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**REPORT ON THE STATE OF PREPAREDNESS
OF THE INTEGRATED CHILD DEVELOPMENT
SERVICES PROJECTS**

(JULY—OCTOBER, 1976)

PROGRAMME EVALUATION ORGANISATION

PLANNING COMMISSION

GOVERNMENT OF INDIA

NEW DELHI

March, 1978

FOREWORD

The evaluation of the Integrated Child Development Services (ICDS) Projects, taken up by the Programme Evaluation Organisation in July, 1976, conceived two phases of field work. The first phase, aimed at understanding the state of preparedness for the implementation of the Scheme, was completed in October, 1976.

The Report on the State of Preparedness of the Integrated Child Development Services Projects, prepared in August, 1977, was meant primarily to guide the officers connected with the implementation of the Scheme. The Report has since been discussed in the meeting of the Technical Advisory Committee of the Study consisting of the representatives of the Ministries of Education and Social Welfare and Health and Family Welfare and experts from medical, nutrition, and allied fields. The main findings of the Study were discussed also in an Inter-Departmental meeting of the Secretaries of the concerned Ministries with the Planning Commission. The Report was finalised in the light of the observations and suggestions received. As the Report is based on the data collected from the field during July-October, 1976, the later developments are not reflected in it. The second round of the Study is in progress and the next Report will reflect the position of the ICDS Projects as prevalent in 1977-78.

There is a persistent demand for the findings of the Study from various Departments of the Central and State Governments and other organisations interested in the area of child development. It is hoped that the publication of this Report will enable all concerned to implement the programme with added vigour and effectiveness.

The ICDS Evaluation Study was launched by my predecessor Shri R.K. Dar and was carried out by 24 field teams under the Project Evaluation Officers. The details of the design of the study and the instruments of observation were developed in the Social Development Division of the Programme Evaluation Organisation at Headquarters. Dr. (Mrs.) Tara Gopaldas assisted in the First Phase of the Study from June, 1976 to May, 1977 particularly on the aspects concerning nutrition and health. Active cooperation of the supporting staff which has made this Study a success is appreciated.

NEW DELHI,

March, 1978

S.M. SHAH

Chief

Programme Evaluation Organisation

PREFACE

The Evaluation Study of the Pilot Projects for the Integrated Child Development Services Scheme visualises two rounds of field observations—the first round being concerned with generating the baseline information and assessing the ‘State of Preparedness’, while the second round would seek to determine the impact of the working of the Projects. The present Report seeks to present for internal use by the Project authorities and the administrators at the Project, District/State/Central levels, the general results of the Baseline observations. It was felt that the presentation of a comparative picture and the situation prevailing in different Projects would be of value at this stage itself. The second round observations are expected to be made very shortly and would seek to correlate at household and beneficiary levels, the changes which may have taken place in the intervening period; the household data would be computer processed and utilised in that context, for both the rounds.

Another object of presenting this Report at this stage is to enable discussion to take place on our first observations. The Project authorities as well as administrators at various levels are invited to make comments on any aspects, so that their observations may enrich our findings in the final round.

It would be appropriate to acknowledge the work done by the PEO field teams and the Headquarters Group in the Social Development Division of the PEO, alongwith the supporting statistical and typing staff. Dr. (Mrs.) Tara Gopaldas, who functioned as Consultant for this Project, played a significant role in designing of the Study and the preparation of the Report, and her contribution is gratefully acknowledged.

NEW DELHI,
June 30, 1977

R.K. DAR

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SUMMARY OF FINDINGS

At the time of sanction of the pilot ICDS Projects, PEO was requested to undertake an independent evaluation.

2. The design of the study provides for the present Report on the 'State of Preparedness' as after one year of operation of the scheme, for which field work was done during July-Oct. 76, and a final report also containing an assessment of the overall impact of the projects, after a repeat round in the mid-1977.

3. A great deal of effort has undoubtedly been put in for getting the ICDS Projects off the ground. The Anganwadi Workers have been appointed and trained in large numbers, there is increasing awareness of the potentials of the projects, a start has been made on monitoring, and various agencies have been assigned definite tasks. The experience in implementation, planning, and control operations, during the first year, however, shows that the Projects are still facing serious teething problems, and it would be unrealistic to be optimistic about the state of organisation of the Programme till certain basic preliminary tasks are successfully performed.

4. Observations on different aspects of the present state of organisation of these projects are recorded in the following paragraphs:

(a) There was inadequate understanding by the ICDS Project authorities of the inter-se priorities among the different components of the scheme—Health, Nutrition and Education. There seems to be clear over-emphasis on the last of these three aspects, possibly owing to the circumstance that the implementing departments/training institutions have traditionally been dealing mainly with women and child social welfare activities.

(b) Means of effective coordination between the CDPOs, MOs (PHCs), and BDOs have not been satisfactorily worked out. The role of health staff in the implementation of the ICDS Scheme has not yet been clearly understood. Besides, the attitude of the medical and health staff towards the programme have not been oriented for ensuring coordinated functioning along with other agencies, for delivery of the total package of services to the target groups.

(c) Survey and household enumeration in assigned Project area has not been systematically undertaken, with the result that the exact size, composition, and other characteristics of the target groups have not yet been determined; consequential programme planning, in terms of actual requirements in each area, has not proceeded in respect of staff, equipment, materials, finances, etc.

(d) In the absence of these basic Surveys, and lack of critical equipment, like weighing scales and printed growth charts, the identification of children, nutritionally-at-risk, who would be eligible for supplementary nutrition and special health care, has not been feasible so far.

(e) At the same time, the most inaccessible and vulnerable group of children, i.e., the 'below threes' who require the most attention in terms of the health and nutritional services have hardly been reached yet.

(f) There are still many gaps in staffing, particularly of health personnel, possible because of a low priority being given to this aspect by the State Health departments.

(g) The training contents and choice of institutions need to be reviewed in terms of suitability of job training in relation to their job performance.

(h) Funds have not been earmarked by the State Governments separately for supplementary nutrition in the ICDS Project areas despite this being an essential pre-condition. Apparently, Annual Plan provisions in 1976-77 did not take the Project requirements specifically into account.

(i) Most capital items, except for weighing machines and refrigerators, have been received. There is a major gap in supply of usable items, particularly of essential medicines, and vaccines required for immunisation work.

(j) The composition of coordination committees is predominantly official and male dominated. It is also noticed that there was a considerable time-lag in their constitution.

(k) Involvement of women, which is an essential component for the success of the programme, is conspicuously absent. Accommodation for the Anganwadis is usually of poor quality.

(l) It is also apparent that mere provision of funds would not be adequate, unless it is followed-up with an actual system of purchase of local food commodities, which would provide the main support for the nutrition component. At present, there is a major reliance on WFP or CARE food, which is contrary to the concept of the scheme. Lack of basic data on the size and composition of target population is a major deficiency in the feeding programme. The existing food delivery system does not guarantee nutrition for the 'below threes', nutritionally-at-risk, and pregnant and lactating women. A sound delivery system needs to be developed.

(m) Release of funds and appointment of health staff are perceptibly slow and halting. The AWWs who are expected to play a major role with regard to the immunisation programme, are not health-oriented. Depending upon the severity and incidence of childhood disease, it is suggested to work out a differential sequencing of immunisation schedule.

(n) The pre-primary education, for a thin segment of target population of 3 to 5 + years, is the main activity. It is necessary that the much needed Health and Nutrition Education is developed and the various activities under the ICDS receive right type of attention.

5. While a great deal of timely information is being obtained under the monitoring system which

has been set up, in the absence of a realistic time schedule and sequencing of supplies and delivery of services to the target/vulnerable groups, the system does not throw light on such aspects as: the strength and weaknesses of the infrastructure of health, nutrition, education, and drinking water supply and whether needs and costs of upgrading them have been worked out and adequately provided for whether the rules of different functionaries have been clearly laid down and the required inter-relationships have been established in the different Project areas, whether a specific rule has been assigned to voluntary agencies in the implementation and mobilisation of local participation. Requirements following from the observations in foregoing paragraphs on different items of critical value in the organisation of Projects at the present stage, also need to be picked up by the monitoring system.

CHAPTER I

THE SCHEME AND ITS EVALUATION

Evolution of the Scheme

1.1 Children's programmes have been accorded the highest priority in the Social Welfare Sector in the Fifth Five Year Plan. The strategy of the Fifth Plan in this regard is to make a concerted and coordinated effort to deliver a basic minimum package of health, nutrition, and educational services in an integrated manner to the vulnerable mother (expectant and nursing) and the young child (0—5 + years).

1.2 The National Policy for children, likewise, recognises the vital importance of children's programmes in the development of human resources for the social and economic advancement of the country. A National Children's Board was set-up in 1974, with the Prime Minister as President. The 15-point programme of the National Policy for Children places the highest priority on child health and nutrition.

1.3 The proposal for an Integrated Child Development Services (ICDS) Scheme was initiated by the Planning Commission as early as 1972 with the following objectives:—

1. To improve the nutritional and health status of children in the age group 0—6 (0—5+) years;
2. To lay foundations for the proper psychological, physical, and social development of the child;
3. To reduce the incidence of mortality, morbidity, malnutrition, and school drop-out;
4. To achieve effectively coordination of policy and implementation among the various departments to promote child development; and
5. To enhance the capability of the mothers to look after the normal health and nutritional needs of the child through proper nutrition and health education.

1.4 A blueprint was prepared by the Department of Social Welfare, Government of India, with a budget proposal for Rs. 140 crores and a coverage of 1000 blocks. The aim of the Scheme was to deliver a package of services consisting of supplementary nutrition, immunisation, health check-up, referral services, health and nutrition education, and non-formal education, in an integrated manner, to infants (0—1 yr), toddlers (1—2+ yrs) and pre-school children (3—5+ yrs); and pregnant, nursing, and other women in the age group of 15—44 years; in the selected rural/tribal Blocks and urban slums.

1.5 Since the ICDS Scheme calls for both integration of a number of services and coordination on an unprecedented scale between various Ministries (Ministry of Education and Social Welfare, the Ministry of Health and Family Planning, the Ministry of Agriculture and Irrigation and the Ministry of Works and Housing), Departments, and Voluntary Organisations, the Planning Commission recommended that 30 ICDS Projects be initially piloted and sanctioned a budget provision for the same for Rs. 3 crores and Rs. 1.30 crores for the financial years 1975-76 and 1976-77¹, respectively.

1.6 This Centrally sponsored Scheme, with 100 per cent financial assistance from the Government of India, is being implemented by the Department of Social Welfare (DSW), Government of India through the Departments of Social Welfare in the States. Thirty-three ICDS Projects (coterminus with Blocks in the case of Rural and Tribal Projects and a few selected contiguous wards of the urban slums in the case of Urban Projects) in different parts of the country were initiated within the sanctioned budget in October, 1975 and had been in existence for approximately 10 months to a year at the time of the Baseline Survey.

Evaluation of the ICDS Pilot Scheme

1.7 At the instance of the Planning Commission, the Programme Evaluation Organisation undertook an evaluation of the impact of the Scheme. This has been designed through a base-line survey in July-September, 1976 and a re-check survey approximately a year later. The base-line survey would broadly gauge the state of preparedness for implementation after approximately a year of the formal start of the Scheme of the Project level. It is hoped that the lessons learnt from this survey would be of some use for further programme improvement. If the present model, so evolved, is found to be feasible, it is intended to expand the Scheme, in a phased manner.

1.8 The re-check survey in mid-1977 would help to assess the actual population reached, in about a year's substantial operation, in areas where ICDS staff were in position by mid-1976. The emphasis will be on the cumulative impact of the Project as judged by the actual delivery of the package of services to the target population, i.e., infants, toddlers, pre-school children, pregnant women and nursing mothers.

1.9 In both the base-line and re-check surveys, the PEO would be mainly concerned with field enquiries about the ICDS activities as they exist at the Project and Anganwadi² levels.

1. The differences in the ICDS budget for the years 1975-76 and 1976-77 is because it was expected that 100 ICDS Projects would be launched in 1975-76. The allocation was reduced in 1976-77 as only 30 Projects were finally sanctioned.

2. *Anganwadi*: A centre for activities/delivery of services under the ICDS, generally covering a village on about 1,000 population.

Objective

1.10 This report is confined to the following Specific Objectives:

1. To examine the availability of basic data at the project level;
2. To study the broad characteristics of the ICDS Projects in relation to feasibility of operation;
3. To review the extent to which infrastructure has been built-up for the delivery of health, nutrition, and education services in the Scheme;
4. To assess the flow and utilization of finances and the flow of supplies to the Projects;
5. To examine the extent to which placement and training of staff has been accomplished; and
6. To assess the involvement and participation of the community in the initial stages of the Project and administrative coordination.

Methodology and Instruments of Observation

1.11. The methodology consisted in designing a Project Schedule to obtain information on the objectives listed above. The schedule was canvassed between July and October, 1976, by trained field staff. The Child Development Officer of each Project was given 1-2 months to build-up data, where it was not readily available for incorporation in the Project Schedule.

1.12. The information obtained in the Project Schedules was reinforced by qualitative Project Level Notes.

1.13. The observations were further strengthened by tours to the Project sites by the Consultant, Project Director, the REOs, and other Senior Headquarters' Officials.

1.14. The information on the current level of activities as noted at the Anganwadies was obtained on another specially designed Schedule.

1.15. Information was also gathered from the Anganwadi Schedule and Village Level Notes to cross-check information obtained at the Project Level.

Selection of the Projects and the Anganwadis

1.16. 29 Projects (17 rural, 8 tribal and 4 urban) were purposively selected, on the basis of the availability of PEO Units, out of a total of 33 ICDS Projects (19 rural, 10 tribal and 4 urban). The selected projects cover 19 out of 22 States and the Union Territory of Delhi where the Scheme has been introduced. 24 PEO Units simultaneously conducted the survey in 24 Projects. The remaining 5 Projects were surveyed when 5 out of 24 PEO Units were free from this first round of field work.

1.17. Six Anganwadis were surveyed in each Project on a stratified random basis, where the criterion of stratification was the distance of the Anganwadi villages from the Project Headquarters. One village was chosen from within a distance of 5 Kms of the Project Headquarters; 3 from within the stratum of 5 to 10 Kms; and the last two from the stratum beyond 10 Kms of the Project Hqrs. Three of these selected villages (one each/per stratum represented situations where both Anganwadi and the Auxilliary Nurse and Midwife (ANM) Centre were present in the village, while 3 (one each per Stratum) represented village, that had an Anganwadi but no ANM Centre .

1.18. Specific Aspects Covered in the Present Report

1. Broad characteristics of the Project area.
2. Build-up of Infrastructure.
3. Flow of Finances and Supplies.
4. Placement of Staff and Training.
5. Peoples' Involvement and Administrative Coordination.
6. Component of Supplementary Nutrition.
7. Component of Health.
8. Component of Education.
9. Performance Indicators.

1.19. The present report is based on information obtained from 29 ICDS Project Level Schedules and Notes that were canvassed in July-October, 1976.

1.20. Details regarding the Project, District, State and the date of canvassing the Project Schedule are presented in Table 1.1.

TABLE 1.1---Projects Covered and Date of Canvassing of the Project Schedule

Sl. No.	Project	District	State	Date of canvassing
1	2	3	4	5
<i>I. Rural</i>				
1.	Kambadur	Anantapur	Andhra Pradesh	3-9-76
2.	Dhakuakhana	Lakhimpur	Assam	1-8-76
3.	Tarapur	Monghyr	Bihar	15-7-76
4.	Kathura	Sonepat	Haryana	31-7-76
5.	T. Narasipur	Mysore	Karnataka	4-11-76
6.	Kangan	Srinagar	J. & K.	2-8-76
7.	Vengara	Malappuram	Kerala	29-9-76
8.	Singroli	Sidhi	Madhya Pradesh	19-10-76
9.	Ukhul	East Distt.	Manipur	24-7-76
				28-7-76
10.	Nurpur Bedi	Rupar	Punjab	6-8-76
				22-8-76
11.	Thalli	Dharmapuri	Tamil Nadu	24-9-76
12.	Nilakottai	Madurai	Tamil Nadu	21-9-76
13.	Chawmanu	North Distt.	Tripura	12-10-76
				15-10-76
14.	Shankargarh	Allahabad	Uttar Pradesh	23-9-76
15.	Dalmau	Rae Bareilly	Uttar Pradesh	31-8-76
16.	Jawan	Aligarh	Uttar Pradesh	10-9-76
17.	Man Bazar	Purulia	West Bengal	3-8-76
<i>II. Tribal</i>				
18.	Utnoor	Adilabad	Andhra Pradesh	18-9-76
19.	Barajamda	Singhbhum	Bihar	16-7-76
				30-7-76
20.	Chhotaudepur	Baroda	Gujarat	21-8-76
21.	Pooh	Kinnaur	Himachal Pradesh	9-9-76
22.	Tokapal	Bastar	Madhya Pradesh	30-7-76
23.	Dharni	Amravati	Maharashtra	28-7-76
				29-7-76
24.	Subdega	Sundergarh	Orissa	28-7-76
25.	Garhi	Banswara	Rajasthan	7-8-76
<i>III. Urban</i>				
26.	Bombay	—	Maharashtra	26-10-76
27.	Madras	—	Tamil Nadu	20-9-76
28.	Calcutta	—	West Bengal	30-7-76
29.	Delhi	—	Delhi	5-10-76

CHAPTER II

BROAD CHARACTERISTICS OF THE PROJECT AREAS

Availability of Basic Data

2.1. Basic data on parameters, such as, the break-up of the target population, and details regarding occupational distribution, literacy, proportion of Scheduled Castes/Tribes (SC/ST) and their occupational distribution and literacy levels was available in a very inadequate form at the Project level. The ICDS Scheme has set norms for the selection of ICDS Projects, of which the predominance of SCs/STs has been given high priority. Very little information is available in this regard.

Break-up of the Target Population

2.2 One of the primary tasks of implementing-staff in a community-based programme is 'to know your community and area'. Even after 10-12 months of Project initiation, the information supplied at the Project level was far from encouraging.

2.3. At the time of canvassing the Project Schedule (July-October, 1976) information was sought on achievement versus targets for specific ICDS services. To cite an example, figures for a service such as immunisations for target children (0.5 + yrs.) or health check-ups for the target pregnant and lactating women which aimed at comprehensive coverage, should have reflected the demographic break-up of these population groups. The most noticeable feature of the field returns, with the CDPO as the respondent, revealed that most of the projects could furnish hardly any meaningful data on this aspect except for Kathura and Subdega.

2.4. Since the completion of the comprehensive base-line survey on the nature and composition of the target population was considered an essential pre-requisite to the programme implementation, another attempt was made to collect this information at a later date (October, 1976) through a specially designed proforma. Clear instructions were given on how target figures were to be arrived at. On the basis of this exercise, the picture improved somewhat, with seven projects supplying accurate demographic break-up of infants (0—1 yr.), toddlers (1-3 yrs), and pre-schoolers (3—5 + yrs). These projects were; Kathura, Nurpur Bedi, Nilakottai, Chhota Udepur, Pooh, Dharni and Garhi. However, when the accuracy of these figures was verified with similar data collected at the Anganwadi level, the Project level data supplied by Dharni and Pooh gave rise to some doubt.

2.5 Fifteen projects gave inaccurate statistics due to an under-estimation of the target groups, namely, Kambadur, Dhakuakhana, Tarapur, T. Narasipur,

Kangan, Vengara, Singroli, Thalli, Chawmanu, Dalmau, Barjamda, Subdega, Bombay, Madras, and Calcutta.

2.6. Two Projects namely, Ukhrul and Shankargarh, grossly over-estimated their child target population (Table 2.1 for paras 2.4 to 2.6).

2.7. It was noted that the Tribal Projects, on the whole, did a more comprehensive and accurate enumeration of the target population than did the Rural or Urban Projects. All in all, there was a very poor state of preparedness in this regard which probably stems from the lack of importance given to this aspect in the training of ICDS staff.

2.8. By way of contrast, the demographic breakdown of the target population furnished at the Anganwadi level by almost all the projects was much more accurate, thereby indicating that at the time the Project Schedules were canvassed, many of the projects had not completed this survey throughout the survey area, or if they had, the information had not been compiled and collated at the project level.

2.9. Information on literacy was available in 19 out of 29 Projects; and that on overall occupational distribution in 26 out of 29 Projects.

Topography

2.10. Thickly forested areas, high altitudes, undulating terrain characterise the majority of Tribal Projects (5 out of 7) and half the Rural Projects (8 out of 16) Table 2.2.

Accessibility

2.11. For a few months during the monsoon, the majority of villages in the interior in 12 out of 23 Rural/Tribal Project get out off from the Project/Block headquarters and the PHC (information was not available in the case of 2 Projects). Even in the Urban Projects (Calcutta and Bombay) the Anganwadis in the low-lying water-logged areas are extremely difficult to reach at the height of the rains. Six Projects, out of 27, were inaccessible for the major period of the year, i.e., Tribal Tokapal (rain for 10 months), Pooh (landslides and snow), and Utnoor (forests and rain), and Rural Kangan (snow, landslides, and no roads), Shankargarh (forest/rain), and Singroli (forests and rain) (Table 2.3).

Area

2.12. The area of the Projects varied a great deal. The range for the Rural Projects was 93 sq. kms. (Kangan) to 1904 sq. kms. (Singroli) with an average

area of 597 sq. kms. The Tribal Projects had a range of 46 sq. kms. (Pooh) to 1,813 sq. kms. (Dharni) with an average area of 585 sq. kms. (Table 2.4—refer upto para 2.15).

Population

2.13 The Population of the Rural Projects ranged from 34,555 (Ukhrul) to 1,82,340 (T. Narasipur) with an average population of 90,666. The Tribal Projects ranged from 16,413 (Pooh) to 1,15,930 (Garhi) with an average population of 62,724. The range of the Urban Projects was approximately 1,00,000 in Madras to 608,168 in Bombay with an average population of 2,67,366.

Density

2.14. The density of population in Rural Projects ranged from 28 per sq. km. (Ukhrul) to 897 per sq. km. (Vengara) with an average of 308 per sq. km. In the Tribal Projects the range was 36 (Dharni) to 203 per sq. km. (Chhota Udepur) with an average of 123 per sq. km. The density of population in Urban Bombay was 3,986 per sq. km. while it was 18,268 per sq. km. in Urban Calcutta. The other two Urban Projects did not provide any information.

Distance of Project Hqrs. from District Hqrs.

2.15. The distance of the Project Hqrs. from the District Hqrs. ranged from 1 km. (Ukhrul) to 136 kms (Thalli) in the Rural Projects with an average of 53 kms. In the Tribal Projects, the range was 22 kms. (Tokapal) to 143 kms. (Dharni) with an average distance of 64 kms. All the Urban Projects were within the city limits.

Summing-up

•2.16. Logistical delivery of goods and services are bound to be difficult in most of the Tribal and half of the Rural Projects, especially during the inaccessible monsoon months. This calls for detailed micro-level planning for the delivery, storage, and distribution of all inputs during the relatively accessible months.

2.17. In these difficult areas, it is necessary to make efforts to locate local Anganwadi workers (AWWs) to ensure regularity of services.

2.18. Mobility of grass-root level personnel is of paramount importance in a Project such as the ICDS. Hence, there is a strong case for the consideration of recruiting an all-male staff as Child Development Project Officers (CDPOs), Supervisors, and AWWs particularly in the highly inaccessible areas. Women workers, due to problems of physical endurance and safety, are bound to be far less mobile. One may even consider recruiting couples—one as an AWW and the other as a helper for such areas only.

2.19. The Auxiliary Nurses and Midwives (ANMs) who will have approximately 4 to 6 villages under their jurisdiction would, in particular, require community support in the way of transportation and escort if they are to execute their duties as envisaged. In the hilly and mountainous regions, bicycles and mopeds (that UNICEF has offered to donate) cannot be used.

2.20. The provision for petrol (POL) should depend on the distance to be covered in each Project. For instance, very large Projects, such as, Kambadur (1250 sq. kms.), Ukhrul (1235 sq. kms), and Dharni (1813 sq. kms) would very definitely need increased inputs not only in terms of POL but other inputs as well, such as more Anganwadis, staff, finance, supplies, etc.

2.21. The Tribal Projects were larger in terms of population than envisaged in the Scheme. Some, i.e., Utnoor (93,823) and Garhi (1,15,930) have a higher population than many of the Rural Projects. Hence, concomitant increases in inputs will have to be considered for these Projects in particular, and all Tribal Projects, in general.

2.22. Ukhrul which is clearly a Tribal Project has by mistake been classified as Rural.

2.23. The relative spareness and widely dispersed population in Tribal Project vis-a-vis rural, needs examination of the number of ANM Centres/Anganwadis and staff that would be required to maintain efficient health and non-health delivery systems to the target populations. Even small Tribal villages well below the norm of one Anganwadi per 1000 population may require an AWW and an Anganwadi. Similar adjustments would be required in relation to ANMs and their Centres, i.e., a coverage of one ANM per 2,500 population rather than the envisaged pattern of one ANM per 5,000 population.

2.24. None of the Project Headquarters either Rural or Tribal, are located very far from the District Hqrs. Hence, all the experimental Projects should have obtained the supervision and guidance from the District level authorities, such as, the District Collector (DC), the District Medical Officer (DMO), and the District Social Welfare Officer (DSWO). It is extremely important to orient the key district level officials to the Scheme and to actively involve the DC at the experimental and developmental stages.

2.25. No Project should be permitted to start Anganwadi activities until a complete enumeration survey of the target population is completed. The importance of these priority activities should be emphasised to the CDPOs, as it would not be possible to estimate the Project's requirements in respect of Anganwadis, staff or supplies, unless this essential and basic information is known.

CHAPTER III

BUILD-UP OF INFRASTRUCTURE

ICDS Infrastructure for Health

3.1. **Hospitals (other than PHCs).** The pre- and post-infrastructure for the delivery of health services shows no marked change and hence only the post ICDS picture is commented upon. In the 29 ICDS Projects examined, 15 had no hospital in the Project area. Eleven out of 17 Rural Projects and four out of eight Tribal Projects, had no hospital in the Project area. A few of the Rural and Tribal Projects on the other hand were well endowed with hospitals—these being; Rural Vengara (3; Thalli (5), Shankargarh (3), and Tribal Barajamda (3). The picture in the Urban Projects was: Bombay (1), Madras (7), Calcutta (6), and Delhi (1) (Table 3.1 Refer upto para 3.3).

3.2. **Dispensaries:** Five out of 29 Projects had no dispensaries at all. The range was 0 to 21 (Garhi) with an average of 5 per project. The averages for Rural, Tribal, and Urban Projects were 4.5, and 12 respectively. Projects which had neither a hospital nor dispensary were Kathura, Man Bazar, Tokapal, and Dharni.

3.3. **Primary Health Centre (PHC), Lady Health Visitor (LHV) and ANM Centres:** In the absence of clearly stated norms for LHV and ANM Centres for Rural/Tribal Projects in the ICDS Scheme, norms have been derived on the basis of enhanced paramedical staff allotted to each type of project. All the 25 Rural and Tribal Projects had at least one PHC, while T. Narasipur and Chawmanu had two each. Madras had 4 Urban Family Welfare Centres while the other 3 Urban Project had none. The Rural average for LHV Hqrs. and ANM Centres were 2 and 10 against the norms of 4 and 16 respectively. Similarly, on an average in the Tribal Projects, there were 10.1 ANM Centres and 1.6 LHV Centres against the norms of 12 ANM Centres and 4 LHV Centres. Although, expansion of ANM Centres had taken place, it is still below the norms set. Further, the mapping of 'ANM area' on the basis of the strengthened staff has taken place in a few projects.

Coverage of ANM Centres by Village and Population

3.4. The strengthened ANM Centres in the ICDS schemes are to play a significant role in the delivery of health care to the target population. Hence, additional posts of ANMs have been allowed in the ICDS budget so that there is at least one ANM for a population unit of 5,000 in each ICDS project area. This implies that new Centres should have been created and smaller operational areas should have been allocated to the strengthened staff. Based on the information available in July-October, 1976, the

coverage of ANM Centres by village and population, though improved, was still far from the norm in most of the Projects (Table 3.2—up to para 3.6).

3.5. In the Rural Projects the range and average of coverage by village was 1 : 0.51 villages in Kamhadur to 1 : 122 in Man Bazar. On an average, an ANM Centre catered to 1 : 22.2 villages. The range and average that obtained in the Tribal projects was a ratio of 1 : 4.4 in Chhota Udepur to 1 : 32.0 in Pooh with an average of 1 : 15.7.

3.6. In the Rural Projects, the coverage by population ratio ranged from 1 : 2948 in Dalmau to 1 : 51,123 in Nilakottai. The average population covered was 1 : 13,759 per ANM Centre. In the Tribal Project the range was 1 : 5040 in Garhi to 1 : 22,646 in Barajamda with an average ANM Centre population ratio 1 : 10,280. Thus there are great disparity in the ANM Centre to population ratio. In three Projects, namely, Nurpur Bedi, Dalmau, and Chhota Udepur, the coverage of ANM to population was more intensive than that specified in the norm of 1 : 5000 population; in the case of Kamabadur, Tarapur, Utnoor, Tokapal, and Garhi, the norms were nearly satisfied; while in the case of the other Rural/Tribal Projects, the ratios were tremendously wide.

Coverage of Anganwadis by Village and Population

3.7. Approximately, 1.64 villages were covered by an Anganwadi when 25 Rural and Tribal Projects were considered. The coverage of Anganwadi by population was 1 : 1,313 and 1 : 1978 in the Rural and Tribal Projects respectively. In the Rural Projects, the range was 1 : 461 (Ukhrul) to 1 : 2,636 (Thalli). In the Tribal Project, the range was 1 : 328 (Pooh) to 1 : 9150 (Tokapal) (Table 3.2).

Pre and Post-ICDS Infrastructure for Supplementary Nutrition

3.8. The network of Anganwadis in the Project areas has vastly strengthened the infrastructure for the distribution and delivery of supplementary nutrition to the young child and mother. The average figures for pre-school feeding outlets before and after the advent of ICDS in all the 29 Projects had increased significantly from 29 to 69 (Table 3.3. Refer upto para 3.11). However, not all that are operational are running feeding programmes (refer Chapter VII).

3.9. In the Rural Projects, the range of operational Anganwadis was 43 to 100, with an average of 75. Generally speaking, the pre-ICDS infrastructure consisted of a few Balwadis through which the Special Nutrition Programme (SNP) operated,

or a few primary schools with an Applied Nutrition Programme (ANP). The exceptions to this among the Rural Projects were Kambadur (42 schools with ANP), Nurpur Bedi (49 Balwadis with SNP), Thalli (143 schools with ANP), Nilakottai (81 schools with ANP), Chawmanu (22 Balwadis with SNP), and Shankargarh (20 Balwadis with SNP). So, before the introduction of the ICDS, there was virtually no strong base to speak of, for pre-school feeding. The Balwadis with SNP have been or are in the process of being merged with the Anganwadi Centres. The feeding centres rose from 23 to 75 on an average, per Project.

3.10. In the Tribal Projects, the range of operational Anganwadis was 45 to 120, with an average of 67. The pre-ICDS infrastructure for feeding in the Tribal Projects was strong with 6 out of 8 having pre-school and/or school feeding programmes. These were Barajamda (9 SNP Centres + 14 schools with ANP), Chhotaudapur (50 schools with ANP), Dharni (16 SNP centres + 10 schools with ANP), Garhi (50 SNP centres and 31 schools with ANP), Tokapal (58 schools with ANP), and Pooi (31 schools with ANP). In the Tribal Projects, the centres for pre-school feeding rose from an average figures of 48 to 67.

3.11. In the 4 Urban Projects of Bombay, Madras, Calcutta, and Delhi, 52 Anganwadis were operating on an average. Bombay had opened only 26 Anganwadis while Madras had a 100. The Calcutta Project in the pre-ICDS set-up had 3.3 feeding centres run by voluntary agencies in the same Project area. Bombay had 26 ANP Centres. Delhi and Madras had no pre-school feeding centres or programmes in the area prior to the ICDS. In the Urban Projects, the existing facilities for supplementary nutrition rose on an average from 15 to 52.

Pre- and Post-ICDS Infrastructure for Non-formal Education and Functional Literacy in the ICDS Projects.

3.12. As in the case, supplementary nutrition, the creation of Anganwadis has strengthened the infrastructure for the delivery of non-formal education and female adult literacy in the Project areas tremendously. The average figures for pre-school or non-formal education centres in all the 29 Project soared from 21 (pre-ICDS) to 90 (post-ICDS) (Table 3. 4—up to para 3.15). And those for adult/functional literacy from 28 to 97. The few that had strong Balwadi/pre-primary school bases before the ICDS were Ukhrul (50), Bombay (28), Delhi (37), and Shankargarh (20). Those that had a substantial number of pre-primary schools were: T. Narasipur (108), Ukhrul (46), Shankargarh (64), and Uttoor (100). With respect to Adult/Functional Literacy Classes— Projects with a strong pre-ICDS infrastructure were; Vengara (100), Singroli (89), Kathura (48), T. Narasipur (43), Ukhrul (51), Nurpur Bedi (59), Shankargarh (47), Uttoor (45), Pooi (50) and Calcutta (48).

3.13. Taking the 17 Rural Projects as a group, the corresponding pre- and post-ICDS figures for adult/functional literacy were 40 and 112.

3.14. In the 8 Tribal Projects, the centres for non-formal/pre-primary education rose from 19 to 86; and that of functional/adult literacy from 19 to 85.

3.15. In the 4 Urban Projects of Delhi, Madras, Bombay, and Calcutta, during the post-ICDS period, pre-school education centres rose from 16 to 68; and that of adult literacy centres from 43 to 95 per Urban Project.

Distribution of Voluntary Agencies in the ICDS Project Areas

3.16. The average distribution of Mahila Mandals, Youth Clubs, and Voluntary Agencies working in women and child welfare and other agencies in the 29 Projects was 17, 17, and 0.9 and 0.4 respectively (Table 3.5—upto para 3.19).

3.17. The range of Mahila Mandals in the 29 Projects was 0 to 56. The total absence of Mahila Mandals in the 4 Urban Projects was conspicuous. These Projects having a well established pattern of Mahila Mandals were; Kambadur (47), Dhakuakhana (45), Dalmau (50), and Subdega (56).

3.18. The range of Youth Clubs was 0 to 76. Projects strong in Youth Clubs were Dalmau (76), Uttoor (70), and T. Narasipur (56).

3.19. Voluntary agencies working primarily for the women and child welfare were conspicuous by their absence. The average figures for Rural, Tribal, and Urban Projects were 0.6, 0.7, and 2.7 respectively with an all India average of 0.9.

Protected Drinking Water in the ICDS Projects

3.20. Protected or safe drinking water can be defined as germ or bacteria free water, such as, piped water which has been either filtered and/or chlorinated, or water drawn from deep tubewells (sunk to a depth of 60 to 80 ft.) or from properly lined and regularly disinfected wells or deep bore or tubewells fitted with handpumps.

3.21. Applying these norms, the water in 7 out of 29 Projects was judged to be safe. It was safe in the 4 Urban Projects and in Rural Kathura, Shankargarh, and in Tribal Chota Udepur. In 8 Projects, the water was safe in parts of the project area. These were: Rural Tarapur, Nurpur Bedi, Ukhrul, Nilakottai, Chawmanu, Jawan and T. Narasipur. It was totally unsafe in 11 Projects and the position was not known in 3. The projects which depend on katcha wells, polluted streams and rivers, stagnant ponds, water holes, etc., were; Rural Kambadur, Dhakuakhana, Kangan Vengara, Singroli, Ukhrul, Dalmau, Man Bazar and Tribal Barajamda, Subdega,

and Dharni (Table 3.6). The expenditure of the State Governments on Rural Water Works in 1975-76 confirms their lackadaisical approach to this vitally important supportive component to the ICDS.

