition and health education
(vi) Non-formal education.

Efforts are also being made to provide safe drinking water in areas where the Integrated Child Development Services Scheme (ICDS) scheme is implemented.

PERFORMANCE OF SCHEME

The ICDS Scheme has succeeded in improving the access to health, nutrition, and education services for children and women of the weaker sections. The Scheduled Castes and Scheduled Tribes women were more benefitted by the health and nutrition education services as compared to others.

> *The states pointed out that the lack of proper storage facilities, weak supply of food items and incomplete identification of several malnurished cases remained the main limitations of the programme. Coordination at the block level among the health, social welfare and block development staff in many states was not effective. Integration in the provision of services at the Anganwadi level was reported to be poor and ineffective. Identification of the target groups based on objective criteria is not being undertaken systematically. Thus the most needy and vulnerable groups have not been able to benefit from this programme.*[20]

1.5 MECHANISM OF ICDS

1.5.1 Anganwadi and Its Role

Anganwadi is a place where the children from the age group of 3 to 6 years are admitted. This period of early childhood is the most impressionable period in the whole span of development. In the Anganwadi centre, the pre-school education is given to the children of this group. The ultimate aim of pre-school is to develop

a wholesome personality in the child. Therefore, an Anganwadi worker (AWW) should bear in mind that she should deal with the children delicately without leaving a sear on their personality.

JOB RESPONSIBILITIES OF ANGANWADI WORKER

(i) To weigh each child every month, record the weight in graph on the growth card.

(ii) To organise non-formal pre-school activities in an Anganwadi.

(iii) To organise supplementary nutrition feeding for children of the group of 0-6 years, expectant and nursing mothers.

(iv) To provide health and nutrition education to mothers.

(v) To make home visits for educating parents to enable mothers to plan an effective role in the child's growth and development particularly in the case of children attending the Anganwadis.

(vi) To maintain routine files and records.

(vii) To elicit community support and participation in running the programme.

(viii) To maintain liaison with other institutions which are relevant to the child development scheme.

IMPORTANCE OF AN ANGANWADI CENTRE (AWC)

(i) In an Anganwadi centre, children come together and play games so that they can get safety.

(ii) The children can play games in an Anganwadi centre so that they can be encouraged for social development.

(iii) In an Anganwadi, children come together and get free benefits of health check-up, medicines and supplementary nutrition regularly.

(iv) The children can learn discipline, dressing themselves neatly, and other good health habits in an Anganwadi centre.

(v) In an Anganwadi centre, children are taught different songs, cultural activities and national anthem so that they can be turned to national integration.

OBJECTIVES OF AN ANGANWADI CENTRE (AWC)

The Anganwadi aims at physical, social, emotional and intellectual development of the child. The broad objectives of an Anganwadi centre are as follows:

(i) To develop a good physique, adequate muscular co-ordination in the child.

(ii) To build up basic skills necessary for personal adjustment in the child.

(iii) To develop desirable social attitudes and manners in the child.

(iv) To develop emotional maturity by guiding the child to express, understand, accept and control his feelings.

(v) To stimulate in the child intellectual curiosity to help him/her understand the world.

(vi) To develop in the child the ability to express his/her thoughts and feelings.

(vii) To prepare the child for formal schooling and thus reducing the school drop-out.

THE PROGRAMME OF THE ANGANWADI CENTRE

The success of an Anganwadi depends on the kinds of programme. If the activities are interesting, the children will be eager to come to the centre. So, the programme should be flexible to serve the needs and interests of the children. The programme should maintain a balance between free and guided activities. It should be functional and meaningful so that the needs of the individual child as well as the group needs are satisfied.[21]

1.5.2 Organisational Structure of ICDS

The success of the scheme depends upon the effectiveness of co-ordination at various levels.

(i) ICDS at National Level

At the national level, Ministry of Social Welfare is responsible for policy-making, planning, direction and controlling of ICDS. Providing linkages with allied programmes and services and departments, laying down priorities, procedures, norms and guidelines, ensuring regular flow of information, feedback and close monitoring of the programmes, training and orientation of staff are the specific co-ordination tasks at National Level.

(ii) ICDS at State Level

At the State level, Department of Social Welfare or the nodal Department for ICDS is responsible for policy planning, implementation, co-ordination, organisation and administration. Provision of inputs and smooth flow of supplies and equipments, linkages with allied schemes, monitoring and solving operational problems are the specific co-ordination tasks at state level.

