INTEGRATED

CHILD DEVELOPMENT

SERVICES

SCHEME OF INTEGRATED CHILD DEVELOPMENT SERCES

GOVERNMENT OF INDIA
MINISTRY OF HUMAN RESOURCE DEVELOPMENT
(Department of Women and Child Development)
SHASTRI BHAVAN, NEW DELHI

CONTENTS

Scheme of Integrated Child Development Services (ICDS)

SCHEME OF INTEGRATED CHILD DEVELOPMENT SERVICES

Introduction :

1. India's population (1981) is 683 million. According to the 1981 Census of India, about 40% population consisted of children up to 14 years of age. Children under 6 years of age constitute about 17% of the population.

2. There were significant achievements in India in the first four Plans in all spheres of development from which children too derived benefit. Nevertheless, various problems concerning child welfare are still of fairly large dimensions. The incidence of mortality, morbidity and malnutrition among children continues to be high. Although the infant mortality rate varies in different parts of the country and is influenced, among others, by physical, geographical, economic and social factors and the level of social and economic development, it is more that a 100 per thousand in most areas. Various surveys have indicated a fairly high incidence of malnutrition among pre-school children. Vitamin A deficiency is reported to be common among children and is considered as a major contributing factor to the large incidence of blindness in India. The occurrence of diarrhea, dysentery, parasitic infection, skin diseases, respiratory infections, whooping cough, measles, etc. is also fairly common. Physical growth (height and weight according to age) and the development of mental capacity of children are consequently affected. Unsatisfactory dietary habits (both in terms of choice of food as well as the preparation), weaning practices, poor knowledge of nutrition and of health and hygiene, and reliance on charms and spirits and on treatment prescribed by quacks, aggravate the problem.

3. There has, for some time been an awareness of the importance of organizing early childhood services for the future development of the child through resource constraints, and a basically sectoral approach to the needs of children had prevented the development of a coordinated strategy. It is now, however, realized that any deferment of action will be detrimental to the development of country's human resource which is key factor in development. It is in early childhood that the foundations for physical, psychological and social development are laid and if an appropriate range of services can be provided, particularly to the weaker and vulnerable sections of the community, wastages arising from infant mortality, physical handicaps, malnutrition, stagnation in school and poor development of mental capacities, can be considerably minimized and positive contribution to the social economic development of the country made through the all-round development of the individual. The organization of early childhood services should therefore, be regarded as an investment in the future economic and social progress of the country.

Strategy of Development of Early Child Services :

4. The then Minister of Planning had, in 1972, suggested that a scheme for Integrated Child Care Services might be worked out for implementation in all States. Accordingly, eight inter-ministerial study teams were constituted by the Planning Commission on the basis of whose studies a proposal for integrated child care services was made for pre-school

children covering supplementary nutrition feeding, immunization, health care including referral services, nutrition education of mother, pre-school education and recreation, family planning and provision of safe drinking water. The steering Group set up by the Planning Commission to advise on the formation of the Fifth Plan also suggested the adoption of an integrated approach to early childhood services. Its recommendations were accepted and the scheme of Integrated Child Development Services was included in the Plan in the Social Welfare Sector to give a definite focus to the development of services for early childhood.

5. After a series of inter-ministerial discussions, the details of the ICDS scheme were finalized. 33 experimental ICDS projects were started in 1975-76. Evaluation of these projects showed that health and nutritional status of children improved and a considerable proportion of children improved and a considerable proportion of children benefited by the scheme belonged to the scheduled castes, scheduled tribes and other poorer sections of society. Encouraged by the results, Government decided to expand the programme. Some states also took up additional ICDS projects in the States Sector.

6. The objectives of the Integrated Child Development Services are :-

   i) to improve the nutritional and health status of children in the age-group 0-6 years;

   ii) to lay the foundation for proper psychological, physical and social development of the child;

   iii) to reduce the incidence of mortality, morbidity, malnutrition and school dropout;

   iv) to achieve effective coordination of policy and implementation amongst the various departments to promote child development; and

   v) 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.