3.22. Except for Ukhrul which spent close to Rs. 2.5 lakhs in 1975-76 on laying a piped water system for its village, Utnoor that spent about Rs. 24,000 and Chawmanu that spent approximately Rs. 40,000 other cases of lack of expenditure on this item are conspicuous. Even the expenditure on Rural Water Works was far less than the amount allocated in Man Bazar and Dharni. The reports of expenditure on Rural Water Supply in the other 19 Rural/Tribal Projects showed returns of either 'nil'; or 'not available' (Table 4.3). In 1976-77, there has been nil allocation and expenditure on Rural Water Supply in the Rural/Tribal Projects. The provision of protected water supply in the ICDS Projects has, therefore, been minimal.

3.23. It is also to be noted that although the 4 Urban Projects have the apparent benefit of piped water, in actual fact the supply is so woefully inadequate or is so priced, that some of the slum dwellers are forced to obtain their drinking water from stagnant and shallow ponds or other such decidedly unsafe sources as in Bombay.

Adequacy of Office-Storage and Residential Quarters for the CDPO/PHC Staff.

3.24. Build-up of infrastructure should necessarily consider the adequacy of office, storage, and residential accommodation for the ICDS staff. It is, therefore, of some concern that out of 29 Projects, only 9 CDPOs considered their accommodation to be adequate, 19 inadequate; while it was not relevant in Dharni where the Block Development Officer (BDO) was in any case, functioning as the CDPO. (Table 3.7 upto para 3.33).

3.25. A similar unsatisfactory situation was reported with respect to storage facilities at the Project level with 7 Projects reporting adequacy, 12 reporting inadequacy, and 10 stating no storage facilities at all.

3.26. With respect to residential accommodation for the CDPOs, 6 had adequate, 9 inadequate, and 14 had not been provided with any accommodation at all.

3.27. With respect to PHC staff, 9 Projects stated that their PHCs were quite spacious; 19 inadequate, and one did not report.

3.28. The storage space at the PHC was considered adequate in the case of 14 Projects, inadequate in the case of 12, and not available at all in the case of 2. In case of Madras, the information was not available.

3.29. Residential quarters for the PHC doctor was stated to be adequate in 6 Projects, inadequate in 15, not available at all in the case of 7, and 1 did not report.

3.30. Electricity was available in 18 PHCs was inadequate in the case of 4, was not available in the case of 6, and one did not report.

3.31. Water supply at the PHCs was adequate in the case of 16, was inadequate in the case of 11 and not available in one (Pooh).

3.32. Sanitary facilities at the PHC were considered adequate in the case of 20 Projects, inadequate in the case of 6, not available in the case of 2, and one did not report.

3.33. Indoor beds were considered adequate in the case of 10 Projects (more than 6 beds), inadequate in the case of 16, not available in one (Delhi) though this is not quite relevant in a metropolis, where there are several hospitals, and 2 did not report.

Summing-up

3.34. The Anganwadi network has strengthened the infrastructure tremendously for the delivery of health, nutrition, and educational services to the young child/women population. The cost-effectiveness in the initial stages of the programme, however, would depend on the comprehensive delivery of health and nutrition services to the 'below threes' and the pregnant women.

3.35. With respect to supplementary nutrition, the Anganwadis which were meant to feed a child population of approximately 100 and a mother population of about 30, per day, per Anganwadi, have provided an excellent potential base for reaching out to these hitherto inaccessible population groups. However, at the present time this potential is not being exploited to the full.

3.36. The Anganwadis are physically very ill-equipped to feed 100 to 130 mouths a day. There is no storage for the food commodity, no proper kitchen area, and physically no place to seat and feed more than 20 to 30 children at one time. This would mean that if an on-the-spot feeding approach was insisted upon, arrangements would have to be made to feed 5 batches per day, leaving virtually no time for any other activity envisaged in the ICDS Scheme. Consequentially, alternative delivery mechanisms such as 'take-home-food' systems which would reach out to many more in the target populations needs to be expeditiously explored, developed and its efficiency and reach compared vis-a-vis 'fed-on-the-spot' systems in the Projects.

3.37. The presence of voluntary agencies working for women or child welfare or the Mahila Mandals is generally weak. In fact, there is a conspicuous lack of voluntary assistance from the community

women to the AWW in conducting the Anganwadi activities. It has been observed that a majority of those attending the functional literacy classes are teen-agers. It is suggested that the functional literacy classes be integrated with the Health and Nutrition Education components. Further, with a certain amount of practical training by the supervisory health and non-health ICDS staff, these girls could function as effective 'AWW-aides' for a group of families, the AWW-aides' who show promise could be earmarked as future AWWs.

3.38. Many delays and interruptions in programme implementation and great inconvenience to project

staff can be caused due to the lack or insufficiency of office and storage space. These deficiencies need to be made good. Lack of residential accommodation may also cause personal inconvenience, but is not such a stringent necessity as adequate office/storage space. The inadequacies in the availability of water supply, sanitary facilities, and indoor beds at the PHC, need to be rectified as soon as possible.

3.39. One of the conditions for the continuation of the ICDS Project should be a firm commitment on the part of the States to provide adequate finances for safe drinking water in the Project areas.

CHAPTER IV
FLOW OF FINANCES AND SUPPLIES

4.1. Most of the Projects were officially inaugurated on 2-10-76, and, therefore, completed only 6 months of the financial year during 1975-76. In the current financial year (1976-77) also, the Projects have accounted for only 4/6 months of their

expenditure. Therefore, the allocation and expenditure patterns in both the years are roughly comparable. Out of 29 Projects, 6 Rural, 1 Tribal, and 1 Urban Projects were unable to furnish either allocation or expenditure data and have, therefore, been excluded from analysis.

Average Allocation and Expenditure Pattern of Central Funds

Projects	1975-76 (October-March)			1976-77 (July-September)		
	Allocation (Rs.)	Expenditure (Rs.)	%	Allocation (Rs.)	Expenditure (Rs.)	%
Rural (11)	21,95,379	9,99,482	45.5	40,42,767	5,57,920	13.8
Tribal (7)	9,46,144	5,30,382	56.1	9,17,064	98,663	10.8
Urban (3)	9,20,453	1,50,100	16.31	20,31,586	2,19,528	10.8
All Projects (21)	40,61,976	16,79,964	41.4	69,91,417	8,76,111	12.5

4.2. The above table clearly demonstrates the under-utilisation of allocated funds in both 1975-76 and in 1976-77. The remarkably poor utilisation of funds in 1976-77 is to be noted. Urban Projects despite their very poor utilisation of funds, were allocated substantially higher amounts than either the Rural or Tribal Projects.

4.3. In the ICDS Scheme, approximately Rs. 4.8 lakhs, Rs. 3 lakhs, and Rs. 5.8 lakhs, per annum were budgeted as Central grants for Rural, Tribal and Urban Projects respectively. If one considers these figures as norms, then a very wide variation was seen to exist within projects in each of the categories mentioned above. This was true of both the financial periods, i.e., 1975-76 and 1976-77 under study. For instance, taking the allocation for Rural Projects in 1975-76 as an example, the variation was as great as Rs. 90,048 (Chawmanu with a population of 49,763) to Rs. 3,56,900 (Nurpur Bedi with a population of 57,021). The utilisation pattern in the same period appeared to be quite haphazard with no expenditure in Tarapur to 125 per cent in Dhakuakhana. Similarly, allocations in 1976-77 varied from just Rs. 69,600 (Ukhrul) to as much as Rs. 9,29,000 in Nurpur Bedi. The same sort of anomalies existed for the Tribal and Urban categories as well (Table 4.1).

4.4. The data base for projects reporting on Establishment, Recurring and Non-recurring costs varies from 9 to 27, thereby highlighting the non-availability and incompleteness of financial statistics with the CDPOs. The following observations are made subject to this major constraint (Table 4.2 upto para 4.12).

4.5. **Establishment:** The average allocation of 1975-76 for 25 Projects was Rs. 92,149 against which there was an average expenditure of Rs. 34,599 (23 Projects reporting) or a percentage utilisation of 38. The corresponding figures in 1976-77 were Rs. 1,69,092 (26 Projects) and Rs. 31,531 (27 Projects) with a percentage utilisation of 19 only.

4.6. In 1975-76, the average utilisation figures of the Rural, Tribal and Urban Projects were 45, 48 and 16 per cent respectively. The extremely poor utilisation figures of the Urban Projects indicate the late start of these projects.

4.7. In 1976-77, the average utilisation figures of the Rural, Tribal and Urban Projects were 19, 48, and 17 per cent respectively. It is clear that all the three categories of Projects, particularly the Urban Projects are still lagging behind in the completion of staffing arrangements. The tribal Projects had a relatively more encouraging utilisation picture.

4.8. **Recurring Expenditure:** The average allocation in 1975-76 was Rs. 38,326 (17 Projects) and the average expenditure was Rs. 18,441 (20 Projects) with a percentage utilisation of 48 only. In 1976-77, the corresponding figures were Rs. 1,85,925 (15 Projects) and Rs. 14,366 (22 Projects) with a percentage utilisation of 8 only. The extremely poor utilisation of the recurring budget in 1976-77 is to be noted.

4.9. Recurring expenditure in the ICDS Scheme was ear-marked for contingencies and rent for Anganwadis, medicines, petrol and maintenance of vehicles, contingencies at the Project level, and the

renting of buildings for medical and para-medical staff. The average allocation for Rural, Tribal and Urban Projects as per the Scheme are Rs. 62,000; Rs. 41,600; and Rs. 1,67,000 respectively. If this be the case, it is puzzling as to why there were tremendous over-allocation of funds during 1976-77, under this head to all the three categories of projects.

4.10. **Non-recurring Expenditure:** The average allocation and expenditure figures in 1975-76 were Rs. 88,291 (17 Projects) and Rs. 45,444 (19 Projects) with a percentage utilisation of 52 only. In 1976-77, the corresponding figures were Rs. 64,868 (10 Projects) and Rs. 10,115 (9 Projects) with a percentage utilisation of 16 only.

4.11. In 1975-76, the Rural, Tribal, and Urban Projects utilised 62, 55 and 15 per cent respectively of the allocated funds. In 1976-77, the utilisation figures were 17, 6 and 4 per cent respectively for the rural, Tribal and Urban Projects, with the poor utilisation of funds being most marked in the Urban Projects.

4.12. The non-recurring budget was for the purchase of *Anganwadi* equipment, furniture at the Project and PHC level, refrigerator, and van. The UNICEF gifted a refrigerator and a jeep to each project and consequently, the estimated annual budget per project under this head was reduced by Rs. 55,000. This saving was kept aside to meet expenses such as the cost of transporting equipment to the project sites and the T.A. expenses of *Anganwadi* Workers during their training, etc.

Flow of Finances from the States to the Projects

4.13. The most noticeable feature of the flow of finances from the States to the Projects is the lack of financial commitment to the ICDS Scheme. It would appear that the State Governments have been extremely slow in allocating funds for the ICDS Projects in their States. (Table 4.3—Upto para 4.16).

4.14. **Supplementary Nutrition:** The ICDS Scheme clearly states that the cost under this head is to be met from the provision made for the SNP in the State Sector under the Minimum Needs Programme (MNP). Instructions were issued by the DSW as early as October, 1975, exhorting the States to specifically earmark funds for the supplementary nutrition component in the ICDS at the level of Rs. 8.21 lakhs for a Rural/Urban Project and Rs. 5.39 lakhs for a Tribal Project, irrespective of the States' acceptance of Cooperative for American Relief Everywhere (CARE) or WFP (World Food Programme) food commodities. Despite these early instructions, most States have made no provision for this ICDS input in either their 1975-76 or 1976-77 budgets (though Plan Provisions³) for the SNP

were made, no earmarking for ICDS was actually done) (Refer Table 4.4).

4.15. The Projects which had made some provisions (although far from adequate in the majority of the cases) for the ICDS Supplementary Nutrition Component in either their SNP or ANP budgets were; Kambadur, Kathura, Kangan, Ukhrul, Chawmanu, Man Bazar, Barajamda, Chota Udepur, Pooch, Dharni and Calcutta. Since the ICDS was officially inaugurated on October 2, 1975, a provision of half of what the annual provision ought to have been, i.e., 6 months of the financial year of 1975-76, was assumed to be a fair norm for the Projects (Read Table 4.3 and Table 7.1 together upto para 4.26).

4.16. Kambadur whose feeding programme had started in June, 1976 had made a provision of Rs. 81,000 against a norm of Rs. 4.15 lakhs. However, no expenditure has been shown. Since CARE food is being programmed, some expenditure must have been incurred for administrative overheads.

4.17. Kathura's supplementary feeding programme commenced only in August, 1976. An allocation of Rs. 4,64,000 was made in 1975-76, under the SNP for feeding in the ICDS. The allocation was for the purchase of a single item—sugar. No details of expenditure, however, were available. It is not clear as to why such an enormous allocation was made for a single item of sugar. A sum of Rs. 57,500 was incurred under the ANP for the purchase of fuel, for which the amount sanctioned is not available. The project is also accepting CARE donated foods for which it must have incurred administrative overheads. The norm was Rs. 4.10 lakhs.

4.18. Kangan allocated Rs. 7,834 under the SNP and spent Rs. 5,982 on administrative overheads and sugar. The feeding component had started only in September, 1976 and WFP foods were being used. The norm was Rs. 2.85 lakhs.

4.19. Ukhrul provided Rs. 42,000 under the ANP in 1975-76. A further sum of Rs. 1,60,708 was provided in 1976-77 in its ANP and SNP budgets, which was spent on the purchase of skim milk powder. WFP food was also programmed, thereby indicating that administrative overheads must have been borne. The feeding input started in June, 1976.

4.20. Chawmanu showed an expenditure of Rs. 62,852 against an allocation of Rs. 79,880. The supplementary feeding programme started only in September, 1976. Since WFP food was being programmed, the expenditure was towards meeting administrative overheads and in buying local pulses. The norm was Rs. 3.0 lakhs.

4.21. Man Bazar made an allocation of Rs. 32,500 under the ANP but no figure has been shown for

3. Table 4.4 gives the factual position of SNP provisions in 1976-77. The States/UT of Assam, Haryana, H.P., J & K, Manipur, Meghalaya, Nagaland, Punjab, Rajasthan, Sikkim, Tripura, and Delhi had under provided for this programme and would not have been able to meet the ICDS commitment out of the outlays provided.

expenditure. The feeding programme started in June, 1976. Expenditure was incurred on administrative overheads for the WFP food and the purchase of pulses. The norm was Rs. 4.31 lakhs.

4.22. In Barajamda, where the feeding input commenced in April, 1976, Rs. 34,750 was allocated and Rs. 20,120 was spent on purchase of local pulses and administrative overheads. The norm was Rs. 6 lakhs.

4.23. Chota Udepur started its feeding programme in February, 1976. It provided Rs. 61,161 under the SNP and Rs. 33,950 under the ANP—the corresponding expenditure were Rs. 38,567 and Rs. 25,930 respectively. The expenditure was on account of administrative overheads for CARE commodities. The norm was Rs. 5.3 lakhs.

4.24. Pooh allocated Rs. 1,93,420 under the SNP and appears to have spent it on the administrative overheads of CARE commodities. The date of commencement of the feeding programme is not known. The norm was Rs. 1.46 lakhs.

4.25. Dharni provided Rs. 77,238 and spent Rs. 60,233 for the administrative overheads of CARE food. The date of commencement of the programme is not known. The norm is Rs. 5.62 lakhs.

4.26. Supplementary feeding was started in April, 1976 in Calcutta Urban Project. A sum of Rs. 1,35,200 was spent in 1975-76, and a sum of Rs. 46,848 was spent in 1976-77. WFP food was accepted. Expenses were towards purchase of local pulses, and administrative overheads. The norm is Rs. 7.06 lakhs.

4.27. **Rural Water Supply (1975-76):** The projects which have been sanctioned funds for Rural Water Supply are Ukhrul, Chawmanu, Man Bazar, Utnoor and Dharni. The remaining 20 Tribal and Rural Projects had made no provision whatsoever. In Kathura, utensils worth Rs. 20,000 were bought under this head. In Ukhrul, Rs. 2,47,000 was sanctioned and spent on giving piped water to 13 villages. Chawmanu also allocated Rs. 43,520 and spent Rs. 37,738. In Man Bazar, only Rs. 9,074 was spent out of an allocation of Rs. 40,500. In Utnoor, there was an over expenditure of Rs. 23,988 versus a sanction of Rs. 10,000 only. In Dharni, only Rs. 8,244 was utilised out of an allocation of Rs. 54,545 (Table 4.3—Upto para 4.28).

4.28. **PHC Staff/Medicines/POL** There is very little meaningful information available on sanctions or expenditure under these heads. Very little has been sanctioned or spent.

4.29. In those cases where the CDPO is not the drawing and disbursing officer as in Bombay, Nurpur Bedi, Chota Udepur, Kathura, etc., great difficulties have been experienced by the CDPOs in even making the smallest of purchases.

Flow of Capital Inputs to the Project

4.30. **Jeep:** 27 out of 29 Projects reported having received a jeep. 16 out of the 17 Rural Projects,

7 out of the 8 Tribal and all the 4 Urban Projects reported having received the jeep donated by the UNICEF. The only 2 Projects that had not received jeeps were Kangan and Dharni. In a majority of cases, the delivery of the vehicle was timely. Each Project received one jeep (Table 4.5—Upto para 4.34).

4.31. **Cycles:** UNICEF also donated cycles for the para-medical staff. In the 17 Rural Projects, 10 had received the cycles on time, while information was not available in the case of one Project. In the 8 Tribal Projects, those that did not have too undulating a topography such as Chota Udepur, Tokapal, Subdega, and Garhi have also received cycles. None of the 4 Urban Projects had received their quota. The range of cycles received by the Projects varied from 5 to 15. Most Projects expressed an inadequacy of the machines supplied and stated they required far more cycles to satisfy the needs of their entire complement of sanctioned staff of Supervisors, LHVs, etc.; approximately 25 per Project or about 600 cycles for the 25 projects that could use them. The Madras Urban Project itself could have absorbed 78 cycles.

4.32. **Refrigerators:** UNICEF also donated a refrigerator per Project except for Kambadur that received 2. 19 out of 29 Projects received refrigerators, 8 had not, and information was not available in the case of two. The slow delivery of refrigerators is causing severe problems in the storage of sera and vaccines. In some Projects, the existing refrigerators are not in working condition. Further, 6 out of the 25 Rural/Tribal Projects (i.e., Dhakuakhana, Chawmanu, Shankargarh, Dalmau, Pooh and Tokapal) require Kerosene refrigerators as there is no electricity. The 8 Projects that did not receive a refrigerator were Tarapur, T. Narasipur, Shankargarh, Man Bazar, Utnoor, Pooh, Subdega and Delhi.

4.33. **Weighing Machines:** These were also supplied by UNICEF at the rate of one weighing machine per Anganwadi. Only 9 Rural Projects out of 17, 3 Tribal Projects out of 8, and all the 4 Urban Projects had received some weighing machines in batches. A comparative statement of the availability of these machines at the Projects varies widely, with the PEO average per Project being 32.5 machines and DSW's average being 103.4. The number of machines as reported having reached the Project level varied from a mere 2 in Chawmanu to 120 in Kambadur. The average number of machines available at the Project level were 53, 38, and 11 at the Urban, Rural and Tribal Projects respectively. Most of the Projects have reported that the delivery of the scales was not timely. Further, two types of scales are being supplied. Both have deficiencies. Both are spring balances of which one is marked in half kilograms and is insensitive to register growth in infants/toddlers and the other type which is calibrated in units of 100 grams has no visible screw for zero adjustment. Neither were supplied in time with trouser seats to seat the child

before weighing. Added to this, it is doubtful if children in the age group of 3 to 5+ would consent to sit in the trouser seat, or alternatively if infants could be placed in them. To compound the problem of weighing machines and weightment, are those of the functionaries (AWWs) who are required to weigh the children. Most of them simply do not know how to do this, how to maintain or adjust these weighing balances, how to assess the age of a young child correctly or how to record and plot weights on the growth charts.

4.34. 28 out of 29 Projects received a typewriter each. These were also supplied by the UNICEF. Their arrival at the Projects was timely.

Flow of Usable Items to the Projects

4.35. Assessment of the flow of usable items to the Projects was based on the availability of 9 selected usable items at the Project level. These were first aid boxes, vessels for drinking water, files/records/registers, health cards, kitchen equipment, bathroom equipment, building blocks, counting frames, paints/brushes, etc. The information pertains to 28 Projects only as information was not supplied by the Bombay Urban Project (Table 4.6—upto para 4.43).

4.36. **First Aid Boxes:** In the 28 Projects, the supply was adequate in 8 Projects, inadequate in 10, not available at all in 10. Since the first-aid boxes were also to contain some supplies of basic drugs for common ailments, their non-availability in 10 Projects reflects some serious gaps in the planning/procurement of items of high priority.

4.37. **Vessels for Drinking Water:** The position in the 28 projects was as follows: adequate in 12, inadequate in 4, and totally not available in 12. It is indeed surprising that 12 Projects had not purchased containers (with lids) for drinking water. Regardless of supplementary nutrition having started or not, one would have expected this very basic necessity to have been provided.

4.38. **Files/Records/Register:** In the 28 Projects, stocks were adequate in 12, inadequate in 11, and 5 Projects had received no stocks at all.

4.39. **Health Cards:** A set of health cards (sometimes including the yellow growth chart and at other times not) were received in adequate quantities by 14 Projects, 7 reporting inadequacy, and 7 reporting no stocks at all. Since some State Governments had opted to print the growth charts on paper supplied by the UNICEF, in almost all these cases the growth charts had not reached the Project level from the State level.

4.40. **Kitchen Equipment:** 20 out of 28 Projects had made some purchase in kitchen equipment although the shopping list of items was far from com-

plete in as many as 16. Eight Projects reported that they had yet to make their purchases in this regard. Many Projects had underestimated their needs in the way of serving utensils as the actual number of Anganwadis required in many Projects exceeded those planned and sanctioned in the Project.

4.41. **Bathroom Equipment:** 23 Projects out of 28 made purchases of most of the items listed under this head except for disinfectant fluid, while 5 had not made any purchases. However, much of this equipment has not found its way to the *Anganwadis*, as almost all of them have no sanitary facility. Another incongruous feature is that the soap containers have been sanctioned in the Scheme, but the CDPOs, by and large have not considered it necessary to buy soap from the contingency funds.

4.42. **Indoor Play Equipment:** Inadequacies or non-purchase of items such as building blocks, counting frames, and paints and brushes were quite common. With respect to building blocks, 7 projects had adequate amounts, 10 did not, and 11 had made no purchases yet. The position with respect to counting frames was very similar, with 10 projects having adequate numbers, 8 reporting inadequacy, and 10 not having bought them at all. With respect to paints and brushes, 8 Projects mentioned adequate stocks, 7 inadequate stocks, and 13 had no stocks at all.

4.43. **Timelines of Purchase/Arrival, of Usable Items:** Delays in the purchase and/or arrival of usable items were experienced in approximately half of the Projects.

Medicines/Vaccines/Nutritive Supplement

4.44. **Medicines:** An enhanced provision of funds for medicines (existing plus strengthened levels) is available at the ICDS Projects. Under the ICDS Scheme, an additional annual sum of Rs. 18,000 for each Rural and Urban Project, and Rs. 6,500 per Tribal Project has been provided from the Central funds. Simultaneously, under the MNP pattern, a sum of Rs. 12,000 is to be provided for the purchase of medicines at the PHC and a sum of Rs. 2,000 is to be made available per SHC based on the formula of one SHC per 10,000 population. Consequently, the total amount to be provided for medicines per ICDS project (MNP formula plus the ICDS budget) ranged from Rs. 6,000 (Pooh) to as much as Rs. 60,000 (T. Narasipur). These were taken as the norm for each ICDS Project, as intimated by the DSW. The corresponding norms for the Urban Projects is not known and needs to be defined by the Health Ministry. The annual provisions for medicines by the States, for the ICDS Projects were then compared with their norms and the percentage provision was calculated. Information was not available in the case of Singroli, Ukhrul, Chawmanu, Man Bazar, Utnoor, and Dharni. In

the remaining 19 Rural/Tribal Projects, the provision in relation to the norm ranged from 8 (Tarapur) to 476 per cent (Nurpur Bedi). On the basis of this exercise, it seems fairly evident, that the provisions made are 'hit or miss affairs' with no real grasp of the concept involved (Table 4.7, refer upto 4.45).

4.45. We would also point out, though the financial figures provided by the DSW have been employed as norms, a calculation based on an annual provision of Rs. 12,000 for medicines at the PHC and a provision of Rs. 2,000 per SHC per 5,000 population (as indicated in the Scheme), works out to be much higher. For example, Kambadur requires 18 SHCs or ANM Centres on the basis of its population (87,715). Hence, the financial provision for medicines alone ought to have been Rs. 12,000 (PHC) + 18 SHCs × Rs. 2,000 = Rs. 48,000. Whereas the norm (under the MNP pattern) for Kambadur is Rs. 30,000. At the present time the ANM centres are very ill-equipped and the ANMs are reported to be very short of basic medicines, vaccines, kits, etc. If the ANM Centres and the *Anganwadis* are to be the primary contact centres for the delivery of basic health services to the target population, there is little point in investing large sums of money in strengthening staff without a concomitant provision for equipment medicines, vaccines, etc.

4.46. **Small-pox Vaccine:** Out of 29 projects, 20 reported adequacy of vaccine, while 1 reported inadequacy and 8 could furnish no information. In the case of DPT/DT, 13 projects assessed their requirements as adequate, 5 reported no stock at all, 6 said their stock was grossly inadequate, and information was not available from 5. In the case of BCG vaccine, 6 reported adequacy and 5 inadequacy, 13 had none, and 5 did not report. In the case of TAB, 14 reported no stock, 5 adequacy, 6 inadequacy, and 4 did not report (Table 4.8, upto para 4.51).

4.47. **Iron/Folio Acid Tablets:** 14 reported adequacy, 10 reported inadequacy, 3 reported no stock, and 2 did not report.

4.48. **Oral Vitamin A:** 13 reported adequacy, 8 inadequacy, 5 no stock, and 3 did not report.

4.49. **Refrigerators:** With respect to refrigerators already existing at the PHCs, the profile for 29 projects was—adequate in 7 Projects, inadequate in 14, none at all in 6, and 2 did not report.

4.50. **Weighing Machines:** In addition to the weighing machines given to each *Anganwadi* each PHC is required to have its own quota from previous donations from the UNICEF. 9 Projects reported adequate number of machines, 16 reported inadequacy, and 4 did not report.

4.51. **Medical Equipment:** This is a different category and could range from adequacy or otherwise in medical/health equipment such as X-ray machines to more mundane items such as blood pressure instruments, apparatus for blood estimation/pathology, etc. 13 projects reported adequacy in this regard, 11 inadequacy, and 5 had no information to offer.

4.52. **Storage:** As mentioned earlier, shortages in office and storage space and in residential accommodation for the ICDS staff was expressed by most of the Rural and Tribal Projects. Ten projects out of 29, said they had no storage space, 12 expressed inadequacy while only 7 assessed their storage needs to be adequate. Shortages of storage space at the project level is certainly a handicap to the collection and distribution to usable items to the *Anganwadis* (Table 3.7).

Summing-Up

4.53. The picture that emerges is one of gross under-utilisation of Centrally allocated resources in both the financial years 1975-76 and 1976-77, in spite of funds being sanctioned by the Centre to the States in time. The reasons for under-utilisation could be many, as under:

1. Delayed release of allocated grants from Centre by the State Governments to the Projects;
2. Poor utilisation of funds by the Projects under Establishment, due to non-completion of staffing requirements especially that of the health staff;
3. Poor utilisation of funds by the CDPOs in respect of recurring expenditure due to non-purchase of extra medicines by the PHC, non-utilisation of contingency funds, POL, renting of buildings for health staff and/or *Anganwadis*, etc.; and
4. Poor utilisation of funds in respect of non-recurring expenditure due to non-completion of purchases under the heads of equipment for all *Anganwadis* as sanctioned in the Scheme and/or furniture, etc., at the Block/PHC level.

4.54. At the State level, the most noticeable feature is the total lack of financial commitment to the ICDS Scheme.

4.55. The financial accounting of allocations and expenditure of State provisions to the Projects is maintained very poorly at the Project level. There are hardly any entries shown. The lack of financial back-up to the ICDS by the States is very evident. Eleven States had made an attempt to provide some funds for the supplementary nutrition input in the ICDS and even where the effort had been made it is far below what the annual provision ought to have been.

4.56. Almost all other States have accepted CARE or WFP donated commodities. It is not clear as to how they will provide for the supplementary nutrition input in an expanded programme if they have been unable to do this in an extremely small-scale experimental programme? Decision to permit States to expand needs to be linked to this crucial issue.

4.57. The State Governments have shown a very poor grasp of the concept of providing an enhanced level of medicines at the PHCs and SHCs as outlined under the MNP programme and the ICDS Scheme. State Governments are not committed to provide funds at the rate of Rs. 2,000 per Health sub-centre as provided under the ICDS Scheme to reduce the coverage of population by an ANM Centre from 10,000 to 5,000. Haphazard provisions have been made by the States/Projects ranging from 8 per cent of the norm in Tarapur to 476 per cent of the norm in Nurpur Bedi. A much higher investment in basic drugs, medicines, and vaccines/sera needs to be carefully worked out by the Health Ministry on the basis of the target population to be covered on a sustained basis without the usual shortages and lacks noticed at this stage of enquiry. The financial provision should be of such magnitude so as to enable the greatly enhanced complement of ANMs and the new cadre of AWWs to be adequately equipped and stocked with the necessary medicines, drugs, sera, and equipment. Such an approach may pay much higher dividends in

obtaining community support and better health status of the target population, than the provision of relatively vast sums of money for the supplementary nutrition component.

4.58. The rather haphazard and un-coordinated arrival of certain critical items of supply, i.e., growth charts and weighing machines, registers/records/files, medicines and vaccines, etc., seems to suggest that the application of certain management concept might have helped considerably in calculating a more realistic 'lead-time' for pre-implementation. For instance, the application of the principles of PERT (Programme Evaluation Review Technique) which serves to put all programme activities, sequential and concurrent in proper perspective and highlights critical activities, would have been valuable in calculating this 'lead-time'. More training in details of logistical planning and materials management may also have been of practical value to the organisers of the programme (DSW) and the implementers at the State and Project levels. It is recommended that this type of expertise be made available to DSW and form an important element of a revised Training Syllabi for ICDS functionaries.

4.59. Lack of storage space at the Project and *Anganwadi* levels is also an example of a critical need which was overlooked. Adequate rooms for storage have either to be donated, rented or built in the current Projects.

CHAPTER V

PLACEMENT OF STAFF AND TRAINING

ICDS Staff

5.1. **CDPOs:** 27 were in position vs. 28 appointed and 29 sanctioned. In Balmau and Dharni, the BDOs were holding charge. (Table 5.1—Refer upto para 5.5).

5.2. **Supervisors:** 102 were in position vs. 104 appointed and 126 sanctioned. The shortfalls in positioned staff were more noticeable in the Rural Projects, with Man Bazar not having a single Supervisor in position.

5.3. **Anganwadi Workers:** 2291 AWWs were in position (81% of the sanctioned staff) vs. 2415 appointed and 2831 sanctioned. Several batches of AWWs were still undergoing training.

5.4. Considering that an entirely new cadre of non-health functionaries had to be recruited, trained, and posted to the various Projects, the non-health ICDS staff profile as it obtained in July-October, 1976 was commendable.

5.5. **PHC Doctors:** The existing PHC set-up is to be strengthened in the ICDS Scheme with one extra doctor so as to have a team of at least 3 doctors at the PHC. Hence, the availability of doctors already in position at the PHC has also to be considered in assessing whether the Projects have been able to satisfy norms set in this regard. First, considering the extra doctor sanctioned to each Project so as to strengthen the ICDS-health infrastructure, the picture as it obtained in July-October, 1976 was not too satisfactory with only 19 in-position vs. 20 appointed and 29 sanctioned. Doctors were not in position in Tarapur, Kathura, Kangan, Singroli, Ukhrul, Nurpur Bedi, Chawmanu, Man Bazar, Tokapal, and Garhi.

Health Staff

5.6 When the combined strength of doctors in position at the PHCs, i.e. normal strength plus the extra doctor under the ICDS budget, was considered, the picture was not discouraging with just 2 Projects having one doctor, 9 Projects having 2 doctors, 7 having 3 doctors, 4 having 4 doctors and the rest having anywhere from 5 upto 20 doctors, one project did not supply any information (Tables 5.1 and 5.2).

5.7. The delivery of the health component is bound to suffer until the leadership necessary for its delivery is available in full strength at the 11 PHCs that fall short of this requirement. The projects having just 1 or 2 doctors at the PHC were: Pooh (1), Tokapal (1), Kambadur (2), Dhakukhana (2), Kathura (2), Ukhrul (2), Nurpur Bedi (2), Man Bazar (2), Dharni (2) and Delhi (2).

5.8. **Lady Health Visitors (LHVs)/Primary Health Nurses (PHNs):** Similarly, the figures for the extra LHVs/PHNs in-position were 34 (64% of sanctioned staff) vs. 34 appointed and 53 sanctioned (Table 5.1). It is to be noted that 9 projects, namely, Kangan, Singroli, Nilakottai, Chawmanu, Man Bazar, Pooh, Tokapal, Dharni, and Garhi (besides 3 urban projects of Bombay, Madras, and Calcutta) had made no efforts to fill these appointments from the ICDS budget. It would also appear from the gaps in staffing of this category, that the State Health Departments have not operationally adopted the priority given to the ICDS Projects.

5.9. A combination with the existing staff in-position gave an unsatisfactory picture for Rural and Tribal Projects where the prescribed norm is 4 per Project. In the 17 Rural and 7 Tribal Projects, 3 had no LHV, 5 had one LHV each, 6 had 2 LHVs each, 4 had 3 LHVs, 2 had 4 LHVs and 4 had 5 to 7 LHVs. Information was not available on existing staff from Tribal Utuoor (Tables 5.1, 5.2 and 5.2(a)—upto apar 5.12).

5.10. With respect to 7 Tribal Projects, only 2 Projects had the prescribed norm of 4 LHVs each. In any case, the LHV-population ratio in Tribal Projects may have to be substantially upgraded since the population of the Tribal Projects is actually much higher than was originally envisaged in the Scheme. Besides, these areas have widely dispersed populations making effective supervision of ANMs difficult.

5.11. The 4 Urban Project showed tremendous variation in their LHV staffing pattern. Madras led with as many as 18 LHVs though it is the smallest Project in terms of population. Delhi and Calcutta reported 7 and 2 LHVs respectively while no information was available from Bombay.

5.12. All in all, the LHV staffing position is very poor and deficiencies need to be made-up immediately.

5.13. **ANMs:** The prescribed norm under the ICDS Scheme is 1 : 5000. The ANM staff in-position from the ICDS budget was 135 (69% of sanctioned staff) vs. 137 appointed and 196 sanctioned. Projects that had not appointed any ANMs from their ICDS budget were: Singroli; Nilakottai, Chawmanu, and Tokapal (Table 5.1).

5.14. The combined picture of existing and extra staff in satisfying the above norm in 29 Projects was as follows: In 7 Projects it exceeded 100 per cent of the requirement, indicating a wasteful use of a scarce personnel resource. The projects guilty of overstaffing in relation to population were: Kangan,

Ukhrul, Nurpur Bedi, Dalmau, Chhotaudepur, Dharni, and Subdega. Those Projects that achieved 75 to 100 per cent of adequacy were Dhakuakhana, Tarapur, Kathura, Vengara, Pooh and Tokapal. Those achieving 50 to 74 per cent adequacy were: Kambadur, T. Narasipur, Thally, Nilakottai, Jawan, Barajamda and Garhi. The rest of the Rural/Tribal Projects lagged far behind [Table 5.2(a)].

5.15. Although, the ANM staffing appears to be satisfactory in a number of Projects, in actual fact this is not so. In almost all the Projects, new sub-centres had not been opened, or if they had, were extremely short of basic drugs, vaccines or equipment. The ANMs were yet to be assigned their new and smaller operational areas.

