

INTEGRATED CHILD DEVELOPMENT  
SCHEME: A STRUCTURED ANALYSIS  
COMPRISING OF THE "IDEAL" AND  
THE "ACTUAL"

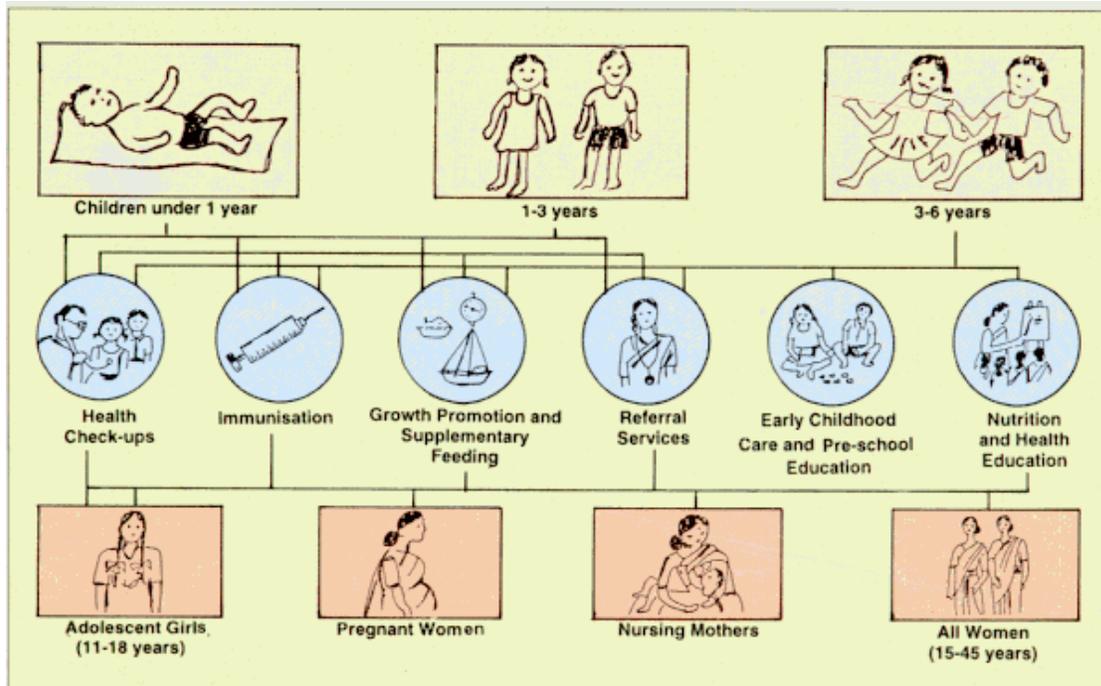
Education, health and well being are the birthright of every child. This applies even to the age group below six years. To protect the rights of the children below six years of age the Supreme Court has issued strict orders related to the “Integrated Child Development Services” commonly referred to as the Anganwadi Program.

“We direct the State Governments/Union Territories to implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under

- Each child up to 6 years of age to get 300 calories and 8-10 grams of protein
- Each adolescent girl to get 500 calories and 20-25 grams of protein
- Each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein
- Each malnourished child to get 600 calories and 16-20 grams of protein
- Have a disbursement centre in every settlement

It is the case of the Union of India that there has been full compliance of its obligations, if any, under the Scheme. However, if any of the States gives a specific instance of non-compliance, the Union of India will do the needful within the framework of the Scheme. "

Integrated Child Development Services (ICDS) is the only major national program that addresses the needs of the children under the age of six years. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care and free school education. Because the health and nutrition needs of a child cannot be addressed in isolation from those of his/her mother, the program also extends to adolescent girls, pregnant women and nursing mothers.



The Integrated Child Development Services (ICDS) Scheme was conceived in 1975 with an integrated delivery package of early childhood services so that their synergistic effect can be taken full advantage of. The Scheme aims to improve the nutritional and health status of vulnerable groups including pre-school children, pregnant women and nursing mothers through providing a package of services including supplementary nutrition, pre-school education, immunization, health check-up, referral services and nutrition & health education. In addition, the Scheme envisages effective convergence of inter-sectoral services in the Anganwadi centers.