The package :

7. The concept of providing a package of services is based primarily on the consideration that the overall impact will be much larger if the different services develop in an integrated manner as the efficiency of a particular service depends upon the support it receives from related services. For instance, the provision of supplementary nutrition is unlikely to improve the health of the child if he continues to be exposed to diarrhoeal infections or unprotected drinking water supply.

8. The selection of services to constitute the package of the child development services scheme is based on the following considerations :

   i) need for the services;

   ii) inter-dependence and mutual support relationship;

   iii) cost; and

   iv) administrative feasibility

9. The following package of services will be provided in the integrated child development services scheme :

    1. Supplementary nutrition
    2. Immunization
    3. Health Check-up
    4. Referral Services
    5. Nutrition and health Education
    6. Non-formal education

10. These services are to be supplemented with non-formal education for women. On account of the key role of protected water supply, efforts should be made for the convergence of the rural drinking water supply programme in the Integrated Child Development Services Project areas. Stress should also be laid on applied nutrition activities like local production and consumption of nutritious foods.

Type of Beneficiaries :

11. The scheme will provide integrated services to children below the age of six years. Restricting the coverage to children 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. Further, earlier childhood is more crucial for child's development and, therefore, it is necessary to make a concerted effort in promoting sound development of early childhood. Early childhood itself would need to be reclassified into different age groups and differential needs taken into consideration in delivering the services.

12. Since the mother has a key role in the physical, psychological and social development of the child, nursing and expectant mothers have to be brought into any scheme which aims at the welfare of the child. Attention has to be given to mothers and, therefore, women of 15-45 years have to be brought within the ambit of Integrated Child Development Services.

13. The delivery of services to the beneficiaries will be as follows :

	Beneficiary		**Service**
1.	Expectant and nursing mothers	i)	Health check-up
		ii)	Immunization of expectant mothers against tetanus
		iii)	Supplementary nutrition
		iv)	Nutrition and Health education.
2.	Other women 15-45 years		Nutrition and health education
3	Children less than 1 year	i)	Supplementary nutrition

		ii)	Immunization
		iii)	Health check-up
		iv)	Referral Services
4.	Children 1-2 years	i)	Supplementary nutrition
		ii)	Immunization
		iii)	Health check-up
		iv)	Referral Services
		v)	Non-formal pre-school education

14. Brief outlines of each services are given below : The details, including specific norms where feasible, are worked out in consultation with the respective departments and specialists. It would be necessary to emphasise that this document gives only the model for the scheme. It is necessary to make a detailed project formulation exercise for each Integrated Child Development Services Project. However, implementation of the scheme can commence in the approved project areas, pending finalisation of detailed Project Plan for each project area.

Supplementary Nutrition :

15. Supplementary nutrition will be given to children below 6 years of age and to nursing and expectant mothers from low income families and in accordance with guidelines issued from time to time for the purpose of selection of beneficiaries. Special attention is required to be paid to the delivery of supplementary nutrition to children below 3 years of age. Adequate funds for supplementary nutrition should be provided in the State Plans under Minimum Needs Programme. New Projects should, as far as possible, be located in areas already covered under SNP programme. Sufficient funds should also be provided for therapeutic food for severely malnourished children. The amount of nutrition will vary according to the age of the child. The type of food (milk, pre-processed or semi-processed food or food prepared on the spot from locally available food-stuff) will depend upon local availability, type of beneficiary, location of the project, administrative feasibility etc. First priority will, however, be given to locally available food. Supplementary nutrition will be given for 300 days in a year. Children who are found, as a result of health check-up, to suffer from third degree of malnutrition will be given enhanced supplementary nutrition (therapeutic food) based on their physical need as recommended by the doctor. On average, the effort should be to provide daily nutritional supplements to the extent of 300 calories and 10 gms. Of proteins per child, 500 calories and 15-20 gms of proteins per pregnant woman/nursing mother, and 600 calories and 20 gms. Of proteins per severely malnourished child. The cost varies depending upon recipes and prevailing prices. The Central Government provides guidelines regarding costs from time to time.