5.16. The ANM population norm is not known for Urban areas. Hence, the 4 Urban Projects have not been scored on the basis of Rural/Tribal Projects. The Urban Projects again presented an extremely wide variation in their ANM staffing pattern. It was as high as 56 in Madras project to nil in the Delhi Project. The reasons for this inexplicable difference in ANM staffing pattern for slum projects (that do not vary to that extent in population) needs to be looked into.

Background, Training, and Orientation of ICDS Workers and Health Staff.

5.17. **Doctors:** Only 18 doctors, out of 29 additional PHC doctors appointed from the ICDS budget, were in-position. In Dharni, the doctor had immediately proceeded on leave after reporting to duty. Information regarding training and background was, therefore, available for 18 doctors. Of the 18, 15 were males and 3 females. These three women doctors were posted to the Urban Projects. Most of the doctors were young (average age of 34 years) and had no experience to several years experience in Government service. Out of the 18, 8 had less than 2 years to no experience in Government service. Eight had some training or a diploma in Child Health and one had a diploma in Social and Preventive Health. The doctors funded from the ICDS budget joined very late—most of them doing so from April, 1976 to as late as September, 1976. This extremely late placement of these additional doctors has been largely responsible for the lack of leadership necessary for the planning, supervision, and delivery of the health input.

5.18. The combined strength of the existing and enhanced ICDS doctors in all the 29 Projects was 104. Of these, only 43 (41.3%) had received orientation in the ICDS Regional Workshops for doctors and para-medical staff organised by the AIIMS. The projects having a zero component of doctors oriented in the ICDS were 10 projects, i.e. Dhakuakhana, Tarapur, Singroli, Jawan, Barajamda, Chhotaudepur, Tokapal, Dharni, Subdega and Delhi. Those with a very low component of ICDS-oriented doctors were: Thalli, Nilakottai, Man Bazar, and Calcutta (4 Projects). The remaining 14 projects had all

their doctors oriented to ICDS. The Rural, Tribal and Urban Projects had sent 69, 18 and 6 per cent of the doctors, respectively for orientation (Table 5.3).

5.19. The reason for the extremely poor orientation of doctors and other health staff was on account of poor programme planning. The orientation of medical and para-medical staff was not run concurrently with the CDPOs, Supervisors and AWWs and was taken-up only 9 months after the initiation of the Projects.— This was a handicap for the ICDS Programme, more so, as the conduct of well-baby clinics, Maternity and Child Health (MCH), and nutritional services is normally only a minor activity in most PHCs as compared to family planning, outdoor clinics, and small pox vaccinations which dominate the scene. The AIIMS is conducting an evaluation of job-orientation in relation to job performance and will submit their report in due course. The Health Ministry has indicated norms of health services to be attained in respect of the beneficiaries in the Projects, i.e., health check-up, refend services, and immunisation, in addition to their normal duties. Yet, detailed job charts, major responsibilities, interact and coordinative functions of the health staff vis-a-vis the non-health ICDS staff have not been spelt out clearly. This has resulted in a lack of co-ordinated view of tasks and services to be delivered by the health staff in the ICDS, upto the present time.

5.20. **LHVs:** Out of a total strength of 87 LHVs in 29 Projects information is presented on the background and training of 38. Information on background and training of the LHVs was not available in Kangan, Singroli, Chowmanu, Man Bazar, Pooh, Tokapal, Dharni, Bombay, Madras and Calcutta. Judging from the remaining Projects, the LHVs were generally fairly mature (68 per cent were above 26 years of age). A majority, i.e., 74 per cent of them had completed their high school or higher secondary (Table 5.4).

5.21. Forty-one out of 87 (47%) had been oriented to the ICDS. The Projects that had not sent the LHVs for orientation were 14 Projects, i.e., Dhakuakhana, Singroli, Thalli, Nilakottai, Chawmanu, Jawan, Barajamda, Pooh, Tokapal, Dharni, Subdega, Bombay, Madras, and Calcutta. As in the case of the doctors, the largest component of LHVs were sent for training by the Rural Projects (65%) followed by the tribal projects (50%) while the Urban Projects had lagged behind very badly and had sent only 15 per cent of the LHVs (Table 5.3).

5.22. **ANMs:** Information on the background and training is available for 158 ANMs out of a total strength of 393 ANMs in position in 28 Projects. ANMs from the ICDS budget had not been appointed in Chawmanu, Tokapal, Delhi, Nilakottai, and Singroli, 135 of the ANMs in-position were appointed from the ICDS budget. Over half (52%)

of the ANMs, like the LHVs, were over 26 years of age. With respect to educational qualifications, the majority (81%) were non-matriculantes (Table 5.5).

5.23. The position of ICDS-oriented ANMs was quite discouraging with a scant 71 (18%) being trained out of total complement of 393 who were in position in 28 Projects. Uttoor did not furnish information. The projects that sent all their ANMs for training were: Kambadur, Kathura, Kangan, Ukhrul, Nurpur Bedi, Chawmanu, Dalamau, Man Bazar, Garhi and Bombay. Those that sent some of their ANMs for orientation were Tarapur, T. Narsipur, Vengara and Shankargarh. Those who had not sent any of their ANMs for orientation were: Dhakukhanafi Singroli, Thalli, Nilakottai, Jawan, none of the Tribal Projects except Garhi, and none of the Urban Projects except Bombay. The percentage of oriented ANMs was 62, 21 and 4 respectively in the Rural, Tribal, and Urban Projects (refer Table 5.3).

5.24. **CDPOs:** There were 27 CDPOs in position in 29 Projects. In Dalmau and Dharni the BDO was functioning as the CDPO. Of these, 10 were male and 17 female. Except for the Tribal Projects, where male CDPOs were in a majority, the picture was the reverse in the Rural and Urban Projects. All, except for 1, were well over 26 years. Of the 27 CDPOs, 25 were graduates while 2 were not. All except 1 who had a degree in Home Science, were graduates in arts, the social science disciplines or education, one even had specialisation in Criminology. 23 were trained, 3 were untrained and information was not available for 1 CDPO (Table 5.6). Practically, all were officers of the State Social Welfare Departments. The DSW had issued instructions (in August 1976) (No. 6-11/75 NCD) stating that it would be desirable if the CDPO was a Graduate of Child Development, Social Work, Home Science, Nutrition or an allied field. The CDPOs were trained in the Family and Child Welfare (FCW) Institution of Jamia Milia in New Delhi. The 2 months job-training was given on the basis of the syllabus developed by the National Institute of Public Cooperation and Child Development (NIPCCD). The NIPCCD in turn developed the syllabus for the CDPO, Supervisors and AWWs based on the report and recommendations of the Working Group appointed by the DSW to formulate relevant syllabi for the non-health ICDS functionaries on the basis of the ICDS Scheme. The syllabi produced by the NIPCCD does not outline the major functions of any non-health worker other than the AWWs. Consequently, the syllabus produced for the training of the CDPOs is non-specific and quite theoretical (170 hours of theory and 85 hours of practicals). The 170 hours of theory included only 5 hours each for the subjects of Nutrition, Health, and Pre-school Education while it devoted as much as 86 hours to topics on Social Work/Welfare that had little bearing on the ICDS Scheme or the every day tasks to be executed by the CDPO. Much more time could have been devoted to relevant topics listed in the syllabus, such as, ICDS Scheme I & II (20 hours) or Record

maintenance, Reporting, etc. (10 hours) that would have been of much greater benefit to the CDPOs. The same lopsided emphasis was noted with respect to the 85 hours of practicals, where 45 hours were devoted to Social Welfare and just 5 hours each to Health, Nutrition, and Pre-school Education. Apart from the disproportionate emphasis on Social Work/Welfare, a scrutiny of the sources offered indicate that the NIPCCD was totally unclear as to what was expected of the CDPOs, in the field situation. This could have been the result of an imprecise brief from the DSW or inadequate development and preparation for the training course on the part of the NIPCCD, or both.

5.25. The Instructors, who were trained for 10 days by the NIPCCD in Jamia Milia, were mostly drawn from the discipline of Sociology/Social Work. They had no direct field experience relating to Projects of the ICDS type. The health training (meagre it was) was imparted by a part-time general practitioner. Guest lecturers were used to a large extent, who, no matter, how good as experts in their relative fields, just could not be expected to give the cohesiveness and continuity required in a job-oriented training programme. Although, some prototype materials, i.e., records, registers, etc., were available for demonstration—these were few and far between.

5.26. **Supervisors:** Out of a total of 103 Supervisors, the majority were quite mature (73 were above 26 years of age); approximately half were graduates while a little under half had at least completed their school final. A very high number, i.e., 90 (87%) had training in the ICDS. Almost all were *Mukhya Sevikas* prior to their ICDS appointment and were quite experienced in women and child welfare programmes (Table 5.7). Almost all were trained at the V.T.K. Institute, Samiyala, Baroda. There has again been an over-emphasis on training in sociological aspects, as the trainers were sociologists themselves. As pointed out earlier, the syllabus developed by the NIPCCD has not outlined the major responsibilities or functions of the Supervisors. Hence, the same deficiencies discussed with respect to the CDPOs training, exist here also. The trainers were given an earlier 10 days orientation at the NIPCCD.

5.27. **AWWs:** The AWWs were a youthful group with 64 per cent of the 2281 recruited under 25 years of age, 18 per cent were a little older, i.e., more than 26 years, while information was not available in the case of 18 per cent. The Tribal projects had 84 per cent of the AWWs under 25 years, the corresponding figures for the Urban projects was 52 per cent. The educational background of 2,281 AWWs in 29 Projects indicated that the all-projects figure was 46 per cent for below matrics, 41 for High School and Higher Secondary; and 3 per cent for graduates, and information was not available in 10 per cent cases. As was to be expected; the below matrics were as high as 71 and 46 per cent respectively in the Tribal and Rural Projects. By way of contrast, the Urban Projects included 10 per cent

graduates (accounting for virtually all the graduates) and 79 per cent with High School qualification (Table 5.8 upto para 5.28).

5.28. With respect to training in the ICDS, as many as 84 per cent were trained while only 11 per cent were still untrained, and information was not available in the case of 5 per cent. It was the first job for almost all of the AWWs who had no experience whatsoever in women and child welfare.

5.29. The AWWs were trained at various State Training Institutions such as the Balsevika Training Institute (BTI), Gram Sevak Training Centres (GTCs), Bhartiya Adimjati Sevak Sangh (BASS), Family Child Welfare Centres (FCWs), etc., as indicated in Annexure II of the ICDS Scheme.⁴

5.30. The trainers of these Institutions received their orientation to the ICDS at Jamia Milia. Generally, the Chief Instructor and a couple of Instructors (who would actually be training the AWWs later) attended the Jamia Course, the former for 10 working days and the latter for one month. Since the trainers were again trained with the NIPCCD syllabus and by Jamia, earlier observations about the overall usefulness of the said orientation remain valid here also.

5.31. The NIPCCD syllabus for the Training of AWWs was vigorously followed. It was noticed that the NIPCCD had drawn heavily from the former syllabus of the Balsevikas Training Programme, which has been condensed to more or less fit into the 3 months training course for the AWWs. The AWWs received a four months course, of which a month was devoted to training in Functional Literacy. The NIPCCD brought out a guide book for the AWWs with a practical approach in September, 1976.⁵

Observations on the quality of Training given to the Non-health ICDS Staff.

5.32. The training at every level is highly theoretical, diffuse, and does not relate to the job functions of the ICDS functionaries.

5.33. Although most of the full-time faculty recognise that the ICDS is primarily a health and nutrition-oriented programme, yet due to their background and capabilities, have placed emphasis on the less important components of pre-school activities, non-formal education, and other aspects of social work.

5.34. The training in nutrition is archaic and completely divorced from the reality of limited incomes and the availability of foods in the Project areas. This is partly due to the fact that hardly any of the full-time staff had any knowledge of or had visited any of the ICDS Project areas.

5.35. Minimal attention has been given to the practical aspects of programme planning, development, day-to-day implementation, simple monitoring or evaluation.

5.36. Training time could perhaps have been considerably cut down if job training has been properly aligned to job-functions and if proto-types of actual equipment, records, registers, health and nutrition education materials, etc., had been employed in the training. The trainers should also take the responsibility of deciding what is essential or non-essential information. In the present curriculum there is quite a mixture of both.

5.37. Although the trainees were taken on visits to hospitals and rural demonstration projects, the time spent at these institutions appears to have been quite inadequate in giving the necessary confidence to the trainees and making them feel capable of handling their complementary/supplementary roles in the delivery, particularly, of the health components. To give a few examples, the CDPOs downwards, feel insecure as to how a weighing scale is to be used or maintained, do not know how to use, record or evaluate a child's nutritional and health status from his growth chart, do not have a clear knowledge as to how to assess a child's age, or of the vital importance of weight in relation to his age, are quite hazy about common childhood ailments and what they should or should not do, and when and to whom they should refer sick cases, some do not know that vaccines have to be stored under refrigeration or that oral Vitamin-A has to be given twice a year, and so on.

5.38. Barring one exception, none of the CDPOs considered it important to first know the dimensions of their target population, or the importance of selecting the most malnourished groups for feeding. They were rather vague as to how this was to be done. Their main aim in any event was to get the Anganwadis started and filled, even exclusively with children in the 3 to 5+ years age-group.

5.39. The training in Health and Nutrition Education was mostly irrelevant, and these aspects were left to the ingenuity of the AWWs. There is an urgent need to supply the Training Institutions relevant materials and visual aids. The UNICEF booklet(6) on basic Health and Nutrition messages to be propagated in the ICDS, had not reached most of the Training Institutions. Relevant health and nutrition education materials have already, been developed by other Organisations/Institutions in the country such as, CARE, Central Health Education Bureau (CHEB), UNICEF, the Vellore Medical College, and the Coordinating Agency for Health Planning, etc. These could be usefully employed at both the training and implementation stages.

4. Integrated Child Development Services Scheme, Department of Social Welfare, Government of India, 1976, PP. 40-41.

5. A Guide-Book for Anganwadi Workers, National Institute of Public Cooperation and Child Development, New Delhi, 1976.

5.40. In a relative ranking, the BTIs appear to be the best equipped in terms of qualified staff and facilities to train the AWWs. The GTCs and the BASS (especially the BASS) were found to be inadequately equipped.

5.41. There were noticeable inter-State differences in the quality of training staff, supervisors, and AWWs. Language barriers were noticed between the trainers and trainees at some AWWs training institutions. The same handicap was also noted between Supervisors and AWWs in some Projects.

Summing-up

5.42. The placement of non-health ICDS Staff by July-October, 1976 was consistently high and commendable. By way of contrast the positioning of the health staff was slow and halting and deficiencies need to be made-up urgently.

5.43. Detailed job charts, major responsibilities, interacting and coordinative functions of the health staff vis-a-vis the non-health staff need to be spelt-out clearly.

5.44. In future Projects, special efforts need to be made to ensure that the CDPOs have a much stronger background in disciplines of health, nutrition or child development rather than in social work or sociology.

5.45. Similarly, it would be highly desirable to ensure that at least one doctor out of the 3 PHC, MOs, has a diploma and/or degree in pediatrics. Since the ICDS Scheme has a very heavy weightage in favour of Social Pediatrics, it may even be worthwhile to experiment in some Projects with such a type of doctor, preferably fairly senior in service, as the CDPO assisted by two junior officials—one with

a background in non-formal pre-school education and the other with a background in food management and general accounting procedures.

5.46. It is doubtful whether a week of orientation would be sufficient for the para-medical staff, especially the ANMs who are expected to provide the basic material and child health care to the target population. A simple guide book, on the lines of the one prepared by the NIPCCD for the AWWs would be extremely useful to the ANMs.

5.47. The CDPO, although experienced in routine Social Welfare Administration are very unsure of themselves in a specific integrated child welfare programme, which involves a major health and nutrition component. Their previous background and lack of familiarity with work in the broader fields of health, nutrition or child development, makes it difficult for them to bring expertise to bear on this new pilot project, where the traditional concern with Balwadi or Non-formal Education components are entirely inadequate. Lack of skills in programme management is also very evident.

5.48. The institution for the training of the CDPOs should be changed to a more management-oriented set-up. The major emphasis should be on in-service field training, through familiarisation with the work successfully done elsewhere, and through attachments to existing Projects.

5.49. The revised syllabus should be based on the experience gained from the 33 experimental projects. There is great need to completely revise the syllabus for CDPOs, Supervisors, and AWWs, by experts who have a sound knowledge and experience in programme management, essentially, of integrated child health nutrition programmes together with the help of field-oriented experts in pre-school education.

CHAPTER VI

INVOLVEMENT OF THE PEOPLE AND ADMINISTRATIVE COORDINATION

Formation of Coordination Committees at the Project Level

6.1. Coordination Committees at the Project Level have been formed in 20 out of 29 Projects, i.e., 14 out of 17 Rural, 4 out of 8 Tribal, and in 2 out of the 4 urban Projects. Eight of the constituted Committees were so done in 1975, while of the remaining 12, one was constituted in January 1976, and the rest were constituted in May 1976 or even as late as end November, 1976 (Table 6.1 upto para 6.3).

6.2. The officials usually out-numbered the non-officials (6 to 3). The Committees were male dominated and had very poor female representation. Most of the members had virtually no experience in women's and child welfare.

6.3. In the Rural Projects, out of the 14 constituted, 7 had held only one meeting, while 2 had held 2 meetings, and one Project (Shankargarh) had held as many as four. The meetings were generally well attended by the official members. In 3 Tribal Projects with Constituted Coordination Committees, Tribal Tokopal had held as many as 5 meetings to nil (Garhi). The official to non-official representation was fairly even. In the case of Urban Projects, complete information was available only for Delhi which had held only one meeting.

Administrative Coordination

6.4. There is another aspect of coordination which is probably of much greater significance for the smooth implementation of the ICDS Scheme. This is regarding the position and day-to-day close coordination between the CDPO, the PHC (MOs), and

the BDO at the ICDS Project level; the Supervisor and the LHV at the Intermediate level; and last but not least, the ANM and the AWW at the village level. Our observations and field reports indicate that the delivery of the package of services is not properly understood, nor being performed, nor emerging as expected in the Scheme.

6.5. In the ICDS Scheme, it is envisaged that all the 3 PHC, MOs and their total paramedical staff will equally divide the ICDS work among them. This implies that clear coordinative linkages have to be spelt out between the CDPO and the three PHC, MOs. Further the PHC, MOs, need clear instructions from their higher authorities on what is expected of them in relation to the ICDS.

Summing-up

6.6. If Coordination Committees are to serve an important role, they should be constituted early, should comprise of members (regardless of male or female) who have a known history of experience and background in health, nutrition, pre-school education, functional literacy, etc. The Committees should strive to involve as many non-official members as possible. The members should be fully conversant with the goals and specific objectives of the Scheme and should be of practical assistance to the CDPO in the planning and implementation of the Project.

6.7. The major responsibilities and coordinative functions of all the ICDS staff (health and non-health) need to be clearly delineated. Staff need to be reassured that each has an equally important role to play.

COMPONENT OF SUPPLEMENTARY NUTRITION

7.1. The ICDS Scheme envisages the delivery of supplementary nutrition to the vulnerable child and mother as one of the most important components of the package of ICDS services. Certain guidelines, if not norms, have been set down in this regard by the Department of Social Welfare. Briefly, the more important elements are as follows:

1. The States should provide sufficient funds in their budgets for the Special Nutrition Programme (SNP) under the Minimum Needs Programme (MNP) in order to meet the supplementary nutrition requirements of the ICDS projects and there should be a timely release of funds to the field offices.
2. Budgetary allocation would have to be made on the basis of supplementary nutrition per beneficiary at 25 paise per day for 300 days per annum or Rs. 75 per beneficiary per annum. Severely malnourished beneficiaries (III or IV degree) will be fed at the rate of 60 p. × 300 days or Rs. 180 per beneficiary per annum.
3. In the case of the World Food Programme (WFP) or the Cooperative for American Relief Everywhere (CARE) donated foods being accepted in 1975-76, and in 76-77, the States will have to make financial provisions for the transportation and administration costs, i.e., 4.5 p. × 300 days or Rs. 13.50 per beneficiary per annum, as is the established practice in the other ongoing national programmes such as SNP and Midday Meals Programmes (MDM).
4. In the case of donated foods, the daily ration level per child would be 80 gm. of blended food and 7 gm. oil and that of a women—125 gm. blended food and 7 gm. oil.
5. The States should give first priority to locally available foods.
6. A comprehensive identification and enrolment of children (0-1 yr, 1-3 yrs, and 3-5+yrs) and pregnant/nursing women should be carried out as per weight-for-age and other socio-economic criteria laid down by the DSW.
7. An attempt should be made to cover at least 40 per cent of the target child population (0-5+ yrs) and 40 per cent of the pregnant/nursing women population of the Rural and Urban Projects. The corresponding coverage in the Tribal Projects should be as high as 75 per cent (target children and women).

7.2. The present chapter attempts to analyse the performance of the various ICDS experimental projects faced with respect to the guidelines listed above. In addition, information on the commencement of supplementary feeding, frequency of delivery of food commodities, conditions of storage and condition of the food commodities at the Project and *Anganwadi levels* is also presented.

Provision of Sufficient Funds in the State Budgets for the ICDS Nutrition Component

7.3. It is very evident that most of the States (18 out of 29) have made no financial provision whatsoever for the ICDS supplementary nutrition input in 1975-76. With the exception of Kathura, the others (10) that have made some provision, have provided amounts for less than what would have been required for a comprehensive nutrition programme for the target groups (Table 4.3.). Except for T. Narasipur and Garhi that commenced supplementary feeding during the tail end of the financial year of 1975-76, all others who have commenced a supplementary feeding programme have done so in the financial year of 1976-77. It is not possible to comment on the budgetary allocations made by the States in 1976-77 under this Head, as very little or no information was available at the Project level even as late in the year as July to October 1976 except for T. Narasipur and Singroli.

7.4. In general, the release of either Central or State funds from the State to the projects was reported to be slow in 1975-76 and even 1976-77.

Priority to Locally Available Foods

7.5. Only 3 projects out of 29 have provided indigenous food commodities and have not relied on WFP or CARE food donations. These were Tarapur (rice and pulses); Man Bazar (pulses); and Subdega (Ragi, pulses, and jaggery). Two out of three Uttar Pradesh ICDS projects had not started the ICDS supplementary feeding on a continuous basis. Shankargarh had made a sporadic attempt with indigenous foods (pulses and jaggery) but had to stop due to lack of funds. In Dalmau, children in the age group of 6-30 months were the beneficiaries of a Supplementary Nutrition Programme run by the India Population Project, but this did not constitute a supplementary feeding input by the ICDS Project. In short, the State Government had not accepted any donated foods, was believed to be seriously thinking of programming indigenous foods, but had not done anything in the matter at the time this information was collected (Table 7.1 refer upto para 7.10).

7.6. Those projects that accepted a major part of donated foods, but also made some minor provision for an indigenous component were; Ukhrul (WFP's Soy-Fortified Bulger and butter oil and an indigenous brand of skimmed milk powder), Chawmanu (WFP's sorghum grits and butter oil, and local pulses), Barajamda (WFP's Bulger, wheat and butter oil and local pulses), Calcutta (WFP's soya fortified Bulger, sorghum grits, butter oil, and local pulses, jaggery and condiments), T. Narasipur (CARE's balahar and oil, and local pulses, jaggery, and condiments), Kathura (CARE's soy-fortified Bulger wheat and oil, and huge quantities of locally purchased sugar).

7.7. Those projects that relied on CARE commodities were Kambadur, Kathura, T. Narasipur, Nurpur Bedi, Singroli, Thalli, Nilakottai, Utnoor, Pooh, Tokapal, Dharni, Garhi, Bombay (WFP food was to replace CARE food shortly) and Delhi.

7.8. Those projects that relied on WFP commodities were, Dhakuakhana, Kangan, Vengara, Ukhrul, Chawmanu, Man Bazar, Barajamda, and Calcutta.

7.9. Most of the Projects accepting CARE or WFP food commodities did manage to provide some funds for condiments, fuel, meagre quantities of pulses and/or vegetables from administrative overheads and/or contingency funds.

7.10. As mentioned earlier, none of the 3 Uttar Pradesh, ICDS Projects or the Madras Urban Project had taken on a supplementary feeding programme. In Dalmau, children 6-30 months of age received a blended, pre-cooked, highly palatable mixture of indigenous wheat, Bengal gram, defatted groundnut flour, sugar, and a vitamin/mineral premix. The food was produced by a local mill.

Provision of Administrative Overheads Transportation Costs for the Donated Local Foods

7.11. It is obvious that wherever an ICDS supplementary nutrition programme was in existence, the State or the Project must have provided some funds to cover the above cost though this is not clearly reflected anywhere in the financial statements. A clear understanding of the food audit, food accounting, and food management at the Project level would be necessary in this regard.

Adherence to Specified Ration Levels

7.12. We are unable to comment on the adherence to specified ration levels (as indicated in DSW's guidelines) or on the under/over utilization of food commodities, as most projects had just commenced with their supplementary feeding programmes.

Comprehensive Enumeration of the Target Population and their Selection for Supplementary Nutrition as per Set Norms

7.13. It has already been brought out in Chapter III that practically none of the projects knew the dimension or composition of the target population at the Project level. As for the selection of beneficiaries for supplementary nutrition, on the basis of weight-for-age criteria, this was conspicuous by its absence in all the projects.

Actual Coverage in Supplementary Feeding versus Target Population at the Project Level.

7.14. In the absence of precise demographic break-up of the target population (children in the age segments of 0-1 yr, 1-3 yrs, and 3-5+ yrs, and pregnant and lactating women), the PEO carried out an exercise wherein the dimensions of the above population segments were calculated on the basis of the 1971 census of the ICDS projects areas, and the demographic norms as set out in the ICDS scheme⁶. (Table 7.2 upto para 7.17).

7.15. Our comments refer to the 25 Rural and Tribal Projects. The 4 Urban Projects have been excluded as the data was very sparse and incomplete. With respect to these 25 projects, the actual achievement versus target was not very encouraging except for the coverage of children in the age group of 3-5+ yrs. The figures for the other target group were; 11 per cent (0-1 yr), 24 per cent (1-3 yrs), 46 per cent (3-5+ yrs), 9 per cent (pregnant women) and 11 per cent (lactating mothers). It will be recalled that the ICDS Scheme aimed at a minimum coverage of 40 per cent of each of the segments of the target population. The preliminary attempts at the implementation and coverage of this component is *disturbing*, as there are clear indications that the least vulnerable child group (3-5+ yrs) is receiving the most attention, for the simple reason that it is institutionalised, and therefore, the most accessible. The traditional 'fed-on-site' feeding approach at this stage of the study establishes its extremely limited capacity to reach of the younger and most nutritionally vulnerable age-segments (i.e., 0-1 and 1-3 years). This suggests the need to urgently consider alternatives.

7.16. It is also important to note that several Rural Projects apparently found the inaccessibility and immobility of the 'below threes' too great an impediment to overcome. Various situations observed were :

1. Projects which quite frankly restricted the programme to the institutionalised 3-5+ years age group, with a smattering of pregnant and

6. Demographic statistics collected at the *Anganwadi* level (1976) indicate that the 0-5+ years segment is 19 per cent and not 17 per cent. However, this would not materially affect our observations. If at all, it would represent the achievement in supplementary feeding in a better light than was actually the case.

lactating women thrown in. These were; Kambadur, Dhakuakhana, T. Narasipur, Kangan, and Singroli:

2. A group of Projects, i.e., Vengara, Ukhurul, Thalli, and Tokapal where children had just then been categorised as 'below three' and 'above three'; and
3. Projects such as Chawmanu, Shankargarh, Man Bazar, and Bombay, where target children were all lumped into one category of '0-5+ years'.

7.17. This failure to recognize the importance of each child age segment and its nutritional vulnerability, is bound to have a negative impact on the programme. Until and unless the training and re-orientation programmes for ICDS staff hammer home the importance of achieving specific targets and the project administration and personnel seriously work and practical means of reaching the 'below threes', the cost and benefit of such supplementary programmes would be highly questionable.

7.18. A further analyses by Rural Projects reveals that the achievement by the 17 Rural Projects was as follows; 5 per cent (0-1 yr), 21 per cent (1-3 yrs), 45 per cent (3-5+ yrs), 10 per cent (pregnant women), and 10 per cent (lactating mothers). Nurpurbedi is a lone exception and stands out for its high coverage for almost all targets segments. On the negative side, Ukhurul presented a picture of gross over-coverage of the target population thereby demonstrating its total inability to identify and enumerate the target population in the ICDS area.

7.19. An analysis of the 8 Tribal Projects, indicated a much more encouraging figure for children, i.e., 28 per cent (0-1 yr), 33 per cent (1-3 yrs), 48 per cent (3-5+ yrs), 7 per cent (pregnant women) and 14 per cent (lactating mothers). It would, however, appear that a coverage of 75 per cent of the target population as set down in the ICDS Scheme may be a difficult target to achieve even in the tribal areas. Projects which appear to be making commendable efforts in covering the 0-3 years age group are; Pooh, Utnoor, Chhotaudepur, and Dharni. However, the spot-checks conducted on different dates, on the six selected *Anganwadis*, per project show a somewhat different picture. The projects that were found to be catering to at least 30 per cent 'below three's,' on an average, per spot-checked *Anganwadi* were; Tarapur, Vengara, and Dharni.

7.20. The Urban Projects have got off to a very poor start. Further it was also extremely difficult, if not impossible to assess the slum population in the ICDS areas precisely as the ICDS population were not concentrated in one area but were scattered over a much wider area of the metropolitan cities.

Frequency of Supply of the Food Commodities

7.21. In the 25 Projects that supplied information on the above, 14 projects obtained their food commodities (usually CARE or WFP) once a month

9 reported a frequency of once in 3 months to less often, while Nurpur Bedi and Bombay which had a daily bread distribution reported a daily supply (Table 7.4).

7.22. The majority of Projects reported a smooth logistical supply system with no interruptions in delivery. The few projects that reported interruptions/delays in the delivery of food commodities were; Kangan, Ukhurul, Shankargarh, Utnoor, Pooh and Garhi.

7.23. The pattern of food distribution from the Project level to the *Anganwadi* level was more or less similar to the flow of food from the district/*taluka* godown to the project; a monthly food delivery was the predominant pattern. Nurpur Bedi and Bombay had a 'daily bread distribution' to the *Anganwadis* while Ukhurul which programmed milk powder, delivered the commodity to the *Anganwadi* once in 15 days.

7.24. Interruptions in the supplementary feeding programme, for lack of stocks, was experienced in Shankargarh and Garhi. In Calcutta, an interruption in feeding at some of the *Anganwadis* occurred due to delays in the delivery of the food commodities from the Project level to the *Anganwadi* level.

Storage Facilities and Problems

7.25. Twentytwo Projects reported about storage facilities and condition of food commodities. The most common place for storing the food commodity was in the CDPO's office (11). Besides, a variety of storage arrangements were mentioned ranging from school buildings, SDO's quarters, *pucca* godowns, *panchayat* office, rented rooms, etc. (Table 7.5 upto Para 7.26).

7.26. Similarly, storage facilities at the *Anganwadi* level were reported by 26 projects. Two mentioned that they had no facility whatsoever (Bombay and Calcutta). The food was most often stored at the *Anganwadi* itself or at the workers' residence, followed by storage of food by members of the community.

Condition of the Food Commodities

7.27. Again out of the 22 projects that reported, the condition of the food commodities was judged as good in 9, fair in 8, poor in 2, very poor in 3, and was not relevant or not available in the case of 7. The project in which food commodities were found to be in very poor conditions were Dhakuakhana (WFP) and Kathura (CARE), those in poor condition were Man Bazar (WFP) and Calcutta (WFP). A whole set of Tribal Projects reported that the condition of the donated foods were only in a fair condition on receipt. These were: Pooh (CARE), Tokapal (CARE), Dharni (CARE) and Garhi (CARE).

7.28. Various factors were cited where food was found in poor condition. There were 'no space and a non-rodent proof room' in Dhakuakhana, a combination of 'no space, non-rodent proof room, damp, heat' in Kathura, 'no space' in Man Bazar; and the non-availability of rodent-proof and dry storage space in Calcutta.

7.29. The condition of the food, as to be expected was in even a worse condition at the *Anganwadi* level. 21 out of 26 Projects responded to this question. Only in 5 Projects was the food found to be in good condition, in 9 it was in fair condition, and 3 in very poor condition. The reasons cited for the poor condition of food were very similar to those listed earlier.

7.30. Kambadur reported that some of the consignments of food were unfit for human consumption when it arrived at the Project. Thally reported a similar situation with some food lots at both the Project and *Anganwadi* levels.

Availability of Major Crops in the ICDS Project area and their Potential use for the ICDS Supplementary Feeding Component

7.31. Local seasonal crops can be utilized to produce simple blended mixes which in step-wise fashion could consist of combinations of a cereal-pulse, a cereal-pulse-oilseed or a cereal-pulse-oilseed-jaggery and so on. These raw food commodities could easily be procured by the ICDS Project staff at the height of the *kharij* or *Rabi* season when prices are the most economical. Since fairly large quantities would have to be purchased and stored in bulk, the provision of proper storage facilities need to be considered seriously at both the Project and *Anganwadi* levels. Rodent, insect, and damp proof bins need to be developed from local materials (Table 7.3 upto para 7.35).

7.32. The actual production of the mixes is a simple enough procedure and can be considered at several levels, i.e., the home of the beneficiary, the village, the block headquarters or even the district (when the programme expands). Depending on the availability and price of the food commodities, several combinations could be evolved where simple proportions such as, 4 parts of cereal to lesser parts (1 or 2) of the other ingredients, such as, oil seeds, pulses, sweetening agents, etc. could be experimented with. There is nothing sacrosanct about the proportioning. The main guiding principle should be the availability of cereal, pulse and/or oilseed. Linear programming techniques can be usefully employed to give optimum mixes in terms of energy and protein specifications, palatability, bulk, keeping quality, and digestibility in relation to least cost.

7.33. The mixes can be prepared out of raw ingredients on a 'take-home basis by the beneficiary child's family, or by the women of the *Mahila Mandals*, or the entire job can be contracted to local village millers, under the supervision of the ICDS staff.

Pre-cooking or processing of the blended foods can be achieved by a preliminary roasting or parching of the grains, pulses and oilseeds.

7.34. As many as 18 out of 25 Rural and Tribal Project had multiple *Kharij* crops of cereals, pulses, oilseeds and/or sugarcane. The exceptions were Dhakuakhana, T. Narasipur, Kangan, Vengara, Ukhrul, Jawan, and Man Bazar that generally had predominantly cereal crops. In the case of the 18 projects, the development and production of ready-to-eat formulations should not be a problem. In fact, local deep-fried but non-spicy recipes such as 'Sev, boondi, muruku, and sakarpara etc. can be easily prepared in the various *Anganwadi* villages itself at 15 day intervals; In the case of the elder infants/young toddlers (6-30 months of age) the same preparation can be powdered and a pulpy preparation can be made instantly by the addition of boiling tea, water or milk. The advantage of deep-fried preparations lies in the fact that it is thoroughly cooked and it is a more low-density-high-energy preparation than, say, the boiled variety of preparation such as, Upuma, Daliya, etc.

7.35. Wherever possible, the cultivation of easily digestible high carbohydrate crops like potato or sweet potato should be encouraged, for example, potatoes in Pooch or sweet potato as in Vengara, for the ICDS feeding. The banana is also a high carbohydrate and highly digestible food and is particularly suited to infant and toddler feeding. In the paddy and sugarcane growing areas, a combination of the soft rice bran and molasses, could make not only a delicious and very inexpensive supplement, but a very nutritious ones as well. High-energy and predominantly carbohydrate foods as the ones suggested above, should be supplemented with modest amount of protein rich foods, such as, sprouted pulses, thick *dal*, groundnuts, parched *channa dal*, etc., to provide the protein complement. In the case of the very young child the protein source should also be reduced to a semi-solid form.

