2.0 INTRODUCTION
“A literature review is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic” (wiki.ask.com, 2012). The review of the related literature is necessary in the field of research because through it the researcher can have an understanding of the previous work that has been done in the field of concern. One cannot develop an insight into the problem to be investigated unless one has learnt what others have done and what remains to be done.

2.1 RELATED LITERATURE IN THE PRESENT STUDY

The review of available literature with regard to the present field of the study has been presented in the following sub categories:

2.1.1 Studies Related to the Services Provided by Anganwadi Centre
2.1.2 Studies Related to the Nutritional Knowledge of Women
2.1.3 Studies Related to the Utilization of Maternal Services by Mothers and their breast feeding practices
2.1.4 Studies Related to the Utilization of Immunization Services by Children and Women

2.1.1 Studies Related to the Services Provided by Anganwadi Centre

Kumar et al. (2010) conducted a study on 300 AWCs situated in rural areas of the state of Uttarakhand and found that 76.06% of AWCs were without toilets, 68.00% of AWCs were run in the government buildings and 32.00% in private buildings.

Assessment of Preschool Education Component of ICDS Scheme was done by Dhingra & Sharma (2009) The results indicate lack of adequate facilities in terms of space (both indoor and outdoor), quality of accommodation, drinking water and toilet facilities, furniture and fixtures and teaching
learning material in AWCs. Preschool education activities were mostly repetitive and lacked novelty. Non availability of adequate infrastructure was found to be an active deterrent in conduct of activities.

**Qadiri and Manhas (2009)** conducted a research to assess parental perception towards preschool education imparted at early childhood education Centres. The sample comprised of 200 parents (100 mothers and 100 fathers) with at least one child in the age group of 3 to 6 years. Half of the selected parents were those who had enrolled their children at Anganwadi Centres and other half was those who sent their children to other preschool Centres. The results revealed that the parents irrespective of whether they sent their children to Anganwadi or preschools held similar views about the meaning of preschool education, skills acquired at early childhood development (ECD) Centres, teaching methodology, and role of ICDS Centres in preschool education. Significant differences were found among the awareness of parents regarding ICDS scheme. Most parents were aware about the nutrition facility only and did not consider these Centres are adequately equipped to provide preschool education. Parents sending their children to regular preschool Centres were found to be less aware about ICDS scheme and its role in preschool education.

**Dongre et al. (2008)** studied “Anganwadi workers (AWW) perceptions of the operational constraints in reducing child malnutrition and the mothers’ perceptions regarding the supplementary nutrition given to beneficiaries.” The AWWs indicated four major groups of operational constraints in reducing malnutrition. The first comprised reasons related to poor cooperation from villagers and parents, irregular and poor health check up activity. The second comprised reasons related to the mothers like failure to follow medical and dietary advice as they remained busy in their seasonal agricultural work. The rest were related to poverty and poor sanitation. The major issue of concern of mothers was related to poor quality of supplementary food.
Prinja et al. (2008) studied 60 ICDS Centres in the North Western state of Haryana and found that “participation in an ICDS Centre affected neither breastfeeding patterns nor the involvement of the mother in the child’s growth monitoring”.

A study A Reality Check was conducted by FORCES (2007) to evaluate the status of the performance of ICDS services in 242 AWCs in Delhi. It was found that “96% AWCs were on rent. Only 57% AWCs had toilets and 58% had clean drinking water. Scarcity of equipment like weighing machines, education kits was reported by 82.23% AWWs. The data collected from beneficiaries showed that 88% pregnant women were immunized. Most (88%) beneficiaries mentioned that they had received iron tablets from Primary Health Centres (PHCs). At many AWCs records were not updated. Data on beneficiaries revealed that 25% children below 6 years had received Vitamin A. Preschool activities were irregular. There was inadequate space for Pre School Education (PSE) activities and inadequate teaching aids. In 44% AWCs no children were attending PSE, 45.62% AWCs had an average of 14 children and in the remaining 11% no children were found. No space for PSE activities was reported by 57.83% AWC, 93% AWWs had received job training and 82% had attended the week long refresher course. Apart from that, 10% AWWs were trained on Reproductive Child Health (RCH), 27% on AIDS and 18% on nutrition”.

