CHAPTER - III

WORKING OF INTEGRATED CHILD DEVELOPMENT SERVICES
INTRODUCTION

To help the women and children in facing their problems, a programme called Integrated Child Development Services was launched on the 106th birth day of Mahatma Gandhi i.e. on October 2, 1975. Initially it was launched only in 33 projects. That small beginning has expanded to 1356 projects by 1985. By 1992 the ICDS was covering 2696 of the total 5092 community development blocks in India. This chapter aims to understand and analyse the working ICDS project.

OBJECTIVES OF I.C.D.S.

The main objectives of the Integrated Child Development Services programme are,

1. To improve the nutritional and health status of children in the age group of 0 to 6 years.

2. To lay the foundations for 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 effective coordination of policy and implementation amongst the various departments to promote child development, and

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

To realise these objectives the following package of services were included in ICDS.

1. Supplementary Nutrition,
2. Immunization,
3. Health check-up,
4. Referral services,
5. Nutrition and Health Education and
6. Non-formal Pre-school Education

The scheme of Functional Literacy for Adult Women (FLAW) was also integrated with ICDS as an integral and essential component. This is expected to improve the health education and non-formal education.

BENEFICIARIES

The package of services was intended to reach the following groups.

a. Children below six years of age,
b. Expectant and nursing mothers and
c. Women in the age group of 15-45 years.

SELECTION OF BENEFICIARIES

The ICDS programme strives for the greatest REACH or COVERAGE. As such the beneficiaries are to be selected carefully. The scheme will provide integrated services to children below the age of 6 years. Restricting the coverage to the children of less than 6 years is based on the consideration that pre-school age can be considered a definite phase in the development of the child for which a suitable strategy can be formulated. Early childhood itself would need to be reclassified into different age groups and different needs taken into consideration in delivering the services.

Pregnant women, nursing mothers, belonging to the families of landless agricultural labourers, marginal farmers, schedule castes, scheduled tribes and other poorer sections of the community whose total monthly income of all members of the family do not exceed Rs. 500 should be enlisted as beneficiaries of the scheme.

Since the mother has a key role in the physical, psychological and social development of the child, nursing and expectant mothers would have to be brought into the
programme of ICDS. Attention will also have to be given to mothers and therefore women from 15-45 years have to be brought within the orbit of ICDS. The delivery of services to the different beneficiary groups are indicated in the following schedule.

**Services for the Beneficiaries**

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Type of Beneficiaries</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Expectant and nursing mothers</td>
<td>1. Health check-up</td>
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<tr>
<td></td>
<td></td>
<td>2. Immunization of expectant mothers against tetanus.</td>
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<td></td>
<td></td>
<td>3. Referral services</td>
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<td></td>
<td></td>
<td>4. Supplementary nutrition</td>
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<td></td>
<td></td>
<td>5. Nutrition &amp; health education</td>
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<tr>
<td>2.</td>
<td>Other women (15 to 45 years)</td>
<td>1. Nutrition &amp; health education</td>
</tr>
<tr>
<td>3.</td>
<td>Children below 1 year of age</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral services</td>
</tr>
<tr>
<td>4.</td>
<td>Children between 1 and 3 years of age</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral services</td>
</tr>
<tr>
<td>5.</td>
<td>Children between 3 and 6 years of age</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Non-formal pre-school education.</td>
</tr>
</tbody>
</table>
As already indicated, supplementary nutrition, immunization, health care, referral services, nutrition and health education and non-formal pre-school education are the major components of I.C.D.S. A detailed account of each component in general are presented in the following pages.

I. SUPPLEMENTARY NUTRITION:

This has been recognized as a pivotal service for women and children. The level of nutrition supplements to children and mothers in I.C.D.S and Special Nutrition Programme was recommended as under:

For children (6-72 months) 300 calories of food and about 10 gm. of proteins.

For severely malnourished children between 6 and 72 months of age 600 calories of food along with 20 gm. of proteins.

For pregnant women (last trimester) and nursing mothers (first six months of lactation): 500 calories of food along with about 20 gm. of proteins.

It was further envisaged that, where the food from Co-operative for American Relief Everywhere (CARE) / World Food Programme (WFP) is being utilized for nutrition supplements, the approved ration implies a higher supplement than the above mentioned limits. In the utilization of aid
food from CARE/WEP, a pattern of double ration for mothers i.e., double the ration prescribed for children who are not severaly malnourished is generally followed and that may be continued. The revised consolidated unit costs of nutritional supplements as effective from 1st April, 1985, are mentioned below.  

1. Children (6-72 months) 75 paise per child per day  
2. Severaly malnourised children (6-72 months) 125 paise per child per day  
3. Pregnant women and nursing mothers 105 paise per beneficiary per day  

To finance the administration a small amount is used by the Ministry of Social Welfare. Due to this administrative cost, the unit costs for nutritional supplements in these projects will be less by ten paise per beneficiary per day. Thus the unit cost for the above mentioned categories worksout to 65, 115 and 95 paise respectively.  