**Objectives of ICDS:**

- Improve the nutritional and health status of children below the age of six years.
- Lay the foundation for the proper psychological, physical and social development of the child.
- Reduce the incidence of mortality, morbidity, malnutrition and school dropouts.

- Achieve effective coordination of policy and implementation among various departments to promote child development.
- Enhance the capability of the mother to look after the normal health and nutritional needs of the child, through proper health and nutrition education.

The motivation behind ICDS can be traced to the national policy for children (1974) which acknowledged that a majority of India's children live in impoverished economic, social and environmental conditions which impede their physical and mental development. The institutional arrangement to concretize the policy objectives of the ICDS is under the **Women and Child Welfare Department**. Healthcare to be delivered through the health department is expected to take care of pregnant women, prenatal and post natal care and children at the village level. It is envisaged that a well oiled, institutional coordination between the two departments would enable a proper utilization of the services, material and other supplies. ICDS services are provided through a vast network of ICDS centers commonly referred to as Anganwadis. The Anganwadi is operated by an Anganwadi worker (AWW) who is assisted by an Anganwadi helper (AWH). She is expected to maintain the data that feeds into the statistics of the government on birth, deaths, growth of children, records for supplies of food, educational material and lists of women who could access the innumerable schemes for assurance of doles, stipends and other schemes. Anganwadis also serve as the meeting place for women groups, Mothers' clubs and Mahila Mandals promoting awareness and joint action for child development and woman's empowerment.

ICDS is India's response to the challenge of meeting the holistic needs of the child, launched initially in 33 blocks, on October 2, 1975. Today, the ICDS is one of the world's largest and most unique programmes for early childhood care and development. It symbolizes India's commitment to its children. ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations with 100% financial assistance for inputs other than

supplementary nutrition which the States were to provide out of their own resources. From 2005-06, it has been decided to extend support to States up to 50% of the financial norms or 50% of expenditure incurred by them on supplementary nutrition, whichever is less. This Central assistance has been proposed to ensure that supplementary nutrition is provided to the beneficiaries for 300 days in a year as per nutritional norms laid down under the Scheme.

It is widely acknowledged that the young child is most vulnerable to malnutrition, morbidity, resultant disability and mortality. The early years are the most crucial period in life, when the foundations for cognitive, social, emotional, language, physical development and lifelong learning are laid. Recognizing that early childhood development constitutes the foundation of human development, ICDS is designed to promote holistic development of children under six years, through the strengthened capacity of communities and improved access to basic services, at the community level. The programme is specifically designed to reach disadvantaged and low income groups, for effective disparity reduction.

ICDS provides increased opportunities for promoting early development, associated with improved enrolment and retention in the early primary stage and by releasing girls from the burden of sibling care, to enable them to participate in primary education. Poised for universal coverage by the turn of the century, ICDS today reaches out to 3.8 million expectant and nursing mothers and 17.8 million children (under six years of age), from disadvantaged groups. Of these, 10.2 million children (three to six years of age) participate in centre-based pre-school activities. The network consists of 3907 projects, covering nearly 70 per cent of the country's community development blocks and 260 urban slum pockets.

The Scheme provides an integrated approach for converging basic services through community-based workers and helpers. The services are provided at a centre called the 'Anganwadi'. The Anganwadi, literally a courtyard play centre, is a childcare centre, located within the village itself.

<b>Services</b>	<b>Target Group</b>	<b>Services Provided By</b>
<b>Supplementary Nutrition</b>	<b>Children below 6 years; pregnant and lactating mothers</b>	<b>Anganwadi Workers (AWW) &amp; Anganwadi Helper (AWH)</b>
<b>Immunization*</b>	<b>Children below 6 years; pregnant and lactating mothers</b>	<b>ANM/MO</b>
<b>Health Check-ups*</b>	<b>Children below 6 years; pregnant and lactating mothers</b>	<b>ANM/MO/AWW</b>
<b>Referral</b>	<b>Children below 6 years; pregnant and lactating mothers</b>	<b>AWW/ANM/MO</b>
<b>Pre-School Education</b>	<b>Children 3-6 years</b>	<b>AWW</b>
<b>Nutrition &amp; Health Education</b>	<b>Women (15-45 years)</b>	<b>AWW/ANM/MO</b>