(iii) ICDS at District Level

At the district level, Co-ordination Committee is responsible for planning, implementation, support and technical guidance. Ensuring regular flow of supplies and equipment, technical support, guidance, training and orientation of project staff are the specific co-ordination tasks.

The committee is chaired by District Collector/

District Magistrate/Deputy Commissioner. The Committee comprises district level officials, non-officials, the ICDS advisor, Child Development Project Officer, Block Development Officer and Medical Officer of ICDS.

(iv) ICDS at Block/Project Level

At the block level, Block Development Officer is the in-charge of the ICDS Scheme. He/she is responsible for planning and implementation. And the project level, Child Development Project Officer is the in-charge of the ICDS scheme. He/she is responsible for planning and administration. Procurement, storage and distribution of supplies, on-the-spot co-ordination in day-to-day functioning, recruitment, placement, deployment and on-job training and supervision of field staff are the specific co-ordination tasks at Block and Project level.

v) ICDS at Village/Local Level

At the village level, the village Mahila Mandals and Panchayats are in-charge of the ICDS scheme. At the local level, Child Development Project Officer is responsible for implementation of ICDS. At both the levels Anganwadi Worker, Health Visitor Nurse, Auxiliary Nurse Midwife and a Multipurpose Worker work together for delivery of services. Mobilising community support and participation for better utilization of programmes and services are the specific co-ordination tasks at

Village/Local level.

(vii) ICDS at Intermediary Level

at the intermediary level, the supervisors (Mukhyasevikas) and the Lady Health Visitors (LHVs) are the in-charge of the ICDS scheme. Close functional ties are to be established between these two categories of functionaries in order to provide adequate and comprehensive guidance and supervision to the grass-root level functionaries. Ensuring co-ordinated functioning of health and non-health programmes, providing guidance and supportive supervision and maintaining liaison with local and project level functionaries are the specific co-ordination tasks at intermediate level.

1.5.3 Selection of Beneficiaries

The selection of beneficiaries is required to be made according to the following criteria:

> *Pregnant women and nursing mothers belonging to the families of landless agricultural labourers, marginal farmers (holding not exceeding one hectare), Scheduled Castes, Scheduled Tribes and other poorer sections of the community (total annual income of all members of the family not exceeding Rs. 7,200/-) should be enlisted for supplementary nutrition.*[22]

In other cases, guidance of the doctor, Lady Health Visitor (LHV) or Auxiliary Nurse Midwife (ANM)

should be sought. A pregnant woman or nursing mother, not belonging to any of the above mentioned categories can be enlisted for supplementary nutrition if the doctor or the para-medical worker so advises on health grounds.

Children below six years of age are to be identified and enlisted for supplementary nutrition on the basis of measuring the upper mid-arm circumference and weight for age. All children below six years should be weighed at the time of initial survey.

Where weighment of children below six years at the time of initial survey is not feasible due to reasons such as non-availability of weighing scales, growth charts etc., selection of children for the purpose of supplementary nutrition would be made by measuring upper mid-arm circumference with the help of the tri-coloured mid-arm circumference strip.[23]

All such beneficiaries and the beneficiary-wise lists are made by the Anganwadi Workers by visiting the homes of the beneficiaries. Then the Child Development Project Officer and the Medical Officer verify the situation and allow the Anganwadi Worker to provide the delivery of packages.

1.6 THE ICDS IN KOLHAPUR CITY

Kolhapur is a district place in western Maharashtra. According to the 1991 census, the total population

of the district is 37,59,693 and the total population of the city is 4,05,118 including 1,06,409 of the total population of the slum dwellers.

Most of the district agriculturists depend on monsoon but recently they have other water sources such as, dams, irrigations and wells. The sugarcane and paddy are the major crops grown here in the district.

The city has a number of educational facilities including a separate university, medical colleges and technical institutes. Apart from these facilities the efforts from MIDC and a traditional industrial location, Shivaji Udyamnagar, there are big industries and small factories being set-up in the city.

Due to all the above facilities the city is commercially and industrially under-developed and hence the slums are found here. There are 57 slums in the city and the Rajendranagar slum is one of them. So far the Government of India have been trying to develop socio-economic condition of the slum-dwellers by implementing the various schemes like ICDS and NRY.

Today the scheme ICDS plays an important role to ensure proper development of the children in the slum areas in Kolhapur city.