The entire cost of supplementary nutrition has to be met from the provisions made for the Special Nutrition Programme (SNP) in the State sector under the Minimum Needs Programme (MNP). With the introduction of ICDS the SNP has

3. All India Institute of Medical Sciences, Monitoring and Continuing Education System, Central Technical Committee on Health and Nutrition, AIIMS, New Delhi, 1988.
been merged with the ICDS programme and ceases to have a separate identity.

**SELECTION OF BENEFICIARIES:**

The beneficiaries of this programme as suggested are pregnant women and nursing mothers belonging to the families of landless agricultural labourers, marginal farmers (holding not exceeding one hectare), scheduled castes, scheduled tribes and other poorer sections of the community. Income level was also to be taken into consideration while selecting the beneficiaries. The families whose income do not exceed Rs. 500/- per month should be enlisted for supplementary nutrition. A pregnant women or nursing mother, not belonging to any of the above mentioned categories can be enlisted for supplementary nutrition if the doctor or para-medical worker so advises on health grounds.

All the children between 3 and 6 years of age, who came for non-formal pre-school education are also entitled for supplementary nutrition, irrespective of their nutritional grades.

The nutritional grading of children below six years of age are to be done for implementing the programme. The grading of children will be done on the basis of
measuring the mid-upper-arm circumference (MUAC) and weight for age.

Children who have MUAC of less than 12.5 cm i.e. falling in the red zone of the coloured strip, are identified as severely malnourished. Similarly, children whose weight for age is less than 60 per cent of the normal is categorized as severely malnourished. These children should be provided with therapeutic nutrition (easily digestable nutrition food) which gives about 600 calories and 20 gm. of proteins per child per day. This should be provided in three to four feeds, of which at least two feeds should be given at the Anganwadi Centre itself.

A child having MUAC of between 12.5 cm to 13.5 cm. i.e. yellow zone with weight for age between 60-70 per cent of the expected weight should be considered moderately malnourished. These children are given 300 calories and 8-10 gms of proteins per day.

Children having MUAC of more than 13.5 cm (i.e. green zone) or weight for age more than 80 per cent of

* For measuring MUAC, a three coloured strip is being commonly used. Based on the MUAC, children are classified as under,
  a. children who are in the green zone are normal,
  b. children in the yellow zone are moderately malnourished
  c. children who are in the red zone are severely malnourished
expected weight, are considered to have adequate nutrition and do not require supplementary at the Anganwadi Centre.

**COVERAGE:**

In rural and urban areas 40.0 per cent of all children under six years of age and 40.0 per cent of all expectant and nursing mothers has to be covered under the Supplementary Nutrition Programme, ensuring food for 300 days in a year or 25 days in a month. In tribal projects as many as 75.0 per cent of children and mothers are to be covered.

**PROCUREMENT:**

The food items are procured by a committee headed by the Additional Deputy Commissioner. This committee approves the rates and ensures uninterrupted food supply and also quality of the food items. Usually, 1-2 months supply is made to each Anganwadi Centre.

**SELECTION OF FOOD ITEMS AND RECIPES**

The scheme provides sufficient flexibility in selection of nutritious food with emphasis on menus prepared from locally available food materials. Generally, cereal-pulse, cereal-pulse-oilseed or cereal-pulse-jaggery mixture
are the preferred foods. At times, nuts and soyabeans also are included in the supplementary nutrition food. The guiding principles for selecting food items are easy availability, acceptability, palatability and preservation qualities. Ready to eat food and special therapeutic nutritious foods were also introduced.

Co-operative for American Relief Everywhere (CARE) provides Soya Fortified Bulgar Wheat (SFBW) and Corn Soya Milk (CSM) to many states for supplementary feeding under ICDS. This apart, WFP Food Commodities also provide Soya Fortified Bulgar Wheat (SFBW) and butter oil for supplementary feeding to ICDS projects in some states.

II. IMMUNIZATIONS:

Immunization against diphtheria, whooping cough, tetanus, polio myelitis and tuberculosis of all infants by their first birth day is proposed in the ICDS areas. Immunization against measles will be given if the local epidemiological situation warrants. Children of 5 to 6 years of age also be given booster dose for diphtheria and tetanus and two doses of typhoid vaccination. As tetanus among newborn is common and is usually dangerous, all expectant mothers will be immunized against tetanus. An immunization schedule is given to all the children on the following lines.
IMMUNIZATION SCHEDULE:

Following schedule of immunization is recommended to be used under the project:

<table>
<thead>
<tr>
<th>AGE</th>
<th>VACCINATION</th>
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<tbody>
<tr>
<td>3 to 9 months</td>
<td>(a) Start with first dose of Diphtheria - Pertusis - Tetanus DPT (injection)</td>
</tr>
<tr>
<td></td>
<td>first dose of Polio myelitis (oral drops) BCG (Tuberculosis injection).</td>
</tr>
<tr>
<td></td>
<td>(b) After an interval of 1-2 months, give second dose of DPT (injection)</td>
</tr>
<tr>
<td></td>
<td>second dose of polio (oral drops).</td>
</tr>
<tr>
<td></td>
<td>(c) After an interval of 1-2 months, give DPT (injection) and polio</td>
</tr>
<tr>
<td></td>
<td>vaccination (oral drops).</td>
</tr>
<tr>
<td>9 to 12 months</td>
<td>Measles vaccine (injection) one dose, where available.</td>
</tr>
<tr>
<td>18 to 24 months</td>
<td>(a) Booster DT (Diphtheria and Tetanus) (injection) first dose of typhoid</td>
</tr>
<tr>
<td></td>
<td>monovalent or bivalent vaccine (injection).</td>
</tr>
<tr>
<td></td>
<td>(b) After an interval of 1-2 months, give second dose of Typhoid vaccine</td>
</tr>
<tr>
<td></td>
<td>(injection).</td>
</tr>
</tbody>
</table>

The ages shown for the various immunizations are considered as the best times. However, if there is any delay in starting the first dose, the periods may be adjusted accordingly. It should be the aim that a child before reaching one year of age should have received one dose of
Polio vaccines can be given at the same time. The minimum interval between doses of DPT and polio vaccine should be one month. Children without BCG scar should be given the BCG vaccination. Infants who have missed DPT and polio vaccine by the first birth day should be given three doses of DPT and three doses of polio by two years of age. Children over two years who have not received DPT should be given two doses of DT at an interval of one to two months.

In case of children of 5-6 years, one dose of DT as a booster will be sufficient if there is a history of receiving DPT or DT earlier. Otherwise two doses of DT at an interval of one to two months will be required. In case of typhoid vaccination, two doses at an interval of one to two months have to be given.

**IMMUNIZATION OF EXPECTANT MOTHERS**:

Under the scheme, expectant mothers are protected with tetanus toxoid immunization. The schedule of tetanus toxoid immunation are as follows.

First dose : 16 - 20 weeks of pregnancy
Second dose : 20 - 24 weeks of pregnancy

The minimum interval between two doses of tetanus toxoid should be at least one month. The second dose given
at least two weeks before the expected date of delivery. However, no pregnant women should be denied even one dose of tetanus toxoid if she is seen late. In case of history of tetanus toxoid immunization in a previous pregnancy, one booster dose will be sufficient.

**PROPHYLAXIS AGAINST BLINDNESS AND ANAEMIA:**

Anganwadi Centres have been used for effective distribution of vitamin-A solution to young children. Further, a high level of coverage has been ensured for anaemia prophylaxis and vitamin-A prophylaxis among children and pregnant and lactating women.

**III. HEALTH CHECK-UPS**

This service includes ante-natal care, post-natal care, care of new borns and care of children under six years of age. More needy mothers and children of poor and landless agricultural labourers and marginal farmers are to be provided with the services of the health check-ups. The health check-ups and care will be rendered by Auxiliary Nurse Midwife (ANM) and Lady Health Visitor (LHV) under the guidance of the medical officer working in Primary Health Centres (PHC).
The Anganwadi worker acts as a primary health care worker. Women alone are appointed as Anganwadi workers. They have been trained to look after minor ailments and has been provided a medicine kit which is replenished at regular intervals.

ANTE-NATAL CHECK-UPS

The expectant mothers are to be identified for ante-natal check-ups as early as possible. Since the Anganwadi worker is stationed in the village, she is closer to them and early identification is possible. The complete registration of ante-natal mothers through regular home visits and contacts with traditional birth attendants is also to be made by the workers.

When ICDS was started, the emphasis was to register pregnant mothers for feeding programmes only (during the second and third trimester of pregnancy). But from 1980 onwards ante-natal mothers are also registered and given tetanus toxoid, iron and folic acid tablets and supplementary nutrition apart from health check-ups. This step is envisaged so as to enlarge the base for family welfare activities by all health workers. The Anganwadi workers are given the minimum supply of adequate equipment at the level of sub-centres. The equipment includes
It has to be recognised that most of the mothers in rural areas deliver in their homes. This fails them in securing scientific post-natal care. As such Anganwadi workers are to make post-natal visits to mothers in their homes twice within 10 days after delivery, if the village have either PHCs or sub centres. If there are no such facilities atleast one visit within the first month after delivery should be made.

In the urban projects more frequent and better post-natal care could be organised. These visits should be utilized to check up the general health and well being of the mothers, establishment of successful breast feeding of the new born and attention to the general health of the infants. Records of deliveries attended by PHC personnel should be kept in the relevant card.

The mothers are to be educated to come to the clinic for post-natal examination of herself as well as of her infant within 6 to 8 weeks after the delivery. The post-natal clinic will provide general physical examination of the mother to know whether she has regained her general
health and is fit to resume her normal work as well as to examine the child and advise on its health and nutrition requirements.

At the post-natal clinics, mothers will be helped to adopt a suitable method for either spacing the next birth or for limiting the family size. The findings of the post-natal examination and the acceptance of the family planning method should be entered in the ante-natal delivery card of the mother.