Vinnarasan (2007) evaluated the factors influencing non-enrolment of children in AWCs, functioning under Chennai Corporation. He concluded that, 40% respondents were not availing any kind of child care services (formal institutional services). Among the participants who were availing non-ICDS child care services, 84.4% were receiving services from private players. Only 34.7% of participants perceived the AWC in their habitation as a place that provided preschool education. Only 34% respondents agreed that AWWs had visited their house for some type of counselling or advice. Very
few (17.3%) respondents had made any attempt to enroll in ICDS. The perception of 93% respondent was that good infrastructure was very much needed to stimulate a child’s learning in a better way. Only 8.7% respondents said that AWCs were well equipped with physical infrastructure. Many respondents (29.3%) said that poor physical infrastructure was the reason for their child’s non-enrolment in the AWC”.

An appraisal of performance of ICDS was done by Gopal et al. (2006) The study assessed "existing status of implementation of ICDS program in rural, urban and tribal areas, identify gaps and problems in the implementation of ICDS, and find out the perception of community and local bodies about ICDS. The study covered 150 ICDS projects from all 35 States and Union Territories (UT). Around 36% AWCs had health facilities and 49% of the AWCs had inadequate space for outdoor and indoor activities. Medicine kits were not available in around 44% AWCs and 52.8% nursing mothers were registered. Data showed that there was evidently more registration of male children (59.1%) than female children (55.2%), but female children availing supplementary nutrition was higher as compared to male children. It was found that AWWs weighed 63.5% of new born children and mothers. About 75% of the children registered attended the AWCs. On an average, 37% children were registered for preschool education at AWCs. Pre-school activities (PSE) were conducted by AWWs in almost all the AWCs. Singing songs (95%), storytelling (91.7%) and counting were the most common PSE activities which were organized in almost all the AWCs, whereas drawing/painting/printing were found in very few AWCs”.

“Data obtained from mothers revealed that 6 out of 10 children (59.6%) between 6 months and 3 years were given Iron Folic Acid (IFA) tablets. About 68.9% pregnant women consumed IFA tablets regularly, whereas 16% took them sometimes, as they did not like the taste. Data showed that 66.1% children were immunized, highest being in rural projects (71.6%), and around
76.2% pregnant mothers received tetanus immunization. About 77.4% nursing mothers reported that their children were immunized, and BCG vaccine coverage was the maximum (82.4%). It was found that birth weight of 7% children was below 2 kg. According to AWWs (75.1%), health functionaries conducted health check-up of children. Nutrition and Health Education Program was organized in 69% AWCs. The average number of visits AWWs made to families was highest in urban projects (46.7%)”.

A report on functioning of Anganwadi canter conducted by Centre for North East Studies and Policy Research (2006) in Guwahatia. The study assessed “the Functioning of AWs in Assam, Kamrup, Dhubri and Dibrugarh, Meghalaya, East Khasi Hills and West Garo Hills. In Kamrup, only 22.5% Centres recorded the total deaths. Out of the total 40 Centres, 34 Centres accounting for 85% provided immunization to the beneficiaries and 6 of the Centres did not keep records of immunization. In Dibrugarh, 15% of AWs did not maintain any records. The average enrolment of children per Centre was 40. Only 26.65% of the male children and 52.5% of the female children were among the 20-24 enrolled children. Only 2.5% of the Centres had recorded more than 10 live births. Majority of the Centres (85%) had not recorded any death. In East Khasi Hills, The average functioning of Anganwadis/ICDS enrolment per Centre was 34.63 children. In West Garo Hills, 7 Centres catered to the needs of nearly 60-69 child beneficiaries. Most of the Centres did not maintain proper records of the nutritional status of children. Only 27 Centres maintained death records, while 13 Centres did not maintained them. In all districts, 5% Centres did not keep any record of the services related to pregnant and lactating mothers. Either they did not provide any services or they were not aware of this service. More than 85% women in rural areas and 98% in remote areas gave birth at home. Only about 42% women in Meghalaya and 58% in Assam had access to safe delivery facilities”.
Gadkar et al. (2006) conducted a situational analysis of Anganwadi workers training Centres in Jharkhand to assess “the existing infrastructure and training facilities available in the AWTCs. The survey covered rural, urban and tribal areas. It was found that there was wide variation in infrastructure, experience of staff, teaching methodologies, transaction of training and management of training Centres, etc. among these locations. Mahila Dastkari Vidyalaya AWTC was located in a rural area but most of the facilities were available there, including 24 hours transport facility. The suggestions were made on the basis of the findings. The buildings of AWTCs need proper maintenance and there should be provision for repair and whitewashing. AWTCs located in urban areas should provide either a desk or table for writing in classrooms with durries”.