7.36. Local bakery products, i.e. biscuits, buns, bread, *namkeen*, nan roti, etc., using locally produced blended cereal-pulse mixes can also be considered as the basis of a cottage industry, to support the ICDS Supplementary Nutrition Programme. As mentioned before, for the very young child who cannot masticate, all that needs to be done is to reduce the product to a semi-solid form, before giving it to the child.

The Pros and Cons of Supplementary Feeding Programmes

7.37. Nutrition programmes are not easy to run. This fact needs to be adequately recognized by the entire gamut of planners, policy makers, and implementors. A very high degree of coordination and logistical support is called for. The efficiency of the feeding programme is largely dependent on an uninterrupted delivery of the food input, its sustained

shelf-life and other supportive inputs throughout the programmes. Feeding programmes, are not 'a-few-shots deal' like an immunization programme but call for day-in-and-day-out, year-in-and-year-out sustained and honest effort by the implementing staff.

7.38. Since policy dictated that supplementary feeding programmes must continue, the type of supplementary food being programmed and the delivery system employed, need to be critically examined in relation to the target groups to be reached. The composition and dimension of the target group composition can only be ascertained through a fairly accurate knowledge of the demographic break-up of these groups (the 0-5+ years age group, and the pregnant and lactating women) in the programme area. From here on alternatives may have to be considered. Either one should select, as in the present approach in ICDS, the most malnourished within the specified target groups, using a fairly reliable indicator, such as, the 'Bangle Test' (plus 10-18%) that will at least identify those most in need or we have to chisel down the relatively less nutritionally vulnerable population segments, from the hard core segments of greatest nutritional need. The hard-core are predominantly children in the age group of 6-36 months and pregnant women in their last trimester. It is both insensitive and unrealistic to employ the same delivery channel and the same food supplement, whether the target group be infants, toddlers, pre-schoolers, pregnant women or lactating mothers. In short, the supplementary nutrition component of the ICDS at the present time (as is true of most of our national programmes aiming to reach the group listed above) has neither Reach nor Specificity.

7.39. The high cost of supplementary feeding programmes, make it imperative that we strive for greatest reach or coverage. For example, if one was to consider the two, 'high-risk', groups as the 'below threes' and the pregnant women, on a priority basis then the other segments, i.e., the 3-5+ years age-group and the lactating mothers would naturally be considered of secondary importance. If one accepts this approach, then it will be recognized that one can take little comfort in the reassuring statistics of 'numbers fed', often reported for supplementary feeding programmes. These almost invariably relate to the more hardy, more mobile, and (for less) nutritionally vulnerable 3-5+ years age-group.

7.40. There is also an urgent need to critically appraise the delivery systems currently in vogue for distribution of the food supplement to the inaccessible and 'hut-bound', 'below-threes' and the tradition-and-superstition-bound pregnant women. It is high time that we experimented with other types of delivery channels that are infinitely more suited to the ecology of these two groups. There is little justification in continuing with a 'fed-on-site' delivery system when its effectiveness in covering these groups is of extremely limited value. Other approaches,

such, as 'take-home-food' systems, and/or the distribution of free or heavily subsidized supplementary foods through the public food distribution systems, or through the various government controlled agencies, or as part wages in food-for-work schemes, need to be tested and tried. It is envisaged that a mass-media nutrition-information system will support each of these approaches.

7.41. A food-supplement can have little impact unless the various 'health-leaks' in the vulnerable groups are first plugged. The government rural health agency, supported and aided by the local indigenous health practitioners should play a signal role in prescribing and distributing locally produced, low-cost, ready-to-eat, cereal-pulse mixtures to the 'nutritionally needy' children. The sanction and authority of a health agency may go a long way in the proper utilization of the supplement for the beneficiary. Mothers could and should be involved in the nutritional rehabilitation of their children in their own homes, and not in rehabilitation centres. The mixes should be such simple proportions and combinations, that it is entirely within the economic means of the family to continue the supplementation, even after the health-agency support is withdrawn.

7.42. There is also an urgent need to recognize the fact, that special foods need to be developed for pregnant/lactating women, that would be both culturally and psychologically acceptable to this group. Hence, nutrition in the form of tablets tonics, or traditional pregnancy/lactation foods such as '*methi-pak*' of Gujarat, '*Lahiyam*' of South India, etc may find much more ready acceptance than programming the same food as for the 0-5+ yrs age groups. One of the knottiest problems of feeding programmes for pregnant/lactating women is that a very few enrol themselves, and these that do, take every opportunity to carry the food home to share with their other children, husband, in-laws, etc.

7.43. The ultimate aim of supplementary feeding programmes ought to be that they are completely phased out over a period of time. During the time they do operate, every opportunity should be taken to educate and convince the community that sparing a little more food from the family pot for the 'below-threes' even among the poorest of the poor families, is possible. Health and nutrition education should be relevant and practical and there is no better way of demonstrating this than by clearly bringing out the implications of child health and nutrition needs before family itself.

7.44. It is indeed strange that a young women of little or no experience in the rearing of the young child, i.e., the *Anganwadi* worker or a young *Bal-sevika*, etc., is trusted infinitely more, than the mother/parents of the child in question. No programme, agency or the State can take on this task indefinitely, as the sheer number of even the severely malnourished children on a national scale is stupendous.

7.45. If the alternative approaches/suggested for the delivery of supplement food to the 'hard-core-nutritionally-vulnerable-groups' also prove to be ineffectual on a large-scale basis, then, we should seriously weigh the cost benefit of supplementary feeding, as a means of direct nutritional intervention, as against the cost benefit of 'high-impact-low-cost'. Indirect intervention possibilities, such as, protected water systems, mass immunization, protection against Vitamin A deficiency, and nutritional anemia of the total child population (0-11 years) rather than the inefficient and ineffective supplementary feeding of a select few. In the same vein a much grater investment in basic drugs and medicines at the PHCs/SHCs and its envisaged ancilliary net-work of indigeneous health practitioners, may have a much greater spread-effect and ultimately provide more nutritional impact, than supplementary feeding programmes, as currently in operation.

Summing-up

7.46. There has been little or no commitment from the States in the provision of funds for the supplementary feeding inputs in the ICDS. An overwhelming majority of Projects have made no attempts whatsoever the programme local foods.

7.47. In the absence of basic data on the size and composition of the target population, it has become very difficult, if not impossible, to select beneficiaries for supplementary feeding on the basis of nutritional needs. The application of the weight-for-age criteria was virtually redundant as very few children had been weighed (based on sample scrutiny of household level data). The enrolment of beneficiaries has, therefore, for the major reasons of convenience and operational feasibility, been extended to pre-primary schoolers (3-5+ years) who are institutionalised in the Anganwadi.

7.48. The preliminary efforts at the implementation of the supplementary nutrition component, makes it very clear that the 'below threes' and the pregnant women who are the most vulnerable are being reached the least. Further, an over attention to the 3-5+yrs age group in the way of non-formal education, their feeding and so on, is diverting attention from the more important tasks of delivering nutrition and related health services (identifying common childhood illnesses, referring very sick eases, etc.) to those truly in need. If one starts feeding the older children jut because they are easily available, it will be difficult at a later stage to accommodate those truly in need.

7.49. The majority of the Rural/Tribal Projects had multiple Kharif crops of cereals, pulses, oilseeds and/or sugarcane. Low-cost ready-to-eat local preparations of roasted and powdered cereal-pulse combinations with or without oilseeds or sweetening

agents could be produced at the ICDS headquarters or at the Anganwadis. The processed blended foods could be produced by the village miller under the supervision of the ICDS staff, or the community women could be organized to assist in this endeavour.

7.50. Ready-to-eat and preferably deep-fried preparations such as Sev, Murku, Mathia, etc., are recommended as these result in high-calorie low-density foods. Groundnut, Til, or puffed Bengalgram, toffee, mixtures of parched rice, and gram, or even baked products like biscuits, buns, etc., made out of the cereal-pulse blended powder could be made in batches to last a week to fifteen days at a time, at the Anganwadi-level.

7.51. If the 3-5+ yrs age group is to receive food supplementation, then, the distribution of snack and finger-foods has several advantages. It considerably reduces the feeding time at the Anganwadi. If distributed as mid-break, and not just before the child departs for his home, there are more chances of the child demanding his full meal at home. Further, there are much greater chances that the mother will not cut-back on the child's main meal, if she believes that all that he got in school was a snack.

7.52. Food delivery systems which will effectively reach the inaccessible child and mother need to be urgently developed.

7.53. There should be a clear recognition that the 'below threes' especially the older infants, need a different type of food preparation from the rest. Preparations, such as, thick gruels, boiled mashed tubers, mashed banana, thick dals, etc., with a generous lacing of butter oil or oil are suitable. The deep fried snack foods described above could also serve as 'take-home' food supplements for the 'below-threes'. The only two points to be stressed and re-stressed are, the conversion of the snack-food to a pulpy mass in boiling water, tea or milk; and frequency of feeding.

7.54. Adequate arrangements need to be made to store the food commodities at the Project and Anganwadi levels. Check rodent and damp proof bins and containers need to be fabricated.

7.55. The planning, organizations, implementation, and the monitoring of supplementary nutrition programmes is not only very time-consuming and expensive, but calls for a good deal of classroom, as well as, on-the-job training, in the various aspects of food management. Much greater attention needs to be paid to this area in the training and re-orientation of all the rungs of the ICDS non-health project staff.

CHAPTER VIII

COMPONENT OF HEALTH

8.1. The ICDS Scheme envisages the delivery of basic health services, such as, health check-up, immunization, health education, and referral services to the vulnerable groups, as perhaps, the single most important component of the ICDS package. In fact, very little, if no impact in the nutritional status of the target population can be expected, unless a basic minimum of preventive and curative health services are simultaneously assured to the target population.

8.2. A series of steps have been outlined in the ICDS Scheme for the strengthening of the PHC infrastructure in the ICDS Projects. This has been strongly reinforced by several communications by the Department of Social Welfare to the States, where explicit guidelines have been given for the achievement of these ends. Instructions were also issued by the Ministry of Health and Family Welfare.

8.3. A list of important action-points connected with the delivery of health services in the ICDS are as follows :

1. Release of funds to the State. Health Departments for the health components of the ICDS.
2. Provision of MOs, LHVs, PHNs Sub-Centres, and medicines as per the approved pattern under the Minimum Needs Programme (MNP) and the Scheme of Integration of Health, Family Welfare, and Nutrition Services; and the provision of the complete strength of MOs, LHVs, and ANMs as per the ICDS pattern.
3. Upgradation of the PHC to a 30-bedded hospital under the MNP.
4. Re-distribution of the project area amongst the total number of ANMs (the existing ANMs, ANMs under the Scheme of Integration of Health, Family Welfare, and Nutrition Services, and ANMs from the ICDS budget).
5. Timely supply of sufficient quantities of medicines, vaccines, oral Vitamin-A doses, and iron and folic tablets to the PHC and Sub-Centres.
6. Supply of first aid material, vitamin-A doses, and iron and folic tablets to the Anganwadis.
7. Preparation and implementation of a detailed schedule for immunization of children and mothers, periodical health check-up, prophylaxis against nutritional anaemia, and vitamin-A deficiency.
8. Supply of necessary equipment and kits to the additional sub-centres in the project area.

9. Active involvement of identified medical colleges in the monitoring of health impact of ICDS projects.

8.4. As in the previous chapter, an analysis is made of how the various ICDS Projects fared with respect to:—

1. Their state of preparedness to meet the enhanced health demands of the ICDS Projects; and
2. Their preliminary attempts to deliver the vitally important component of health.

Timely Release of Funds to the State Health Departments

8.5. Very few Projects with the exception of Kambadur, Chawmanu, Kangan, Utnoor, Chhotbaudepur, Dharni, or Garhi could furnish any sort of financial statistics in their State budgets (1975-76) on allocation or expenditure for the PHC and/or medicines. The inference to be drawn is that scant attention had been paid to action point at para 8.3(1). The State Governments appear to have been very slow in releasing the necessary funds to the Projects via their State Health Departments. Centrally allocated funds for the ICDS, however, had been disbursed to the States by the DSW well in time.

Completion of Staff Requirements as Set-down in the ICDS Scheme

8.6. The States, by and large, were either very indifferent or slow in meeting the enhanced staffing requirements at the PHCs and Sub-Centres (Para 8.3(2)). The necessary adjustments had to be made from already existing health staff, and had the right priority being given by the States to these experimental Projects, the ICDS health staff could and should have been in-position even ahead of the ICDS non-health staff, the majority of whom had to be recruited from scratch. Apart from non-completion of health staffing requirements, relatively few of the health staff that were in position were sent for orientation in the ICDS. This was particularly glaring in the case of the ANMs where only 18 per cent had received orientation in the ICDS (Tables 5.2(a) and 5.3).

Upgradation of the PHC to a 30-Bedded Hospital Under the MNP

8.7. The majority of the Rural and Tribal Projects (15 out of 25) expressed inadequacy of beds for indoor-patients at the PHC. If the PHC is to function as the primary referral base for the outlying sub or ANM centres, this aspect needs immediate attention (Table 3.7).

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The returns indicated that the majority could furnish no information. The standard of coverage through sub-centres to be newly created appeared to have been on paper. The Project and Village informants confirm that even where enhanced ANMs were available, their appointments advanced to delivery of health inputs apart from advice, as most of them had no access to a minimum in the way of drugs, vaccines, etc.

Availability of Sufficient Quantities of Medicines/and Nutritive Supplements

Observations on the adequacy or inadequacy of stocks are based on (subjective) responses of the medical officer of the PHC. The most severe shortage was expressed with respect to BCG and vaccines, followed by DPT/DT. Most Project and Urban Projects had adequate stocks of smallpox vaccines. Urban Projects were generally better equipped to have adequate stocks of vaccines/medicines and so of nutritive supplements. Lack of health facilities was mentioned in 6 Projects (1, Man Bazar, Utnoor, Pooh, Subdega, etc. (Table 4.6).

First Aid Kits and Other Simple Drugs, Vaccines and Supplements to the Anganwadis

Of 28, 10 Projects reported shortages and 18 Projects reported 'nil' stocks of First Aid Kits. Information was available on extra medicines and nutritive supplements supplied (Table 4.5).

Availability of a Detailed Health Services Implementation Schedule

The absence of a time-and-events plan of health services was most noticeable with respect to the health services. This was noticed at all levels, i.e., PHC, Project and Anganwadi.

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Whether the old or new ANM Centres had the facilities to quote of the above. In fact, the new centres were existing only in name and many did not have a rented room to operate from.

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8.15. It is clear from Table 8.1, that except from a few exceptions, the delivery of the selected services to the child population (0.5+ yrs) has been extremely poor. The ICDS programme has the enormous task ahead of it of having to cover virtually a total target child population for practically every health service (apart from primary smallpox vaccination).

8.16. **Wellbaby Clinics:** Only 10 per cent of the target child population had ever benefitted from health-checks or having been weighed. As to be expected this service was utilized maximally in the Urban Projects (18%) followed by the Rural Projects (7%) and lastly by the Tribal (4%). The Projects which have done really well were Nurpur Bedi (63%), and Kambadur (41%).

8.17. **DPT Immunization:** The achievement against the target figures was 2 percent (All Projects), 3 percent (Rural), 2 percent (Tribal) and 2 percent (Urban). It is to be noted that Dhakuakhana is the only Project in the post ICDS period that has taken on a massive immunization drive (10%).

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8.11. The absence of a time-and-events plan of action was most noticeable with respect to the health component. This was noticed at all levels, i.e., Centre, State, Project and Anganwadi.

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8.12. Neither the old or new ANM Centres had the requisite quote of the above. In fact, the new centres were existing only in name and many did not even have a rented room to operate from.

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the country. Bombay has reported an utilization figure of 20 percent while Calcutta and Delhi have reported nil coverage. There is no information from Madras.

8.20. Primary Small-Pox Vaccination: Primary Small-Pox vaccination is perhaps the only health service that is utilized by the infant group (approximately 18 percent of the 0-5+ years age segment) maximally in any given year. The utilization figures were 18 percent in all the three categories of Projects. The other immunizations were yet to be accepted throughout the length and breadth of the country in the same way. A sample check of the Household Schedule indicate that protection of immunization through DPT, BCG, TAB, etc., was never heard of. For more needs to be done in the way of information dissemination campaigns, preceding mass inoculation drives. It is, however, both surprising and disturbing that the PHC complexes of Dhakuakhana, Singroli, Barajamda, Pooh, and Tokapal have reported nil coverage of Primary Small-pox vaccination during the reference period.

8.21. Distribution of Iron and Folic Acid Tablets: Nutritional anemia is widespread both among the child and adult populations in the country. Very little appears to have been done in this regard (except for Tokapal which has reported a high utilization figure of 58 percent). The All Projects figure stands at a mere 1 percent.

8.22. Oral Vitamin A Distribution: Prophylaxis against Vitamin A deficiency by the administration of a massive bi-annual oral dose of vitamin-A to all children (1-5+) is one of the national nutrition programmes in the country. The All-Projects coverage figure (11 percent) looks more encouraging than is probably the case, due to the reporting of very high figures in Kangan (247 percent achievement versus target), Chawmanu (180 percent), and Tokpal (86 percent). The Southern and Eastern States are traditionally the worst affected. It is a matter of serious concern that several Projects in this belt reported nil achievement. These are: Kambadur, Tarapur, Kathura, Nurpur Bedi, Jawan, Man Bazar, Barajamda, Chhotaudepur, Dharni, Garhi, Calcutta, and Delhi.

8.23. Supplementary Feeding Through the PHC Complex: None of the 29 ICDS Projects reported any sort of Supplementary feeding programme through the PHC or the sub-centres.

8.24. Referral: A total number of only 34 children was referred to the PHC or a higher medical institution in all the 29 Projects during the reference period. The channels of referral services are yet to be created.

8.25. Maternal Services—Pre-ICDS: The concept and methodology for evaluating the baseline level of utilization of selected maternal services through the PHC complex during the reference period (April

1975 to March 1976) was very similar to that described earlier for the utilisation of child health services. The services selected were, ante- and post-natal care, administration of tetanus toxoid, and the conduct of deliveries by the PHC staff for the pregnant women, the distribution of iron and folic acid tablets, and referral services for both pregnant and lactating women, and the number of IUCD insertions or tubectomies conducted on eligible women (15-44 yrs). The target population for pregnant women was calculated at 4 percent of the total population, that of pregnant and lactating women at 10 per cent of the total population, and that of eligible women (15-44 years) at 20 per cent of the total population. The percentage benefit or utilization was calculated in terms of actual number benefited versus the specific target population available (Table 8.2 upto para 8.31).

8.26. Ante/Post-Natal Care: The All-Projects figure of 118 percent is misleading and is contributed by a very high multiple utilization of this service by individual pregnant women in Nurpur Bedi (134%), Dharni (227%), and Bombay (323%). Projects which show 10 per cent or less utilization are: Kambadur (0%), Dhakuakhana (1%), Tarapur (5%), Singroli (7%), Ukhrul (1%), Thalli (4%), Shankargarh (5%), Barajamda (6%), Manbazar (8%), Pooh (3%), and Tokapal (2%).

8.27. Conduct of Deliveries: The statistics were: All-Projects (18%), Rural (11%), Tribal (6%) and Urban (37%). Projects where not even 10 percent of the available target population of pregnant women had been delivered by health staff were: Dhakuakhana (2%), Kangan (5%), Vengara (4%), Singroli (1%), Ukhrul (3%), Nurpur Bedi (0%) it needs reverification as to how the reported utilization of ante and post natal care from the PHC was reported at (134%), Thalli (0%), Manbazar (7%), Barajamda (6%), Chhotaudepur (6%), Pooh (5%), Dharni (7%), where again claimed utilization of ante and post natal services is reported to be as high as (227%). Subdega (9%), and Garhi (8%).

8.28. Administration of Tetanus Toxoid: The figures were: All Projects (5%), Rural (8%), Tribal (6%), and Urban (0%). Projects which showed absolutely no coverage for this service input were: Kambadur, Tarapur, Ukhrul, Chawmanu, Barajamda, and Pooh. Those Projects which had done relatively well, i.e., at least 20 per cent coverage, were: Vengara, Nurpur Bedi, and Nilakottai.

8.29. Distribution of Iron and Folic Acid Tablets: The picture looks far more encouraging than is actually the case as several Projects, such as, Kathura (368%), Kangan (168%), and Shankargarh (255%) appear to have listed the same beneficiary over and over again. This has resulted in giving an inflated All-Projects figure of 72 per cent coverage. Two Projects, i.e., Dharni and Garhi had given the information in terms of tablets distributed, and not for

individuals benefited, and the date had to be excluded. The corresponding figures were: Rural Projects (50%), Tribal Projects (21%), and Urban Projects (6%).

8.30. Referral Services: A total of 255 women were referral to the PHC or a higher medical institution, mostly (160) from the Urban Projects. Referral of women patients was surprisingly high in Barajamda.

8.31. Family Planning Services—IUCD and Tubectomies: The coverage figures were: All Projects (1%) Rural Projects (2%), Tribal Projects (0%), and Urban Projects (0%) of the eligible population, during the reference period.

8.32. Preliminary Attempts at the Delivery of Health Services through the Anganwadis in the ICDS Projects (Achievements vs. Targets): It is not surprising that the preliminary efforts at delivering the basic maternal and child health services in the ICDS, were extremely poor, in fact, almost all the Projects were yet to reach a reasonable state of preparedness to deliver the various elements of this component (Table 8.3 upto para 8.39).

8.33. Child Health Services Through the Anganwadis: Even 10-12 months after the inauguration of the ICDS Projects, the preliminary attempts to deliver the selected child health services was negligible.

8.34. Immunizations: A single dose of any immunization was counted as one child benefited. The achievement versus the target was: All Projects (5%), Rural Projects (7%), Tribal Projects (12%), and Urban Projects (0.1%). Only 383 villages (13.4% coverage) were taken up out of a target number of 2858 in 29 Projects. Only 26168 children (most of them older, pre-school children) out of an available target population of 4,99,437 children (0-5+) were administered even a single inoculation. Approximately 68 children were immunized in each village that was taken up, versus an average target population of 170-190 children. The 'below threes', again, the group with the least immunity were, by and large, by-passed. The Projects which stand out in their preliminary attempts to deliver this service were: Dhakuakhana (87%), Utnoor (58%), and Ukhrul (36%).

8.35. Health Checks: Here again the achievement as against the targets was deplorable, and the All-Projects figures stood at a mere 2 per cent. No health checks were conducted in the Tribal Projects. It was 3 percent in the Rural Projects and a scant 1 per cent in the Urban Projects. The late posting of PHC Doctors has definitely caused grave delays in the planning, organization, and delivery of this basic health input.

8.36. Referral: Only 8 children in 8 villages (out of all the villages in 29 Projects) were referred to a PHC or higher medical institution. All the 3 were

from Dalmau, where the strongly established India Population Project had already been in existence and had since been merged with the ICDS.

Maternal Health Services—Through the Anganwadis

8.37. Immunization of Pregnant Women with Tetanus Toxoid: A sum total of 756 pregnant women out of 61567 in 323 villages in 29 Projects, were administered a tetanus toxoid immunization. The figure were— All Projects (0.6%), Rural (0.4%), Tribal (2.5%), Urban (no information).

8.38. Health Checks: Only 1036 (0.3%) women out of a target population of 2,98,711 pregnant and lactating women, in 29 Projects were given health checks. Only 171 villages out of a target of 2,852 were taken up. On an average, only 6 women were benefitted per Anganwadi village, against an average target population of 100 pregnant women and lactating mothers.

8.39. Referral: Only 3 women, all of them from Dalmau were referred.

Summing-up

8.40. The greatest deficiencies were noted with respect to the planning, organization, and delivery of the health component, as compared with similar efforts made with respect to the delivery of the nutrition and education components.

8.41. The lacks and deficiencies with respect to the delivery of the health component were all-pervading and reflect a situation of a lack of full involvement on the part of the health agencies at every level, (Centre, State, District, and Block), to get the ICDS health component off to a start. Release of centrally sponsored funds as well as provisions to be made by the State Departments have been very slow. Completion of staffing requirements has again been slow and halting. An extremely small proportion of the ANMs have been oriented to the ICDS. The same picture is true, though to a lesser extent, of the PHC, MOs and LHVs. Most of the PHCs have not been equipped with enough beds for indoor-patients for referral services. The smaller operational areas have not been allocated among the greatly enhanced number of ANM staff. The logistical flow of vaccines and sera has been particularly faulty. The AWWs who are expected to play the role of health scouts have neither been given sufficient training by the PHC staff, nor have many of the Anganwadis been provided even with First-Aid Boxes or a stock of simple medicines.

8.42. It may be worthwhile to consider working out specific, Project by Project, priorities by working out differential sequencing of immunization schedules, depending on the local situation of severity and incidence of the childhood diseases. Apart from protection from small-pox and tetanus, which are universal needs for every new-born child, the priorities for immunization against diphtheria, whooping

cough, tuberculosis and polio could perhaps be sequenced against need. For example, polio vaccine may be a greater need in the port cities. BCG would be required on a priority basis in areas that have a high incidence of T.B. like Barajamda, or an anti-whooping cough vaccine may be the first immunization need in an area like Ukhrul, and so on.

8.43. It may also be worthwhile to explore the extent to which poly-vaccines and 'one-shot' vaccines which do not produce severe side-reactions in the child, could be produced. It is a well known feature that there is a very high drop-out-rate after the administration of the first dose of a two-stage or three-stage inoculation which results in very poor coverage of the target child population.

8.44. Attempts should be made to produce vaccines which are stable at room temperature.

8.45. An attack of measles becomes a grave health hazard in the case of the malnourished child. Since a very large segment of our children are moderately-to-severely-malnourished, measles becomes a dangerous childhood disease. Therefore, energetic attempts should be made to either produce or import a low-cost measles vaccines.

8.46. The present delivery level of MCH services through the existing PHC and its sub-centres, even after the recent advent of the ICDS, remains at an extremely low level. Urgent efforts are required to improve the delivery of the health component, so that the health or nutritional impact of the ICDS experimental programme, would start showing-up, within the shortest time, otherwise, the cost-effectiveness of the expending infrastructure may well soon be questioned.

CHAPTER IX

COMPONENT OF EDUCATION

9.1. Non-formal or pre-primary education for children (3-5+ years); and health and nutrition education for women (15-44 years), also form components of the ICDS package.

9.2. It is envisaged that children (3-5+) will receive the necessary social, mental and emotional development through the pre-primary educational component, which will help them adjust suitably to the discipline of the primary school. A great deal of emphasis has been given to organized activities and play through prayers, action songs, nursery rhymes, games, building blocks, toys, etc., and to creative development through acting drama, colouring, painting, drawing, pasting, clay modelling, etc.

9.3. The Health and Nutrition education component for women is to be delivered to women 15-44 years, with special emphasis to pregnant women and lactating mothers. Several methods of communication have been suggested in the Scheme such as, mass media, special campaigns, home visits by the AWWs, special short courses for the community women, cooking and feeding demonstrations, especially by the Mobile Food and Extension Unit of the Ministry of Food and Agriculture, and the Utilization of the health education materials brought out by the Ministry of Health, particularly those of the Central Health Education Bureau.

9.4. Relevant and practical guidelines on the content of Health and Nutrition Education have been circulated by the DSW (No. 12-2/76-CD, 15th March 1976) to all the Projects (Refer Annexure I).

9.5. The Health and Nutrition Education component has been dovetailed into functional literacy classes, wherever possible. Since the PEO is not evaluating Functional Literacy (which is a separate programme) it is possible that some information on health/nutrition education imparted through this channel, may not be available for PEO evaluation.

9.6. This Chapter deals with two specific aspects related to the delivery of the education component, namely:

1. The state of preparedness of the ICDS projects as viewed by the availability of infrastructure, trained staff, and the availability of important materials/equipment; and
2. The preliminary achievements in the delivery of the service.

State of Preparedness with Respect to the Delivery of the Education Component

9.7. As discussed in Chapters III and V, almost all the ICDS Projects were well prepared to deliver the pre-primary education component with respect to infrastructure. However, in Chapter IV (to be read with village level notes), shortages of play items and relevant teaching aids, charts, posters, etc., for the Health/Nutrition education input have been observed.

9.8. The quality of training given to the AWWs, with respect to the delivery of Health Education to the women was found to be extremely deficient in terms of relevance, content, media or communications techniques. The simple manual prepared by UNICEF on the subject had not reached many training institutions in time.

9.9. The picture, however, was quite different with respect to the training given to the AWWs for the delivery of the pre-primary education component. Most of the training institutions, such as, the Bal-sevika Training Institutes or Gram Sevika Training Centres, especially the former, have traditionally trained functionaries of pre-primary education. Consequently, quite an exhaustive grounding was given in non-formal or pre-primary education to the AWWs. The AWWs likewise appeared to feel most comfortable and confident in the delivery of this input, which did not call for the level of knowledge or skills required in the delivery of Health/Nutrition education, supplementary feeding, or health services.

Preliminary Attempts in the Delivery of the Education Component

9.10. The ICDS Scheme has set a norm of enrolment of at least 40 children (3-5+) per *Anganwadi*. In a population of 1,000, which is generally an *Anganwadi* population, one could expect double the number of children in this age-group. Projects which achieved at least 75 per cent of the norm set down by the Scheme were, Kambadur, Kangan, Ukh-rul, Man Bazar, and Subdega (Table 9.1).

9.11. There was no consolidation of information on the delivery of Health/Nutrition education to women at the Project level. Home visits by the AWWs were few and far between, as most of their time was taken up with attending to the needs of the pre-schoolers in the *Anganwadi*. When home visits were made, it was mostly to urge mothers to send absentee pre-schoolers to the *Anganwadi*. Information collected at the *Anganwadi* level suggests that the topics of education (when given) were scarcely of prime importance (covering general topics

on environmental sanitation or personal hygiene, such as construction of garbage pits, removal of garbage, bathing a baby, etc.), when compared to the urgency and specificity of messages outlined in the guidelines presented in Annexure I. Feed back from the household level and the high levels of 'non-awareness' reported for the various service inputs, reveals that ICDS staff spent very little time in explaining the service inputs and their potential benefits to the beneficiary families. Irrelevant health/nutrition education and negligible to nil efforts at information-dissemination on the specifics of the ICDS programme, dominate the scheme.

Summing-up

9.12. The ICDS experimental programme was perhaps the best prepared to deliver the pre-primary education component, rather than any of the other components making up the package.

9.13. To ensure simple and precise information on the various service inputs of the ICDS, there appears to be lot of scope for developing information dissemination system.

9.14. Great deficiencies were noted in the quantum, content, and communication of health/nutrition education to the women. Training institutions

themselves need to be oriented to health and nutrition problems of the ICDS areas. Guidelines as issued by the DSW should be strictly followed by trainers and trainees.

9.15. A serious view needs to be taken of the disproportionate amount of time given to possibly, this least important component of the ICDS—pre-primary education for just one thin segment of the target population—the 3 to 5+ age group. One needs to have hard data on what real emotional, social, and educational benefits would accrue to these *Anganwadi* pre-schoolers, if and when, they enter primary school? A decision needs to be taken as to whether this service should be given higher priority than the other tasks of the delivery of health and nutrition services, as seems to be the case, at the present.

9.16. A view also needs to be taken on whether a child (3-5+) needs to be in an *Anganwadi* for half the day, or whether the duration of his stay can be considerably reduced, thereby allowing the AWW to attend to her more important tasks, such as, identifying sick children, identifying and following-up cases of severe malnutrition, dispensing simple first aid or medication for common ailments, conducting more meaningful health and nutrition education classes for the women, and organizing the supplementary feeding programme in a much more competent manner.

CHAPTER X

PERFORMANCE INDICATORS

Objective

10.1. The purpose of this exercise was to develop a set of indicators which could serve as a fairly objective tool to score and evaluate the 29 experimental ICDS Projects with respect to two programme aspects, namely;

1. Their state of preparedness; and
2. Their preliminary attempts to implement the programme.

Methodology

10.2 The data base for this exercise has been provided by the statistical tables pertaining to Chapters II to IX of this Report. Two broad sets of indicators, hereafter named the 'Preparedness Indicators' and the 'Implementation Indicators' were developed. The 'Preparedness Indicators' which comprised 13, were further sub-divided into a set of 6 'Critical Preparedness Indicators' and a set of 7 'Less-Critical Preparedness Indicators'. A set of 3 'Preliminary Implementation Indicators' were also developed to assess the efforts to implement the health, the nutrition, and the education components of the ICDS package. At the current stage of evaluation the greatest emphasis has been placed on the 'Critical Preparedness Indicators'. The 'Non-Critical Preparedness Indicators', though important, have been put into a separate category as, either, information was not available on an uniform basis from all the projects, and/or they were basically considered to be less crucial for the initial start-up of an effective programme. The 'Implementation Indicators', it is hoped, will help in 'milestoning' the progress of individual Projects from the time of the Baseline Survey (June-September, 1976) to the time of the Recheck Survey (Scheduled for September/October, 1977).

Selection of Critical Preparedness Indicators

10.3. These were as follows:—

1. Identification of the target population in terms of size and composition. This indicator was considered of prime importance as it has a direct bearing on all aspects of programme management, namely, planning, implementation, and evaluation.
2. Percentage of sanctioned non-health and health staff that were in position. This was considered to be a basic indicator of infra-structural preparedness.

3. Percentage of health and non-health staff who had received the necessary training or orientation in the ICDS. This again was considered to be a basic but qualitative indicator of infra-structural preparedness.
4. The actual Vs. the planned setting up of *Anganwadi* again a basic indicator of infra-structural preparedness.
5. Availability and adequacy of sera, vaccines, and other non-food nutritive supplements. Since the improvement in the health status (which includes nutritional status) of the target population is considered the paramount goal of the ICDS, the smooth flow or otherwise of the above, was considered to be a critical indicator of the state of preparedness with respect to the delivery of health services.
6. Availability and adequacy of medicines in relation to budgetary norms. This indicator was considered to be critical, for the same reasons stated above at (5).

Selection of Less Critical Preparedness Indicators

10.4. These were as follows:

1. Extent of ANM health staff needs met by a combination of pre-existing and the newly-posted staff: This would be reflected to a large extent in item (2) of the Critical Indicators.
2. Percentage expenditure to allocation in 1975-76. Indicator relating to the release and flow of funds.
3. Outlay of State funds for the ICDS Supplementary nutrition component in 1975-76, and its adequacy in relation to the estimated annual budgetary provision. Indicator relating to the release and flow of funds.
4. Availability of selected capital inputs at the Project level, i.e., the jeep, refrigerator, weighing machines, and typewriters. Indicator relating to the sequencing and flow of capital inputs.
5. Availability of selected usable items. Indicator selected for the same reason stated at (4).
6. Adequacy or otherwise of office, storage, and residential quarters for the CDPO and PHC staff. Indicator relating to provision of adequate physical facilities for the programme.
7. Constitution of Coordination Committees. Indicator relating to the Projects' attempts at the coordination and mobilization of community support.

Selection of Preliminary Implementation Indicators

10.5. These were as follows:

1. Actual Vs. the planned delivery of the nutrition component.
2. Actual Vs. the planned delivery of the health component.
3. Actual Vs. the planned delivery of the education component.

Criteria Developed to Score the Critical Preparedness Indicators

10.6. Accurate Identification of the Target Population: In the case of identification of the target groups, a maximum score of 2 points was assigned for this indicator. Only a few Projects were accorded the maximum score, as evidenced by target break-up figures which were more or less in conformity with the demographic norms set down, i.e., 3, 6 and 8 percent for infants (0-1 yr), toddlers (1-3 yrs) and pre-schoolers (3-5+ yrs), respectively, for the total Project area. Those Projects that obtained a fairly correct figure for the total child population (17.19% or so) but failed to give a detailed break-up, obtained 1 point. Those who gave very incorrect demographic percentages scored 0. It may be worthwhile to mention that a supplementary proforma was despatched to all the CDPOs in late September 1976, as the earlier Project Schedule revealed very little information regarding this vitally important basic item.