**CHILD CARE:**

The following activities are proposed at I.C.D.S. centres for child care who are six years of age.

1. Serial recording of the height and weight of children,
2. Watch over major events in the growth and development of the child,
3. Provide all the immunizants according to the policy enunciated,
4. Provide general check-up every three/six months in order to detect diseases and other evidence of malnutrition or infection,
5. Provide treatment for the widely prevalent diseases like diarrhoea, dysentery, upper respiratory-tract infections, skin diseases, eye diseases like trachoma, conjunctivities etc.
6. Deworming against the prevalent parasitic infections, round worm, thread-worm, hook worm etc,
7. Prophylactic measures against diseases of nutritional origin like anaemia, vitamin deficiencies, marasmus
etc., through distribution of drugs and diet supplements, and

8. Refer serious cases to the appropriate hospital for specialized treatment.

Health records of children should be maintained in cards. A card should also be given to the mothers of children under five years of age. A card with the mother helps in educating and sustaining her interest in the health of the small children and make them understand and avail of the services offered by the project.

IV. REFERRAL SERVICES:

Pregnant mothers and children with problems requiring specialized treatment will be referred to the upgraded PHC/sub-division/districts headquarters hospital. Based on the conditions, the medical officer of PHC will refer such cases with a referral slip prescribed for the purpose. The hospital after completing the treatment are to refer the mother/child back to the PHC with notes of treatment given and further treatment/advice to be followed.

RECORDS AND REGISTERS:

The records and registers meant for pregnant mothers and children include the following.

1. Register of DPT/tetanus immunization
2. Ante-natal card
3. Delivery card
4. Card for children aged over 5 years
5. Child's card under five years of age
6. Referral card
7. Nominal Register.

V. NUTRITION AND HEALTH EDUCATION:

The I.C.D.S. also aims at nutrition and health education activities. At Anganwadi centres young children are given instructions on healthy habits like hand washing, cutting of nails, eating clean food, mouth washing and gargling and drinking clean water. During feeding and weighing sessions, mothers are given specific messages on nutrition and health.

The I.C.D.S. provides adequate educational material on nutrition and health education to Anganwadi centres. The material is normally made available in local languages. Posters, charts and other printed materials are also form part of education material. Film strips and slide projectors have also been provided at the project level.

Anganwadi workers have to organise women's groups, like mahila mandals and young women's groups. Linking of craft centres and adult education centres with Anganwadi education activities are also common. Functional literacy groups as part of the functional literacy for adult women
were also organized to enable women to enhance their capabilities to look after the health and nutritional needs of their children.

VI. NON-FORMAL PRE-SCHOOL EDUCATION (NFPSE):

Non-formal Pre-school Education seeks the foundation for the proper physical, psychological, cognitive and social development of the child, ushering in all-round development of the child. The focus of non-formal education are children who are between 3-5 years of age. The main purpose of this education is to develop desirable social attitudes, values and behavioural pattern, and provide environmental stimulations for the children. Learning methods followed are normally play-way methods.

The objectives of NFPSE through I.C.D.S are to (i) develop adequate muscular coordination and basic motor skills in children, (ii) develop creativity and aesthetic appreciation and elementary hygienic sense, (iii) provide opportunities for interacting with other children of the same age group, (iv) develop in the child the ability to express his/her thoughts and feelings in fluent, correct and clear speech, and (v) develop the habit of attending the anganwadi centre regularly.
The NFPSE activities are organised by the anganwadi workers at the anganwadi centres. The children aged between three and five years are enrolled for this purpose. On an average two hours per day are spent on NFPSE activities. Many efforts have to be made to attract children for these activities, whose major part comprises supplementary nutrition, rich play material and indigenous games.

VII. CONVERGENCE OF OTHER SUPPORTIVE SERVICES LIKE WATER SUPPLY AND SANITATION

The UNICEF has strongly recommended to the States /Union Territories that before selecting ICDS project areas, special efforts should be made to ensure the supply of safe drinking water and improve the environmental sanitation of the villages. It was further suggested that all functionaries should make continued efforts to improve the quality of drinking water and hygienic conditions in their respective project areas.¹

In response to the UN sponsored water supply and sanitation decade (1981 - 1990), the Government of India set targets for achieving 80 per cent sanitation coverage of the urban and 25 per cent coverage of rural population by 1990.²

FAMILY WELFARE SERVICES IN ICDS

The survey registers of Anganwadi workers are to be used effectively to identify eligible couples and to follow-up the sterilized cases. Health workers and anganwadi workers have to move together as a team to enlist the eligible couples. Anganwadi workers are to give suggestions to mothers in the reproductive age period who seek their help for contraception. They are also to build a favourable climate for the family welfare programme during feeding sessions. Pregnant mothers are also to be motivated by the workers to limit the size of the family. Anganwadi worker should function as a promotor of the programme and lay emphasis on spacing, small family and better child development. 4, 5

CRITERIA FOR SELECTION OF PROJECT AREA

The package of activities to be introduced naturally depends on the need of the beneficiaries. Therefore the project has to be selected based on the types

4. UNICEF, The Imperative to Succeed, statement by David P. Haxton, Regional Director, UNICEF, South Central Asia Region at the ICDS Review meeting, New Delhi, 1982.

of beneficiaries and the socio-economic conditions of the area where the project is to be located.