The risk factors of under five year old children of ICDS centre of urban Allahabad were studied by Kumar et al. (2006) “Initiation of breast-feeding after six hours of birth, deprivation from colostrums and improper complementary feeding were found significant (P<0.05) risk factors for underweight in children registered at ICDS. Wasting was not significantly associated (P>0.10) with any infant feeding practice studied. ICDS benefits received by children failed to improve the nutritional status of children. Delayed initiation of breast-feeding, deprivation from colostrums, and improper weaning are significant risk factors for under nutrition among under-fives. There is need for promotion and protection of optimal infant feeding practices for improving nutritional status of children”.

Bulliyya (2006) has reported that since 1997, the Integrated Child Development Services (ICDS) has been operating in Lanjigarh block of Kalahandi district in Orissa as a comprehensive, multipronged program to reduce the burden of child malnutrition and mortality. The study indicates widespread malnutrition in the studied block in spite of almost complete ICDS coverage.
Arora et al. (2006) evaluated Non-formal preschool educational services provided by 15 AWCs. Results of the study revealed that “non-formal pre-school education was provided to the children at the AWC. AWWs used two-way interaction method and took the help of teaching aids for imparting education to the children. Indigenous material was used to make teaching aids like puppets, vegetables, and fruits. Most of the parents were satisfied with the non-formal education provided at the AWC but few weren’t, as they felt that AWWs laid more emphasis on nutrition”.

A Social assessment of ICDS conducted by Indian Institute of Management (2005) in Bangalore, found that “pre-school education (PSE) was the weakest link of the ICDS program. Toys, playground and teaching equipment were not available in a number of Centres. The supplementary nutrition (SN) distribution was not regular. Storage facilities, measuring scales and cooking facilities were not available or were inadequate. Proper buildings constructed at the right locations were a major problem. Clean drinking water was not available in many AWCs. Some AWTCs did not have adequate physical infrastructure. A need to improve the buildings and provide proper toilet facilities, clean drinking water and proper storage facilities was emphasized”.

Vaid et al. (2005) conducted a study on beneficiaries and non- beneficiaries of ICDS program in Jammu city. Result revealed that “all the ICDS Centres were providing supplementary nutrition to children, pregnant women and nursing mothers who enrolled in the Anganwadi. Most of the mothers had the knowledge about the nutritional status of children and got information from the AWWs. AWWs assessed the nutritional status of children by taking height and weight. Results indicated that majority of the non beneficiary mothers said that it was not necessary for the children to attend any ICDS Centres. They also did not have any knowledge regarding supplementary foods and nutritional needs of the children. Majority of the non beneficiary mothers got their children immunized from the primary health centres (PHCs). It was
found that children who attended Anganwadi Centre had good health or appearance as compared to their counterparts. It was also observed that ICDS children had good dietary intake as compared to the children who did not attend ICDS Centres”.

A Evaluation study of ICDS conducted in Haryana by Dept. of Economics and Statistics, Chandigarh (2004) indicated that “all (100%) AWWs were fully trained. Only 4889 (32%) beneficiaries were medically checked up either by ANM/ LHV or Medical Officer during the preceding three months. A total of 4839 (83%) children received PSE benefit, out of which 2549 (53%) were males and 2290 (47%) were females. Around 126 (88%) pregnant women received folic acid tablets from AWCs. Majority of the expecting (89%) women got ante-natal care from AWWs and were satisfied with their advice. Out of 144 nursing mothers, 97% were visited by AWWs after delivery. SN was distributed on an average of 25 days in a month. Only 62% children took SN to their homes thus defeating the very purpose of the scheme. Only 60% AWCs were running in Panchayat/Government buildings, whereas 40% were run in rented/private buildings”.

Bharti et al. (2003) evaluated the health services provided to children aged 3-6 years at ICDS Centres in urban slums of Jammu city the sample comprised of 15 AWCs, 15 AWWs and 30 parents. The study revealed that “majority of these Centres is located in hygienic surroundings. In 60% of the Anganwadi Centres, play activities are performed for promoting healthy growth and development of children. Health cards were not given by the Anganwadi workers to the beneficiaries, but they maintained their records and registers were up to date”.