16. The cost of supplementary nutrition has to be met form the provision made for the special nutrition programme in the state sector under the Minimum Needs Programme. Some aid food is also made available to states. Assistance under centrally sponsored wheat-based

supplementary nutrition programme can also be used to supplement (not to substitute) state efforts.

17. Nutrition and health education will be given to all women in the age-group 15-45 years; priority will be give to nursing and expectant mothers. A special follow-up will be made of mothers whose children suffer from malnutrition or from frequent illness.

18. The methods of carrying the message of health and nutrition education will be :

i) use of mass media and other forms of publicity;

ii) special campaigns at suitable intervals aimed at saturating the project area;

iii) home visits by the Anganwadi workers;

iv) specially organized short courses in the village for about 30 women at a time;

v) demonstration of cooking and feeding; and

vi) utilization of the health and nutrition education Programmes of the Ministry of Health and Family Welfare. Ministry of Agriculture (especially Department of Food and Directorate of Agricultural Extension) etc. (at the Centre and in the States/Union Territories).

19. The Department of Food in the Union Ministry of Agriculture will extend the facilities of its Mobile Food and Extension Units for training, demonstration and education Units for training, demonstration and education in the field of nutrition especially with reference to best use of the locally available nutritious food. Similarly, effort should be made to secure convergence of the health and nutrition education programme of the Ministry of Health and Family Welfare and the schemes of non-formal education for women of other Departments/Ministries. It is expected that implementation of the schemes of non formal education literacy for women in the ICDS Project area will in particular generate general awareness and promote public participation for more effective implementation of this scheme.

Immunization

20. Immunization against Diphtheria, Whooping Cough, Tetanus, Poliomyelitis and Tuberculosis of all infants (by first birth-day) is proposed in the project area. Immunization against measles will be given if the local epidemiological situation warrants it. Children of 5 to 6 years of age (School entry) should receive booster dose for Diptheria and Tetanus (D.T) and two doses of typhoid vaccination. As Tetanus among new born is common and is usually fatal, all expectant mothers will be immunized against tetanus. The immunization schedule is given in Appendix ‘A’.

Health Check-up and Referral Services

21. This will include :

i) ante-natal care of expectant mothers;

ii) post-natal care of nursing mothers and care of new born infants;

iii) care of children under six years of age.

22. The details of services proposed to be provided may be seen at Appendix 'B'. In certain areas and in certain cases the scope of health check-up and treatment may be wider. Children requiring referral services will be provided appropriate facilities at the referral hospitals/ upgraded PHCs (Primary Health Centres) /community health centres/district hospitals.

Non-formal Education

23. Children 3-6 years will have the benefit of non-formal pre-school education through the institution of anganwadi to be set up in each village and in each centre in an urban project. Where, however, balwadis or anganwadis, run by voluntary organisation, local bodies or Government, are already functioning these will be utilised for implementing the schemes. The programme in urban projects will be coordinated with other similar schemes in the project area. The anganwadi will be the focal point for delivery of the entire package of child development services.

24. Non-formal pre-school education in these projects will imply the organisation of pre-school activities for children below 6 years of age in each anganwadi. It will not impart formal learning but will develop in the child desirable attitudes, values and behaviour patterns and aim at providing environmental stimulation. No attempt will be made to achieve uniformity of teaching/learning procedure in the anganwadi in regard to all children and in regard to play and other activities. There will be flexibility and the child will be encouraged and stimulated to grow at his own pace. The anganwadi would strive to satisfy the curiosity of the child and channel it in a creative direction. The material to be used in anganwadis should be of indigenous origin, made by the teachers or local artisans, and inexpensive. In determining the content of non-formal pre-school education, organisation of anganwadis, equipment, training etc. the recommendation of the Education Commission (1964-66) the Report of the Study Group on the Development of the Pre-school Child (1972) etc. are taken into consideration. The anganwadi proposes to establish links with the elementary school so that the child moves from the anganwadi to the school with the necessary emotional and mental preparation.

25. In some village/centres, anganwadis can be easily started with the readily available trained Balsevikas who are willing to work as anganwadi workers, while in others, anganwadis will be developed by selecting a local women, with some educational qualification, who will be provided three months' training (Training period will be extended to four months for these Anganwadi Workers who have to conduct literacy / educational classes for women.) to enhance her competence to handle the programme.