In the selection of projects in rural areas, priority consideration was given to the following areas.

1. Areas predominantly inhabited by tribals, particularly backward tribes.
2. Backward areas,
3. Drought-prone areas / flood-prone areas,
4. Areas inhabited predominantly by scheduled castes,
5. Nutritionally deficient areas, and
6. Areas poor in development of social services.

In the selection of ward(s) in urban areas for urban projects, priority consideration will be given to the following factors.

1. Location of slums, and
2. Areas predominantly inhabited by scheduled castes.

In the initial stages, the major consideration was to convert existing supplementary feeding centres located in tribal and rural areas and in urban slums in selected ICDS project areas into Anganwadis under the ICDS scheme.
The administrative unit for the location of I.C.D.S project is a community development block in rural areas, a tribal development block in tribal areas and a group of slums in urban areas. In some states, the taluka is the administrative unit. The Anganwadi is the focal point for delivery of the package of services to mothers and children. An Anganwadi is a mother and child development centre and covers about 1000 population in rural/urban areas and 700 in tribal areas. The key person who manages the Anganwadi is known as the Anganwadi worker. Women of the same village is chosen having qualifications of middle/matric or even primary level education in some areas. As the I.C.D.S is a multi-sectoral programme, the organization at various levels is indicated with the help of the chart 3.1.

**JOB FUNCTIONS OF ANGANWADI WORKERS:**

The Anganwadi worker is an honorary worker and receives only an honorarium. She is assisted by a Helper who is also a local women and is also paid a small honorarium. She is responsible for:

1. community survey and enlisting of beneficiaries,
2. non-formal pre-school education,
CHART 3.1
ORGANISATIONAL POSITION OF ICDS FUNCTIONARIES

MINISTRY OF HEALTH AND FAMILY WELFARE

MINISTRY OF HUMAN RESOURCE DEVELOPMENT DEPARTMENT OF WOMEN'S WELFARE

STATE HEADQUARTERS

DIRECTOR HEALTH SERVICES STATE COORDINATOR (HEALTH INPUTS)

DIRECTOR/ PROJECT OFFICER INCHARGE OF ICDS

DISTRICT LEVEL

CHIEF MEDICAL OFFICER ADVISER

DISTRICT SOCIAL WELFARE DISTRICT TRIBAL WELFARE OFFICER/ICDS PROGRAMME OFFICER

BLOCK PRIMARY HEALTH CENTRAL LEVEL

MEDICAL OFFICER (MO)

CHILD DEVELOPMENT PROJECT OFFICER(CDPO) BLOCK DEVELOPMENT OFFICER (BDO)

SUB-CENTRAL LEVEL

HEALTH ASSISTANT FEMALE (HAF) LADY HEALTH VISITOR (LHV)

MUKHYA SEVUKA (SUPERVISOR)

HEALTH WORKER FEMALE(HMF) AUXILIARY NURSE MIDWIFE (AMM)

VILLAGE LEVEL

HEALTH GUIDE AMGARWADI WORKER

COMMUNITY
3. supplementary feeding of children and mothers,
4. primary health care and first aid,
5. assisting health staff in immunization and health check-ups,
6. referral services to severely malnourished, sick and 'at risk children',
7. health and nutrition education,
8. enlisting community support for Anganwadi functions,
9. organizing women's groups and mahila mandals,
10. school enrolment of children, and
11. maintenance of records and registers.

JOB RESPONSIBILITIES OF SUPERVISORS

The work of Anganwadi workers is supervised by Mukhya Sevikas (supervisors) who guide and help them. Mukhya Sevikas are appointed to look after 25, 20 and 17 Anganwadis in urban, rural and tribal projects respectively. Her specific duties include guidance to Anganwadi workers in household surveys, assuring adequate coverage of target groups, use of weighing scales and arm bands, conducting home visits, maintenance of records, monitoring immunization coverage and other important support systems.

She acts as a liaison between both the Anganwadi workers and the PHC staff, which delivers the basic health services of the ICDS programme. Between the Anganwadi
workers and Child Development Project Officer also Mukhya Sevikas function as liaison workers.

**JOB RESPONSIBILITIES OF CDPO**

Child Development Project Officer (CDPO) is incharge of each ICDS project. The CDPO co-ordinates and implements the ICDS programmes and is responsible for managing the project. The CDPO supervises and guides the entire project team, including the Mukhya Sevikas and Anganwadi workers, making field visits and calling staff meetings for this purpose.