10.7. Percentage of Sanctioned Health and Non-health Staff in-position. The non-health functionaries considered were the CDPO, the supervisors and the ANMS. The health functionaries considered were the PHC-MOs, the LHVs, and the ANMs.

	<i>Score</i>
Over 75% of the sanctioned staff in position	2
50—75% of the staff in-position	1
Less than 50% of the staff in-position	0

A sub-score was obtained for each functionary. The sub-scores were totalled and were divided by 6 (6 type of functionaries) to give the final score.

10.8. Percentage of Trained Health and Non-health Staff in Position: The non-health functionaries considered were again the CDPO, the Supervisors and the AWWs. The health functionaries were the PHC-MOs, the LHVs, and the ANMs.

	<i>Score</i>
Over 75% of the sanctioned staff (in-position) who were trained	2
50%—75% of the sanctioned staff (in-position) who were trained	1
Less than 50% of the sanctioned staff (in-position) who were trained	0

As above, a sub-score was obtained for each type of functionary. The sub-scores were then totalled and divided by 6 (6 types of functionaries) to obtain the final score.

10.9. Actual Vs. Planned Setting up of Anganwadis: The targeted number of Anganwadis required by each Project was taken from the DSWs monthly report. The actual number of Anganwadis available at the time of the Baseline Enquiry was taken as achievement.

	<i>Score</i>
Over 75% of the planned number of Anganwadis available	2
50—75% of the planned number of Anganwadis available	1
Less than 50% of the planned number of Anganwadis available	0

10.10. Availability and adequacy of Sera, Vaccines, and Non-food Nutritive Supplement. The vaccines and sera considered were for the small pox, DPT/DT, BCG, TAB, and nutritive supplements as the Iron and Folic acid and oral Vitamin-A.

	<i>Score</i>
If the vaccine, sera, and nutritive supplement was found to be adequate	2
If the vaccine, sera and nutritive supplement was found to be inadequate	1
If the vaccine sera, and nutritive supplement were not available at all	0

Each sera, vaccine and nutritive supplement was scored separately. The sub-scores were totalled and divided by six (6 elements) to obtain the final score.

10.11. Availability and Adequacy of Medicines in Relation to the Budgetary Norms: Budgetary norms have been indicated by the DSW on the basis of the minimum needs pattern and the enhanced provisions for medicines in the ICDS Schemes (Table 4.7). The financial provisions vary from Project to Project depending on the population of the ICDS area.

	<i>Score</i>
Over 75% financial provision for medicines Vs. the suggested norm	2
50%—75% of financial provision for medicines Vs. the suggested norm	1
Less than 50% financial provision for medicines Vs. the suggested norm	0

7. Assessment of the field staff on the basis of interviews sub-scores were calculated for each of the 5 selected items. The scores were totalled, and the figure was divided by 5 for obtaining the final score.

Criteria Developed to Score the Less-Critical Preparedness Indicators

10.12. Extent to which ANM Health Staff Norms have been met by a Combination of Existing and Strengthened Staff: The adequacy of ANM staffing is of paramount importance as these functionaries are the first and most important contact with the community. As per the ICDS Scheme, one ANM is required for 5,000 population, hence, the norm varies from project to project, depending on the population of the ICDS area.

	Score
Over 75% of the norm met	2
50%—75% of the norm met	1
Less than 50% of the norm met	0

10.13. Availability of Selected Capital Inputs: The capital inputs selected for scoring were the jeep, cycles, refrigerator, and typewriter.

	Score
Adequacy of the item	2
Inadequacy of the item	1
Nil or not available	0

10.14. Availability of Selected Usable Items: The *Anganwadi* items considered were First Aid Boxes, vessels for drinking water, files, records/registers, health cards, kitchen equipment, bathroom equipment, building blocks, counting frames, paints/brushes.

	Score
Adequacy of the item	2
Inadequacy of the item	1
Nil or information not available	0

As in the previous cases, the 9 elements were individually given sub-scores the final score was obtained by totalling and dividing the same by nine.

10.15. Percentage Expenditure to Allocation in 1975-76: A majority of States (17) could give no indication of what their allocation or expenditure was in relation to the ICDS projects. The criteria for scoring was as below:

	Score
Over 75% expenditure against allocation	2
50%—75% expenditure against allocation	1
Less than 50% expenditure of the allocation or non-availability of information	0

10.16. Provision of Funds in the State Budgets, as per Prescribed Norms, for the ICDS Supplementary Nutrition Component: Here again, the majority of Projects (18) could furnish no information. Since the projects were officially inaugurated in October 1975, there were only 6 months to be considered in

the financial year of 1975-76. Hence, in scoring the performance of Projects, only half the value of the norm was considered.

	Score
Over 75% provision of 1/2 the annual norm	2
50%—75% provision of 1/2 the annual norm	1
Less than 50% provision of 1/2 the annual norm or non-availability of information	0

10.17. Adequacy or otherwise of Office, Storage Space and Residential Quarters for the CDPO and PHC staff; and the Availability of Basic Amenities at the PHC: A number of elements were considered in the scoring of this indicator. For example, the adequacy or otherwise of office, storage space, and residential quarters of the CDPO were considered as a set of elements and the criteria applied were as under:

	Score
Adequacy of office space	2
Inadequacy of office space	1
Nil or no information	0

This was assigned a sub-score A1 similar sub-scores were developed for the adequacy or otherwise of storage space (sub-score A2); and for the residential quarters (A3). The sub-scores $\frac{(A_1+A_2+A_3)}{3} = X$

was assigned as the final sub-score for the category of the CDPO.

A similar exercise $\frac{(B_1+B_2+B_3)}{3} = Y$ was carried but to assess the adequacy of clinic, storage, and residential quarters for the PHC Staff.

The criteria applied to the scoring of the 4 physical facilities, i.e., electricity, water supply, sanitary facility and beds for in-door patients was the same as above, and sub-scores of C₁, C₂, C₃, and C₄ were given. The overall sub-score for basic amenities was calculated as $\frac{C_1+C_2+C_3+C_4}{4} = Z$.

The final score for the indicator was calculated as follow:

$$\frac{X+Y+Z}{3} = Q \text{ (Table 10.1)}$$

10.18. Constitution and Composition of Coordination Committees: The criteria applied for giving a value to the constitution of the Committees was as under:

	Score
Coordination committee formed in 1975	2
Coordination committee formed in 1976	1 (A)
Not formed	0

10.19. The criteria applied to score the composition of the committees was as follows:

	<i>Score</i>
Composition with two thirds official and one-third non-official	2
Composition with equal number of official and non-officials	1(B)
Composition with more officials (more than two thirds) and less non-official	0

10.20. The final score was arrived at by dividing the two sub-scores by 2, i.e., $\frac{A+B}{2} = X$

Criteria Developed to Score the Preliminary Implementation Indicators

10.21. **Nutrition Inputs:** The three child segments of infants (0-1 yr), toddlers (1-3 yrs) and pre-schoolers (3-5+ yrs) were considered. The same criteria were applied, irrespective of the Project being Rural, Tribal and Urban. It may be recalled that the planned coverage in Tribal areas was expected to be as high as 75% of the total available target population.

	<i>Score</i>
40% or more coverage of infants	2
20%—39% coverage of infants	1
Less than 20% coverage of infants	0

Sub-scores were developed for each segment and the final score was calculated by totalling the 3 sub-scores and dividing by 3.

10.22. **Education Inputs:** Only the child segment of 3-5+ yrs which was eligible for pre-primary or non-formal education was considered. The criteria for scoring coverage of children for the input was as follows:

	<i>Score</i>
Coverage or enrolment of more than 37.5% of children (3-5+ Years) for pre-primary education	2
25% to 37.5% coverage	1
Less than 25% coverage	0

10.23. In the preliminary stages, the enrolment of 40 children per Anganwadi was considered to be the norm. This figure constitutes approximately 50 percent of the target population in the 3-5+ years age-group. Consequently a coverage of 37.5 percent (which is 75% of 50%) would qualify for the maximum score of 2.

10.24. **Health Inputs:** Four elements of health delivery were considered i.e., health checks for children (0-5+ years); immunization of children; and health checks of pregnant and lactating woman; and tetanus toxoid immunizations for pregnant women. The criteria applied were as follows:

	<i>Score</i>
Over 75% percent of all children (0-5+ yrs) covered by health checks	2
50—75 per cent children (0-5+ yrs) covered by health checks	1
Less than 50 percent children (0-5+ yrs)	0

Sub-scores were developed for each of the 4 elements considered. As before, the final score was obtained by dividing it by 4.

Ranking of Projects

Ranking of Projects by Critical Preparedness Indicators:

10.25. In view of the scores obtained (out of a maximum score of 12), the Projects can be ranked as under:

A	B	C
Kathura (11.0)	Dalmau (8.2)	Nilakottai (6.7)
Garhi (10.2)	T. Narasipur (8.2)	Tarapur (6.2)
Chhotaudepur (9.9)	Tokapal (8.2)	Uklrul (6.2)
Nurpur Bedi (9.5)	Vengara (8.2)	Dharni (5.7)
	Kangan (7.8)	Jawan (5.7)
	Pooh (7.8)	Shankargarh (5.7)
	Subdega (7.5)	Thalli (5.3)
	Kambadur (7.4)	Barajamda (5.2)
	Dhakuakhana (7.0)	Chawmanu (5.1)
		Madras (4.5)
		Man Bazar (4.5)
		Utnoor (4.2)
		Singroli (4.1)
		Delhi (4.0)
		Calcutta (3.7)
		Bombay (3.5)

Ranking of Projects by Critical and Less Critical Indicators

10.26. In view of the scores obtained (out of a maximum score of 26), the Projects can be ranked as under :

A	B	C
None	Kathura (18.9) Chhotaudepur (17.4) Dhakuakhana (16.5) Garhi (16.3) Tokapal (16.1) Dalmau (15.4) Kambadur (15.2) Vengara (14.5) Nurpur Bedi (14.4) Pooh (14.4) Kangan (14.0) Shankargarh (14.0) Jawan (13.6) Subdega (13.6) T. Narasipur (13.0) Ukhrul (13.0) Tarapur (12.7)	Nilakottai (11.3) Dhami (11.1) Singroli (11.0) Uttoor (10.7) Calcutta (10.5) Barajamda (9.7) Manbazar (9.7) Chawmanu (9.3) Thalli (8.2) Madras (8.0) Delhi (7.6) Bombay (6.3)

10.27. For details on the individual scores obtained by the various Projects with respect to their state of preparedness or with respect to their preliminary efforts to execute the programme, Tables 10.2 and 10.3 may be referred.

Findings on the State of Preparedness

10.28. In brief, the findings on the state of preparedness are as follows :

1. Whether assessed by the set of 6 critical preparedness indicators or the overall set of 13 critical and less-critical indicators, the top scorers were Kathura, Garhi, Chhattaudepur, and Nurpur Bedi.
2. The four Urban Projects and the three Tamil Nadu Projects have fared badly by either tally. So have Dhami (Maharashtra), Singroli (M.P.), Barajamda (Bihar), Man Bazar (West Bengal), and Chawmanu (Tripura).
3. If one considers the critical preparedness indicators as being a more sensitive set to reflect the performance of Projects in the early stages of initiation of the programme, than all 12 Projects listed in category 'C' will have to make very real efforts to even come up to average performance.
4. The four projects listed in category, 'A' and perhaps even some of those listed in category

'B' (Dalmau, T. Narasipur, Kambadur, Tokapal and Vengara) have done very well in being adequately prepared to take on the ICDS. However, a closer examination of the state of preparedness in conjunction with initial attempts at implementation (Table 10.3) suggests that it is only 3 Projects that could qualify as satisfactory models, i.e. Nurpur Bedi, Chhotaudepur, and Vengara.

5. Further, a thorough study may be made of Chhattaudepur, Nurpur Bedi and Vengara by the DSW to examine the reasons for their superior performance over the other Projects. Lessons learnt in this exercise could serve as specific action-points to be taken up by the other Projects. Such Projects could also serve as useful training grounds for existing and future ICDS functionaries.

Suggestions for an Alternative Model to the ICDS

10.29. Experience so far suggests that the ICDS strategy may be too ambitious for all the areas so far taken up under the 33 rural projects which have been initiated. As such, perhaps a step-by-step gradual build-up of the components of the strategy may have to be considered, depending on the stage of development of the strategy of any operation. From this points of view, if the primacy of the different components of the ICDS, is kept in view, the build-up would be as follows:

8 Though Dhakuakhana, Tokapal, Dalmau Kambadur and Vengara have obtained higher total scores, Nurpur Bedi is included among the top scorers on account of its better performance under the critical-preparedness indicators.

States of Build-up

- I. Protected drinking water (PD).
- II. PD + Therapeutic nutrition to the severely malnourished children, in age-group 0-5+ years (TN).
- III. PD + delivery of health inputs to support health needs of a local population or at least the target population (HN).

IV. PD + TN + HN.

V. PD + HN + TN + a very thin slice of pre-primary education (PPE).

VI. ICDS, i.e., PD + HN + TN + thick PPE.

10.30. Only 5 out of 29 Projects may be said to have reached somewhere near the stage VI, most of the remaining have thicker PPE + thin TN + thin HN.

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TABLE 2.1

Percentage Target Population to total Population in the Project Area

Project	Total Population	Child Population (%)			Women Population (Pregnant/Lactating) (%)	
		0—1	1—3	3—5+	Pregnant	Lactating
1	2	3	4	5	6	7
<i>I. Rural</i>						
1. Kambadur	87,715	1.2	2.4	3.2	1.2	1.5
2. Dhakuakhana	72,028	..	..	5.7	..	..
3. Tarapur	83,811	0.5	2.7	3.5	0.6	1.4
4. Kathura	87,200	3.2	5.8	7.5	3.2	4.4
5. T. Narasipur	182,340	0.7	4.6	5.9	1.0	1.1
6. Kangan	35,684	..	5.3	7.4	0.9	3.5
7. Vengara	121,956	4.0	..	3.4	0.4	0.4
8. Singroli	139,371	1.2	2.4	3.2	..	2.8
9. Ukhrul	34,555	..	12.4	33.9	5.2	7.7
10. Nurpur Bedi	57,021	3.0	6.0	8.0	4.0	6.0
11. Thalli	113,345	..	1.1	1.5	0.5	0.5
12. Nilakottai	102,247	3.0	6.0	8.0	4.0	6.0
13. Chawmanu	49,763	2.0	2.2	3.7	..	3.6
14. Shankargarh	82,360	9.7	10.9	9.7	3.6	4.9
15. Dalmau	88,454	..	4.7	..	0.6	1.1
16. Jawan	112,097	NA	NA	NA	NA	NA
17. Man Bazar	91,356	..	14.7	..	8.8	1.1
	1,541,303	2.1	3.3	6.1	1.5	2.0
<i>II. Tribal</i>						
18. Utnoor	93,823	3.8	5.3	4.6	0.5	1.1
19. Barajamda	67,938	2.2	4.2	5.7	1.4	2.7
20. Chhotaudepur	60,362	3.4	7.2	6.8	1.3	0.5
21. Pooh	16,413	3.0	6.0	8.0	4.0	6.0
22. Tokapal	43,922	..	..	16.0	..	2.5
23. Dharni	64,682	3.0	6.0	8.0	..	7.0
24. Subdega	38,718	1.7	2.3	14.1	1.2	1.4
25. Garhi	115,930	3.0	6.0	8.0	3.0	4.0
	501,788	2.7	5.0	8.1	1.4	3.0
<i>III. Urban</i>						
26. Bombay	608,168	1.2	..	0.9	0.5	0.7
27. Madras	100,000	..	4.0	..	..	..
28. Calcutta	238,026	1.9	3.8	5.0	2.2	2.2
29. Delhi	123,270	NA	NA	NA	NA	NA
	1,069,464	0.5	1.7	2.3	0.8	1.0
All Projects	3,112,555	1.6	3.0	5.2	1.3	1.9

NOTE :—The demographic breakup of the target population should approximate 3%, 6%, 8%, 4%, and 6% respectively for infants (0—1 Yr), toddlers (1—3 Yrs) Pre-schoolers(3—5+yrs), Pregnant Women (4%) and Lactating mothers (6%).

TABLE 2.2
Topography and Terrain

Projects (N=27)	Hilly Forested	Plains	Total
1. Rural	8 (50.0)	8 (50.00)	16 (100.0)
2. Tribal	5 (71.4)	2 (28.6)	7 (100.0)
3. Urban . . . . .	..	4 (100.0)	4 (100.0)
All Projects	13 (48.1)	14 (51.9)	27 (100.0)

Percentages in parentheses.

NOTE : Information for Jawan (rural) and Utnoor (tribal) not available.

TABLE 2.3
Topography and Accessibility

Project	Accessibility all the year round	Inaccessible		Total
		Major part of the year (Mon- soon/Land slides/Snow)	For a few months	
1. Rural	4 (26.7)	3 (20.0)	8 (53.3)	15 (100.0)
2. Tribal	1 (12.5)	3 (37.5)	4 (50.0)	8 (100.0)
3. Urban	2 (50.0)	..	2 (50.0)	4 (100.0)
All Projects	7 (26.2)	6 (22.2)	14 (51.8)	27 (100.0)

Percentages in parentheses

NOTE: Information for Jawan (rural) and Utnoor (tribal) not available.

TABLE 2.4

Area, Population, Density, and Distance from the Distt. Headquarters

Sl. No.	Project/Inception	Area in Sq. Kms.	Popula- tion	Density per sq. km.	Distance (km.) of the Project from		
					Distt. Hqrs.	Sub-Divi- sional Hqrs.	Taluka Hqrs.
1	2	3	4	5	6	7	8
<i>I. Rural</i>							
1.	Kambadur 2-10-75	1,250	87,715	702	90	75	32
2.	Dhakuakhana 6-10-75	510	72,028	141	80	40	16
3.	Tarapur 15-11-75	131	83,811	644	50	50	00
4.	Kathura 2-10-75	347	87,200	251	51	16	16
5.	T. Narasipur 16-2-76	595	182,340	307	32	32	00
6.	Kangan 26-10-75	93	35,684	381	40	00	21
7.	Vengara 2-10-75	136	121,956	897	20	35	23
8.	Singroli 2-10-75	1904	139,371	73	108	00	00
9.	Ukhrul 2-10-75	1,235	34,555	28	1	1	1
10.	Nurpur Bedi 2-10-75	341	57,021	167	30	18	18
11.	Thalli 8-1-76	1,186	113,345	97	136	27	16
12.	Nilakottai 7-6-76	225	102,247	454	51	35	00
13.	Chawmanu 2-10-75	608	49,763	82	67	67	00
14.	Shankargarh 2-10-75	577	82,360	148	48	79	79
15.	Dalmau 2-10-75	256	88,454	344	29	1	1
16.	Jawan 2-10-75	385	112,097	290	16	16	16
17.	Man Bazar 2-10-75	371	91,356	241	54	54	00
	Total (Rural)	10,150	1,541,303	5,247	903	546	239
	Average	597.0	665.0	308	53	32.0	14
<i>II. Tribal</i>							
18.	Utnoor 12-12-75	726	93,823	50	54	54	00
19.	Barajamda 2-10-75	421	67,938	161	44	44	00
20.	Chhotaudepur 15-10-75	298	60,362	203	105	00	00
21.	Pooh Oct. 75	46	16,413	N.A.	75	00	00
22.	Tokapal 2-10-75	343	43,922	128	22	22	22
23.	Dharni 1-11-75	1,813	64,682	36	143	00	00
24.	Subdega 8-12-75	325	38,718	119	29	29	29
25.	Garhi 2-10-75	708	115,930	164	40	40	00
	Total (Tribal)	4,680	501,788		512	189	51
	Average	585.0	62,724	123	64.0	23.6	6.4
<i>III. Urban</i>							
26.	Bombay 21-1-76	153	608,168	3,986	N.R.	N.R.	N.R.
27.	Madras Oct. 75	N.A.	100,000 (Approx)	N.A.	N.R.	N.R.	N.R.
28.	Calcutta 19-11-75	13	238,026	18,268	N.R.	N.R.	N.R.
29.	Delhi 2-10-75	N.A.	123,270	N.A.	N.R.	N.R.	N.R.
	Total (Urban)	166	10,69,464				
	Average	83.0	267,366	..	..	..	..
	All Projects	14,996 (555.4)	31,12,555 (107,330)	207	1,415 (56.6)	735 (29.4)	290 (11.6)
	No. of projects reporting	27	29	27	25	25	25

TABLE 3.1

ICDS Health Infrastructure in the Project Areas

Project	Hospitals	Dispensaries	P.H.C. Centres	L.H.V. H. Qrs.	ANM Centre	Requirement on the basis of 5000 population
1	2	3	4	5	6	7
<i>I. Rural</i>						
1. Kambadur	0	5	1	4	17	18
2. Dhakuakhana	0	1	1	2	5	14
3. Tarapur	0	2	1	1	16	16
4. Kathura	0	0	1	2	12	18
5. T. Narasipur	0	3	2	6	20	36
6. Kangan	0	8	1	2	5	7
7. Vengara	3	6	1	5	20	24
8. Singroli	0	5	1	1	15	28
9. Ukhrul	1	6	1	1	22	8
10. Nurpur Bedi	0	9	1	3	16	12
11. Thalli	5	1	1	0	10	22
12. Nilakottai	1	0	1	1	NA	20
13. Chawmanu	0	4	2	2	NA	10
14. Shankargarh	33	8	1	0	3	16
15. Dalmau	1	4	1	7	21	18
16. Jawan	0	2	1	3	16	22
17. Man Bazar	0	0	1	1	2	18
Total (Rural)	14	64	19	41	193	307
Average	0.8	3.8	1.1	2.4	10.0	18.0
<i>II. Tribal</i>						
18. Utnoor	2	1	1	4	16	19
19. Barajamda	3	1	1	2	3	14
20. Chhotaudepur	1	1	1	0	15	12
21. Pooh	1	16	1	0	1	4
22. Tokapal	0	0	1	4	12	9
23. Dharui	0	0	1	1	8	13
24. Subdega	0	1	1	1	3	8
25. Garhi	0	21	1	1	223	24
Total (Tribal)	7	41	8	13	81	103
Average	0.9	5.1	1.0	1.6	10.1	12.0
<i>III. Urban</i>						
26. Bombay	1	18	NR	0	6*	..
27. Madras	7	16	4	0	5*	..
28. Calcutta	6	13	NR	NA	NA	..
29. Delhi	1	1	NR	4	3	..
Total (Urban)	15	48	4	4	14	..
Average	3.7	12.0	4.0	1.3	4.6	..
All Projects	36	153	31	58	265	410
Average	1.2	5.3	1.2	2.0	9.4	16.4
No. of Projects Reporting	29	29	26	28	28	25

*Maternity Centres.

TABLE 2.4
TABLE 2.4

Coverage of ANM and Anganwadi Centres by Village and Population

Project	Anganwadi Coverage by		PHC Coverage by population	ANM Centre coverage by	
	Village	Population		Village	Population
1	2	3	4	5	6
<i>I. Rural</i>					
1. Kambadur	1:0.88	1:1740	1:87715	1:2.6	1:5160
2. Dhakuakhana	1:1.67	1:720	1:72028	NA	NA
3. Tarapur	1:1.84	1:1035	1:83811	1:9.3	1:5238
4. Kathura	1:0.30	1:872	1:87200	1:2.5	1:7267
5. T. Narasipur	1:1.25	1:1861	1:91172	1:6.1	1:9117
6. Kangan	1:0.89	1:700	1:35684	1:8.4	1:7137
7. Vengara	1:0.7	1:1220	1:121958	1:0.5	1:9381
8. Singroli	1:2.84	1:1467	1:139371	1:15.8	1:8198
9. Ukhrul	1:0.84	1:461	1:34555	1:31.5	1:17278
10. Nurpur Bedi	1:1.84	1:950	1:57021	1:6.9	1:3564
11. Thalli	1:1.25	1:2636	1:113345	1:6.0	1:12594
12. Nilakottai	1:0.59	1:2086	1:102247	1:14.5	1:51123
13. Chawmanu	1:4.76	1:995	1:24882	1:59.5	1:12440
14. Shankargarh	1:5.08	1:1716	1:82360	1:81.3	1:27453
15. Dalmau	1:1.24	1:884	1:88454	1:4.1	1:2948
16. Jawan	1:1.41	1:862	1:112097	1:9.8	1:9341
17. Man Bazar	1:5.70	1:2125	1:91356	1:12.20	1:45678
Total (Rural)	32.45	22330	1425256	377.8	233917
Average	1:1.90	1:1313	1:83838	1:22.2	1:13759
<i>II. Tribal</i>					
18. Utnoor	1:1.69	1:938	1:932823	1:10.6	1:5864
19. Barajamda	1:1.40	1:1359	1:67938	1:23.3	1:22646
20. Chhotaudipur	1:0.92	1:958	1:60362	1:4.4	1:4643
21. Pooh	1:0.64	1:328	1:16413	1:32.0	1:16413
22. Tokapal	1:1.46	1:9150	1:43922	1:8.8	1:5490
23. Dharni	1:0.30	1:1437	1:64682	1:20.9	1:9240
24. Subdega	1:1.00	1:691	1:38718	1:18.7	1:12906
25. Garhi	1:1.39	1:966	1:115930	1:7.3	1:5040
Total (Tribal)	8.80	15827	501788	126.0	82242
Average	1:1.10	1:1978	1:62723	1:15.7	1:10280
<i>III. Urban</i>					
26. Bombay	NR	1:23391	NR	1:5.33	1:101361
27. Madras	NR	1:1000	1:25000	1:5.4	1:20000
28. Calcutta	NR	1:5410	NA	NR	..
29. Delhi	NR	NA	NA	NR	NA
Total (Urban)		29801	25000	10.7	121361
Average		1:9933	1:25000	1:5.3	1:60680
All Projects	42.75	67958	1952044	514.5	437520
Average	1:1.58	1:2427	1:75078	1:19.0	1:16204

TABLE 3.3
Pre and Post ICDS Infrastructure for Supplementary Feeding

Project	Anganwadis		Balwadi with S.N.P.		Schools with A.N.P.		Others	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	2	3	4	5	6	7	8	9
<i>I. Rural</i>								
1. Kambadur .	0	50	0	0	42	42	0	0
2. Dhakuakhana .	0	100	3	3	6	6	0	0
3. Tarapur .	0	81	0	0	0	0	0	0
4. Kathura .	0	100	2	2	3	3	0	0
5. T. Narasipur .	0	98	2	2	0	0	0	0
6. Kangan .	0	51	0	0	0	0	0	0
7. Vengara .	0	100	0	0	0	0	0	0
8. Singroli .	0	95	0	0	0	0	0	0
9. Ukhrol .	0	75	0	0	0	0	0	0
10. Nurpur Bedi .	0	60	49	49	0	0	0	0
11. Thalli .	0	43	0	0	143	143	0	0
12. Nilakottai .	0	49	0	0	81	81	0	0
13. Chawmanu .	0	50	22	22	0	0	0	0
14. Shankargarh .	0	48	20	20	4	4	0	0
15. Dalmau .	0	100	0	0	5	5	0	0*
16. Jawan .	0	130	0	0	0	0	0	0
17. Man Bazar .	0	43	2	2	6	6	0	0
Total (Rural)	0	1,273	100	100	290	290	0	0
Average .		74.9	5.9	5.9	17.0	17.0		
<i>II. Tribal</i>								
18. Utnoor .	0	100	4	4	4	4	0	0
19. Barajamda .	0	50	9	9	14	14	0	0
20. Chhotaudepur .	0	63	0	0	50	50	0	0
21. Poch .	0	50	2	2	31	31	0	0
22. Tokapal .	0	48	2	2	58	58	0	0
23. Dharri .	0	45	16	16	10	10	0	0
24. Subdega .	0	56	0	0	0	0	0	0
25. Garhi .	0	120	50	50	31	31	107†	107†
Total (Tribal)	0	532	83	83	198	198	107	107
Average .		66.5	10.3	10.3	24.7	24.7	13.3	13.3
<i>III. Urban</i>								
26. Bombay .	0	26	26	26	0	0	1‡	1‡
27. Madras .	0	100	0	0	0	0	0	0
28. Calcutta .	0	44	0	0	0	0	33	33
29. Delhi .	0	37	0	0	0	0	0	0
Total (Urban)	0	207	26	26	0	0	34	34
Average .		51.7	6.5	6.5	..	..	8.5	8.5
All Projects	0	2012	209	209	488	488	141	141
Average .		69.4	7.2	7.2	16.8	16.8	4.8	4.8

NOTE : Averages have been calculated on the number of Projects reporting.

*Through 21 ANM Centres to be stopped.

†Mid-day meals in primary Schools.

‡Mobile dispensary of Bombay Municipal Corporation (BMC).

TABLE 3.4

Pre and Post IGDS Infrastructure for Non-formal Education

Project	Anganwadis		Balwadis		Pre-Primary/Nursery		Adult/functional Literacy	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	2	3	4	5	6	7	8	9
<i>I. Rural</i>								
1. Kambadur	50	2	2	..	..	50	100
2. Dhakuakhana	100	3	3	..	..	6	106
3. Tarapur	81	..	..	..	..	5	86
4. Kathura	100	2	2	..	..	48	148
5. T. Narasipur	98	2	2	108	108	43	141
6. Kangan	51	..	..	..	..	..	51
7. Vengara	100	1	1	3	3	100	200
8. Singroli	95	..	..	..	..	89	184
9. Ukhrul	75	50	50	46	46	51	126
10. Nurpur Bedi	60	7	7	..	..	59	119
11. Thalli	43	..	..	..	..	..	43
12. Nilakottai	49	8	8	12	12	..	49
13. Chawmanu	50	9	9	..	..	21	71
14. Shankargarh	48	20	20	64	64	47	95
15. Dalmau	100	..	..	..	..	30	130
16. Jawan	130	..	..	..	..	29	159
17. Man Bazar	43	2	2	..	..	2	45
Total (Rural)	..	1,273	106	106	233	233	580	1,853
Average	74.9	6.2	6.2	13.7	13.7	34.1	109.0
<i>II. Tribal</i>								
18. Utnoor	100	8	8	100	100	45	145
19. Barajamda	50	9	9	..	..	12	62
20. Chhotaudepur	63	4	4	..	..	20	83
21. Pooh	50	2	2	..	..	50	100
22. Tokapal	48	2	2	..	..	..	48
23. Dharni	45	12	12	..	..	15	60
24. Subdega	56	..	..	..	..	..	56
25. Garhi	120	..	..	..	..	6	126
Total (Tribal)	..	532	37	37	100	100	148	680
Average	66.5	4.6	4.6	14.3	14.3	18.5	85.0
<i>III. Urban</i>								
26. Bombay	26	28	28	NA	NA	..	26
27. Madras	100	..	..	NA	NA	..	100
28. Calcutta	44	..	..	NA	NA	48	92
29. Delhi	37	37	37	4	4	37	74
Total (Urban)	..	207	65	65	NA.	NA	85	292
Average	51.7	16.2	16.2	..	..	21.2	72.9
All Projects	2,012	208	208	333	333	813	2,825
Average	69.4	7.2	7.2	13.3	13.3	28.0	97.4

TABLE 3.5
Distribution of Voluntary Agencies in ICDS Project Areas

Project	Mahila Mandal	Youth Club	Vol. Agencies in Women and Child Welfare	Others	Remarks
1	2	3	4	5	6
<i>I. Rural</i>					
1. Kambadur	47	22	1	0	
2. Dhakuakhana	45	32	0	0	
3. Tarapur	0	0	1	0	
4. Kathura	6	8	0	0	
5. T. Narasipur	23	56	0	0	
6. Kangan	8	0	0	2	
7. Vengara	8	2	0	0	
8. Singroli	34	11	0	0	
9. Ukhrul	20	7	6	0	
10. Nurpur Bedi	7	24	0	0	
11. Thalli	30	0	0	0	
12. Nilakottai	30	4	1*	0	*Gandhigram, Family and Child Welfare Training Centre.
13. Chawmanu	16	15	0	0	
14. Shankargarh	20	30	0	0	
15. Dalmau	50	76	0	1	India Population Project
16. Jawan	N.A.	20	1	0	
17. Man Bazar	5	1	0	0	
Total (Rural)	349	316	10	3	
Average	20.5	18.6	0.6	0.2	
<i>II. Tribal</i>					
18. Utnoor	42	70	2	0	
19. Barajamda	4	6	0	0	
20. Chhotaudepur	26	12	1*	0	*Backward Class Sewa Mandal.
21. Pooh	32	9	1	0	
22. Tokapal	2	0	1	0	
23. Dharni	10	10	1	3	
24. Subdega	56	17	0	0	
25. Garhi	12	21	0	0	
Total (Tribal)	184	145	6	3	
Average	23.0	18.1	0.7	0.4	
<i>III. Urban</i>					
26. Bombay	0	0	1†	0	†Borivali Taluka Association.
27. Madras	0	0	6‡‡‡	0	‡Children : 1. Vivekanand Mission.
28. Calcutta	0	32	4	2	2. New Residents Welfare Trust.
29. Delhi	0	3	0	4	3. Agarwal Trust.
Total (Urban)	0	35	11	6	Women : 1. Mission Society.
Average		8.7	2.7	1.5	2. Shenoy Nagar Mother Sangam.
All Projects	503	496	27	12	3. Lions Club.
Average	17.3	17.1	0.9	0.4	4. New Residents Welfare Trust.

NOTE : Averages have been calculated on the number of Projects reporting.

TABLE 3.6

Availability of Protected Drinking Water in the ICDS Project Area

Project	Remarks
1	2
<i>I. Rural</i>	
1. Kambadur . . .	Open Well Water/adequate/no comment on disinfection (Unsafe).
2. Dhakuakhana . . .	Safe drinking water sources do not exist/inadequate/no comment (Unsafe).
3. Tarapur . . .	480 Kutchha wells, 2519 pucca wells/disinfection once in a year/some hand pump tubewell (partially safe).
4. Kathura . . .	Drinking water wells are disinfected periodically (safe).
5. T. Narasipur . . .	Out of 132 villages 12 have supply of pipe water, 28 bore wells with hand pump. Wells often chlorinated, 50 villages facing water scarcity (partial).
6. Kangan . . .	Use rivulets/river/spring/no arrangement for disinfection/no protected supply (unsafe).
7. Vengara . . .	Well water used for drinking purpose/in summer months the water is inadequate disinfection arrangement not commented (unsafe).
8. Singroli . . .	No tap water, open wells, disinfected once in a year (unsafe).
9. Ukhrul . . .	Depending on spring water, main source well or tanks. Block has spent approximately Rs. 2.5 lakhs on Rural Water Works. 13 villages get this (partial).
10. Nurpur Bedi . . .	40% of villages getting piped water supply, disinfected once or so in a year (partial).
11. Thalli . . .	Not reported.
12. Nillakottai . . .	Out of 188 villages, 22 had overhead tanks, 6 GLR, 8 villages with hand bore, others have open wells (partial).
13. Chawmanu . . .	Tube well—80; Ringwell—148; Tubewell—5; Storage tanks—30, position not satisfactory (partial).
14. Dalmau . . .	Rs. 15,200 for boring 5 tubewells, drinking water is not conducive to good health. Bleaching powder is being dropped casually (unsafe).
15. Shankargarh . . .	150 villages through taps but inadequate (safe).
16. Jawan . . .	Hand pumps and wells (partial)
17. Man Bazar . . .	Inadequate drinking water, no comment on disinfection (Unsafe).
Total (Rural) . . .	Safe—2, Partial—7, unsafe—7, NA—1=Total 17.

TABLE 3·6- -Contd.