The study conducted by Rani (2002) was carried out in Chittoor district in a Andhra Pradesh in Primary Health Centres (PHC), where ICDS was operational and the other (PHC) were ICDS scheme was not in operation. “The aim of the study was to know the nutritional and health status of people
in the PHC area; and to understand the role of health staff at the PHC in the promotion of nutrition and health programs. A sample of 380 households from each PHC was taken, and children aged 1-6 years were examined for nutritional deficiency diseases. Interviews were conducted for data collection. It was observed that anaemia was more prevalent among children in the non-ICDS areas (52.2%). In both PHCs, 40% respondents preferred home deliveries. In the PHC with ICDS scheme, 32.5% reported deliveries in government hospitals and 19.5% went to private hospitals; while in the non-ICDS PHCs, 30.6% respondents went for deliveries in private hospitals, followed by government hospitals (28.3%). It was found that the health status of children was better in PHC area with ICDS scheme rather than PHC area without ICDS scheme. It was recommended that the ICDS scheme should be expanded to all PHCs in the country. ICDS functionaries and PHC staff should work in a coordinated manner for achieving higher immunization coverage, and providing better pre-natal, natal, and post-natal services to mothers”.

A comparison between the ICDS children with 50 Non-ICDS children was done by Komala et al. (2002) to see the difference in their level of development in all the areas. The study reveals that ICDS children’s development in most of the areas was better than that of Non-ICDS children. Highly significant differences at $P < 0.001$ regarding their physical, personal-social and intellectual development were observed. Non-ICDS children were significantly better in their emotional and language development than their counterparts. Thus the formal preschool educations in ICDS Centres have positive effect on development of children in physical, personal-social and intellectual areas.

Kant et al. (2001) studied “the profile of 96 AWWs of Inderpuri project area. Only 17% AWW lived and worked in the small locality. Only 4% AWW were aware that ICDS service was meant for children below 2 years and only 3%
were aware that ICDS provides services for pregnant and lactating mothers. Majority (92.71%) could not tell full form of ICDS. Most of them (90.21) could not enumerate all the services being provided by Anganwadi and none could list out their own job responsibilities. It is recommend that the existing training of AWWs needs to be evaluated and their continuous education strengthened”.

An evaluation study of ICDS was conducted by Barman (2001) to assess the impact of the ICDS program on beneficiaries, and also to assess the performance of AWWs in Jorhat district of Assam. The studying covered 50 AWCs and a total of 150 beneficiary women. “The immunization status of children below 1 year of age against BCG, measles, DPT and polio was 52.2%, 49.45%, 41.59% and 86.7% respectively. Immunization of children in the age group 1-3 years for DPT booster and polio drops was 52.16% and 80.40% respectively. Of the total pregnant mothers, only 54.25% received Tetanus Toxoid vaccine. All (100%) the beneficiaries were aware of the health services provided, and about 60% were satisfied with the services. Most (60%) AWWs mentioned that health check-up was carried out for both children and women at least once in 3 months. Medicine kit was available in all AWCs, which was replenished regularly. Only 26.67% AWWs arranged meetings for imparting NHE to mothers, and only 6.67% used aids during meetings. All the AWWs weighed the children, but only 46.67% of them interpreted the growth trends. Only 33.33% AWCs had adequate indoor space. Outdoor space and storage space was available only in 40% and 13.33% of the AWCs respectively. All beneficiaries were aware that supplementary nutrition was provided by AWWs but none of them were satisfied with the services due to irregular supply of food, poor quality and insufficient quantity of food. All (100%) beneficiaries were aware of the PSE component, but only 26.67% of them were satisfied with PSE being imparted at AWCs. The reasons for dissatisfaction were the informal character of PSE and unsatisfactory activities conducted under the preschool component”.
2.1.2 Studies related to the Nutritional Knowledge of Women

Devi and Padmavati (2006) studied the effects of the nutrition and health education program of the Integrated Child Development Services on the nutrition/health knowledge levels and hygienic practices of woman and on the nutritional status of their children. Anganwadi workers carried out the education program, which consisted of 12 sessions (one per month). A total of 300 children and their mothers were included in the intervention group, while another 100 children and their mothers served as the control group. Mothers in the intervention group had significantly higher scores on nutrition and health knowledge, and hygienic practices than the control mothers. The education intervention did not have significant impact on the nutritional status of children. This study confirms the value of an education program in improving the nutrition and health knowledge of rural mothers.