**A table showing the comprehensive package of services provided by the Anganwadis**

A package of following six services is provided under the ICDS Scheme:

- 1) **Supplementary nutrition:** This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi attempts to bridge the protein energy gap between the recommended dietary allowance and

average dietary intake of children and women. Food supplements are provided to pregnant women and nursing mothers, to help meet the increased requirements during this period. This provides an important opportunity to counsel pregnant women enabling utilization of key services i.e. antenatal, immunization Iron folic acid supplementation and improved care, adequate extra family food and rest during pregnancy. Tablets of Iron and folic acid are administered to expected mothers for prophylaxis and treatment and to children with anemia. The Anganwadi worker/ auxiliary nurse/ Midwife monitor the utilization of such tablets. Further the use of only Iodized salt is encouraged in order to prevent iodine deficiency disorders.

The effort is to provide, on an average, daily nutritional supplements to the extent indicated below:

<b>Beneficiaries</b>	<b>Calories (cal)</b>	<b>Protein (g)</b>
Children below 3 years*	300	8-10
Children 3-6 years	300	8-10
[Severely malnourished Children on medical advice after health check-up]	(double of above)	
Pregnant & Lactating (P&L) Mothers	500	20-25



**An Anganwadi situated in the Nawab Pet Mandal**

**Growth Monitoring and nutrition surveillance** are two important activities that are undertaken. Children below the age of three years are weighed once a month and children 3-6 years of age are weighed every quarter. Children are weighed on a graded scale ranking from A-D wherein A represents balanced normal growth of a child and D represents malnourishment. Special attention is given to the children who belong to the D category by providing them with double ration in a day. Also a lot of emphasis is laid on the counseling the parents of such children so as to ensure that they are given adequate and timely meal at home as well. However if the child's weight does not increase even after such kind of

follow up measures the child is referred to medical services. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to health sub-centers, Primary Health Centers as and when required. Through discussion and counseling growth monitoring also increases the participation and capability of mothers in understanding and improving child care and feeding practices, for promoting child growth and development. The Anganwadi centers are also expected to maintain a record of the nutritional statuses of all the children in the community. This helps the community in understanding what the nutrition status of its children is, why it is so and what can be done to improve the same. In many a situations this has enabled a lot of community support wherein the inhabitants of the community as well as the influential political elites have contributed to provide for various kinds of local resources to the Anganwadi centers.



**An example of a weighing machine used for children upto the age of 1 year**

- 2) **Non-formal pre-school education:** This component for the three-to six year old children in the Anganwadi is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. Child-centered play way activities (placards, Acrobats), which build on local cultures and

practices, using local support materials developed by Anganwadi workers through enrichment training are promoted. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling and offering substitute care to younger siblings, thus freeing the older ones – especially girls – to attend school.

- 3) **Immunization**: Immunization of pregnant women and infants protects children from six vaccine preventable diseases-poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. These are major preventable causes of child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces maternal and neonatal mortality. This service is delivered by the Ministry of Health and Family Welfare under its Reproductive Child Health (RCH) programme. In addition, the Iron and Vitamin "A" Supplementation to children and pregnant women is done under the RCH Programme of the Ministry of Health and Family Welfare. In order to ensure that these services are accessed by large number of people the Anganwadi worker tries to mobilize support from within the community. For this the Anganwadi worker conducts extensive surveys and registers the same, of all the families in the community to identify children below six years of age and pregnant and nursing mothers. Fixed day immunization sessions or days are organized to promote a healthy prenatal and post natal environment.