(1)	(2)
<i>II. Tribal</i>	
18. Utnoor	No comments available (N.A.).
19. Barajamda	Open wells, unprotected water, no comments on disinfection (Unsafe).
20. Chhotaudepur	Wells disinfected regularly (Safe).
21. Pooh	No comments available (N.A.).
22. Tokapal	Streams/Channels, 50% of the hand-pumps installed (out of 33) are out of order. No comments on disinfection (Unsafe).
23. Dharni	Wells, rivers, disinfection is done occasionally (unsafe).
24. Subdega	Wells, disinfection done occasionally during the epidemics (Unsafe).
25. Garhi	70 villages have tap/hand pump. Rest depend on well water. Disinfection once/twice a year (partial).
Total (Tribal)	Safe—1; Unsafe—4; N.—A. 2; Partial—1; Total=8
<i>III. Urban</i>	
26. Bombay	Facility available on a community basis. But due to acute shortage of taps, water is sold by individuals who own taps.
27. Madras	Inadequate irregular (safe).
28. Calcutta	One water tap per 50 slum dwellers (safe).
29. Delhi	No problem (safe).
Total (Urban)	Safe—4
All Projects	Safe—7; partially safe/unsafe—8; Unsafe—11; N.A.—3; Total=29

NOTE : Criteria to assess water as safe:—Piped Water, deep bore wells, hand-pumps, regular fortnightly, or monthly disinfection, properly lined and disinfected wells.

TABLE 3.7

Storage and Residential Quarters for the CDPO/PHC Staff

Project	DPO									PHC									PHC Staff																											
	Office			Storage			Residential			Centre			Storage			Electricity			water			Sanitary Facility			Indore beds			Residential																		
	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N																
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																
<i>I. Rural</i>																																														
1. Kambadur		I			I			I			I			I			A				A					I				I				I												
2. Dhakuakhana		I			I			I			I			A					N	A			A			A					I				I											
3. Tarapur			A			A					I			I			I			I			A				I				I				I											
4. Kathura								N			I				A			A				A								I				I			I									
5. T. Narasipur										N	A				A				I				I							I				A												
6. Kangan										N	A				A				A				A							A				A												
7. Vengara										N				I			I			A			A								I							I								
8. Singroli								N	A					I			I			A			A						N				I						I							
9. Ukhrul								N			N	A				A				I				I						I				A					A							
10. Nurpur Bedi										N				I				N	A											I				I						I						
11. Thalli										N				I			I			A										I					A						I					
12. Nilakottai														I				N	A					A						A					A								N			
13. Chawmanu										N				I						I							N			I				A							I					
14. Shankargarh								N			I				I					N			I								I				A						I					
15. Dalmau										N				I						N								N			I											I				
16. Jawan														I						N											I												I			
17. Man Bazar								N	A					I						I											I													I		
Total (Rural)	4	13			4	8	5	4	5	8	3	14		7	8	2	10	3	4	9	8			10	6	1	5	12			4			9	4											

II. Tribal

18. Uttnoor	.	.	.	.	.	I	..	..	..	N	..	I	..	A	..	..	A	..	..	..	I	..	A	..	..	..	..	N	A	..	..	..	I	..
19. Barajamda	.	.	.	.	.	I	..	..	I	..	..	I	..	..	I	..	A	..	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..
20. Chhotaudepur	.	.	.	.	A	..	..	..	N	..	..	N	..	I	..	A	..	..	A	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..
21. Pooh	.	.	.	.	.	I	..	..	I	..	..	..	N	A	..	..	A	..	..	..	N	..	..	N	A	..	..	A	..	..	..	..	N	..
22. Tokapal	.	.	.	.	A	..	..	..	I	..	A	..	..	A	..	..	A	..	..	..	N	..	I	..	A	..	..	A	..	..	..	..	I	..
23. Dharni	.	.	.	.	..	..	N	..	..	N	..	..	N	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	..	I	..	..	I	..
24. Subdega	.	.	.	.	..	I	..	..	..	N	..	I	..	A	..	..	..	I	..	A	..	..	A	..	..	A	..	..	..	I	..	..	I	..
25. Garhi	.	.	.	.	..	I	..	..	..	N	..	..	N	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..	..	I	..
Total (Tribal)	.	.	.	.	2	5	1	0	3	5	1	3	4	4	4	..	4	4	..	5	1	2	4	3	1	7	..	1	5	3	..	1	6	1

III. Urban

26. Bombay	.	.	.	.	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	..	..	N	A	..	..	..	..
27. Madras	.	.	.	.	..	I	..	..	I	..	..	..	N	Not available																				
28. Calcutta	.	.	.	.	A	..	..	A	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	..	I	..	..	..	N	..
29. Delhi	.	.	.	.	A	..	..	A	..	..	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..	..	N	..	..	N	..
Total (Urban)	.	.	.	.	3	1	..	3	1	..	I	1	2	2	1	..	3	..	..	3	..	..	3	..	..	3	..	..	1	2	1	..	2	..
All Projects	.	.	.	.	9	19	1	7	12	10	6	9	14	9	19	..	14	12	2	18	4	6	16	11	1	20	6	2	10	16	2	6	15	7

A=Adcquate, I=Inadequate, N=Nil.

TABLE 4.1
Allocation and Expenditure Pattern

Project	1975-76			1976-77		
	A	E	%	A	E	%
1	2	3	4	5	6	7
<i>I. Rural</i>						
1. Kambadur	243580	171793	71	263980	41977	16
2. Dhakuakhana	172400	215772	125	346000	70608	20
3. Tarapur	144608	0	0	347428	6071	2
4. Kathura	NA	108386	NA	445600	36031	8
5. T. Narasipur	NA	NA	NA	NA	NA	NA
6. Kangan	310400	81150	26	NA	55212	NA
7. Vengara	NA	NA	NA	NA	NA	NA
8. Singroli	148000	114240	77	421200	86200	5
9. Ukhrol	353000	11510	3	69600	45170	65
10. Nurpur Bedi	356900	34807	10	929000	29065	3
11. Thalli	0	0	0	335474	63519	19
12. Nilakottai	0	0	0	348878	26903	8
13. Chawmanu	90048	76114	85	385607	89589	23
14. Shankargarh	115926	103068	89	NA	NA	NA
15. Dalmau	NA	NA	NA	NA	NA	NA
16. Jawan	151517	149712	99	NA	NA	NA
17. Man Bazar	109000	41316	38	150000	62787	42
Total (Rural)	2195379	999482	45.5	4042767	557920	13.8
<i>II. Tribal</i>						
18. Utnoor	174260	133132	76	513900	54468	11
19. Barajamda	79884	22425	28	198764	4631	2
20. Chhotaudapur	NA	NA	NA	NA	NA	NA
21. Pooh	267700	97387	36	204400	39564	19
22. Tokapal	105700	95960	91	38000	30993	NA
23. Dharni	5700	5700	100	NA	NA	NA
24. Subdega	133200	64268	48	NA	NA	NA
25. Garhi	179700	111510	62	NA	NA	NA
Total (Tribal)	946144	530382	56.5	917064	98663	10.76
<i>III. Urban</i>						
26. Bombay	NA	NA	NA	490000	58203	12
27. Madras	30853	30853	100	562131	44148	8
28. Calcutta	529600	50145	10	479455	56595	12
29. Delhi	360000	69102	19	500000	60582	12
Total (Urban)	920453	150100	16.31	2031586	219528	10.81
All Projects	4061976	1679964	41.36	6991417	876111	12.53

A=Allocation ; E=Expenditure

TABLE 4.2

Average Allocation and Expenditure Pattern of Funds from the Centre

Project	1975-76						1976-77					
	Establishment		Recurring		Non-recurring		Establishment		Recurring		Non-recurring	
	A	E	A	E	A	E	A	E	A	E	A	E
1	2	3	4	5	6	7	8	9	10	11	12	13
<i>I. Rural</i>	70549	31406 (45)	37949	23231 (61)	106587	66208 (62)	163929	31020 (19)	174446	15557 (9)	79578	13926 (17)
No. of Projects reporting	14	12	10	10	11	10	15	15	10	14	4	6
<i>II. Tribal</i>	80199	38785 (48)	17509	15039 (86)	49900	27474 (55)	141702	68319 (48)	111475	8899 (8)	21900	1205 (6)
No. of Projects reporting	8	8	6	7	5	6	7	8	2	5	3	1
<i>III. Urban</i>	224818	36210 (16)	167000	10748 (6)	79000	12167 (15)	236364	39873 (17)	273820	17920 (7)	88224	3139 (4)
No. of Projects reporting	3	3	1	3	1	3	4	4	3	3	3	3
All Projects (Average)	92149	34599	38326	18441	88291	45444	169092	31531	185925	14366	64868	10115
No. of Projects reporting	25	23 (38)	17	20 (48)	17	19 (52)	26	27 (19)	15	22 (8)	10	9 (16)

Percentage in Parentheses

TABLE 4.3

Flow of Finances from the States (1975-76)

Project	PHC		Supplementary Nutrition		A.N.P.		Rural water supply		Medicines		Annual provision that should have been made for ICDS supplementary Nutrition (Rs. Lakhs)*
	A	E	A	E	A	E	A	E	A	E	
1	2	3	4	5	6	7	8	9	10	11	12
<i>I. Rural</i>											
1. Kambadur .	47251	47251	0	0	81000	0	NA	NA	NA	NA	8.29
2. Dhakuakhana .	0	0	0	0	0	0	0	0	0	0	6.73
3. Tarapur .	0	0	0	0	0	0	0	0	0	0	7.80
4. Kathura .	NA	NA	NA	464000	NA	57500	NA	20000	NA	NA	8.21
5. T. Narasipur .	0	0	0	0	0	0	0	0	0	0	17.16
6. Kangan .	NA	NA	0	0	7834	5982	0	0	6000	6000	6.30
7. Vengara .	NA	NA	0	0	0	0	0	0	0	NA	11.49
8. Singroli .	0	0	0	0	0	0	0	0	0	0	13.14
9. Ukhrul .	NA	NA	0	0	42000	42000	247000	247000	NA	NA	6.69
10. Nurpur Bedi .	Not Available										5.25
11. Thalli .	Not Available										10.67
12. Nillakottai .	Not Available										9.60
13. Chawmanu .	5000	2421	79880	62852	0	0	43520	37738	0	0	6.00
14. Shankargarh .	Not Available										7.72
15. Dalmau .	0	0	0	0	0	0	0	0	0	0	8.70
16. Jawan .	Not Available										10.59
17. Man Bazar .	0	0	0	0	32500	0	40500	9074	NA	NA	8.62
Total (Rural)	52251	49672	79880	526852	163334	99500	331020	313812	6000	6000	

<i>II. Tribal</i>											
18. Utnoor	0	0	0	0	0	0	10000	23988	7000	0	16.62
19. Barajamda	0	0	0	0	34750	20120	0	0	0	0	12.00
20. Chhotaudepur	NA	117948	61161	38567	33950	25930	0	0	12000	10800	10.62
21. Pooh	0	0	193420	193420	0	0	0	0	0	0	2.92
22. Tokapal	Not Available										7.85
23. Dharni	6280	6280	77233	60233	0	0	54545	8244	NA	NA	11.23
24. Subdega	Not Available										6.77
25. Garhi	77800	84380	NA	NA	NA	NA	NA	NA	26000	15000	20.62
Total (Tribal)	84080	208608	331319	292220	68700	46050	64545	32232	45000	25800	
<i>III. Urban</i>											
26. Bombay	NA	NA	0	0	NA	NA	NA	NA	NA	NA	7.96
27. Madras	0	0	0	0	NA	NA	0	0	0	0	9.44
28. Calcutta	Spent Rs. 1,35,200 in 1975-76 and Rs. 4,68,418 in 1976-77.										14.12
29. Delhi	Not Available										9.44
Total (Urban) . . . . .	..	..	..	..	..	..	..	..	..	..
All Projects	136331	258180	411699	819072	232034	145550	395565	346044	51000	31800	

*Source :—Supplement to guidelines and instructions issued upto June, 1976 regarding the schemes of ICDS and functional literacy for adult women and letter No. 12-1/75-CD dated 22nd December, 1975 from the Department of Social Welfare, (Govt. of India) to the State Governments and the Union Territory of Delhi.

A: Allocation.

E: Expenditure.

TABLE 4.4

State Plan—1975-76 and 1976-77—Allocation for Special Nutrition Programme

(Rs in Lakhs)

States	Allocation	
	1975-76	1976-77
1	2	3
1. Andhra Pradesh	113.00	113.00
*2. Assam	13.50	13.50
3. Bihar	51.00	55.00
4. Gujarat	75.00	72.00
*5. Haryana . . . . .	..	..
*6. Himachal Pradesh	13.00	13.00
*7. Jammu and Kashmir	3.00	3.00
8. Karnataka	78.00	68.00
9. Kerala	75.00	87.00
10. Madhya Pradesh	154.00	154.00
11. Maharashtra	121.00	126.00
*12. Manipur	3.14	4.00
*13. Meghalaya	9.75	9.75
*14. Nagaland	11.00	16.50
15. Orissa	123.00	123.00
*16. Punjab	8.00	13.00
*17. Rajasthan	18.50	12.00
*18. Sikkim . . . . .	..	6.00
19. Tamilnadu	52.75	70.00
*20. Tripura	6.00	6.00
21. Uttar Pradesh	54.75	62.00
22. West Bengal	84.00	84.00
Total States	1067.39	1111.35
<i>Union Territories:</i>		
1. Andaman & Nicobar Islands	2.17	1.85
2. Arunachal Pradesh	1.20	2.00
3. Chandigarh	2.08	2.12
4. Dadra & Nagar Haveli	2.01	4.44
*5. Delhi	10.00	13.00
6. Goa, Daman & Diu	0.50	2.60
7. Lakshadweep	0.30	1.00
8. Mizoram	7.50	7.50
9. Pondicherry	2.80	4.31
Total U. Ts.	28.48	38.82
Grand Total	1095.87	1150.17

Source : Nutrition Division (Planning Commission).

States/UTs marked by astrick (*) appear to have under provided for SNP, since contribution from State Plans for ICDS alone was expected at Rs. 8.21 Lakhs for Rural/Urban and Rs. 5.39 for Tribal Projects.

TABLE 4.5

Selected Capital Inputs Available at the Project Levels

Project	Jeep	Cycle	Refrigerator	Typewriter	Weighing Machines (No)	
					P.E.O.	D.S.W.
1	2	3	4	5	6	7
<i>I. Rural</i>						
1. Kambadur	1	5	2	1	120	120
2. Dhakuakhana	1	10	1	1	30	120
3. Tarapur	1	0	0	1	0	120
4. Kathura	1	10	1	1	0	120
5. T. Narasipur	1	NA	0	1	0	100
6. Kangan	0	10	1	1	0	65
7. Vengara	1	0	1	1	100	100
8. Singroli	1	10	1	1	100	165
9. Ukhrol	1	0	1	1	0	110
10. Nurpur Bedi	1	10	1	1	0	115
11. Thalli	1	0	1	1	100	100
12. Nilakottai	1	0	1	0	70	100
13. Chawmanu	1	10	1	1	2	50
14. Shankargarh	1	10	0	1	0	145
15. Dalmau	1	12	1	2	40	120
16. Jawan	1	10	1	1	80	150
17. Man Bazar	1	10	0	1	0	120
Total (Rural)	16	107	14	17	642	1920
Average	0.9	6.7	0.8	1.0	37.7	112.9
<i>II. Tribal</i>						
18. Utnoor	1	0	0	1	0	120
19. Barajamda	1	0	1	1	0	60
20. Chhotaudepur	1	15	1	1	0	80
21. Pooh	1	0	0	1	10	60
22. Tokapal	1	10	1	1	30	75
23. Dharni	0	0	1	1	0	60
24. Subdega	1	5	0	1	50	65
25. Garhi	1	10	1	1	0	140
Total (Tribal)	7	40	5	8	90	660
Average	0.9	5.0	0.6	1.8	11.2	82.5
<i>III. Urban</i>						
26. Bombay	1	0	NA	1	81	105
27. Madras	1	0	NA	1	55	105
28. Calcutta	1	0	1	1	35	105
29. Delhi	1	0	0	1	40	105
Total (Urban)	4	..	1	4	211	420
Average	1.0	..	0.5	1.0	52.7	105.0
All Projects	27	147	20	29	943	3000
Average	0.9	5.3	0.7	1.0	32.5	103.4

TABLE 4.6

Flow of Selected Usable Items (non-health) to the Project

Project	First Aid Box			Vessels for drinking			Files Records Registers			Health cards			Kitchen equipment			Bathroom equipment			Building Blocks			Counting frame			Paints & Brushes					
	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N			
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28			
<i>I. Rural</i>																														
1. Kambadur .	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
2. Dhakuakhana .	A	..	..	A	..	..	A	..	..	A	..	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
3. Tarapur .	..	I	..	..	I	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..
4. Kathura .	..	..	N	..	..	N	..	I	..	A	..	..	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N
5. T. Narasipur .	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..
6. Kangan .	..	..	N	A	..	..	..	..	N	A	..	..	..	I	..	A	..	..	..	..	N	..	..	N	A	..	..	..	..	N
7. Vengara .	..	I	..	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	..	..	N	..	I	..	..	..	N	..	..	N
8. Singroli .	..	I	..	..	I	..	A	..	..	A	..	..	..	I	..	A	..	..	..	I	..	..	I	..	A	..	..	..	..	N
9. Ukhrul .	A	..	..	..	..	N	..	I	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	..	..	N
10. Nurpur Bedi .	..	..	N	..	..	N	..	..	N	..	..	N	..	I	..	..	I	..	..	I	..	..	..	N	..	..	N	..	..	N
11. Thalli .	..	..	N	..	..	N	..	..	N	A	..	..	..	I	..	..	..	N	..	..	N	A	..	..	..	..	N	..	..	N
12. Nilakottai .	..	..	N	..	..	N	A	..	..	..	I	..	A	..	..	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N
13. Chawmanu .	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	..	N	..	..	N	..	..	N	..	..	N
14. Shankargarh .	..	I	..	..	..	N	..	I	..	..	I	..	..	..	N	..	I	..	..	I	..	A	..	..	..	..	I	..	..	I
15. Dalmau .	A	..	..	..	..	N	A	..	..	A	..	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
16. Jawan .	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	..	I
7. Man Bazar .	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	A	..	..	..	I	..	..	..	N	..	..	I	..	..	I
Total (Rural) .	5	7	5	7	3	7	7	7	3	8	5	4	2	9	6	8	5	4	4	7	6	6	6	5	6	5	5	7	5	7

I. Tribal

18. Utnoor	.	.	A	..	..	A	..	..	A	..	..	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	
19. Barajamda	.	.	A	..	..	..	N	..	I	..	A	..	..	..	I	..	..	I	..	..	..	N	..	..	N	..	..	N	
20. Chhotaudepur	.	..	I	..	A	..	..	A	..	..	..	..	N	..	I	..	A	..	..	..	..	N	A	..	..	A	..	..
21. Pooh	.	.	A	..	..	..	N	A	..	..	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..
22. Tokapal	.	.	..	..	N	..	..	N	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..
23. Dharni	.	.	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N
24. Subdega	.	.	..	..	N	A	..	..	A	..	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..	..	..	N
25. Garhi	I	..	A	I	..	A	I	I	I	I	I	..
Total (Tribal)	.	.	3	2	3	4	..	4	4	3	1	4	1	3	1	5	2	4	3	1	3	2	3	4	2	2	3	2	3	

III. Urban

26. Bombay	.	.	N.A.																											
27. Madras	.	.	..	..	N	..	I	..	..	..	N	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	N		
28. Calcutta	.	.	..	..	N	A	..	..	A	..	..	A	..	..	..	I	..	..	..	N	..	..	N	..	..	N	..	..	N	
29. Delhi	.	.	..	..	I	..	..	..	N	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..	..	..	N	..	..	N
Total (Urban)	.	.	..	..	1	2	1	1	1	1	1	1	2	1	..	1	2	..	..	3	..	..	2	1	..	1	2	..	..	3
All Projects	.	.	8	10	10	12	4	12	12	11	5	14	7	7	4	16	8	12	11	5	7	10	11	10	8	10	8	7	13	

A: Adequate; I: Inadequate; N: Nil; NA: Not Available.

TABLE 4.7

Provisions for Medicines at P.H.C.

Project	Amount to be provided for medicines by the State Govt. as per MNP pattern (Rs)*	Amount provided for medicines after ICDS	Percentage
1	2	3	4
<i>I. Rural</i>			
1. Kambadur	30000	30000	100.0
2. Dhakuakhana	26000	18000	69.2
3. Tarapur	28000	2200	7.8
4. Kathura	30000	37400	124.7
5. T. Narasipur	60000	42000	70.0
6. Kangan	20000	3000	15.0
7. Vengara	36000	46000	127.8
8. Singroli	40000	NA	..
9. Ukhrul	20000	NA	..
10. Nurpur Bedi	24000	114238	475.9
11. Thalli	34000	18000	52.9
12. Nilakottai	32000	30000	93.7
13. Chawmanu	34000	NA	..
14. Shankargarh	28000	21000	75.0
15. Dalmau	30000	34494	114.9
16. Jawan	34000	15000	44.1
17. Man Bazar	30000	NA	..
Total (Rural)	536000	411332	76.7
<i>II. Tribal</i>			
18. Utnoor	30000	NA	..
19. Barajamda	26000	4400	16.9
20. Chhotaudepur	24000	12000	50.0
21. Pooh	16000	4713	29.4
22. Tokapal	20000	18000	90.0
23. Dharni	26000	NA	..
24. Subdega	20000	15600	78.0
25. Garhi	36000	34520	95.8
Total (Tribal)	198000	89233	45.06
<i>III. Urban</i>			
26. Bombay	NR (No provision)	NA	..
27. Madras	NR (No provision)	NA	..
28. Calcutta	NR (No provision)	NA	..
29. Delhi	NR (No provision)	NA	..
Total (Urban) . . . . .	..	..	..
All projects	734000	500565	68.2

*Source: Department of Social Welfare (Govt. of India).

TABLE 4.8

Post ICDS Profile Regarding the Availability of Essential Equipment/Vaccines/Nutritive Supplements at the PHC

Project	Refrigerators			Weighing machine			Equipment			Small pox. Vac.			DTP/DT			BCG			TAB			Iron/Folic Acid			Oral Vit A		
	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N	A	I	N
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
<i>I. Rural</i>																											
1. Kambadur	A	..	..	..	I	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..
2. Dhakuakhana	..	I	..	..	I	..	..	I	..	..	NA	..	A	..	..	..	..	N	..	..	N	A	..	..	A	..	..
3. Tarapur	..	I	..	..	I	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..
4. Kathura	..	I	..	..	I	..	..	..	N	A	..	..	A	..	..	..	..	N	A	..	..	..	..	N	..	NA	..
5. T. Narasipur	..	I	..	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	..	I	..	..	I	..	..	I	..
6. Kangan	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	..	..	NA	..	..	..	A	..	..	A	..	..
7. Vengara	A	..	..	..	NA	..	..	NA	..	..	NA	..	..	NA	..	..	..	N	..	..	N	A	..	..	A	..	..
8. Singroli	..	I	..	..	I	..	..	I	..	..	NA	..	..	I	..	..	..	N	..	..	N	A	..	..	..	I	..
9. Ukhrul	A	..	..	..	I	..	A	..	..	..	..	..	..	NA	..	..	..	..	..	..	..	A	..	..	A	..	..
10. Nurpur Bedi	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	N	..	..	N	..	I	..	..	I	..
11. Thalli	..	I	..	..	I	..	..	I	..	A	..	..	..	..	N	..	..	N	..	..	N	..	..	N	..	..	N
12. Nilakottai	..	I	..	..	NA	..	..	..	..	..	NA	..	..	..	..	..	..	N	..	..	N	..	..	N	..	NA	..
13. Chawmanu	..	I	..	..	I	..	..	I	..	A	..	..	..	..	N	..	..	N	..	I	..	..	I	..	..	I	..
14. Shankargarh	..	..	N	..	I	..	..	I	..	A	..	..	A	..	..	..	NA	..	..	..	N	A	..	..	..	I	..
15. Dalmau	A	..	..	..	I	..	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	..	I	..	A	..	..
16. Jawan	..	I	..	..	I	..	..	I	..	A	..	..	..	I	..	..	I	..	..	I	..	..	I	..	..	I	..
17. Man Bazar	..	..	N	A	..	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
Total (Rural)	5	10	2	2	13	..	4	10	I	12	..	..	8	4	2	3	3	8	2	5	8	7	7	3	6	8	I
<i>II. Tribal</i>																											
18. Utnoor	..	..	N	..	I	..	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	A	..	..	A	..	..
19. Barajamda	A	..	..	..	I	..	..	I	..	A	..	..	..	..	N	..	..	N	..	..	N	..	I	..	..	..	N
20. Chhotaudapur	..	I	..	..	I	..	A	..	..	A	..	..	A	..	..	A	..	..	..	..	N	A	..	..	A	..	..
21. Pooh	..	..	N	A	..	..	A	..	..	A	..	..	..	..	N	..	..	N	..	..	N	A	..	..	A	..	..
22. Tokapal	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	..	I	..	..	I	..	A	..	..	A	..	..
23. Dharni	..	I	..	A	..	..	A	..	..	A	..	..	..	..	N	A	..	..	A	..	..	A	..	..	A	..	..
24. Subdega	..	..	N	A	..	..	A	..	..	..	I	..	..	I	..	..	..	N	..	..	N	..	I	..	..	..	N
25. Garhi	..	I	..	A	..	..	A	..	..	A	..	..	..	I	..	..	I	..	..	..	N	..	I	..	..	..	N
Total (Tribal)	2	3	3	5	3	..	7	1	..	7	1	..	3	2	3	2	2	4	1	1	6	5	3	..	5	..	3

TABLE 4·8—Contd.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28		
<i>III. Urban</i>																													
26. Bombay	.	.	_____													NA	_____												
27. Madras	.	.	_____													NA	_____												
28. Calcutta	I	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
29. Delhi	N	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..	A	..	..
Total (Urban)	1	1	2	..	..	2	..	..	2	..	..	2	..	..	2	..	..	2	..	..	2	..	..	2	..	..
All Projects	.	.	7	14	6	9	16	..	13	11	1	21	1	..	13	6	5	7	5	12	5	6	14	14	10	3	13	8	4

A: Adequate; I: Inadequate; N: Nil; NA: Not available.

TABLE 5.1

Position of the ICDS Staff

Project	CDPO			Doctors			Supervisors			LHV/PHN			ANM			Anganwadi workers			
	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
<i>I. Rural</i>																			
1. Kambadur .	1	1	1	1	1	1	5	5	5	2	2	2	10	10	10	100	50	50	
2. Dhakuakhana .	1	1	1	1	1	1	5	5	5	2	2	2	8	8	8	100	100	100	
3. Tarapur . .	1	1	1	1	1	..	5	4	4	2	2	2	8	5	5	100	81	81	
4. Kathura . .	1	1	1	1	..	..	5	5	5	2	1	1	8	4	4	100	100	100
5. T. Narasipur .	1	1	1	1	1	1	5	5	5	2	2	2	8	8	8	100	98	96	
6. Kangan . .	1	1	1	1	..	..	4	4	4	2	..	..	8	6	6	100	51	51
7. Vengara . .	1	1	1	1	1	1	5	5	5	2	2	2	8	8	8	100	100	100	
8. Singroli . .	1	1	1	1	..	..	5	4	4	2	..	..	11	..	..	133	130	130
9. Ukhrul . .	1	1	1	1	..	..	5	5	3	2	1	1	8	8	8	75	75	44
10. Narpur Bedi .	1	1	1	1	..	..	5	3	3	2	1	1	8	7	7	100	87	60
11. Thalli . .	1	1	1	1	1	1	5	4	4	2	2	2	8	8	8	93	93	93	
12. Nilakottai . .	1	1	1	1	1	1	5	3	3	2	..	..	8	..	..	100	100	100
13. Chawmanu . .	1	1	1	1	..	..	5	3	3	2	..	..	8	..	..	100	50	50
14. Shankargarh .	1	1	1	1	1	1	5	5	5	2	2	2	8	6	6	148	105	105	
15. Dalmau . .	1	1	..	1	1	1	5	2	2	2	2	2	8	8	8	100	99	87	
16. Jawan . .	1	1	1	1	1	1	5	5	5	2	2	2	8	8	8	130	125	125	
17. Man Bazar . .	1	1	1	1	..	..	5	..	..	2	..	..	8	4	4	100	92	43
Total (Rural) . . .	17	17	16	17	10	9	84	67	65	34	21	21	141	98	98	1779	1539	1415	
Percentage		100.0	94.1	58.8	32.9		79.7	77.4		61.7	61.7			69.5	69.5		84.4	79.3	

TABLE 5.1—Contd.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
<i>II. Tribal</i>																		
18. Utnoor . . .	1	1	1	1	1	1	5	2	2	2	2	2	8	3	3	100	52	52
19. Barajamda . . .	1	1	1	1	1	1	3	3	3	2	1	1	4	3	3	50	50	50
20. Chhotaudepur . . .	1	1	1	1	1	1	3	3	3	2	2	2	6	4	4	63	61	61
21. Pooh . . .	1	1	1	1	1	1	3	3	3	2	..	..	4	2	2	50	50	50
22. Tokapal . . .	1	1	1	1	..	..	3	3	3	2	..	..	4	..	..	48	48	48
23. Dharni . . .	1	..	..	1	1	*	3	1	1	1	..	..	7	7	7	65	45	45
24. Subdega . . .	1	1	1	1	1	1	3	3	3	2	2	2	4	4	4	56	56	54
25. Garhi . . .	1	1	1	1	..	..	5	3	3	2	..	..	8	6	6	120	96	96
Total (Tribal) . . .	8	7	7	8	6	5	28	21	21	15	7	7	45	29	29	552	458	456
Percentage . . .		87.5	87.5		75.0	63.5		75.0	75.0		46.7	46.7		64.4	64.4		83.0	82.6
<i>III. Urban</i>																		
26. Bombay . . .	1	1	1	1	1	1	4	4	4	..	..	..	4	3	3	100	100	100
27. Madras . . .	1	1	1	1	1	1	4	4	4	..	..	..	4	2	..	100	100	100
28. Calcutta . . .	1	1	1	1	1	1	2	2	2	..	..	..	2	2	2	100	98	98
29. Delhi . . .	1	1	1	1	1	1	4	4	4	4	4	4	..	..	..	200	70	70
Total (Urban) . . .	4	4	4	4	4	4	14	14	14	4	4	4	10	7	5	500	368	368
All Projects . . .	29	28	27	29	20	19	126	104	102	53	34	34	196	137	135	2831	2415	2291
Percentage . . .		96.5	93.1	69.0	71.4	65.5		82.5	81.0		64.2	64.2		69.9	68.9		85.3	80.9

A: Sanctioned; B: Appointed; C: In position.

TABLE 5.2

Normal Health Staff (PHC)

Project	Doctor		LHV/PHN		ANM	
	A	B	A	B	A	B
1	2	3	4	5	6	7
<i>I. Rural</i>						
1. Kambadur	1	1	..	..	3	3
2. Dhakuakhana	2	1	..	..	6	5
3. Tarapur	3	3	2	..	8	8
4. Kathura	2	2	2	2	8	10*
5. T. Narasipur	4	4	4	4	12	12
6. Kangan	5	5	1	1	7	7
7. Vengara	2	2	3	3	11	11
8. Singroli	3	3	3	1	15	10
9. Ukhrul	2	2	1	1	8	8
10. Nurpur Bedi	2	2	2	2	8	8
11. Thalli	2	2	3	3	6	6
12. Nilakottai	2	2	2	2	12	12
13. Chawmanu	8	7	2	..	8	4
14. Shankargarh	2	2	1	1	10	10
15. Delmau	3	3	5	5	22	21**
16. Jawan	2	2	2	1	8	8
17. Man Bazar	2	2	1	1	4	4
Total (Rural)	47	45	34	27	156	147
Percentage		95.7		79.4		94.2
<i>II. Tribal</i>						
18. Utnoor	NA	NA	NA	NA	NA	NA
19. Barajamda	3	3	2	..	7	5
20. Chhotaudepur	3	3	2	2	9	9
21. Pooh	1	..	1	..	2	1
22. Tokapal	2	1	2	1	8	6
23. Dharni	3	2	2	..	8	8
24. Subdega	2	2	2	2	6	6
25. Garhi	2	2	1	..	16	11
Total (Tribal)	16	13	12	5	56	46
Percentage :		81.2		41.6		82.1
<i>III. Urban</i>						
26. Bombay	NA	NA	NA	NA	NA	NA
27. Madras	NA	20	NA*	18	NA*	54
28. Calcutta	11	8	2	2	12	12
29. Delhi	3	1	5	3	..	..
Total (Urban)	14	29	7	23	12	66
Percentage		64.3		71.4		100.0
All Projects	77	87	53	55	224	259
Percentage		87.0		69.8		91.5

A: Sanctioned; B: In position.

*Two ANMs under MNP.

**Includes ANMs of Indian Population Project (IPP).

TABLE 5.2 (a)

Combined Health Staff

Project	Combined Doctor	Combined LHVs	No. of		
			Combined ANMs	ANMs re- quired at 1 ANMs; 5000 popu- lation	ANM re- quirement met(%)
1	2	3	4	5	6
<i>I. Rural</i>					
1. Kambadur	2	2	13	18	72
2. Dhakaukhana	2	2	13	14	93
3. Tarapur	4	2	13	16	81
4. Kathura	2	3	14	18	78
5. T. Narasipur	5	6	20	36	56
6. Kangan	5	1	13	7	186
7. Vengara	3	5	19	24	79
8. Singroli	3	1	10	28	36
9. Ukhrul	2	2	16	8	200
10. Nurpur Bedi	2	3	15	12	125
11. Thalli	3	5	14	22	64
12. Nilakottai	3	2	12	20	60
13. Chawmanu	7	..	4	10	40
14. Shankargarh	3	3	16	16	100
15. Dalmau	4	7	30	18	161
16. Jawan	3	3	16	22	73
17. Man Bazar	2	1	8	18	44
<i>II. Tribal</i>					
18. Utnoor	Not available				
19. Barajamda	4	1	8	14	57
20. Chhotaudepur	4	4	13	12	108
21. Pooh	1	..	3	4	75
22. Tokapal	1	1	6	9	75
23. Dharni	2	..	15	13	107
24. Subdega	3	4	10	8	125
25. Garhi	2	2	17	24	71
<i>III. Urban</i>					
26. Bombay	NA	NA	NA	NA	..
27. Madras	20	18	56	NA	..
28. Calcutta	9	2	14	NA	..
29. Delhi	2	7	..	NA	..

TABLE 5.3

Training of Doctors, LHVs, and ANMs in ICDS

Project	Doctor			L.H.V.			A.N.M.		
	In position	Trained	% age	In position	Trained	% age	In position	Trained	% age
1	2	3	4	5	6	7	8	9	10
<i>I. Rural</i>									
1. Kambadur	2	2	100.0	2	2	100.0	13	13	100.0
2. Dhakuakhana	2	0	..	2	0	..	13	0	..
3. Tarapur	4	0	..	2	2	100.0	13	5	38.5
4. Kathura	2	2	100.0	3	3	100.0	12	12	100.0
5. T. Narasipur	5	5	100.0	6	4	66.7	20	13	65.0
6. Kangan	5	5	100.0	1	1	100.0	13	13	100.0
7. Vengara	3	3	100.0	5	5	100.0	19	11	57.9
8. Singroli	3	0	..	1	0	..	17	0	..
9. Ukhrul	2	2	100.0	2	2	100.0	16	16	100.0
10. Nurpur Bedi	2	2	100.0	3	3	100.0	15	15	100.0
11. Thalli	3	1	33.3	5	0	..	14	0	..
12. Nilakottai	3	1	33.3	2	0	..	12	0	..
13. Chawmanu	7	7	100.0	..	..	..	4	4	100.0
14. Shankargarh	3	3	100.0	3	3	100.0	18	16	88.9
15. Dalmau	4*	4*	100.0	7*	5*	71.4	30*	30*	100.0
16. Jawan	3	0	..	3	0	..	16	0	..
17. Man Bazar	2	1	50.0	1	1	100.0	8	8	100.0
Total (Rural)	55	38	69.1	48	31	64.8	253	156	62.0
<i>II. Tribal</i>									
18. Utnoor	Not available								
19. Barajamda	4	0	..	1	0	..	8	0	..
20. Chhotaudepur	4	0	..	4	4	100.0	13	0	..
21. Pooh	1	1	100.0	..	..	..	3	0	..
22. Tokapal	1	0	..	1	0	..	6	0	..
23. Dharni	2	0	..	..	..	..	15	0	..
24. Subdega	3	0	..	4	0	..	10	..	..
25. Garhi	2	2	100.0	2	2	100.0	15	15	100.0
Total (Tribal)	17	3	17.6	12	6	50.0	70	15	21.4
<i>III. Urban</i>									
26. Bombay	1†	1†	100.0	NA	NA	NA	3†	3†	100.0
27. Madras	20	NA	..	18	NA	..	56	NA	..
28. Calcutta	9	1	11.1	2	0	..	14	0	..
29. Delhi	2	0	..	7	4	57.1	..	..	..
Total (Urban)	32	2	6.0	27	4	14.8	70	3	4.1
All Projects	104	43	41.3	87	41	47.1	393	71	18.1

*Includes IPP Health Staff.