Agarwal (2004) studied the difference in the extent of utilization of maternal services by the mothers of the ICDS and the non-ICDS areas. Results reveal that although the level of utilization of maternal services was by and large low in both the areas, but it was slightly better in the ICDS area as compared to the non-ICDS area. Thus, there is a need for involvement of the community and a strengthened network of the health services in the urban areas.

Joshi (2001) assess “the knowledge, attitude and practices regarding nutrition of rural, urban and tribal AWWs and beneficiary mothers (BMs). AWWs and BMs in urban areas had maximum awareness about the nutritional requirements of growing children that was 100% and 87.5% respectively. Although 95% urban AWWs were giving iron tablet yet only 94.3% BMs were taking them. In rural areas 95% AWWs were giving iron tablets but only 31.9% mothers in rural areas were taking iron tablets. Both, urban groups of AWWs and BMs and tribal AWWs were moderately good regarding practices of taking additional food during pregnancy, and the figures were 65%, 56.3% and 60% respectively. Only 14-27% mothers and 5-
30% AWWs had partially right practices regarding the same. Regarding the practice of taking additional food during lactation, only 75% and 48% urban in comparison to 95% and 72% rural and 95% and 88% of tribal AWWs and BMs consumed extra food during lactation. All urban AWWs (100%) had right knowledge about practice of breastfeeding within 6 hours of delivery in comparison to 85% rural and 65% tribal AWWs. Similarly, 90% urban mothers started breastfeeding within 6 hours of delivery in comparison to other groups of mothers. Right practices of breast feeding children with a bowl was seen in 95%, 80% and 80% of urban, rural and tribal AWWs and 88.7%, 68.7% and 70% of beneficiary. In urban area AWWs had complete (100%) knowledge of immunization in childhood, but only 70% AWWs in rural group and 85% AWWs in tribal group were aware in this regard. Awareness of mothers regarding vaccination was found to be 86.6% in rural areas, 82.5% in urban areas”.

2.1.3Studies related to the Utilization of Maternal Services by Mothers and their Breast Feeding Knowledge

Kulkarni et.al. (2009) found that 98% mothers were having knowledge about breastfeeding but the knowledge was executed in practice only by 44% mothers, 98% mothers were of view to avoid pre-lactate foods but due to traditional practice and elder’s adamant behaviour only 40% mothers could avoid pre-lacteal feedings. All mothers were aware of colostrum feeding and a large population i.e., 94% mothers could have done it in practice. All mothers knew the importance of early initiation and understood that it meant breast feeding within 30 minutes of delivery but due to obstetrician support & personal eagerness 36% mothers were able to do it. 22% mothers said that they were advised to take rest for 4-6 hours by their obstetrician and health care staff and 42% mothers felt hitch & shyness in feeding their babies while surrounded by so many family members and relatives - females and males. Awareness and perception on continuation of breast feeding up to 6 months
was 70% and 60% respectively against the knowledge of ideal wean age (should be 6 months) to 80% mothers only 70% mothers applied this knowledge in practice.

Mridula et al. (2006) the nutritional status of 273 children from ICDS and 262 children from non ICDS urban slum areas in Varanasi city, was assessed over a year. Protein energy malnutrition was more prevalent in non ICDS than ICDS children (62.67% vs. 58.33%) however, the difference was not significant. The percentage of ICDS children with normal nutritional status (based on weight for age) decreased from 40% at baseline to 19% at final assessment; among non-ICDS children, the percentage decreased from 36.26 to 18.07% statistically similar rate of nutritional status deterioration was observed in both ICDS (44.69%) and non-ICDS (41.6% children. The rate of improvement in nutritional status was marginally higher in ICDS (6.59%) than non-ICDS (3.82%) children. Only 33.33% of children with severe grade of malnutrition improved in a years.