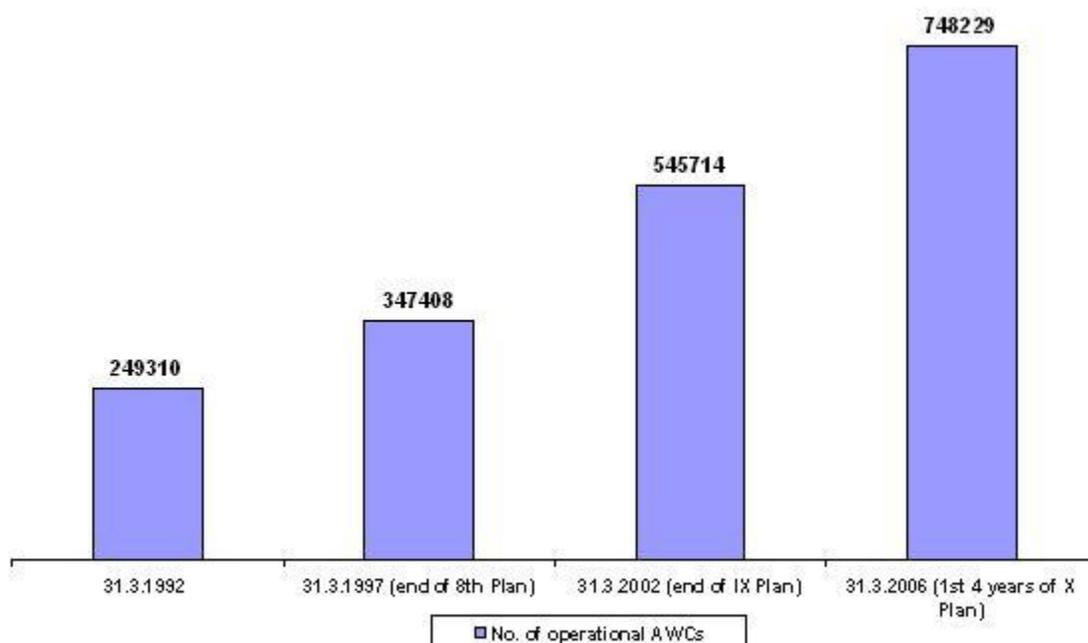
- 4) **Health Check-up:** This includes health care of children less than six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. These services are provided by the Auxiliary Nurse Midwife (ANM), Medical Officers in charge of Health Sub-Centers and Primary Health Centers under the RCH programme of the Ministry of Health and Family Welfare. The various health services include regular health check-ups, immunization, management of malnutrition, treatment of diarrhea, de-worming and distribution of simple medicines etc.
- 5) **Referral services:** During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Centre or its sub-centre. The Anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases and refers them to the ANM and Medical Officer in charge of the Primary Health Centre/ Sub-centre. These cases referred by the Anganwadi worker are to be attended by health functionaries on priority basis.
- 6) **Nutrition and Health Education:** Nutrition and Health Education (NHE) is a key element of the work of the Anganwadi worker. NHE comprises of basic health, nutrition, information related to child care and development, infant feeding practices, utilization of health services, family planning and environmental sanitation. A crucial aspect here is providing health, education through home visits. This forms part of BCC (Behavior Change Communication) strategy. This has the long term goal of capacity-building of women – especially in the age group of 15-45 years – so that they can look after their own health, nutrition and development needs as well as that of their children and families. Sustained support and guidance aims to

be provided in the period spanning from pregnancy to early childhood to mothers and families of young children and thereby build upon local knowledge attitude and practice. This helps promote early childhood care for survival, growth, development and protection.

Thus as can be observed the ICDS programme is one of the most important public programmes in India, reaching out to the most neglected sections of the population. However its coverage needs to be expanded to include every child, pregnant and nursing mothers, and adolescent girls. There have been some positive developments in the last few years that are a ray of hope for the women and children of our country and need to be worked upon. For instance in April 2001, **Peoples Union for Civil Liberties** (PUCL, Rajasthan) submitted a writ petition to the Supreme Court of India seeking enforcement of the **Right to Food**. The basic argument is that the right to food is an aspect of the fundamental right to life enshrined in Article 21 of the Indian Constitution. The Court made it clear that the right to life should be interpreted as a right to live with dignity which includes the right to food and other basic necessities. The Judgment came in the wake of severe draughts and starvation deaths while buffers stocks were rotting in the Food Corporation of India warehouses.

The Supreme Court has issued a series of “**interim orders**” aimed at safeguarding various aspects of the Right to Food. The First major order dated 28 November 2001, directed the government to fully implement nine food related schemes (including ICDS) as per official guidelines. In effect this order converted the benefits of these schemes into legal entitlements. In the case of ICDS the order directed the government to **universalize** the programme. This means that the ICDS should reach every child below six years of age, every pregnant and lactating mother and every adolescent girl. It also stated that the all SC/ST hamlets should be covered as a matter of priority. The government was explicitly directed expand the number of Anganwadis from 6 lakhs to 14 lakhs. Though the

number of operational Anganwadis has increased, it still falls short of meeting the requirements for the entire country.