†No information is available for normal health staff.

TABLE 5.4
Background of L.H.Vs.

Project	Age(yrs)			Educational qualification				
	Below 20	20-25	Above 26	N.A.	Below Mat-ric.	High/High-er Sec.	Gra- duate and above	N.A.
1	2	3	4	5	6	7	8	9
<i>I. Rural</i>								
1. Kambadur	2	..	2	..	..	..
2. Dhakuakhana	..	1	1	..	..	2	..	..
3. Tarapur	2	..	..	2	..	..
4. Kathura	..	1	..	..	..	1	..	..
5. T. Narasipur	2	..	..	..	2
6. Kangan
7. Vengara	2	..	..	2	..	..
8. Singroli
9. Ukhrul	1	..	..	1	..	..
10. Nurpur Bedi	1	..	..	1	..	..
11. Thalli	..	1	1	..	..	..	..	2
12. Nilakottai	2	..	..	2	..	..
13. Chawmanu
14. Shankargarh	..	1	1	..	..	2	..	..
15. Dalmau	1	1	..	1	..	1
16. Jawan	2	..	2	..	..
17. Man Bazar
Total (Rural)	..	4	14	5	2	16	..	5
Percentage	..	17.4	60.9	21.7	8.7	69.6	..	21.7
<i>II. Tribal</i>								
18. Utnoor	2	..	..	2	..	..
19. Barajamda	..	1	..	..	1	..	..	..
20. Chhotaudepur	..	2	2	..	1	3	..	..
21. Pooh
22. Tokapal
23. Dharni
24. Subdega	2	..	..	2	..	..
25. Garhi	2	..	..	2	..	..
Total (Tribal)	..	3	8	..	2	9	..	..
Percentage	..	27.3	72.7	..	18.2	81.8	..	..
<i>III. Urban</i>								
26. Bombay
27. Madras
28. Calcutta
29. Delhi	4	..	..	3	1	..
Total (Urban)	4	..	..	3	1	..
Percentage	100.0	..	..	75.0	25.0	..
All Projects	..	7	26	5	4	28	1	5
Percentage	..	18.4	68.4	13.2	10.5	73.7	2.6	13.2

TABLE 5.5
Background of the ANMs.

Project	Age(yrs)				Educational Qualifications		
	Below 20	20-25	Above 26	N.A.	Below Matric/ High/ Higher Sec.	Graduate and above	N.A.
1	2	3	4	5	6	7	8
<i>I. Rural</i>							
1. Kambadur . . . . .	..	3	7	..	10	..	..
2. Dhakuakhana . . . . .	..	8	..	..	8	..	..
3. Tarapur . . . . .	..	1	2	2	2	..	3
4. Kathura . . . . .	..	2	2	..	4	..	..
5. T. Narasipur . . . . .	..	1	3	4	4	..	4
6. Kangan . . . . .	..	2	4	..	6	..	..
7. Vengara . . . . .	..	2	6	..	8	..	..
8. Singroli	NA	NA	NA	NA	NA	NA	NA
9. Ukhrul	2	6	..	..	8	..	..
10. Nurpur Bedi . . . . .	..	4	3	..	7	..	..
11. Thalli . . . . .	..	2	6	..	8	..	..
12. Nilakottai . . . . .	..	2	10	..	10	..	2
13. Chawmanu	Not appointed so far						
14. Shankargarh	1	6	1	..	7	..	1
15. Dalmau . . . . .	..	4	4	..	8	..	..
16. Jawan . . . . .	..	3	5	..	..	..	8
17. Man Bazar . . . . .	..	4	..	..	..	..	4
Total (Rural)	3	50	53	6	90	..	22
Percentage	2.7	44.6	47.3	5.4	80.4	..	19.6
<i>II. Tribal</i>							
18. Utnoor . . . . .	..	..	3	3	3	..	3
19. Barajamda . . . . .	..	..	3	..	3	..	..
20. Chhotaudepur . . . . .	..	6	7	..	13	..	..
21. Pooh . . . . .	..	2	..	..	2	..	..
22. Tokapal	Not appointed so far						
23. Dharni . . . . .	..	..	7	..	7	..	..
24. Subdega . . . . .	..	3	1	..	..	..	4
25. Garhi . . . . .	..	3	1	..	4	..	..
Total (Tribal)	..	14	22	3	32	..	7
Percentage	..	35.9	56.4	7.7	82.0	..	17.9
<i>III. Urban</i>							
26. Bombay . . . . .	..	..	3	..	3	..	..
27. Madras . . . . .	..	..	2	..	2	..	..
28. Calcutta . . . . .	..	..	2	..	2	..	..
29. Delhi	Not appointed so far						
Total (Urban)	..	..	7	..	7	..	..
Percentage	..	..	100.0	..	100.0	..	..
All Projects	3	64	82	9	129	..	29
Percentage	1.9	40.5	51.9	5.7	81.1	..	18.9

TABLE 5.7

Background and Training of Supervisors

Project	Age (yrs)			Educational Qualifications				Training in ICDS			Total	
	Below 20	20-25	Above 26	N.A.	Below Mat-ric	High/High-er Sec.	Grad-uate & Above	N.A.	Trai-ned	Un-trai-ned		N.A.
	2	3	4	5	6	7	8	9	10	11		12
1	2	3	4	5	6	7	8	9	10	11	12	13
<i>I. Rural</i>												
1. Kambadur	5	..	..	4	1	..	5	..	..	5
2. Dhakuakhana	5	..	..	5	..	..	5	..	..	5
3. Tarapur	2	2	..	2	..	2	4	..	..	4
4. Kathura	1	3	1	..	..	3	2	..	5	..	..	5
5. T. Narasipur	3	2	..	5	..	..	5	..	..	5
6. Kangan	4	..	..	..	..	4	..	4	..	..	4
7. Vengara	4	1	..	3	1	1	4	..	1	5
8. Singroli	2	2	..	..	..	4	..	4	..	..	4
9. Ukhrol	1	2	..	..	..	3	..	3	..	..	3
10. Nurpur Bedi	3	..	..	3	..	..	3	..	..	3
11. Thalli	4	..	..	4	..	..	4	..	..	4
12. Nilakottai	2	1	..	3	..	..	3	..	..	3
13. Chawmanu	3	..	..	1	2	..	3	..	..	3
14. Shankargarh	5	..	..	1	4	..	5	..	..	5
15. Dalamau	5	..	..	..	5	..	3	2	..	5
16. Jawan	5	..	..	2	3	..	4	1	..	5
17. Man Bazar
Total (Rural)	1	10	51	6	..	36	29	3	64	3	1	68
Percentage	1.5	14.7	75.0	8.8	..	52.9	42.6	4.4	94.1	4.4	1.5	..
<i>II. Tribal</i>												
18. Utnoor	2	..	..	2	..	..	..	..	2	2
19. Barajamda	3	..	3	..	..	..	3	..	..	3
20. Chhotaudepur	2	1	..	..	..	3	..	2	1	..	3
21. Pooh	3	..	..	1	2	..	3	..	..	3
22. Tokapal	3	..	..	..	..	3	..	3	..	..	3
23. Dharni	1	..	..	1	..	..	1	..	..	1
24. Subdega	3	..	..	1	2	..	3	..	..	3
25. Garhi	2	1	..	..	..	3	..	2	1	..	3
Total (Tribal)	7	14	..	3	5	13	..	17	2	2	21
Percentage	33.3	66.7	..	14.3	23.8	61.9	..	80.9	9.5	9.5	..
<i>III. Urban</i>												
26. Bombay	4	..	..	..	..	4	..	3	1	..	4
27. Madras	4	..	..	4	..	..	4	..	..	4
28. Calcutta	2	..	..	2	..	..	2	..	2
29. Delhi	4	..	..	..	4	..	2	2	..	4
Total (Urban)	4	8	2	..	4	10	..	9	5	..	14
Percentage	28.6	57.1	14.3	..	28.6	71.4	..	64.3	35.7	..	..
All Projects	1	21	73	8	3	45	52	3	90	10	3	103
Percentage	0.9	20.4	70.9	7.8	2.9	43.7	50.5	2.9	87.4	9.7	2.9	..

TABLE 5.8

Background and Training of AWWs

Project	Age (Yrs.)				Edunl. Qualifications				Training in ICDS			Total
	Below 20	20—25	Above 26	N.A.	Below Matric	High/Higher Sec.	Graduate & above	N.A.	Trained	Untrained	N.A.	
1	2	3	4	5	6	7	8	9	10	11	12	13
<i>I. Rural</i>												
1. Kambadur	—Not yet received—											
2. Dhakuakhana	64	35	1	..	92	8	..	..	100	..	..	100
3. Tarapur	25	49	7	..	80	1	..	..	81	..	..	81
4. Kathura	10	70	18	2	..	68	31	1	100	..	..	100
5. T. Narasipur	8	65	23	2	49	49	..	..	98	..	..	98
6. Kangan	27	13	3	8	41	10	..	..	45	6	..	51
7. Vengara	5	24	8	63	53	47	..	..	74	1	25	100
8. Singroli	11	26	55	41	30	61	2	40	93	..	40	133
9. Ukhrul	15	25	3	32	42	2	..	31	75*	..	..	75
10. Nurpur Bedi	32	23	5	..	21	39	..	..	60	..	..	60
11. Thalli	13	27	3	50	..	43	..	50	93†	..	..	93
12. Nilakottai . . . . .	..	..	..	100	..	..	..	100	..	49	51	100
13. Chawmanu . . . . .	..	23	27	..	23	26	1	..	50	..	..	50
14. Shankargarh	28	56	21	..	73	30	2	..	105	..	..	105
15. Dalmau	18	55	24	..	49	45	..	3	28	69	..	97
16. Jawan	14	59	52	..	61	60	4	..	31	94	..	125
17. Man Bazar	15	22	6	..	31	12	..	..	43	..	..	43
Total (Rural)	285	572	256	298	645	501	40	225	1076	219	116	1411
Percentage	20.2	40.5	18.1	21.1	45.7	35.5	2.8	15.9	76.3	15.5	11.8	

II. Tribal

18.	Utnoor	.	.	.	.	28	47	16	5	61	31	..	4	96	..	..	96
19.	Barajamda	.	.	.	.	14	33	3	..	39	11	..	..	50	..	..	50
20.	Chhotaudepur	.	.	.	.	12	45	6	..	53	10	..	..	62‡	1	..	63‡
21.	Pooh	.	.	.	.	13	31	6	..	47	3	..	..	50	..	..	50
22.	Tokapal	.	.	.	.	7	35	6	..	20	28	..	..	48	..	..	48
23.	Dharni	.	.	.	.	2	35	8	..	11	34	..	..	25	20	..	45
24.	Subdega	.	.	.	.	..	49	5	..	39	15	..	..	54	..	..	54
25.	Garhi	..	.	.	.	18	53	25	..	87	9	..	..	96	..	..	96
Total (Tribal)		.	.	.	.	94	328	75	5	357	141	..	4	481	21	..	502
Percentage		.	.	.	.	18.7	65.3	14.9	1.0	71.0	28.1	..	1.0	95.8	4.2	..	

III. Urban

26.	Bombay	.	.	.	.	22	61	17	..	36	64	..	..	100§	..	..	100§
27.	Madras	.	.	.	.	¶	¶	¶	100	..	100	..	..	100	..	..	100
28.	Calcutta	.	.	.	.	11	51	36	..	..	78	20	..	98	..	..	98
29.	Delhi	.	.	.	.	8	37	25	..	5	49	16	..	70	..	..	70
Total (Urban)		.	.	.	.	41	149	78	100	41	291	36	..	368	..	..	368
Percentage		.	.	.	.	11.1	40.5	21.2	27.2	11.1	79.1	9.8	..	100			
All Projects		.	.	.	.	420	1049	409	403	1043	933	76	229	1925	240	116	2281
Percentage		.	.	.	.	18.4	46.0	17.9	17.7	45.7	40.9	3.3	10.0	84.4	10.5	5.1	

*31 undergoing training.

†50 undergoing training. Details not available.

‡Two expired recently, steps have been taken to fill the post.

§21 AWWs are under training.

¶AWWs are in the age group of 20—30.

TABLE 6.1

Functioning of the Coordination Committee in the ICDS Projects

Project	Whether Coordination Committee formed Yes/No	If yes, Date of Constitution	Composition				Meeting and attendance			
			Officials (nos.)	Non-officials (nos.)	Male	Total	No. of meeting	Av. attendance		
								Official	Non-official	Total
1	2	3	4	5	6	7	8	9	10	11
<i>I. Rural</i>										
1. Kambadur	Yes	13-5-76	7	1	5	7	1	7	1	8
2. Dhakuakhana	Yes	10-5-76	9	2	10	11	1	8	1	9
3. Tarapur	Yes	23-11-76	7	3	9	10	..	..	..	..
4. Kathura	Yes	4-5-76	7	2	7	9	1	6	..	6
5. T. Narasipur	Not yet formed									
6. Kangan	Not yet formed									
7. Vengara	Yes	22-11-75	4	3	3	7	1	4	3	7
8. Singroli	Yes	22-11-75	6	6	N.A.	12	Nil	Nil	Nil	Nil
9. Ukhrul	Yes	Nov. 75	7	3	9	10	1	6	1	7
10. Nurpur Bedi	Not yet formed									
11. Thalli	Yes	N.A.	7	Nil	5	7	1	6	..	6
12. Nilakottai	Yes*	June '76	7	1	5	8	Nil	..	..	..
13. Chawmanu	Yes	2-10-76	10	5	12	15	Nil	..	..	..
14. Shankargarh	Yes	20-12-75	5	1	3	6	4	4	1	5
15. Dalmau	Yes	29-9-75	3	1	4	4	2	3	1	4
16. Jawan	Yes	1-12-75	5	1	5	5	2	4	1	5
17. Man Bazar	Yes	24-1-76	6	3	8	9	1	3	3	6
Total (Rural)	14	..	90	32	85	120	15	51	12	63
Average			6.4	2.4	6.5	8.6	1.5	5.1	1.5	6.3

II. Tribal

18. Utanoor	Yes	12-5-76	7	1	6	8	..	..	..	..
19. Barajamda	Not yet formed									
20. Chhotaudapur	Yes	5-8-76	4	10	12	14	1	4	7	11
21. Pooh	Not yet formed									
22. Tokapal	Yes	31-10-75	5	2	6	7	5	5	2	7
23. Dharni	Not yet formed									
24. Subdega	Not yet formed									
25. Garhi	Yes	N.A.	4	1	5	5	..	..	..	..
Total (Tribal)	4	..	20	14	29	34	6	9	9	18
Average			5.0	3.5	9.2	8.5	3.0	4.5	4.5	9.0

III. Urban

26. Bombay	Not yet formed									
27. Madras	Not yet formed									
28. Calcutta	Yes	1975	5†	3	NA	8	NA	NA	NA	NA
29. Delhi	Yes	10-9-76	7	1	4	8	1	5	1	6
Total	2	..	12	4	4	16	1	5	1	6
Average			6.0	2.0	4.0	8.0	1.0	5.0	1.0	6.0
All Projects	20	..	122	50	118	170	22	65	22	87
Average			6.1	2.5	6.2	8.5	1.6	5.0	1.8	6.2
No. reporting			20	20	19	20	14	13	12	14

*Committee formed at the district level.

†Two more members are yet to be nominated by Directorate of Public Relations and Delhi Council of Child Welfare.

TABLE
Date of Commencement of ICDS Supplementary

Project	Month/year of start	Contribution by						
		Admn, Trans- portation	Fuel/ condi- ments- sund- ries	Pulses	Cereals	Sweet- eners	Food pro- cessing charges	Uten- sils
1	2	3	4	5	6	7	8	9
<i>I. Rural</i>								
1. Kambadur	June '76	+	+					+
2. Dhakuakhana	Aug. '76	+						
3. Tarapur	Sept. '76	+		+	+			
4. Kathura	Aug. '76	+				+		+
5. T. Narasipur	Mar. '76	+	+	+		+		+
6. Kangan	Sept. '76	+				+		
7. Vengara	Apr. '76	+						
8. Singroli	Do.	+						
9. Ukhrol	Jun. '76	+						
10. Nurpur Bedi	Aug. '76	+						
11. Thalli	Sept. '76	+						
12. Nilakottai	Apr. '76	+						
13. Chawmanu	Sept. '76	+		+				
14. Shankargarh	Oct. '76	+	+	+	+			+
(Interruption in feeding)								
15. Dalmau	N.A.							
16. Jawan	Not Started							
17. Man Bazar	Jun. '76	+		+				+
Total								
<i>II. Tribal</i>								
18. Utnoor	May. '76	+		+	+			+
19. Barajamda	Apr. '76	+	+	+	+	@		
20. Chhotaudepur	Feb. '76	+						
21. Poolh	N.A.	+						
22. Tokapal	Oct. '76	+						
23. Dharni	N.A.	+						
24. Subdega	Aug. '76	+		+	+	+	+	
25. Garhi	Feb. '76	+	+					+
Total								
<i>III. Urban*</i>								
26. Bombay	Nov. '76	+						+
27. Madras	Nov. '75							
28. Calcutta	Apr. '76	+	+	+				
29. Delhi	N.A.	+						No information supplied
Total								

@Wheat/Rice; ¹: Mung; ²: Ragi; ³: Jaggery

*Date of feeding beyond the 25th of a month has been counted as the next month. The information SFGS: Soya-Fortified-Soighum-grits, SFBW: Soya-Fortified-Bulger-Wheat, Bulger: Bulger-Wheat, Oil

Achievement in Supplementary Feeding Versus

Project	Total Population 1971 Census	0—1 year			1—3 year		
		TP	A	%A	TP	A	%A
1	2	3	4	5	6	7	8
<i>I. Rural</i>							
1. Kambadur	87715	2631	..	..	5262	..	..
2. Dhakuakhana	72028	2160	..	..	4321	..	..
3. Tarapur	83811	2514	205	8	5029	1230	24
4. Kathura	87200	2616	..	..	5232	327	6
5. T. Narasipur	182340	5470	..	..	10940	..	..
6. Kangan	35684	1070	..	..	2141	..	..
7. Vengara	121956	3559	..	..	7317	5000*	46
8. Singroli	139371	4181	..	..	8362	..	..
9. Ukhrul	34555	1036	..	..	2073	4094*	132
10. Nurpur Bedi	57021	1710	1470	86	3421	1819	53
11. Thalli	113345	3400	..	..	6800	305*	3
12. Nilakottai	102247	3067	612	20	6134	1423	23
13. Chawmanu	49763	1492	..	..	2985	..	..
14. Shankargarh	82360	2470	..	..	4941	..	..
15. Dalmau	88454	2653	..	..	5307	3485	44
16. Jawan	112097	3362	..	..	6725	..	..
17. Man Bazar	91356	2740	..	..	5481	..	..
Total (Rural)	1541303	42869	2287	5	85746	17683	21
<i>II. Tribal</i>							
18. Utnoor	93823	2814	2806	74	5629	2612	46
19. Barajamda	67938	2038	180	9	4076	720	15
20. Chhotaudepur	60362	1810	460	25	3621	2561	71
21. Pooh	16413	492	632	129	985	946	96
22. Tokapal	43922	1317	..	..	2635	1257*	32
23. Dharni	64682	1940	680	35	3881	1236	32
24. Subdega	38718	1161	206	18	2323	528	23
25. Garhi	115930	3478	..	..	6956	..	..
Total (Tribal)	501788	15050	4244	28	30106	9870	33
R + T Total & %	1930994	57919	6531	11	115852	27553	24
<i>III. Urban</i>							
26. Bombay	608168	18245	..	..	36490	..	..
27. Madras	100000	3000	..	..	6000	..	..
28. Calcutta	238026	7141	..	..	14281	396	3
29. Delhi					No information		
Total (Urban)	946194	28386	..	..	56771	396	1
All Projects	2877186	86305	6531	8	172623	27949	16

T.P. Calculated available target population; A: Achievement; % A: % Achievement.

*0—3 years—Vengara, Ukhrul, Thalli; @Pregnant women & Lactating Mother—Thalli and Pooh;

†0.5+years—Chawmanu, Shankargarh, Man Bazar, Kambadur.

7.2

Target Population at the Project Level

3—5+ years			Pregnant women			Lactating mothers		
TP	A	%A	TP	A	%A	TP	A	%A
9	10	11	12	13	14	15	16	17
7017	5748†	39	3508	..	..	5263	..	..
5762	2900	24	2881	..	..	4321	..	..
6705	1845	28	3352	340	10	5029	339	7
6976	2000	29	3488	200	6	5032	137	3
14587	4281	29	7293	..	..	10940	..	..
2854	1200	42	1427	..	..	2141	..	..
9756	4000	41	4878	500	10	7317	500	7
11150	4001	36	5575	187	3	8362	256	3
2764	11321	410	1382	1746	126	2073	2497	120
4561	2663	58	2280	531	23	3421	140	43
9067	1600	18	4533	..	..	6800	827@	7
8180	1867	23	4090	647	16	6134	612	10
3981	1450†	17	1990	..	..	2985	..	..
6588	4060†	29	3294	500	15	4941	612	12
7076	..	..	3538	490	14	5307	961	18
8967	..	..	4483	..	..	6725	..	..
7308	6621†	43	3654	532	15	5481	615	111
114332	51497	45	61646	5673	10	92272	8826	10
7505	3022	40	3752	320	9	5629	842	15
5435	2160	40	2717	180	7	4076	360	9
4828	2507	52	2414	507	21	3621	230	6
1313	1262	96	656	..	..	985	772	47
3513	1711	49	1756	250	14	2635	815	31
5175	1437	28	2587	..	..	3881	833	13
3097	5000	161	1549	95	6	2323	280	12
9274	2350	25	4637	..	..	6956	..	..
40141	19449	48	20068	1352	7	30106	4132	14
154473	70946	46	77231	7025	9	115433	12958	11
48653	4298†	4	24327	..	..	36490	..	..
8000	..	..	4000	..	..	6000	..	..
19042	2310	12	9521	59	1	14281	63	..
No information								
75695	6608	9	37848	59	..	56771	63	..
230168	77554	34	115079	7084	6	172224	13021	8

TABLE 7.3

Availability of major Cereals, Pulses, Oilseeds and Sugarcane Crops as potential Sources of Locally Available Food Supplement

Project	Kharif	Rabi	Summer
1	2	3	4
<i>I. Rural</i>			
1. Kambadur .	Horsegram, Jowar, Bajra, Groundnut, Castor	Paddy, Groundnut	..
2. Dhakuakhana .	Paddy	Paddy, Pulses	Paddy, Mustard
3. Tarapur .	Paddy, Maize, Pulses	Wheat, Pulses, Jowar	Maize
4. Kathura .	Bajra, Paddy, Sugarcane, Jowar, Giwara	Wheat, Gram, Oilseeds	..
5. T. Narasipur .	Paddy, Jowar	..	.. Paddy, Ragi, Groundnut, Sugarcane, Horsegram
6. Kangan .	Paddy, Maize	Wheat, Oilseeds	..
7. Vengara .	Paddy, Tapioca, Coconut	Paddy	Paddy, Ragi
8. Singroli .	Paddy, Millet, Arhar, Blackgram, Til	Mustard, Potato	..
9. Ukhrul .	Paddy, Maize	Oilseeds, Pulses, Vegetables	..
10. Nurpur Bedi	Maize, Groundnut, Bajra	Wheat, Gram	..
11. Thalli	Paddy, Ragi, Jowar, Groundnut, Sugarcane Arhar, Mustard	Paddy, Mustard	Paddy, Ragi, Groundnut, Redgram
12. Nilakottai .	Paddy, Jowar, Bajra, Ragi, Groundnut	Paddy, Jowar, Groundnut, Sugarcane	..
13. Chawmanu	Paddy, Pulses, Sugarcane	Wheat, Pulses, Potato, Mustard	Paddy
14. Shankargarh	Paddy, Jowar, Bajra, Arhar, Til	Wheat, Barley, Gram, Mustard	Maize
15. Dalmau .	Paddy, Jowar, Arhar, Bajra	Wheat, Barley, Gram, Pulses	Pulses, Millet
16. Jawan .	Maize, Bajra, Sugarcane	Wheat, Barley	..
17. Man Bazar	Paddy, Maize,	Wheat, Oilseeds	..
<i>II. Tribal</i>			
18. Utnoor .	Jowar, Blackgram, Paddy, Groundnut, Redgram	Wheat, Bengalgram	..
19. Barajamda .	Paddy, Maize, Pulses	Wheat, Pulses, Oilseeds	Paddy
20. Chhotaudipur .	Paddy, Jowar, Maize, Groundnut, Pulses	Wheat, Jowar	..
21. Pooh .	Millets, Pulses, Potato	Barley, Wheat	..
22. Tokapal .	Paddy, Maize, Til	Horsegram, Mustard, Sugarcane	..
23. Dharni .	Paddy, Jowar, Arhar, Pulses	Wheat, Gram, Pulses	..
24. Subdega .	Paddy, Pulses, Sugarcane	Pulses, Wheat	..
25. Garhi	Maize, Paddy, Blackgram, Arhar, Sugarcane	Wheat, Gram, Mustard	..
<i>III Urban (As per the Ration Card System)</i>			
26. Bombay .	Wheat, Rice, Sugar		
27. Madras .	Do.		
28. Calcutta .	Do.		
29. Delhi .	Do.		

TABLE 7.4

Frequency of Supply of the Flood Commodities by Different Agencies (1976-77)

Project	Once a month			Once in three months & above			A smooth Logistical supply with no interruption	Reported Interruption
	State Govt.	CARE	WFP	State	CARE	WFP		
1	2	3	4	5	6	7	8	9
<i>I. Rural</i>								
1. Kambadur . . . . .	..	Yes	..	..	..	..	Yes	..
2. Dhakuakhana . . . . .	..	..	..	..	..	Yes	Yes	..
3. Tarapur	Yes	..	..	..	..	..	Yes	..
4. Kathura . . . . .	..	Yes	..	..	..	..	Yes	..
5. T. Narasipur	Yes	Yes	..	..	..	..	Yes	..
6. Kangan . . . . .	..	..	..	..	..	Yes	..	Yes
7. Vengara . . . . .	..	..	Yes	..	..	..	Yes	..
8. Singroli . . . . .	..	..	..	..	Yes	..	Yes	..
9. Ukhrul . . . . .	..	..	Yes	Yes	..	..	Yes	..
10. Nurpur Bedi* . . . . .	..	..	..	..	..	..	..	Yes
11. Thalli . . . . .	..	Yes	..	..	..	..	Yes	..
12. Nilakottai . . . . .	..	Yes	..	..	..	..	Yes	..
13. Chawmanu	Yes	..	Yes	..	..	..	Yes	..
14. Shankargarh . . . . .	..	..	..	..	..	..	..	Yes
15. Dalmau . . . . .	..	..	Yes†	..	..	..	Yes	..
16. Jawan . . . . .	..	..	..	NR	..	..	..	..
17. Man Bazar	Yes	..	Yes	..	..	..	Yes	..
Total (Rural)	4	5	5	1	1	2	13	3
<i>II. Tribal</i>								
18. Utnoor . . . . .	..	Yes	..	..	..	..	..	Yes
19. Barajamda	Yes	..	Yes	..	..	..	Yes	..
20. Chhotaudepur . . . . .	..	..	..	..	Yes	..	Yes	..
21. Pooh . . . . .	..	..	..	..	..	Yes	..	Yes
22. Tokapal . . . . .	..	Yes	..	..	..	..	Yes	..
23. Dharni . . . . .	..	Yes	..	..	..	..	Yes	..
24. Subdega . . . . .	..	..	..	Yes	..	..	Yes	..
25. Garhi . . . . .	..	..	..	..	Yes	..	..	Yes
Total (Tribal)	1	3	1	1	2	1	5	3
<i>III. Urban</i>								
26. Bombay . . . . .	..	..	..	..	..	..	Yes	..
27. Madras . . . . .	..	..	..	..	No Supply		..	..
28. Calcutta . . . . .	..	..	..	Yes	..	Yes	Yes	..
29. Delhi . . . . .	..	..	..	NR			..	..
Total (Urban) . . . . .	..	..	..	1	..	1	2	..
All Projects	5	8	6	3	3	4	20	6

*In case of Nurpur Bedi and Bombay, daily supply of Bread and Bun by the CARE and State Govt. respectively have been reported.

†World Bank.

TABLE 7.5

Storage Facilities and Condition of Food Commodities

Project	Storage Facilities									Condition of Food Commodities				
	GDPOs Office	School Building	SDOs qrs.	Pan-chayat office	Rented Rooms	PHC Office	Pucca godown	Food Dept Godown	Good	Fair	Poor	Very Poor	Not relevant Not available	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	
<i>I. Rural</i>														
1. Kambadur				Yes					..	Yes	..	..	..
2. Dhakuakhana						Yes			..	..	..	Yes	..
3. Tarapur							Yes		Yes	..	..	..	..
4. Kathura	Yes								..	..	..	Yes	..
5. T.Narasipur	Yes	..	..	..	..	..	..	..	Yes	..	..	..	..
6. Kangan	Yes	..	..	..	..	..	..	..	Yes	..	..	..	..
7. Vengara	Yes	..	..	..	..	..	..	..	Yes	..	..	..	..
8. Singroli	..	..	..	Yes	..	..	..	..	..	..	..	Yes	..
9. Ukhrul	..	..	Yes	..	..	..	..	..	..	Yes	..	..	..
10. Nurpur Bedi	NR.												Yes	
11. Thalli	..	..	..	Yes	..	..	..	..	..	Yes	..	..	..
12. Nilakottai	..	..	..	Yes	..	..	..	..	Yes	..	..	..	..
13. Chawmanu	..	..	..	..	..	..	..	Yes	Yes	..	..	..	..
14. Shankargarh			NR						..	..	..	..	Yes
15. Dalmau	Yes	..	..	..	..	..	..	..	Yes	..	..	..	..
16. Jawan	NR.	..							..	..	..	..	Yes
17. Man Bazar	Yes	..	..	..	..	..	..	..	..	..	Yes	..	..
Total (Rural)	6	..	1	4	..	1	1	1	7	3	1	3	3	

II. Tribal

18. Utnoor	Yes	..	..	..	..	..	..	..	..	..	Yes	..	..	..
19. Barajamda	..	..	..	..	..	..	..	Yes	..	Yes	Yes	..	..	..
20. Chhotaudepur	Yes	..	..	..	..	..	..	..	..	Yes	..	..	..	..
21. Pooh	Yes	..	..	..	..	..	..	..	..	..	Yes	..	..	..
22. Tokapal	..	Yes	..	..	..	..	..	..	..	..	Yes	..	..	..
23. Dharni	N.R.										Yes			
24. Subdega	Yes	..	..	..	..	..	..	..	..	..	Yes	..	..	..
25. Garhi	..	..	..	..	Yes	..	..	..	..	..	Yes	..	..	..
Total (Tribal)	4	1	..	..	1	..	1	..	2	5	..	..	1	

III. Urban

26. Bombay	NA				..	..	..	..	..	..	..	..	..	Yes
27. Madras	Nil.				..	..	..	..	..	..	..	..	..	Yes
28. Calcutta	Yes	..	..	..	..	..	..	..	..	..	..	Yes	..	..
29. Delhi	N.R.										Yes			
Total (Urban)	1	..	..	..	..	..	..	..	..	..	..	1	..	3
All Projects	11	1	1	4	1	1	2	1	9	8	2	3	7	

TABLE 8.1

Pre ICDS Utilization of Selected Child Health Service through the PHC Health Centre Complex (April 1975-March, 1976).

Project	PHC Sub-Centres	Population of 0-5+ Yrs. Children	Well Baby Clinics	Immunisation			Nutritive Supplement				Re-ferral
				D.P.T.	B.C.G.	Polio	Primary Small pox Vaccine	Iron & Folic Acid	Oral Vitamin A	Other Nutritional Services	
1	2	3	4	5	6	7	8	9	10	11	12
<i>I. Rural</i>											
1. Kambadur . . .	17	14910	6045(41)	491(3)	0(0)	0(0)	2506(17)	0(0)	0(0)	0(0)	0(0)
2. Dhakuakhana . . .	5	12243	0(0)	1198(10)	0(0)	0(0)	0(0)	0(0)	6000(49)	0(0)	0(0)
3. Tarapur . . .	16	14248	0(0)	145(1)	0(0)	145(1)	1076(9)	0(0)	9(0)	0(0)	0(0)
4. Kathura . . .	12	14824	2728(18)	0(0)	0(0)	0(0)	4224(28)	0(0)	0(0)	0(0)	0(0)
5. T. Narasipur . . .	20	30997	0(0)	669(2)	0(0)	0(0)	11271(36)	0(0)	5053(16)	0(0)	0(0)
6. Kangan . . .	5	6065	600(10)	50(0)	(0)0	0(0)	1394(23)	0(0)	15000(247)	0(0)	0(0)
7. Vengara . . .	20	20732	494(2)	NA	NA(—)	NA(—)	8161(39)	1655(8)	1362(7)	0(0)	0(0)
8. Singroli . . .	15	23693	305(1)	188(0)	NA(0)	0(0)	54(0)	0(0)	890(4)	0(0)	0(0)
9. Ukhrul . . .	12	5873	7(0)	0(0)	0(0)	0(0)	982(17)	0(0)	NA(—)	0(0)	NA(—)
10. Nurpur Bedi . . .	16	9692	6045(63)	491(5)	0(0)	751(8)	1840(19)	0(0)	0(0)	0(0)	2(0)
11. Thalli . . .	10	19267	42(0)	3269(17)	0(0)	0(0)	4431(23)	0(0)	3847(20)	0(0)	0(0)
12. Nilakottai . . .	NA	17381	504(3)	NA	NA(—)	NA(—)	2018(12)	NA(—)	858(5)	0(0)	12(0)
13. Chawmanu . . .	NA	8458	65(0)	0(0)	0(0)	0(0)	1834(22)	0(0)	15289(180)	0(0)	2(0)
14. Shankargarh . . .	3	13999	75(0)	200(1)	150(1)	NA—	316(2)	NA(—)	NA(—)	NA(—)	NR(+)
15. Dalmau . . .	21	15036	1497(10)	1179(8)	0(0)	0(0)	3485(23)	0(0)	4000(27)	0(0)	NA(0)
16. Jawan . . .	16	19054	444(2)	71(0)	0(0)	0(0)	3313(17)	593(3)	0(0)	0(0)	0(0)
17. Man Bazar . . .	2	15529	0(0)	210(1)	(0)	0(0)	1238(8)	210(1)	0(0)	0(0)	0(0)
Total (Rural) . . .	180	262001	18851(7)	8161(3)	150(0)	896(0)	48143(18)	2458(1)	52411(20)	0(0)	16(0)

<i>II. Tribal</i>													
18. Utnoor	.	.	16	15348	NA								
19. Barajamda	.	.	3	11549	0(0)	0(0)	0(0)	0(0)	424(4)	0(0)	0(0)	0(0)	12(0)
20. Chhotaudepur	.	.	15	10253	1862(18)	286(3)	8317(81)	0(0)	1426(14)	0(0)	0(0)	0(0)	NA(0)
21. Pooh	.	.	1	2770	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)	70(3)	0(0)	0(0)
22. Tokapal	.	.	12	2910	9(0)	176(0)	0(0)	0(0)	0(0)	1698(5)	2515(85)	0(0)	0(0)
23. Dharni	.	.	8	7465	NA(—)	0(0)	0(0)	0(0)	2957(4)	0(0)	0(0)	9(0)	0(0)
24. Subdega	.	.	3	6581	857(13)	0(0)	0(0)	0(0)	643(10)	0(0)	700(11)	0(0)	6(0)
25. Garhi	.	.	23	19708	0(0)	1118(6)	1560(8)	2230(11)	7974(40)	0(0)	0(0)	0(0)	NA(—)
Total (Tribal)	.	.	81	76584	2719(4)	1580(2)	9877(13)	2230(3)	13424(18)	1688(2)	3285(4)	9(0)	18(0)

III. Urban

26. Bombay	.	.	6	103388	NA(—)	490(0)	8845(9)	20646(20)	22987(22)	NA(—)	NA(—)	NA(—)	NA(—)
27. Madras	.	.	5	17000	NA								
28. Calcutta	.	.	NA	40464	0(0)	0(0)	0(0)	0(0)	5404(13)	0(0)	0(0)	0(0)	0(0)
29. Delhi	.	.	3	(0)	2346(0)	1943(—)	0(0)	506(0)	24(0)	0(0)	0(0)	0(0)	0(0)
Total (Urban)	.	.	14	160852	28464(18)	2433(2)	8845(5)	21152(13)	28415(18)	0(0)	0(0)	NA(0)	NA(—)
All Projects	.	.	275	499437	50034(10)	12174(2)	18872(4)	24278(5)	89982(18)	4156(1)	55696(11)	9(0)	34(—)

Percentages in Parentheses.