Das (2005) Studied 383 infants, of them 152 were in the age group of 0-6 months and 231 between 6 months to 1-year age. Maximum number of mothers (51.4%) received antenatal care from health worker (Female), followed by 19.8% by Health Assistant and trained Dais (6.6%). 11.8% mothers did not receive antenatal care. The main source of knowledge regarding exclusive breast feeding came from Anganwadi workers (16.8%), followed by health workers (Female) (12.55%), trained Dais (3.67%), Medical Officers (4.69%) and Mass Media (2.36%). 37.18% did not have any knowledge of Exclusive Breast Feeding (EBF). The main cause of non-exclusive Breast Feeding was inadequate or no milk secretion (69.3%). The other reasons were child’s health (9.3%) and mother’s health (3.6%). Some of the mothers were unaware of the benefits of EBF (4.5%) and hence did not practise it. Boiled water (58.6%) was the main feed given along with breast feeding. This was followed by Water & Honey (11.7%), Animal Milk (19.9%) and powdered
milk (9.6%). The time of initiation of breast-feeding after the birth of the baby was more between 24-48 hrs in (41.51%) followed by those initiating between 12-24 hrs (18.54%). Most (86.4%) babies were given some or the other pre-lacteal feeds (boiled water, missri added boiled water, Honey). The type of inaugural feeds given by the mothers revealed that more number of mothers preferred giving boiled water to the infant (37.60%), honey and boiled water (10.97%) and cow’s milk and goat’s milk in (9.1%). Maximum mothers (42.9%) exclusively breast-fed their child for 1-2 months. Only 8.6% mothers continued with EBF for the scheduled 4-6 months. Majority of the mothers had a domiciliary delivery (94.5%). Most mothers (37.18%) were unaware about exclusive breast-feeding.

2.1.4 Studies related to the Utilization of Immunization Services by Children and Women

In this regard, Socio-Economic and Educational Development Society (SEEDS) evaluated the implementation of the ICDS program in Haryana (2005) found that “43% of respondents mentioned that AWWs made home visits thrice a week, followed by 24% who mentioned once a week, 30% once in a month and 4% said AWW never made home visits. It was found that in Haryana the awareness level for immunization was not very high. 25% of the population mentioned that the AWW made home visits for immunization. Majority of the beneficiaries mentioned that AWW helped in the immunization program by informing them about it from time to time. It was revealed that all the children below 6 years of age had been immunized against BCG, measles and polio. 15% of respondents mentioned that health check-up camps were organized once a week. In Ambala district, maximum number of villages had health check-up camps. 17.63% of respondents depended on traditional dais (birth attendants) and quacks for ante-natal check-up, 58.67% sought ante-natal check-up from ANM and 13.87% went to nearby Health Centres/ Sub-Centres. 93.63% of beneficiaries went for child
delivery to the ANMs or trained dais, but 2.31% still depended on traditional dais and a few on elderly women in the locality. 34.4% of respondents mentioned about the role of AWWs in supplying medicines for minor ailments. 36.8% of respondents recognized the AWW’s role in providing medicines during pregnancy. It was found that the majority of expectant mothers in ICDS areas received regular health check-up during pregnancy and most of them were referred to PHCs/ hospitals by ANM/AWW”.

Child Care and Immunization (2002-04) report states the “percent distribution of children under the age of three years who did not receive any vaccination. About one third of the children did not receive any vaccination because the mothers of children were unaware of the need for immunization and 14 percent of children were not vaccinated, as the mothers felt that they were too young, other reasons for not immunization of the children as reported by the mothers were that the place or time of vaccination was not know (13%), place or time of vaccination was inconvenient (7%), fear of side effects (5%), no faith in vaccination (3%) and ANM absent/vaccine not available (8%), family problems (9%) and other reasons (6%). The percentage of children who did not receive any vaccination is considerably lower in urban area (15%) than in rural area (21%). Children from those villages where health facilities are available are slightly less likely to report that they were unaware of the need for immunization as compared to those villages where health facilities were not available. Where health facilities were available, fear of side effects and no faith in immunization were given as reasons for not immunization of the children’s”.
Conclusion - The researcher has reviewed a number of researches that have been conducted on ICDS services provided in the length and breadth of the country. The inconsistency in the results is clearly evident. Moreover the researcher did not find any study that had been conducted on the ICDS Centres of Agra. Agra is a major city of Utter Pradesh and the documentation of the facts of city is imperative. Therefore an independent research focusing on the services of ICDS in Agra and their effect on beneficiary is important.