**Figure showing increase in coverage of the Scheme (No. of Operational Anganwadi Centres 1992, 1997, 2002, 2006)**

The universalization of ICDS would help to halt the inter generational perpetuation of social inequality by creating more equal opportunities for growth and development in early childhood. It would also foster social equity by creating a space where children eat, play and learn together irrespective of class caste and gender. The universalization of ICDS, with quality improvements, can help to break the vicious cycle of malnutrition and poverty. It is an essential step towards the realization of children's fundamental right to nutrition, health and education.

The present UPA government in its **Common Minimum Programme** has committed itself to universalizing the ICDS scheme to "provide a functional Anganwadi in every settlement and ensure full coverage for all children.

The **National Advisory Council** (NAC) has shown keen interest in ICDS, and made detailed recommendations to improve the coverage and quality of the programme. These include a six fold increase in financial allocations for ICDS over a period of two to three years. This would provide for the expansion of ICDS to all habitants in the country, and for doubling per child expenditure as a first step towards facilitating quality improvements.

However there has been relatively little progress in terms of the situation on the ground. The expansion of the ICDS is very slow and in most cases there is little evidence of substantial quality improvement. There are many shades of achievement and failure with regards to the programme. These shades were apparently visible to the researcher who had the opportunity to visit various Anganwadi centers and attend a few collective meetings of Anganwadi teachers and Gram Panchayats in various Mandals of **Ranga Reddy District** of Andhra Pradesh. The subsequent paragraphs highlight the shortcomings of the overall functioning of the ICDS as had been observed by the researcher during her field visits.

- 1) **INADEQUACY OF THE ANGANWADI WORKER**: The Anganwadi programme relies on the frontline functionary, the Anganwadi worker to realize the policy makers dream of a society that respects women takes care of adolescent girls, gives them dignity and space, rectifies gender imbalance, ensures safe delivery of the infant and maintains the nutritional status of children until he/she reaches six years of age. She is expected to maintain the data that feeds into the statistics of the government on birth, deaths, growth of children, records for supplies of food, educational material and lists of women who could access the innumerable schemes for assurance of doles, stipends and other schemes. For all responsibilities assigned to her, she is neither professionally trained nor paid even the minimum wages according to law for her services. Unfortunately there are some centers wherein a day in

an Anganwadi is nothing more than the distribution of a ready to eat mixture (panjiri) to the children and some hasty filling or fudging of centers. This has contributed towards the common tendency amongst the villagers to look at the Anganwadi centers as nothing but mere “Powder Centers”. However the scenario was not so dismal in all Mandals. In certain areas the Anganwadi workers came across as strong women who believed in elaborate and extensive work to bring about a remarkable difference in the health and nutritional status of the women and children in the community. This was particularly true in situations wherein the Anganwadi workers were residents of the same community as those of the women and children.

- 2) **INFRASTRUCTURAL LIMITATIONS:** One of the major concerns observed was that most of the Anganwadis did not have a place/building of their own. In many a situations the Anganwadi center was located in community centers or the home of the Anganwadi workers. The Anganwadis were located within the premises of primary schools. Most of them did not have the bare essentials that are expected out of the Anganwadis such as adequate Play way materials, functional weighing machines, cooking utensils, storage containers, toys, charts and related equipments. Almost all the Anganwadis fell short of basic amenities such as safe drinking water, taps, open spaces, regular electricity supply, proper ventilation, compound walls. Sanitation also appeared to be a source of concern as there were no toilets. The researcher also observed that there was a general lack of a sense of cleanliness and hygiene on the part of the Anganwadi workers and therefore the importance of these was not really communicated to the children.
  