26. The anganwadi workers will be responsible for:

(a) non-formal pre-school education, i.e. organizing pre-school activities in an anganwadi for about 40 children in the age-group 3-5 years of age; the toys, play equipment, etc. to be used should be rural in character and origin, in designing and making which the anganwadi worker will play a leading roles;

(b) organizing supplementary nutrition feeding for children (6 months to 5+ years) and expectant and nursing mothers; in planning the menu, the priority will be given to locally available food and local recipes;

c) giving health and nutrition education to mothers;

d) making home visits for educating parents, particularly in the case of children attending the anganwadi so that the mother of the child can be enabled to play an effective role in child's growth and development;

e) eliciting community support and participation in running the programme;

f) assisting the Primary Health Centre Staff in the implementation of the health component of Integrated Child Development Services Projects viz. immunization, health check-up, referral services, and health education;

g) maintaining routine files and records to enable measurement of the impact of the services;

h) reporting to the Child Development Project Officer (to be appointed for each block) the developments in the village which require further attention, particularly in regard to the working of the coordinating arrangements of different departments in the village;

i) maintaining liaison with other institutions in the village which have relevance to her functions (mahila mandal etc.); and

j) maintaining liaison with the lady school teacher for assistance in organizing pre-school activities and for participation of the primary/middle school girls (where they exist) in the programmes of the anganwadi, thus enabling the girls to acquire work experience.

Selection of Project Areas

27. The administrative unit for the location of Integrated Child Development Services Projects will be the community development blocks in rural areas; tribal development blocks in predominantly tribal areas and ward(s) or slums in urban areas.

28. In the selection of projects in rural areas priority consideration will be given to the following factors (The serial number does not indicate the order of priorities. Several factors may operate jointly in some areas due to high correlation of their occurrence)

1. areas predominantly inhabited by tribes, particularly backward tribes;

2. areas inhabited predominantly by Scheduled Castes;

3. backward areas;

4. drought-prone area;

5. nutritionally deficient areas; and

6. areas poor in development of social services.

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

i) location of slums; and
ii) areas predominantly inhabited by Scheduled castes.

30. In the initial stage, however, a major consideration will be the conversion of the existing supplementary nutrition feeding centres, located in tribal and backward rural areas and in urban slums in the selected ICDS project areas, into Anganwadis under ICDS scheme.

31. The selection of project areas, will be coordinated with the programme of the Health and Family Welfare Ministry to strengthen the primary health set-up and programmes for protected water supply of the Ministry of Works and Housing. Other programmes of different departments at the Centre and in the States which have a bearing on the successful implementation of the scheme, will also be coordinated with it.

Number of Beneficiaries :

32. The demographic and other characteristics very significantly from block to block. For purpose of this document :

A Rural Project (a community development block) is assumed to have a population of 1,00,000 of which 17 per cent i.e 17,000 are less than 6 years (3 per cent i.e. 3,000 are less than 1 year, 6 per cent i.e. 6,000 are 1-2 years and 8 per cent i.e 8,000 are 3-5 years); the number of women in the age group 15-45 years is estimated at 20,000 of this, the number of nursing and expectant mothers at any point of time is estimated at 4,000.

The number of villages in a rural project is assumed to be 100.

An urban Project (one or more wards/slums) is assumed to have the same demographic characteristics as a rural project.

A tribal Project (a tribal development block) is assumed to have population of 35,000 of which 17 per cent i.e. 5,950 are less than 6 years (3 per cent i.e. 1,050 are less than 1 year, 6 per cent i.e. 2,100 are 1-2 years and 8 per cent i.e. 2,800 are 3-5 years); the number of women 15-45 years is estimated at 7,000; of this the number of nursing and expectant mothers at any point of time is estimated at 1,400. The number of villages in a tribal project is assumed to be 50.