TABLE 8.2

Pre-ICDS-Utilization of Selected Maternal Health Services through the PHC or Urban Health Centre Complex (April 1975-March 1976)

Project	PHC Sub Centres	Population of pregnant & Lactating women	Pregnant women Population	15-44 Yrs. Female Population	Ante/Post Natal	Conduct of Deliveries	Tetanus Toxoid	Iron & Folic Acid	Referral	IUCD & Tubectomies for female (15-44 Yrs.)		
										IUCD	TT	% covered (Col 11 +12)
1	2	3	4	5	6	7	8	9	10	11	12	13
<i>I. Rural</i>												
1. Kambadur .	17	8771	3508	17540	0(0)	586(17)	0(0)	0(0)	0(0)	21	166	(1)
2. Dhakukhana .	5	7202	2881	14400	30(1)	50(2)	30(1)	6000(83)	0(0)	41	0	(0)
3. Tarapur .	16	8381	3352	16760	164(5)	457(14)	5(0)	432(5)	0(0)	36	75	(0)
4. Kathura .	12	8520	3408	17040	540(16)	605(18)	127(4)	31363(368)	0(0)	220	125	(2)
5. T.Narasipur .	20	18233	7293	36460	NA—	1096(15)	255(3)	305(2)	0(0)	220	403	(2)
6. Kangan .	5	3568	1427	7130	551(38)	68(5)	177(12)	6000(168)	0(0)	94	0	(1)
7. Vengara .	20	12195	4878	24390	1080(22)	215(4)	1175(24)	1655(14)	0(0)	76	45	(0)
8. Singroli .	15	13937	5575	27880	376(7)	51(1)	188 (3)	174(1)	0(0)	49	5	(0)
9. Ukhrul .	2	3455	1382	6910	14(1)	36(3)	0(0)	1800(52)	0(0)	25	0	(0)
10. Nurpur Bedi .	16	5701	2280	11400	3057(134)	6(0)	834(37)	1154(20)	0(0)	537	320	(7)
11. Thalli .	10	11333	4531	22670	160(4)	17(0)	246(5)	1316(12)	0(0)	10	0	(0)
12. Nilakottai .	NA	10224	4089	20450	1428(35)	1131(28)	925(23)	1424(14)	0(0)	55	428	(2)
13. Chawmanu .	NA	4975	1990	9950	658(33)	374(19)	0(0)	132(3)	8(0)	0	0	(0)
14. Shankargarh .	3	8235	3294	16470	157(5)	485(15)	NA—	21000(255)	0(0)	89	160	(2)
15. Dalmau .	21	8845	3538	17690	1103(31)	804(23)	514(15)	1099(12)	0(0)	130	154	(2)
16. Jawan .	16	11208	4484	22420	794(18)	430(10)	64(1)	1317(12)	23(0)	286	61	(2)
17. Man Bazar .	2	9135	3654	18270	293(8)	240(7)	145(4)	1110(12)	0(0)	53	775	(5)
Total(Rural)	180	153918	61567	307830	10405(17)	6658(11)	4685(8)	76281(50)	31(0)	1942	2717	(2)

<i>II. Tribal</i>												
18. Utnoor . . .	16	9381	3752	18760	-----			NA	-----			
19. Barajamda . .	3	6793	2718	13590	210(6)	155(6)	0(0)	100(1)	60(1)	10	0	(0)
20. Chhotaudepur	15	6035	2415	12070	1420(52)	135(6)	418(1)	3520(58)	NA—	41	47	(1)
21. Pooh . . .	1	1641	656	3280	73(3)	35(5)	0(0)	70(4)	0(0)	0	0	(0)
22. Tokapal . . .	12	4391	1756	8780	14(2)	247(14)	83(5)	619(14)	3(0)	34	0	(1)
23. Dharni . . .	3	6468	2587	12940	3993(227)	171(7)	500(19)	(—)	9(0)	0	44	(0)
24. Subdega . . .	8	3872	1548	7740	547(21)	139(9)	60(4)	0(0)	0(0)	2	244	(3)
25. Garhi . . .	23	11593	4637	23180	1274(82)	369(8)	100(2)	0(0)	0(0)	13	92	(0)
Total (Tribal)	81	50174	20069	100340	7531(38)	1251(6)	161(6)	4309(21)	72(0)	150	427	(0)
<i>III. Urban</i>												
26. Bombay. . .	6	60817	24323	121640	78669 (323)	10251(42)	NA	NA	NA	0	0	(0)
27. Madras . . .	5	10000	4000	20000	-----			NA	-----			
28. Calcutta . . .	NA	23802	9521	47600	38024	2770(69)	Nil	2688(11)	25(0)	0	0	(0)
29. Delhi . . .	3	..	..	..	5766	824	1301	2785	135(0)	153	504	(NA)
Total (Urban)	14	94619	37849	189240	122459(324)	13845(37)	1301	5473(6)	160(0)	153	504	(0)
All Projects . .	275	298711	119484	597420	140395(118)	21754(18)	6147(5)	86063(72)	255(0)	2245	3648	(1)

Pregnant women: Calculated at 4% of the total population. Pregnant Women and Lactating mothers: Calculated at 10% of the total Population.
 Women eligible for FP services: Calculated at 20% of the total population.

Percentages in Parenthesis % of cols. 6,7 & 8 to Col. 4, % of cols. 9 & 10 to Col. 3, % of Cols. 11+12 to Col. 5 given under Col. 13.

TABLE
Preliminary Attempts at the Delivery of Health

Project	Villages	Target		Achievement			
		Population		Children (0—5+)			
		0—5+	Pregnant & Lactating Women	Immunisation		Health Check up	
		villages	No. (%)	Villages	No. (%)		
1	2	3	4	5	6	7	8
<i>I. Rural</i>							
1. Kambadur	40	14910	8771	..	—(—)	..	—(—)
2. Dhakukhana	167	12243	7202	142	10684(87.2)	142	1356(11.0)
3. Tarapur	98	14248	8381	..	—(—)	..	—(—)
4. Kathura	30	14824	8520	..	—(—)	..	—(—)
5. T. Narasipur	124	30997	18233	49	2130(6.8)	49	4799(15.4)
6. Kangan	42	6065	3568	..	—(—)	NA	25(0.4)
7. Vengara	7	20732	12195	..	—(—)	..	—(—)
8. Singroli	270	23693	13937	..	—(—)	..	—(1)
9. Ukhrul	63	5873	3455	35	2100(35.0)	..	—(—)
10. Nurpur Bedi	110	9692	5701	..	—(—)	..	—(—)
11. Thalli	54	19267	11333	..	—(—)	..	—(—)
12. Nilakottai	188	17381	10224	..	—(—)	..	—(—)
13. Chawmanu	238	8458	4975	..	—(—)	..	—(—)
14. Shankargarh	212	13999	8235	..	—(—)	..	—(—)
15. Dalmau	124	15036	8845	28	1503(9.9)	28	2567(17.0)
16. Jawan	108	19054	11208	..	—(—)	..	—(—)
17. Man Bazar	223	15529	9135	36	670(4.3)	1	33(0.2)
Total (Rural)	2098	262001	153918	290	17087(6.5)	220	8780(3.3)
<i>II. Tribal</i>							
18. Utnoor	162	15348	9381	93	8871(57.7)	..	..
19. Barajamda	70	11549	6793	..	—(—)	..	..
20. Chhotaudepur	59	10253	6035	..	—(—)	..	..
21. Pooh	32	2770	1641	..	—(—)	..	..
22. Tokapal	70	2910	4391	..	—(—)	..	..
23. Dharni	144	7465	6468	..	—(—)	..	..
24. Subdega	56	6581	3872	..	—(—)	..	..
25. Garhi	167	19708	11593	..	—(—)	..	..
Total (Tribal)	760	76584	50174	93	8871(11.6)	..	..
<i>III. Urban</i>							
26. Bombay . . . . .	..	103388	60817	..	—(—)	..	..
27. Madras . . . . .	..	17000	10000	..	—(—)	..	..
28. Calcutta . . . . .	..	40464	23802	..	210(0.5)	..	1312(3.2)
29. Delhi . . . . .	..	..	..	..	—(—)	..	..
Total (Urban)	..	160852	94619	..	210(0.1)	..	13120.8
All Projects	2858	499437	298711	383	26168(5.2)	220	10092(2.0)

Percentages in Parenthesis

Base to estimate coverage of Pregnant women with tetanus was taken to be 61567 women,

8.3

Services—Targets and Achievements

Pregnant women and Lactating mothers							
Referral		Immunisation		Health Check up ..		Referral	
Villages	No. (%)	Villages	No. %	Villages	No. %	Villages	No (%)
9	10	11	12	13	14	15	16
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	142	206(7.0)	142	233(3.2)	..	—(—)
..	—(—)	..	(—)—	..	—(—)	..	—(—)
..	—(—)	..	(—)—	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
..	—(—)	..	—(—)	..	—(—)	..	—(—)
8	8(0.05)	28	50(—)	28	801(9.4)	3	3(0.03)
..	—(—)	—(—)	—(—)	—(—)	—(—)	—(—)	—(—)
..	—(—)	1	4(—)	1	2(0.02)	..	—(—)
8	8(0.003)	171	260(0.4)	171	1036(0.6)	3	3(0.002)
(—) ..	..	93	78(2.0)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	59	418(17.3)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—)	—(—)	152	496(2.5)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(3.2) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(—) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(0.8) ..	—(—)	..	—(—)	..	—(—)	..	—(—)
(2.0)	8.(0.002)	323	756(0.6)	171	1036(0.3)	3	3.(0.001)

TABLE 9.1

Achievement in Non-formal Education Vs. Target for Pre-school Children (3—5+yrs.)

Project	Target population children (3—5+yrs)	Enrolment of children (3—5+yrs)	Percentage to Col. 2
1	2	3	4
<i>I. Rural</i>			
1. Kambadur	7,017	5,748	81.9
2. Dhakuakhana	5,762	2,900	50.3
3. Tarapur	6,705	1,845	27.5
4. Kathura	6,976	2,000	28.7
5. T. Narasipur	14,587	4,281	29.3
6. Kangan	2854	7200*	252.3
7. Vengara	9756	4000	41.0
8. Singroli	11150	4000	35.9
9. Ukhrul	2764	2716	98.3
10. Nurpur Bedi	4561	2663	58.4
11. Thalli	9067	1600	17.6
12. Nilakottai	8180	1867	22.8
13. Chawmanu	3981	1450	36.4
14. Shankargarh	6588	4060	61.6
15. Dalmau	7076	..	0.0
16. Jawan	8967	..	0.0
17. Man Bazar	7308	6221	85.1
Total (Rural)	123299	52551	42.6
<i>II. Tribal</i>			
18. Utnoor	7505	3022	40.3
19. Barajamda	5435	2160	39.7
20. Chhotaudepur	4828	2507	51.9
21. Pooh	1313	1262	96.1
22. Tokapal	3513	1711	48.7
23. Dharni	5175	1437	27.8
24. Subdega	3097	5000*	161.4
25. Garhi	9274	2350	25.3
Total (Tribal)	40140	19449	48.4
<i>III. Urban</i>			
26. Bombay	48653	4298	8.8
27. Madras	8000	..	0.0
28. Calcutta	19042	2310	12.1
29. Delhi	TVD	NA	0.0
Total (Urban)	75695	6608	8.7
All Project	239134	78608	32.9

*Enrolment figures appear to be high.

TABLE 10.1

Indicator to Assess Adequacy or Inadequacy of Office/Storage and Residential Quarters for the CDPO/PHC Staff and Availability of Basic Amenities

Project	Individual Score			Sub score	Individual Score			Sub score	Individual Score				Sub score	Final score
	A1	A2	A3		B1	B2	B3		C1	C2	C3	C4		
	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<i>Rural</i>														
1. Kambadur	1	1	1	1.0	1	1	1	1.0	2	2	1	1	1.5	1.7
2. Dhakuakhana	1	1	1	1.0	1	2	1	1.3	0	2	2	2	1.5	1.3
3. Tarapur	2	2	2	2.0	1	1	1	1.0	1	2	1	1	1.2	1.4
4. Kathura	1	0	1	0.7	1	2	1	1.3	2	2	2	1	1.8	1.3
5. T. Narasipur	1	1	0	0.7	2	2	2	2.0	1	1	2	1	1.2	1.3
6. Kangan	1	2	0	1.0	2	2	2	2.0	2	2	2	2	2.0	1.7
7. Vengara	1	1	0	0.7	1	1	0	0.7	2	2	2	1	1.8	1.1
8. Singroli	2	0	2	1.3	1	1	1	1.0	2	2	0	1	1.2	1.2
9. Ukhrul	2	0	0	0.7	2	2	2	2.0	1	1	1	2	1.2	1.3
10. Nurpur Bedi	2	2	0	1.3	1	0	1	0.7	1	1	1	1	1.2	1.1
11. Thalli	1	1	0	0.7	1	1	0	0.7	2	1	2	1	1.5	1.0
12. Nilakottai	1	1	2	1.3	1	0	0	0.3	2	2	2	2	2.0	1.2
13. Chawmanu	1	2	0	1.0	1	1	2	1.3	0	1	2	1	1.0	1.1
14. Shankargarh	1	0	1	0.7	1	1	1	1.0	0	1	2	1	1.0	0.9
15. Dalmau	1	1	0	0.7	1	2	0	1.0	0	1	1	1	0.8	0.8
16. Jawan	1	1	1	1.0	1	2	1	1.3	2	2	2	2	2.0	1.4
17. Man Bazar	1	0	2	1.0	1	1	1	1.0	2	1	1	1	1.2	1.1
<i>I. Tribal</i>														
18. Utnoor	1	0	1	0.7	2	2	1	1.7	1	2	0	2	1.2	1.2
19. Barajamda	1	1	1	1.0	1	1	1	1.0	2	1	2	1	1.5	1.2
20. Chootaudepur	2	0	0	0.7	1	2	2	1.7	2	1	2	2	1.8	1.4
21. Pooh	1	1	0	0.7	2	2	0	1.3	0	0	2	2	1.0	1.0
22. Tokapal	2	1	2	1.7	2	2	1	1.7	0	1	2	2	1.2	1.5
23. Dharni	0	0	0	0.0	1	1	1	1.0	2	2	2	1	1.8	0.9
24. Subdega	1	0	1	0.7	2	1	1	1.3	2	2	2	1	1.8	1.3
25. Garhi	1	0	0	0.3	1	1	1	1.0	2	2	2	2	2.0	1.1
<i>II. Urban</i>														
26. Bombay	2	2	2	2.0	2	2	2	2.0	2	2	2	0	1.5	1.8
27. Madras	1	1	0	0.7	0	0	0	0.0	0	0	0	0	0.0	0.2
28. Calcutta	2	2	0	1.3	2	2	0	1.3	2	2	2	1	1.8	1.5
29. Delhi	2	2	1	1.7	1	2	0	1.0	2	2	2	0	1.5	1.4

A1—Office space for CDPO; A2—Storage space for CDPO; A3—Residential quarters for CDPO; B1—Clinic Space at PHC; B—2 Storage space at PHC; B—3—Residential quarters of PHC Staff; C1—Electricity; C2—Water supply; C—3 Sanitary facility; and C4—Indoor beds at the PHC.

TABLE 10.2

Preparedness Indicators—IODS

Project	Individual Score						Critical indicators Sub-score	Individual Score						Less Total Critical indicators Sub-score		
	A	B	C	D	E	F		G	H	I	J	K	L		M	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
<i>I. Rural</i>																
1. Kambadur	0	1.5	1.7	1.0	1.2	2.0	7.4	1.0	1.0	0	2.0	1.6	1.7	0.5	7.8	15.2
2. Dhakuakhana	0	2.0	1.0	2.0	1.0	1.0	7.0	2.0	2.0	0.0	1.8	1.9	1.3	0.5	9.5	16.5
3. Tarapur	0	2.0	1.0	2.0	1.2	0	6.2	2.0	0	0	1.5	1.1	1.4	0.5	6.5	12.7
4. Kathura	2.0	2.0	2.0	2.0	1.0	2.0	11.0	2.0	0	2.0	1.8	0.3	1.3	0.5	7.9	18.9
5. T. Narasipur	0	2.0	1.7	2.0	1.5	1.0	8.2	1.0	0	0	1.3	1.2	1.3	0	4.8	13.0
6. Kangan	1.0	1.5	2.0	2.0	1.3	0	7.8	2.0	0	0	1.5	1.0	1.7	0	6.2	14.6
7. Vengara	0	2.0	1.5	2.0	0.7	2.0	8.2	2.0	0	0	1.3	0.9	1.1	1.0	6.3	14.5
8. Singroli	0	1.5	0.9	1.0	0.7	0	4.1	0	2.0	0	1.8	1.4	1.2	1.5	6.9	11.0
9. Ukhrul	0	1.5	2.0	2.0	0.7	0	6.2	2.0	0	0	1.3	1.2	1.3	1.0	6.8	13.0
10. Nurpur Bedi	2.0	1.5	2.0	1.0	1.0	2.0	9.5	2.0	0	0	1.5	0.3	1.1	0	4.9	14.4
11. Thalli	0	2.0	1.0	0	0.3	1.0	5.3	1.0	0	0	1.3	0.6	1.0	0	2.9	8.2
12. Nilakottai	2.0	2.0	0.7	0	0	2.0	6.7	1.0	0	0	1.3	0.6	1.2	0.5	4.6	11.3
13. Chawmanu	0	1.0	1.3	2.0	0.8	0	5.1	0	2.0	0	1.8	0.8	1.1	0.5	4.2	9.3
14. Shankargarh	0	1.5	2.0	0	1.2	1.0	5.7	2.0	2.0	0	1.5	0.9	0.9	1.0	8.3	14.0
15. Dalmau	0	2.0	1.0	2.0	1.2	2.0	8.2	2.0	0	0	1.8	1.6	1.8	1.0	7.2	15.4
16. Jawan	0	2.0	0.5	2.0	1.2	0	5.7	1.0	2.0	0	1.5	1.0	1.4	1.0	7.9	13.6
17. Man Bazar	0	1.0	1.5	0	2.0	0	4.5	0	1.0	0	1.5	1.1	1.1	0.5	5.2	9.7
Total (Rural)	7.0	29.0	23.8	23.0	17.0	16.0	6.9	23.0	12.0	2.0	26.5	17.5	20.1	10.0	6.3	13.2
<i>II. Tribal</i>																
18. Utnoor	0	0.5	0.4	2.0	1.3	0	4.2	4.0	2.0	0	1.0	1.8	1.2	0.5	6.5	10.7
19. Barajamda	1.0	2.0	0.7	1.0	0.5	0	5.2	1.0	0	0	1.5	0.8	1.2	0	4.5	9.7
20. Chhotaudepur	2.0	2.0	1.2	2.0	9.7	1.0	9.9	2.0	0	0	1.3	1.3	1.4	1.5	7.5	17.4
21. Pooh	2.0	1.5	1.3	2.0	1.0	0	7.8	1.0	0	2.0	1.0	1.6	1.0	0	6.6	14.4
22. Tokapal	4.0	1.5	1.0	2.0	1.7	2.0	8.2	1.0	2.0	0	1.5	0.9	1.5	1.0	7.9	16.1
23. Dharni	2.0	1.5	0.5	4.0	1.7	0	5.7	2.0	2.0	0	0.5	0	0.9	0	5.4	11.1
24. Subdega	4.0	2.0	1.0	2.0	0.5	2.0	7.5	2.0	0	0	1.5	1.3	1.3	0	6.1	13.6
25. Garhi	2.0	1.5	1.9	2.0	0.8	2.0	10.2	1.0	1.0	0	1.8	1.2	1.1	0	6.1	16.3
Total (Tribal)	9.0	12.5	8.0	13.0	9.2	7.0	7.3	10.0	7.0	2.0	10.1	8.9	9.6	3.0	6.3	13.5
<i>III. Urban</i>																
26. Bombay	0	2.0	1.5	4.0	0	0	3.5	0	0	4.0	1.0	0	1.8	0	2.8	6.3
27. Madras	0	1.5	1.0	2.0	0	0	4.5	0	2.0	4.0	0.5	0.8	0.2	0	3.5	8.0
28. Calcutta	0	1.0	0.7	4.0	2.0	0	3.7	0	0	2.0	1.3	1.0	1.5	1.0	6.8	10.5
29. Delhi	0	1.0	1.0	4.0	2.0	0	4.0	0	0	4.0	1.0	0.7	1.4	0.5	3.6	7.6
Total (Urban)	0	5.5	4.2	2.0	4.0	..	3.9	..	2.0	2.0	3.8	2.5	4.9	1.5	4.2	8.1
ALL PROJECTS	16.0	47.0	36.0	38.0	30.2	23.0	6.6	34.0	20.0	6.0	40.4	28.9	35.4	14.5	6.0	12.2

A : Identification of Target Population; B : Placement of Staff; C : Training of Health and Non-health staff; D : Actual Vs. Planned Setting-up of Anganwadi; E : Adequacy of Vaccines, etc.; F : Adequacy of Medicines to Budgetary Norms; G : Fulfilling Health Staff requirement; H : Expenditure to Allocation; I : Outlay for SNP/ANP; J : Flow of Capital Inputs; K : Flow of Useable Inputs; L : Accommodation; M : Coordination.

TABLE 10.3

Implementation Indicators

Project	Supple- mentary Nutrition	Pre-Pri- mary Education	Health	Total score	Remarks	
1	2	3	4	5	6	
<i>I. Rural</i>						
1. Kambadur	0.3	2.0	0	2.3		
2. Dhakuakhana	0.3	0	0.5	0.8		
3. Tarapur	0.7	1.0	0	1.7		
4. Kathura	0.3	1.0	0	1.3	It is to be noted that although Kathura demonstrated an excellent state of preparedness its preliminary attempts at implementation have been below average.	
5. T. Narasipur	0.3	1.0	0	1.3		
6. Kangan	0.7	2.0	0	2.7		
7. Vengara	1.3	2.0	0	3.3		Vengara acquitted itself well in both 'Preparedness' and implementation.
8. Singroli	0.3	1.0	0	1.3		Very poor in preparedness. Good in implementation. Nurpur Bedi has also done excellently good in 'Preparedness' and implementation.
9. Ukhrul	1.3	2.0	0	3.3		
10. Nurpur Bedi	2.0	2.0	0	4.0		
11. Thalli	0	0	0	0		
12. Nilakottai	1.0	0	0	1.0		
13. Chawmanu	0	0	0	0		
14. Shankargarh	0.3	1.0	0	1.3		
15. Dalmau	0.7	0	0	0.7		
16. Jawan	0	0	0	0		
17. Man Bazar	0.7	2.0	0	2.7		
• Total (Rural) Average	10.2	17.0	0.5	27.7		
	..	..	..	1.6	
<i>II. Tribal</i>						
18. Utnoor	2.0	2.0	0.3	4.3	It is surprising how Utnoor with a poor 'preparedness' score has done well in implementation. Needs investigation.	
19. Barajamda	0.7	2.0	0	2.7		
20. Chhotaudepur	1.7	2.0	0	3.7	Chhotaudepur has done extremely well with respect to both 'Preparedness' as well as implementation.	
21. Pooh	2.0	2.0	0	4.0		
22. Tokapal	1.0	2.0	0	3.0	Pooh has done very well in both preparedness and implementation.	
23. Dharni	1.0	1.0	0	2.0		
24. Subdega	1.0	2.0	0	3.0	Garhi which topped in 'preparedness' has done poorly in implementation.	
25. Garhi	0.3	1.0	0	1.3		
Total (Tribal) Average	9.7	14.0	0.3	24.0		
	..	..	..	3.0	
<i>III. Urban</i>						
26. Bombay	0	0	0	0	Urban Projects have been extremely slow and halting in all respects. Needs thorough investigation and perhaps restructuring of the programme.	
27. Madras	0	0	0	0		
28. Calcutta	0	0	0	0		
29. Delhi	0	0	0	0		
Total (Urban) . . . . .	..	..	..	..
ALL PROJECTS Average	19.9	31.0	0.8	51.7		
	..	..	..	1.8	

The maximum score that can be obtained by a project is 6.

ANNEXURES

ANNEXURE I

Copy of the letter No. 12-2/76-CD dated 15 March, 1976 from the Department of Social Welfare, Government of India to State Governments and the Union Territory of Delhi.

SUBJECT : Health and Nutrition Education under ICDS.

Several programmes for improvement of nutritional status of the vulnerable section of the population have been taken up by the Central and the State Governments. These include the Special Nutrition Programme, the Balwadi Nutrition Programme, the Mid-day Meals programmes etc. These programmes provide supplementary nutrition feeding to children and pregnant and nursing mothers. Convergence of supporting health services and health and nutrition education can make these programmes very effective in improving the health and nutritional status of the target population. However, it has been the general experience that health and nutrition education of the community has not converged in any substantial measure on any of the group nutrition feeding programmes. The Integrated Child Development Services aim at an integrated delivery of a package of services, which include, amongst other services, the component of health and nutrition education of women. Child care education is the core of health and nutrition education. Guidelines on child care education are enclosed with a request that the messages, included in these guidelines, may be communicated to the community in the ICDS project areas by using various communication media. These guidelines may be brought to the notice of all authorities and agencies concerned with ICDS and various feeding programmes. Copies of this letter along with the guidelines are being endorsed to all the training institutions for the training of personnel under ICDS programmes so that these guidelines are kept in focus in the training programmes of these functionaries.

***Guidelines on Child Care Education.**

I. Basic messages

1. Breast feed as long as possible
2. Introduce semi-solid food from five to six months
3. Feed young children three to six times a day
4. Don't reduce food in illness
5. Use the health services available
6. Get children immunized
7. Keep yourself and your surroundings clean; drink clean water
8. Have you more than two or three children, two to three years apart

II. Components

1. Pregnant Mother
 - (i) *Eat more than usual amount of cereals and pulses, and plenty of dark green yellow vegetables and fruits.
 - (ii) Visit PHC doctors/ANM during last three months of pregnancy.
2. New Baby
 - (i) Mother's milk is best don't discard colostrum.
 - (ii) If you feed additional liquids, use a traditional feeding vessel; instead of a spoon.
3. Keep on breast
 - (i) Feeding as long as possible, but this is not sufficient by itself after the age of five to six months.
4. Mothers' breast feeding to the child
 - (i) Mother should eat more than usual amount of cereal and pulse, and plenty of dark green and yellow vegetables and fruits.
 - (ii) Visit the doctor/ANM for check-up.
5. Start semi-solid food (local staple or mashed ready-to-eat foods) after five to six months, and also undiluted cow's milk if you can. Those foods must be prepared carefully. Give what you would normally give later much earlier, as raw vegetables and fruits.

6. As the child grows amount and variety of foods should be increased. By the time he is a year old he should be fed similar foods as are given to the rest of the family—cereals, pulses, green vegetables, perhaps supplemented by processed ready-to-eat foods—but in order to get as much as he needs he should be fed these solid foods three or four times a day.
7. When you are unable to feed the child with your own milk, solid food (which may include supplementary ready-to-eat foods) should be given five or six times a day. Also, if possible, undiluted cow's or buffalo's milk or Milktone. (Milktone is 50 per cent milk extracted from vegetable sources).
8. Do not use excessive water for cooking rice and vegetables. If you drain the water after cooking do not discard it, it is good for you and should be consumed.
9. To prevent the child from getting some diseases he should be immunized. This will probably make him a little ill, but will prevent him from getting terrible scars later and perhaps dying.
10. To prevent him from getting other diseases he should be kept clean and his surroundings should be as clean as possible. Don't spit or cough at or near him.
11. Do not let excreta lie around where your baby may be playing. Remove it quickly to a place outside his reach. After baby defecates, wash him clean with soap and wash your hands. Your child may be sick if he puts dirty hands in his mouth.
12. Hands should be washed before eating, and before preparing foods, and before holding and feeding baby.
13. Kitchen and feeding utensils should be kept clean and not allowed to attract flies. Flies means dirt and dirt means danger.
14. Food should be kept covered from flies and dust.
- 15.† Only the safest available water should be drunk. A child needs plenty of water.
- 16.‡ Learn to recognize signs of common diseases : cough, diarrhoea-dehydration fever, running ear, skin diseases, sore eyes, and poor sight. Learn their management and how to deal with accidents in the home and when to seek advice from ANM/doctor.
- 17.* When the child is ill with fever or diarrhoea-continue to feed him as before—but you may have to prepare the food more appetisingly. You may have to force him a little. He will get better quicker if he eats plenty of cereal, pulses, green vegetables etc.
18. Encourage the child to play with simple household articles and things he can gather in the neighbourhood.
- 19.§ Children cared for in this way are likely to be alert and curious and grow well.
20. Children cared for in this way are likely to survive much better than those who are not. You may not want so many children, family planning can show you how to achieve this, and how to space those you do have by two to three years.

*Give examples of particular cereals, pulses, vegetables and methods for their preparation. If it is customary to eat animal foods such as eggs, meat or fish, and these can be readily obtained, they should be referred to.

†Source of this water to be discussed in detail with women by those who are communicating child care messages.

‡(i) If there are local schemes for the provision of Vitamins A capsules, or iron/folic acid tablets, explain how these can be obtained, and why.

(ii) If rickets is a problem (parts of central India) explain importance of allowing child some exposure to sunlight.

§'and grow well' — If the mother is likely to come in contact with a centre using health record/weight charts, these should be referred to and explained.

ANNEXURE II

Project Team*Project Director*

B.N. Sahay — Joint Director

I. HEADQUARTERS STAFF

Social Development Division

1. V. E. Easo	— Deputy Director
2. Champa Aphale	— Asstt. Director
3. Ashok Kumar	— Sr. Economic Investiga
4. C. A. Kadam	— Do.
5. J. M. Sahoo	— Do.
6. R. S. Mangla	— Economic Investigator
7. P. D. Hinduan	— Do.
8. Tara Dutt	— Tabulation Clerk
9. K. L. Kathuria	— Computer
10. S. N. Gupta	— Personal Assistant
11. Lalit Kumar	— Do.
12. M. M. Joshi	— Stenographer
13. Karam Chand	— Do.

II. FIELD STAFF

Region	Deputy Director	Asstt. Director	Investigators
1	2	3	4
1. Northern (Punjab, H.P., J. & K. & Haryana)	R. P. Singh	Y. K. Gupta M. S. Narula S. P. Sharma	I. C. Tyagi Ram Sarup O. P. Chauhan Prem Chand M. R. Kohli Balwinder Pal Kanwar Bhan J. N. Kalla Ram Datt R. P. Mehta Gurdev Singh
2. North—Central (U.P. & Bihar)	R. P. Jain	M. P. Agarwal A.S. Srivastva R. K. Shahi S. K. Roy B. P. Verma	N. S. Rawat Z. M. Gufran Khem Chand Awadesh Singh H. C. Dhar Dubey D. Barla R. R. Srivastava Ram Lal O. P. Gupta K. S. Choudhary K. R. Singh G. P. Verma

II. FIELD STAFF—*Contd.*

1	2	3	4
3. Central (M.P. & Rajasthan)	R. K. Sachdeva	G. B. Dube S.S. Jain A. S. Nikhade M. R. Dohare	Ramchandra C. H. Gohil Prem Chand H. P. Sharma R. K. Chawla C. M. Kulethwale G. R. Khanna M. G. Bakshi B. L. Sharma R. L. Meena
4. Eastern (Assam, Orissa, W. Bengal, Manipur and Tripura)	K. S. Shetty	A. K. Chakravorty N. Dasgupta A. K. Neog M. Roy V. K. Kalvade	T. B. Suryakar S. Mukhopadhyay B. K. Banerjee S. Sur R. N. Biswas A. C. Das A. K. Sarkar S. Mohanta J. K. Chanda Wahedullah Bhudev Chakravorty Golak Chand Sinha G. C. Sahu S. K. Mohanty
5. Western (Gujarat & Maharashtra)	V. R. Suri	V. V. Subba Rao P. A. Madiwale V. V. Oak	Miss A. Khanum V. V. Paranjape G. S. Gupte N. L. Borkar C. M. Patil B. R. Gawali M. I. Farooqui N. T. Ataliwale
6. South Central (Andhra Pradesh & Karnataka)	G. A. Sastry	V. Rama Rao D. Amarnath P. M. Rangasami	M. S. Shankarnarayanan D. V. Biniwale P. N. Satpathy K. Narasimhaiah K. C. Lingaswamy A. N. Sastry B. S. Murthy P. G. Rao B. C. Narasimhulu A. Narayanaswamy P. Pandian
7. Southern (Kerala and Tamil Nadu)	K. T. Varkey	T. Narayana N. Muthukrishnan K. N. Chandra- sekar V. K. Manoharan	G. Subramany M. Penthaswamy H. Lakshminarasimhan T. Lakshmanan S. Kesavan P. S. Ragavan A. V. Thomas Smt. Sankarivenkateswaran K. K. Narayanan Smt. M. N. Sreedevi Amma C. M. Mathew Abraham Varghese

ANNEXURE III

Members of the Technical Advisory Committee for the Evaluation of ICDS Projects

1. Shri Ajit Mozoomdar,
Secretary, Planning Commission, New Delhi.
2. Dr. S. M. Shah,
Chief (PEO), Planning Commission, New Delhi.
3. Director (CD),
(Shri S. Kapoor), Department of Social Welfare,
Shastri Bhavan, New Delhi.
4. Dr. A. B. Bose,
Director (PREM), Department of Social Welfare,
Shastri Bhavan, New Delhi.
5. Dr. N. V. K. Nair,
Adviser (Nutrition), D.G.H.S., Department of Health,
Nirman Bhavan, New Delhi.
6. Dr. (Miss.) E. V. Sebastian,
Deputy Commissioner, (MCH),
Department of Family Welfare,
Nirman Bhavan, New Delhi.
7. Dr. B. N. Tandon,
Professor & Head, Deptt. of Gastroenterology and
Human Nutrition, All India Institute of Medical Sciences,
Ansari Nagar, New Delhi.
8. Prof. K. Ramachandran,
Associate Professor of Bio-Statistics,
All India Institute of Medical Sciences,
Ansari Nagar, New Delhi.
9. Shri S. N. Dutta,
Deputy Secretary, Department of Education,
Shastri Bhavan, New Delhi.
10. Dr. K. G. Krishnamurthy,
Joint Director (SW), Planning Commission, New Delhi.
11. Dr. B. N. Sahay,
Joint Director (PEO), Planning Commission, New Delhi.

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