- 3) **LACK OF COMMUNITY INVOLVEMENT:** Involving the community in ICDS is important so that the village feels a sense of ownership of the center. The process of consensus building, community mobilization

inevitably results in the creation of new values that are internalized and owned by the community. Enabling the community to question, negotiate with authorities to deliver services would pave the way for enhancing every child's access to the ICDS and making it an institution for protecting the rights of the children belonging to the age group of 0-6. On several occasions the community has got together to pool in greater local resources for the Anganwadi centers. There have been donations made to these centers in terms of cash, utensils, steel tanks, food grains etc. In other cases the inhabitants of the communities have written petitions to the concerned authorities for improving the services of ICDS. However there have been cases where in the communities have largely been indifferent towards the Anganwadi centers. This lack of ownership has opened the doors for large scale and blatant corruption.

- 4) **INABILITIES OF THE ANGANWADIS TO DEAL WITH PROBLEMS OF GENDER DISCRIMINATION AND CHILD MARRIAGE:** In Ranga Reddy district as in the rest of India gender discrimination is deep rooted, with women worse off on all indicators of social, political and economic development. The literacy rate for women is lower, fewer girls are enrolled in school and a larger proportion of them drop out. Social norms dictate that girls get involved in domestic chores at an early age and many are married off while still children, often when they are as young as of seven years. Despite intensive participation of women and adolescent girls in the Anganwadi centers the problem continues to be unaddressed as the women even today are denied opportunities which are provided to their male counterparts. Similarly child marriage is a fairly wide spread practice. The institution of dowry whereby the parents of the girl have to make substantial payment to the boy's parents encourages this practice. The older and more educated the girl is, the more difficult it is to find a suitable groom, and the higher is the amount that has to be paid in dowry. Faced with this, parents choose the alternative that appears to them a

lesser burden. Here again there is an urgent need for the women to take ownership so as to prevent this menace.

Also the Anganwadis have been quite ineffectively dealing with the problems of Alcoholism and Drug abuse.

- 5) **NUTRITIONAL CONCERNS:** Regular provision of nutritious food is an essential precondition for the success of any Anganwadi. If there is no food or the food is tasteless few children attend and no activity can take place. Two types of foods are provided at the Anganwadis, a) Panjiri and b) cooked food. The panjiri is usually mixed with water and administered to the children in form of Laddus. Though emphasis is laid on the children having their food in the Anganwadi center itself one would find several children taking the powder back home and dropping large chunks of it on their way. As far as the recording of data with regards to the nutritional status of children is concerned that Anganwadi workers have strong incentives to under report severe malnutrition (grade C and D). Among children enrolled in ICDS, to avoid being blamed for the problem. It is no secret that in many places the supplementary powder is sold by the Anganwadi workers to farmers as feed for buffalos. In other instances the powder is strained to extract the sugar.
  
- 6) **INSTITUTIONAL HANG UPS:** Many of the functions of the ICDS programme depend on the health department for their success. For instance immunization, ante natal care, family planning and referral services are all provided by the health department. The role of the Anganwadi worker is to act as a motivator and a link person between the community and these services. At present there is no institutionalized mechanism for this coordination beyond the village level. At the village level the ANM liaises with the Anganwadi worker as a contact person in the village and gets data from her on who is pregnant and whether any

deliveries or deaths have taken place. Sometimes, basic first aid material is also left with the Anganwadi worker e.g. Oral Rehydration Solution packets and paracetamol tablets. This kind of coordination is not the result of a careful plan of action worked out by the concerned departments at the higher level. Coordination between the health and education departments is required for maximum efficiency. Also it is important to set clear goals, so that achievements can be assessed and work given direction. Any programme that aims at improving the health of women and children must begin by addressing the lack of norms. It is the responsibility of the government, through the Anganwadi centers to work towards creating new norms that support mothers and children's rights. The ICDS programme reaches out to only a small section of the village population, giving the impression that it is a project and not a universal entitlement. The number of beneficiaries gets fixed on an arbitrary basis and there is no flexibility to change it.

Closely related to lack of coordination is the problem of haphazard and top down planning. There is no clarity on the roles of the supervisor and the Child Development Project Officer. The supervision is reduced to monitoring the different registers that are to be maintained by the Anganwadi workers. This top down approach to planning must be replaced by a more decentralized system where the Anganwadi workers are given space to review their experiences and share what they think must be done to achieve the goals of ICDS.

- 7) **INADEQATE HEALTH SERVICES:** The health scenarios in the Anganwadi centers reflected similar kind of concerns which included
- Lack of coordination with the primary health care system.