**OTHER HEALTH INPUTS**

All the anganwadi areas in a project are devided into Mukhya Sevika Circles. The anganwadi areas are also divided among Auxiliary Nurse Midwives (ANM) or Multipurpose Female Health Workers (MFHW). Ideally, the health workers service area will correspond to that of Mukhya Sevika in order to facilitate joint visits to the Anganwadis. On an average, an ANM looks after about five Anganwadis. A Lady Health Visitor (LHV) looks after the work of about four ANMs. The entire project area is also geographically devided among the total members of medical officers in the PHC. Each
medical officer is responsible for all the PHC activities included in the ICDS programme in his area.

The PHC and subordinate infrastructure will deliver the following health services to the beneficiaries of ICDS.

1. Health check-ups,
2. Referral services,
3. Immunization,
4. Health and nutrition education to women in the 15 - 25 years of age group,
5. Continuing education of ICDS and health functionaries,
6. Monitoring of the health components of ICDS, and
7. Support the AWW and supply additional medicines in the kit of the AWW.

WORKING OF ICDS IN ANANTAPUR DISTRICT

The working condition of ICDS in Anantapur district has been measured in comparison with Andhra Pradesh and India. Table 3.1 provides necessary information in this regard.
Table 3.1

Working of ICDS in India, Andhra Pradesh and Anantapur District.

<table>
<thead>
<tr>
<th>S.No.</th>
<th>India</th>
<th>Andhra</th>
<th>Anantapur</th>
</tr>
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<tbody>
<tr>
<td>1. Project sanctioned up till 1992</td>
<td>2,692</td>
<td>169</td>
<td>17</td>
</tr>
<tr>
<td>2. Fully operational</td>
<td>2,428</td>
<td>148</td>
<td>17</td>
</tr>
<tr>
<td>3. No. of Anganwadis reporting</td>
<td>249,310</td>
<td>17,588</td>
<td>2,099</td>
</tr>
<tr>
<td>4. Population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Children</td>
<td>29,638,502</td>
<td>1,981,685</td>
<td>244,066</td>
</tr>
<tr>
<td>b) Average no. of children per AW</td>
<td>118.9</td>
<td>112.7</td>
<td>116.3</td>
</tr>
<tr>
<td>c) Mothers</td>
<td>5,404,786</td>
<td>380,813</td>
<td>38,879</td>
</tr>
<tr>
<td>d) Average no. of mothers per AW</td>
<td>21.7</td>
<td>21.7</td>
<td>18.5</td>
</tr>
<tr>
<td>5. Supplementary Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No. of Anganwadis providing SNP</td>
<td>223,287</td>
<td>16,481</td>
<td>2,099</td>
</tr>
<tr>
<td>b) Total children receiving SNP</td>
<td>13,959,975</td>
<td>1,209,917</td>
<td>125,225</td>
</tr>
<tr>
<td>c) Average children per AW</td>
<td>62.52</td>
<td>73.41</td>
<td>59.65</td>
</tr>
<tr>
<td>d) Mothers receiving SNP</td>
<td>2,685,976</td>
<td>261,177</td>
<td>25,837</td>
</tr>
<tr>
<td>e) Average mothers per AW</td>
<td>12.03</td>
<td>15.85</td>
<td>12.30</td>
</tr>
<tr>
<td>6. Pre-school Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No. of AWs providing PSE</td>
<td>234,468</td>
<td>16,047</td>
<td>2,099</td>
</tr>
<tr>
<td>b) Total children attending PSE</td>
<td>8,566,189</td>
<td>631,164</td>
<td>61,748</td>
</tr>
</tbody>
</table>
7. Immunization

a) BCG 2,358,511 101,798  
b) DPT 2,327,170 95,590  
c) Polio 2,336,778 96,656  
d) DT 321,890 11,728  
e) Measles 2,142,614 98,197  
d) TT 1,899,368 95,701

8. Nutrition and Health Education

a) No. of AWs where NHEd activities were organised 1,379  
b) Total women participated in all AWs 24,149  
c) Average mothers per AW 17.51


Till 1992, 2,692 ICDS projects have been sanctioned in India and of them, 2,428 are fully operational. The total number of Anganwadis reporting are 249,310 in India. Through this Anganwadis 5,404,786 mothers and 29,638,502 children are to be served. In average number
of mothers per Anganwadi in India works out to 21.7. In Andhra Pradesh too the figure is same. However in Anantapur it is much lower at 18.5. The average children per Anganwadi who are given supplementary nutrition works out to 62.52 in India, 73.41 in Andhra Pradesh and 59.65 in Anantapur. A comparison on the same lines in case of mothers works out to 12.03, 15.85 and 12.30 respectively for India, Andhra Pradesh and Anantapur. The average children per Anganwadi receiving pre-school education is 36.53 in India 39.33 in Andhra Pradesh 29.41 in Anantapur. No comparative figures are available regarding immunization for India, Andhra Pradesh and Anantapur. Same is the case with nutrition and health education.