33. The above average have been assumed for the purpose of arriving at a first approximation of the number of beneficiaries, etc. However, detailed exercises will be necessary for each project based on actual demographic and other features of each selected project area. The number of Anganwadi workers and supervisors will, therefore, be adjusted according to population topography, number of villages etc. On an average, there will be an Anganwadi worker for 1000 population in a rural/urban project and 700 population in a tribal project with suitable adjustments, where necessary, in the light of local conditions like topography, number of villages etc.

34. The total population in each age-group and target population for each project will, on the basis of assumed averages, be as shown in the following statements (through actual figures will differ for each project as these would depend on the actual demographic and other features of the project area). The percentage coverage given

on the next page is approximate and is not in any way a limit. Actual coverage will vary from project to project.

RURAL PROJECT

(1,00,000 population, 100 villages)

Total population in each group	Service	Target Population	Remarks
Children 0-5 years (17,000 children)	Immunization Health check-up Supplementary nutrition Referral	17,000 17,000 6,800	100% coverage 100% coverage 40% coverage* Where necessary
Children 3-5 year (8,000 children)	Non-formal Pre-school education	4,000	50% coverage
Nursing and expectant mothers (4,000 in number-2,400 expectant women and 1,600 nursing mothers upto first six months of Lactation	Supplementary nutrition Health check-up (expectant mothers) Immunization against tetanus (expectant mothers)	15,000 2,400	40% coverage 100% coverage
Women 15-45 years (20,000 women)	Nutrition and Health Education	20,000	10% coverage progressively
URBAN PROJECT Same as for rural project			
*Beneficiaries of Supplementary nutrition should be selected as per guidelines issued by the Ministry of Human Resource Development (Department of Women and Child Development). The actual number will, therefore differ from project to project.			

TRIBAL PROJECT

(35,000 population, 50 villages)

Total population in each group	Service	Target Population	Remarks
Children 0-5 years (5,950 children)	Immunization Health check-up Supplementary nutrition Referral	5,950 5,950 4,462	100% coverage 100% coverage 75% coverage* Where necessary
Children 3-5 year (2,800 children)	Non-formal Pre-school education	2,100	75% coverage progressively
Nursing and expectant mothers (1400:910 expectant women and 490 nursing mothers upto first six months of Lactation)	Supplementary nutrition Health check-up (Expectant mothers) Immunization against tetanus (expectant mothers)	1,050 910 910	75% coverage progressively 75% coverage 100% coverage
Women 15-45 years (7,000 women)	Nutrition and Health Education	5,250	75% coverage progressively
URBAN PROJECT Same as for rural project			

*Beneficiaries of Supplementary nutrition should be selected as per guidelines issued by the Ministry of Human Resource Development (Department of Women and Child Development). The actual number will, therefore differ from project to project.

Functional Responsibility :

35. In the Plans, the scheme of Integrated Child Development Services has been classified as a centrally sponsored programme and will be implemented through the State Government with 100 per cent financial assistance from the Central Government for inputs other than supplementary nutrition (the states have to provide funds for supplementary nutrition under minimum needs programme in the State Sector). The Central Social Welfare Board, Voluntary organizations, local bodies, Panchayati Raj institutions (where these are functioning efficiently) etc. are to be actively involved in this programme for implementation, soliciting community support etc. The Central Social Welfare Board and the State Board should make efforts for organizing a larger number of voluntary organizations in the project areas. The intention is to entrust the running of Anganwadis to voluntary organizations, local bodies, Panchayati Raj institutions etc. (wherever these are functioning

efficiently) and give them grant-in-aid on the basis of the support required for the Anganwadis (Appendix-C). Nutrition inputs can be provided to these bodies by the states or by the Central Government under Wheat-based nutrition programme. The State Government may itself run an Anganwadi only if no organization as suggested above is available.

36. Since the scheme is based on the strategy of an inter sectoral approach to the development of children, coordination of the efforts of different Ministries and Departments at all levels will be necessary.