- Lack of sustained interest in the health care system on the part of the ANM and other medical in charges.
- Inadequate supply of iron tablets for pregnant and nursing mothers.
- Neglect of referral services and home visits.
- Lack of sanitation and personal hygiene.

However there are Mandals where in the Anganwadi workers have played an important role in improving the health status of women and children by engaging in continued counseling and follow ups of the concerned families.

The quality of ICDS varies a great deal between different states, and sometimes even between different Anganwadis within the same state. Generally, the quality of ICDS is not very good, and there is a big gap between promise and reality. However, experience shows that with adequate political will, the conditions required for ICDS to work can be created. These enabling conditions involve, for instance, higher budget allocations, a better infrastructure, closer monitoring, improved accountability, and more active community participation. The most important reason for the gap between promise and reality is that the rights and wellbeing of children under six is not a political priority. This is partly because children are not voters. But there is more to it than that. There is poor understanding about early childhood across the country and in all strata of society. Not many are familiar with scientific facts about the critical importance of early childhood in the development of a human being. This has led to indifference and rampant neglect on the part of the government, and also at the level of community involvement

Civil society groups can play a very important role in exerting pressure over the government authorities and thereby ensure the effective implementation of the ICDS. An important name here is that of **M. Venkatarangaiya Foundation** (MVF) which was established in 1981. Starting out as a research institution on

issues relating to social transformation, the Foundation later involved itself in mobilizing communities for abolition of child labour. This Endeavour is principally through its belief that no child must work and all children have a right to education. Over the years the work of the Foundation has expanded to cover more and more villages both through direct implementation of the programme and as a resource centre supporting other NGO's and government. MVF utilizes existing government institutions and follows a conscious policy to include the official machinery into its programmes without setting up parallel institutions. This approach has contributed to the replicability of the programme in other areas.

MVF has also initiated programmes related to the right to health and nutrition of children under six years of age, right to safe motherhood and rights of adolescent girls. It adopted several strategies to strengthen the ICDS. These include:

It tries to conduct elaborate and extensive surveys in order to identify the children, expectant and nursing mothers in the villages. MVF having firm belief in democratic means realizes the link between Gram Panchayats and strengthening of ICDS and Anganwadi centers and therefore tries to involve influential figures such as the village Sarpanch in all its programmes. Sarpanches of concerned villages are invited for the meetings conducted by MVF staff to converse about the status of the village in providing medical and educational facilities and thereby collectively decide upon the ways and means in which the identified problems can be solved. Ward members are also motivated to keep an effective check on various activities in the village. MVF also arranged meetings at the Zila/ Mandal level to discuss the problems of Anganwadi centers and Primary Health Centers. The organization has also conducted several rallies to spread awareness about the importance of the Anganwadi in improving upon the health and nutritional status of women and children in the community. Thus a door to door approach is followed to bring about awareness in the community.



### **An Anganwadi teachers meeting at the Vikarabad Mandal**

MVF tries to work along the lines of inclusivity so as to ensure that no one is discriminated against on grounds of race, religion, caste or sex. In its attempt to do so it has attempted to ensure that all children under a habitation come under the beneficiary roof of ICDS. The organization has also been able to ensure the following:

- Regularity of Anganwadi teachers and helpers
- Regular weighing of children
- Timely motivational counseling of families in the villages
- Accountability of the standing committees formed by the Panchayat such as the Education Committee, Health and Nutrition Committee

- Adequate food supply to the children as well as pregnant and nursing mothers
- Prevention of wastage of food at the Anganwadis by generating greater awareness with regards to the way in which food should be distributed at the centre
- Greater awareness among the Community members with regards to the utility of the ICDS
- Greater coordination between the ANM and Anganwadi teachers
- Lesser incidence of child marriage and female feticide
- Awareness about the need for sufficient gaping between child births

MVF has also conducted several Mothers meetings to identify the children who are physically or mentally weak. These cases are then reported to the ANM to ensure necessary follow ups. These meetings have also enabled the registration of pregnant women with the Anganwadi centers.