The first Anganwadi centre was sanctioned in 1975 in Anantapur District. By the end of 1992 - 93, the total number of centres sanctioned were 2,252. Of them 2,099 centres are functioning which works out to 93.2 per cent. The year-wise sanction of Anganwadi centre was given in table 3.2.
Table 3.2

<table>
<thead>
<tr>
<th>Year of sanction</th>
<th>No. of Anganwadi centres</th>
<th>No. of Anaganwadi centres</th>
<th>Percentage functionary to sanctioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>156</td>
<td>117</td>
<td>75.0</td>
</tr>
<tr>
<td>1982 - 83</td>
<td>311</td>
<td>271</td>
<td>87.1</td>
</tr>
<tr>
<td>1986 - 87</td>
<td>200</td>
<td>200</td>
<td>100.0</td>
</tr>
<tr>
<td>1989 - 90</td>
<td>361</td>
<td>359</td>
<td>99.4</td>
</tr>
<tr>
<td>1991 - 92</td>
<td>613</td>
<td>613</td>
<td>100.0</td>
</tr>
<tr>
<td>1992 - 93</td>
<td>611</td>
<td>539</td>
<td>88.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2252</strong></td>
<td><strong>2099</strong></td>
<td><strong>93.2</strong></td>
</tr>
</tbody>
</table>

Source: District ICDS Cell, Anantapur.

The project wise distribution of Anganwadi centres are given in table 3.3. It can be observed from the table that in few project areas like Kambadur and Rayadurg, the number of Anganwadis functioning are much less as compared to the sanctioned number of centres.

There are 17 ICDS projects in Anantapur District. As many as 2,252 Anganwadi centres were originally sanctioned and 2,099 were functioning by 1993-94 in the following places i.e., 1. Kambadur 2. Dharmavaram 3. Anantapur(U) 4. Rayadurg 5. Madakasira 6. Singanamala 7.
<table>
<thead>
<tr>
<th>Project Name</th>
<th>No. of Anganwadis sanctioned</th>
<th>No. of Anganwadis functioning</th>
<th>Percentage of centres functioning to sanctioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kambadur</td>
<td>156</td>
<td>117</td>
<td>75.0</td>
</tr>
<tr>
<td>2. Dharmavaram</td>
<td>89</td>
<td>76</td>
<td>85.4</td>
</tr>
<tr>
<td>3. Anantapur (urban)</td>
<td>120</td>
<td>120</td>
<td>100.0</td>
</tr>
<tr>
<td>4. Rayadurg</td>
<td>102</td>
<td>75</td>
<td>73.5</td>
</tr>
<tr>
<td>5. Madakasira</td>
<td>200</td>
<td>200</td>
<td>100.0</td>
</tr>
<tr>
<td>6. Singanamala</td>
<td>151</td>
<td>151</td>
<td>100.0</td>
</tr>
<tr>
<td>7. Kalyandurg</td>
<td>105</td>
<td>103</td>
<td>98.1</td>
</tr>
<tr>
<td>8. Kanekal</td>
<td>105</td>
<td>105</td>
<td>100.0</td>
</tr>
<tr>
<td>9. Penukonda</td>
<td>121</td>
<td>121</td>
<td>100.0</td>
</tr>
<tr>
<td>10. Hindupur</td>
<td>253</td>
<td>253</td>
<td>100.0</td>
</tr>
<tr>
<td>11. Kadiri (West)</td>
<td>114</td>
<td>114</td>
<td>100.0</td>
</tr>
<tr>
<td>12. Kadiri (East)</td>
<td>125</td>
<td>125</td>
<td>100.0</td>
</tr>
<tr>
<td>13. Kudair</td>
<td>107</td>
<td>104</td>
<td>97.1</td>
</tr>
<tr>
<td>14. C.K. palli</td>
<td>106</td>
<td>104</td>
<td>98.1</td>
</tr>
<tr>
<td>15. Uravakonda</td>
<td>84</td>
<td>73</td>
<td>86.9</td>
</tr>
<tr>
<td>16. Gooty</td>
<td>140</td>
<td>117</td>
<td>83.6</td>
</tr>
<tr>
<td>17. Tadipatri</td>
<td>174</td>
<td>141</td>
<td>81.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2252</strong></td>
<td><strong>2099</strong></td>
<td><strong>93.2</strong></td>
</tr>
</tbody>
</table>

Source: District ICDS Cell, Anantapur.

The ICDS projects are functioning in earstwhile Panchayath Samithi areas as project areas. The project so far covered 2,82,945 beneficiaries (children and mothers). There are 2,111 female Anaganwadi workers and 2,134 Anganwadi Helpers in the district.

The scheme in Anantapur district provides the following services.

1. Immunization
2. Supplementary Nutrition
3. Health check-up
4. Referral services
5. Treatment of minor illness
6. Nutrition and health education
7. Pre-school education

The above services are being implemented in the Anganwadi centres through the Anaganwadi workers. Apart from the schemes mentioned above, the following schemes are also implemented by the assistance of the World Bank.
ADOLESCENT GIRLS SCHEME - I

In this scheme three Adolescent girls are identified in the village and are given inservice training at the Anganwadi centre from the Anganwadi worker, the A.N.M., the ICDS supervisor and Health Assistant on all the activities of the Anganwadi centres. The three adolescent girls selected in Anaganwadi area would work in the Anganwadi centre for 2 days in a week each. The adolescent girls would provide supplementary nutrition at the Anganwadi centre in the same scale as the women.