37. The participation of the Ministry of Health and Family Welfare in the scheme of Integrated Child Development Services is as follows :

i) The Ministry has indicated the norms of the health services to be attained in the project area (Appendices A and B)

ii) The PHC and subordinate health infrastructure will deliver the following health services to the beneficiaries in the scheme of Integrated Child Development Services :-

(a) health check-up

(b) referral services

(c) immunization

iii) For the health services envisaged for children in the project, certain personnel (both medical and paramedical) and other inputs will be provided to supplement the primary health services network in the project areas. For the ICDS Projects sanctioned upto 1981-82, additional health personnel were provided form ICDS budget so as to have one ANM or HW (Female) for a population of 5,000 and one LHV or HA (Female) for 4 ANMs/HWs (Female) and one additional H.O. in the PHC. Now, the Ministry of Health and Family Welfare is providing 100% central assistance for upgrading the health set up to nationally accepted norms (one HW(F) for 5,000 population in rural areas and 3,000 population in tribal areas and one HA(F) for supervising 6 HWs(F), one Health Guide in every village, and an additional Medical Officer in the PHC). Therefore, in rural/tribal ICDS projects sanctioned from 1982-83 onwards, no health personnel will be provided from ICDS budget. However, in urban ICDS projects, health personnel will continue to be provided from the ICDS budget.

iv) Additional inputs of personnel, equipment, etc. from the Integrated Child Development Services budget in ICDS Projects sanctioned upto 1981-82 will form an integral part of the overall PHC structure and not function as a separate entity. The PHC would, however, assume responsibility to meet the targets envisaged for the project.

v) The up gradation of health set-up in PHCs in the sixth Plan should cover with the opening of Integrated Child Development Services (ICDS) projects. This will facilitate planned delivery of health services to the beneficiaries of the ICDS project by ensuring that the entire complement of staff, medicines, etc. is

available in the PHCs so that they do not suffer from shortages of personnel, equipment, medicines etc.

vi) Since the PHC structure would function under the administrative control of the Department of Health in the States, the nodal Department for ICDS in the States would not exercise administrative control over the health staff provided under the ICDS budget in the projects sanctioned upto 1981-82. The State Social Welfare or other nodal Departments for ICDS would deal with the state Health Departments who would be administratively responsible for attaining the ICDS target for health services. **This is obviously not relevant where the Health Department in the State is itself the nodal Department for ICDS.**

vii) The Health Departments in the States/Union Territories would make available their services for health and nutrition education of women (15-45 years) in the ICDS projects.

viii) Requirements of vaccines, medicines etc. to cover the target groups for the Integrated Child Development Services would be met by the Union Ministry of Health and Family Welfare from its own allocations. Some additional provision is available from ICDS budget for simple medicines at the Anganwadis.

ix) In urban areas the urban family welfare centres of the Department of Family Welfare will be linked with the urban projects of Integrated Child Development Services.

x) The training of health personnel for the delivery of health services envisaged in the Integrated Child Development Services envisaged in the Integrated Child Development Services projects, will be arranged by the Ministry of Health and Family Welfare.

Flow of Administrative Control :

38. A diagrammatic representation flow of administrative control in the implementation of ICDS project in rural/ tribal blocks is given at Appendix D.A coordination machinery will be set up at all levels as the scheme is basically an inter-departmental endeavour.

39. The Ministry of Human Resource Development, Department of Women and Child, is responsible for budgetary control and administration of scheme from the centre. At the State level, the Secretary of the Department of Social Welfare, or the nodal Departments as decided by the State Government is responsible for the overall direction and implementation of the programme. The Central Government has provided assistance for strengthening the State level set-up in the Directorate/Secretariat. At the District level, the District level Officer as directed by the State Government is responsible for coordination and implementation of the scheme. In districts have five or more projects, the Central Government has provided assistance to the States for setting up district level ICDS cells.

40. A Child Development Project Officer is appointed for implementation of the programme at each block. He/ She will be directly incharge of the scheme. He/She will coordinate his/her work with the Block Development Officer and the Medical Officer of the Primary Health Centre. the CDPO will be responsible for implementing

the scheme at the field level. The CDPO should be carefully selected and should preferably be a lady graduate in Child Development, Social Work, Home Science, Nutrition or any allied field.