> *Under this scheme there are total 23,389 beneficiaries in the district and 8,239 beneficiaries are under nutrition treatment from the slums,*

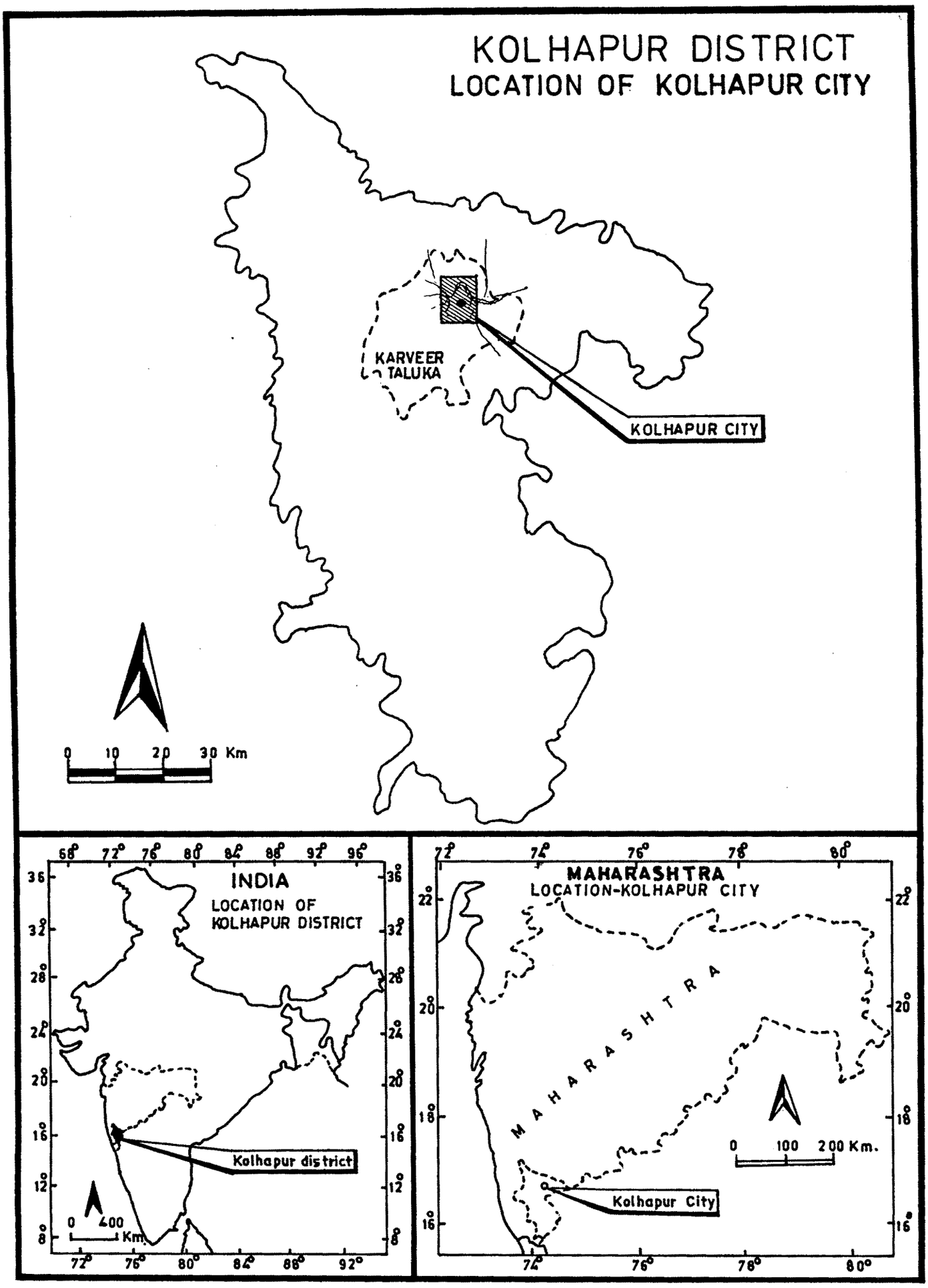
in the Kolhapur City.