**CONCLUDING REMARKS:**

There has been significant progress in the implementation of ICDS Scheme during the last few years both, in terms of increase in number of operational projects and Anganwadi Centres (AWCs) and coverage of beneficiaries as indicated below:-

<b>Year</b>	<b>No. of operational projects</b>	<b>No. of operational AWCs</b>	<b>No. of Supplementary nutrition beneficiaries</b>	<b>No. of pre-school education beneficiaries</b>
<b>31.03.2003</b>	<b>4903</b>	<b>600391</b>	<b>387.84 lakh</b>	<b>188.02 lakh</b>
<b>31.03.2004</b>	<b>5267</b>	<b>649307</b>	<b>415.08 lakh</b>	<b>204.38 lakh</b>

<b>31.03.2005</b>	<b>5422</b>	<b>706872</b>	<b>484.42 lakh</b>	<b>218.41 lakh</b>
<b>31.03.2006</b>	<b>5659</b>	<b>748229</b>	<b>562.18 lakh</b>	<b>244.64 lakh</b>

The coverage of the ICDS programme needs to be expanded to include every child, pregnant and nursing mothers and adolescent girls. Its functions need to be separated, with a specialized person to provide pre school education and another worker to take charge of health and nutrition aspects. Coordination between the health and education departments is required for maximum efficiency. Also it is important to set clear goals so that achievements can be assessed and work given direction. The process of ensuring that every child is taken care of as a matter of right involves societal pressure through public action and democratization of all public institutions. As Dr. Shanta Sinha writes “in a democracy every child must be regarded as indispensable and the government must be accountable for the deaths of children and mothers. Unfortunately the issue of children’s health seldom finds space in contemporary political discourse in India. The situation can be amended only when the newborn child is welcomed and taken care of.

## **AN ARTICLE:**

### **COMMUNITY MOBILIZATION FOR ICDS IN ANDHRA PRADESH**

In rural India, the health of infants and children is not a public concern. If a baby is born with a low birth weight, or if an infant dies, it is seen as the mother's problem. The M.V. Foundation is working in about 300 villages of Ranga Reddy District to change these perceptions, and to bring accountability in Anganwadis and Primary Health Centers. To create a feeling of social responsibility for children's right to nutrition and health, public meetings were held with Gram Panchayat members, women, youth and others. Data on children aged 0-6 were presented and the reasons for each child death were discussed. The groups were also informed about ICDS and the role of the Anganwadi worker. It was decided that the Anganwadi worker (AWW), the Auxiliary Nurse Midwife (ANM), the school headmaster, Gram Panchayat members and others in the community would jointly review the state of all children in the village every month. Many changes have happened due to these review meetings. For instance, in village Burugupally (Mominpet Mandal) the Anganwadi worker used to come once a fortnight. The Sarpanch warned her at the review meeting that he would have to make a complaint if she did not attend regularly. The AWW was politically influential and paid no heed to the warning. The 39 Action for ICDS Sarpanch, youth leaders and mothers' committee then sent a petition to the CDPO. The CDPO sent a memo to the AWW and she finally yielded to the pressure. The village youth also noticed that children were given supplementary nutrition powder in their pockets or in plastic covers, and were dropping it on the way as they walked home. Dogs were chasing these children, most of whom were dropping the packets and running away. In the next review meeting, the AWW was asked to make '*laddus*' of the powder and feed the children at the Anganwadi itself. The AWWs now discuss their problems with the Gram Panchayat. These problems are then raised by the Sarpanches in Mandal General Body meetings that are attended by officials of all departments. Some

issues, such as lack of plates at the Anganwadi or repair of play equipment, are resolved at the village level itself. The M.V. Foundation has also involved the AWWs in intensive follow-up of children in the 0-3 age-group who are suffering from Grade III or Grade IV malnutrition. The MVF volunteer and the AWW visit the houses of these children together, counsel the mother, and give double rations of the supplementary nutrition. The AWW, who used to “hide” these children in the records for fear of being reprimanded by her supervisors, now showcases them as her success when the supervisor or CDPO visits the village. As a result of the review meetings, and close monitoring of over 30,000 children, many of the Anganwadis in these eight Mandals of Ranga Reddy District are now active. Children attend regularly, malnourished children are taken care of, and the health of infants and young children has become a public concern.

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This report is a compilation of articles, facts and figures from field work experiences of the researcher, the internet, EPW articles, MVF publications and Focus survey.

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