The objectives of the scheme for the adolescent girls are:

1. to improve the nutritional and health status of girls in this age group.

2. to provide them the required literacy and numeracy skills through the non-formal stream of education.

3. to generally improve their qualities and them as future leaders of the community.

This scheme was implemented in eleven ICDS project except in Anantapur (Urban) in the district.

ADOLESCENT GIRLS SCHEME - II

This scheme aims for introducing vocational training linked up with production for adolescent girls in the age group of 15-17 years. For this purpose, a vocational skill development-cum-production centre will be established in the village. In this scheme 15 willing girls are selected
in the village. The centre will provide training in one or more skills. Preference is given to those skills which are common locally and are an existing or have potential. This scheme is implemented in 10 Anganwadi centres in Anantapur District. The activities under this scheme included are leaf plate making, paper bags, plastic basket making, embroidery works, masala powders, pickles preparation and music and dance.

Under this scheme an initial amount of Rs. 500 will be given as one time grant for initial equipment and materials. For replenishment of materials Rs. 25 per month per centre will be given. Supplementary nutrition also be provided to the girls on all days.

WOMEN'S INTEGRATED LEARNING FOR LIFE:

The WILL programme mainly aims at imparting literacy. The scheme seeks to provide non-formal education to illiterate girls and women. The girls and women studied up to VIII and willing to take up the work of running the WILL classes are selected as WILL instructors. She will be paid a honorium of Rs. 100 per month under this scheme. The teacher in charge of each class will maintain a register of the adult women in the class, reflecting the attendance and was implemented in ICDS project areas of Singanamala and Kalyandurg blocks with total number of 4,414 women beneficiaries.
NUTRITION REHABILITATION CENTRE (NRC):

The main purpose of N.R.C is to provide integrated nutrition and health services to 'at risk mothers' and children (below 3 years) who are severely malnourished and for whom mere supplementary nutrition is not effective. It also to provide diet, medical treatment and nutrition health education to be beneficiaries.

The objectives of Nutrition Rehabilitation Centres are

1. to device simple, effective, less expensive dietary receipts for treatment on nutritional problems using locally available foods.

2. to demonstrate to mothers the dramatic improvement in malnourished children when they are fed right quantity and quality of food and at right frequency.

3. to impart skills to mothers in making use of locally available foods to prevent malnutrition in children and in family.

4. to bring about ever-lasting behavioural change among mothers regarding feeding of children.

The N.R.C will be located in Primary Health Centre. It accommodates 'at risk children' and pregnant women as in-patients. Each nutrition rehabilitation centre would have seven beds and the centre consists of two wards, one of which would be an emergency ward. Beneficiaries having medical problems will be admitted to the emergency ward. The other ward will be kept free from infections and for
children who are malnourished but have no medical problem or whose medical problems have been treated in the emergency ward and for women with obstetrical risk. The mothers of 'at risk children' will also stay at N.R.C.

The N.R.C will serve as a link between beneficiary, health staff of Primary Health Centre and Anganwadi centre and will also be responsible in follow up through Anganwadi worker and supervisor.

**CIVIL WORKS:**

The World Bank ICDS project provide for the construction of 15 Anganwadi buildings in each block at an estimated cost of Rs. 65,000 per building and C.D.P.Os office-cum-godown at an estimated cost of Rs. 2.00 lakhs per building. It is also proposed to install hand pumps in 8 out of the 15 villages selected for construction of Anganwadi buildings. The estimated cost of each hand pump is Rs. 2,500.

The number of Anganwadi centre buildings sanctioned for construction up to 1993 - 94 are 240. Out of which, 98 have been completed and the remaining 142 are under construction. Number of office-cum-godowns for ICDS projects sanctioned up to 1993 - 94 are eight. In the case of four, the construction work was under progress. The
administrative position of ICDS in Anantapur District are given in table 3.4.

Table 3.4
Administration and Co-ordination 1993 -94.

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Category</th>
<th>Sanctioned in position</th>
<th>Vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CDPQ</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>ACDPO</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Supervisors</td>
<td>133</td>
<td>62</td>
</tr>
<tr>
<td>4</td>
<td>AWWs</td>
<td>2303</td>
<td>2111</td>
</tr>
<tr>
<td>5</td>
<td>Helpers</td>
<td>2303</td>
<td>2134</td>
</tr>
<tr>
<td>6</td>
<td>Ministreial posts</td>
<td>56</td>
<td>20</td>
</tr>
<tr>
<td>7</td>
<td>Drivers</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>Peon</td>
<td>21</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: District ICDS Cell, Anantapur.

It can be seen from table 3.4 that, there is a lot of gap between the sanctioned administrative positions and the actual number of personnel working for ICDS. It is pertinent to note, in this connection that, more than 50 percent of the supervisors' posts are vacant. If at all, there appears to be any reason for failure of the programme the absence of supervisory control over ground level workers of ICDS seem to be the prime reason.