> *There are 100 Anganwadi centres run by ICDS in the city. In all these centres 550 pregnant women are under nutrition service and 7,689 children are under the same treatment. Thus there are total 8,239 beneficiaries under nutrition out of 14,637, the recorded beneficiaries for the year 1992-93.*[24]

However, an observation of the process of implementation of the ICDS in Kolhapur city reveals some deficiency. The scheme has not achieved any significant success in developing the child growth in the slums. The result was that in many cases the children are not physically well and sometimes the costly medicines are not provided regularly to them. The treatment was many times discontinued even to the expectant and nursing mothers. It was also found that many children from the age group of 5 to 6 years did not attend the Anganwadi centres regularly as they have to look after siblings.

Most of the women beneficiaries are not aware of nutrition and health education as well as non-formal pre-school education. Though the Anganwadis are ultimately the links in the beneficiaries, it is also pointed out that except Anganwadi Workers the attention of the other officials of the ICDS hardly goes to the beneficiaries with a view to providing the various services of the scheme to the beneficiaries.

MAP NO.1


KOLHAPUR DISTRICT
LOCATION OF KOLHAPUR CITY
KARVEER TALUKA
KOLHAPUR CITY
0 10 20 30 Km
INDIA
LOCATION OF KOLHAPUR DISTRICT
Kolhapur district
0 400 Km.
MAHARASHTRA
LOCATION-KOLHAPUR CITY
MAHARASHTRA
0 100 200 Km.
Kolhapur City

1.7 RAJENDRANAGAR SLUM POCKET

1.7.1 Location

Rajendranagar slum is a newly developed rehabilitation centre to rehabilitate the temporary settlers within the city limits of the Kolhapur Municipal Corporation. When the authorities of KMC started implementing the scheme of Town Planning of the city, they wanted to rehabilitate illegal encroachment of such temporary dwellers to the remote area of the extended city limits. As a result of this, a new slum dwellers' area has been created and named as Rajendranagar slum in the year, 1983.

This slum is situated in the Southern-most parts of the city adjacent to Leprosy Colony. Its exact location can be pinpointed by naming the prominent societies and colonies round about. To the Northern side is Subhashnagar and beyond it Jawaharnagar Society; in between these two is Dhor Vasahat. To the Eastern side, there is Shivaji University campus and on the Western side, there is Nehrunagar society. The City Survey No. indicated on the map is 384.

1.7.2 Welfare Facilities Provided by KMC

As this area falls under the jurisdiction of KMC, it has provided minimum comforts and facilities under the provision mentioned in Slum Clearance and

Improvement Scheme.

(i) EDUCATION

At present there is a primary school run by KMC. In all there are four grades in the school and the total number of students taking education is 322. Out of this strength of the students, boys are 194 and girls 128. The total number of staff is 7 including a Head Master.

(ii) WATER SUPPLY

The KMC has constructed a small water tank to provide drinking and washing water to the slum dwellers of this area. As it has come under the observation of the researcher, there are water taps laid in that area. But water supply is not provided regularly to them, so the small tank is the only source of water supply to all the people over there. As a result, there is always a big rush and fighting amongst the females and children for getting water. This has become a common scene day in and day out. The supply of water through water tanker by KMC is also found irregular by the researcher.

(iii) HYGIENIC CONDITIONS

All over India, it is a most sorry picture of our Indian slum pockets. Not a single slum area has

been completed by implementing an upto date plan. This being the state of affairs on all India level, the slum of Rajendranagar is not an exceptional case. How can we expect from KMC the high standard hygienic conditions to be provided to the slum dwellers? This goes to indicate that, Rajendranagar slum dwellers are seriously suffering from different illnesses and diseases due to lack of hygienic conditions. It is also observed by the researcher that, there are no sufficient number of lavatories, urinals, proper drainage system as well as adequate street lighting. Besides these inadequacies, there is also no Health Clinic Centre. The patients have to walk a long distance either to Subhashnagar or nearby housing societies where the medical facilities are available.

Similarly, to comment upon transport and communication facilities, we have to exhibit our blank faces. There is only one Bus-stop and the frequency of buses plying is very poor and irregular. This is the biggest bottleneck for the people of this slum area who have to go to the city and other places.

(iv) STANDARD OF LIVING

Taking into consideration the vivid description mentioned above, it goes to show that, the level of standard of living of these slum dwellers is below the mark of satisfaction. They are already grinding under

poverty with many vices such as alcoholism, prostitution, gambling, drug addiction etc.. Under such circumstances, no body expects any qualitative standard of living from this slum dwellers. It is a very sorry bemoaning picture which the researcher has come across about the slum dwellers of Rajendranagar slum area.

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