41. As stated earlier, the Anganwadi will be the focal point for the delivery of services. Immunization and health check-up will be delivered at the Anganwadi through the net-work of health services in the project area. The services of supplementary nutrition feeding, nutrition and health education and non-formal pre-school education will be provided through the Anganwadi with support from the community development, health and other departments.

42. In the case of urban projects, the Child Development Project Officer, will be responsible to the nodal Department in the State Government for the implementation of the scheme.

Personnel :-

43. As stated earlier, the Child Development Project Officer will be incharge of the project. Each will have an Anganwadi worker. She will be assisted by a helper in organizing supplementary nutrition feeding programme etc. In each rural/urban project, there will be one Anganwadi worker for 1000 population and in each tribal project, there will be one Anganwadi worker for 700 population. This number can be further adjusted/increased on the basis of local conditions regarding number of villages, topography etc.

44. The Anganwadi worker may be a matriculate or not. She will receive monthly honorarium at the rate approved by the Government of India from time to time. Each urban project may have all matriculate Anganwadi workers, though the proportion of matriculate and non-matriculate Anganwadi workers will vary from project in rural/tribal areas.

45. As one CDPO will not be able to supervise and guide the work of 50 to 100 Anganwadi workers, supervisors of the rank of Mukhya Sevikas will be provided at the rate of one supervisor for 20, 25 and 17 Anganwadis in each rural, urban and tribal project respectively. In sparsely populated areas, their number can be increased suitably.

46. The health personnel to be provided are indicated above in paragraph 37(iii).

47. Even though funds will. Be provided by the Central Government, the Stall will be borne on the appropriate cadres of the States and therefore, the State should sanction the posts (as per appendix C) in the appropriate corresponding State pay scale. The Anganwadi workers and their helpers will be honorary workers.

Project Formulation, Monitoring and Evaluation:

48. A nucleus secretarial set-up in the Ministry of Human Resource Development, Department of Women and Child Development, will direct the entire programme. The Programme Evaluation Organization of the Planning Commission has evaluated it. Prime Minister's office Cabinet Secretariat and Ministry of Programme Implementation in Government of India oversee the programme with reference to some critical indicators. Medical colleges have been involved in the monitoring and

surveys of health and nutrition aspects. The project will be closely monitored at the state level. States/U .Ts. are also provided with a Cell at State/UT HQ to facilitate planning, monitoring and evaluation of projects. ICDS consultants nominated by the State Governments from medical colleges or State Health and nutrition aspects. NIPCCD and other organizations (e.g. Home Science Colleges and Schools of Social Work) have been associated for evaluating other aspects of the programme like pre-school education, extension work, community participation ete. It is proposed to introduce concurrent evaluation of service delivery with the help of selected organizations.

Cost of the project:

49. Total cost for each project excluding the nutrition component which is to be provided from the State Sector under the Minimum Needs Programme, will be met by the Government of India. Actual expenditure in each project will differ from project to project because the pay scales etc. are different from State to State, and the number of functionaries may also vary from project to project depending upon population, topography, number of villages etc.

50. The cost in regard to inputs other than supplementary nutrition is met by the Ministry of Human Resource Development (Department of Women and Child Development) in the centrally sponsored sector. The cost in regard to supplementary nutrition feeding will be borne in the nutrition sector in the State plan. Assistance under the centrally sponsored wheat-based nutrition programme can be provided to supplement (not to substitute) the State Government's outlays on nutrition. Details of posts and other items on which expenditure will be met by Central Government are given at Annexure-C.

Training of personnel

51. The functionaries of Integrated Child Development Services Project will have to be trained or appropriately oriented for the task expected of them. The training/ orientation of different personnel will be arranged by the Ministry of Human Resource Development, Department of Women and Child Development and the entire expenditure thereon will be borne by the Government of India. For this purpose, detailed guidelines are issued from time to time. The National Institute of Public Cooperation an<1 Child Development (NIPCCD), New Delhi, some Gramsevika Training Centres, the Indian Council for Child 'Welfare, selected medical colleges etc. are actively involved in the training programmes. The pattern of assistance for the training of Anganwadi workers is show 11 in Appendix-E This is subject to revision as per requirement from time to time. Training of CDPOs is conducted by NIPCCD Training of Supervisors is organized by NIPCCD through selected organizations which are provided with necessary funds and guidance by NIPCCD.

Forms:

52. Some forms and registers have to be maintained at different levels. These will be simple and few. The States may use regional language for these forms and registers, if

they so desire, but reports to the Government of India may be sent in Hindi or English only.

UNICEF/Bilateral Aid:

53. Some of the areas of UNICEF cooperation are consultancy service, training, jeeps and other supplies, equipment, monitoring, research and evaluation. USAID and NORAD are also assisting some ICDS projects in few States CARE and WFP are providing food commodities for some ICDS projects in a few States

General

54. This brief description of the scheme is supplemented by the Government of India, from time to Home, by issuing detailed guidelines on various aspects of the scheme. Compilations of such guidelines are also printed and distributed periodically. Manuals have have been prepared and distributed for some categories of workers. These guidelines, compilations, manuals etc. have to be referred to by the ICDS functionaries and other concerned workers for detailed information or guidance on any specific aspect of the Scheme.

APPENDIX-A

IMMUNIZATION SCHEDULE

Immunization of Children upto 6 years of age:

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

Age 1 ½ to 3 ½ months	a. Start with First dose of DPT (injection), First dose of polio (oral drops), BCG (injection)
	b. After an interval of 1-2 months give: Second dose of OPT (injection) Second dose of polio (oral drops)
	c. After an interval of 1-2 months give OPT (injection) and polio Vaccination (oral drops)
9 to 12 months	Measles vaccine (injection) one dose where available.
18 to 24 months	Booster OPT (injection) Booster Polio Vaccine (oral drops)
5 to 6 years	Booster DT (Diphtheria and Tetanus) (injection) First dose of typhoid monovalent or bivalent vaccine (injection)
	b. After an interval of 1-2 months give second dose of typhoid vaccine (injection)

The ages shown for the various immunization are considered 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 BCG, three

doses of DPT and three doses of Polio. BCG, DPT and 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 3 doses of DPT and 3 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 (school entry), one dose of DT as a booster will be sufficient if there is a history of receiving DPT or D1' earlier. Otherwise two doses of D1' 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 will have to be given.

Immunization of expectant mothers:

Schedule of tetanus toxoid immunization

First dose 16-20 weeks

Second dose 20-24 weeks

The minimum interval between two doses of tetanus toxoid should be at least one month. The second dose be given at least two weeks before the expected date of delivery. However, no pregnant woman should be denied over 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.

APPENDIX-B

Health check-up and Referral Services :

These services will include :

i. Ante-natal care. of expectant mothers
ii. Post-natal care of nursing mothers and care of new-born
iii. Care of children under six years of age.

i) Ante-natal care. of expectant mothers

At the Ante-natal Clinics, apart from complete physical and obstetrical examination of the mother, serial recording of weight, blood pressure, hemoglobin and examinations of urine should be done as a routine. Immunization against tetanus should be given. Iron and Folic Acid tablets along with protein supplements should be given. Attention should be paid to health education of the mother on hygiene of pregnancy/breast feeding of the infant and other aspects of mother craft and child rearing with special reference to the spacing of the next child.

A minimum of four physical examinations of the mother during her pregnancy should be the target Of these, at least one visit should be in the home of mother and one visit after 36 weeks of pregnancy.

High risk mothers identified during the ante-natal clinics, Le., mother with bad obstetrical history grand multi-para,

As most of the mothers in rural areas deliver in their homes, only limited post-natal care will be possible to be given to them. Efforts should be made to give post-natal visits to mothers in their homes twice within the 10 days after delivery in those villages where primary health centres and sub-centres are located, and villages nearby. In other areas at least one visit within

the first month after delivery should be aimed at. However, in the urban projects more frequent and better post-natal care could be organised. These visits should be utilized to check on 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 the deliveries attended by PHC personnel should be kept in the relevant card.

Greater emphasis should be placed on including the mother to come to the clinic for post-natal examination of herself as well as of her infant 6 to 8 weeks after her delivery. The post-natal clinic will provide general physical examination of the mother with special reference to the condition of her breast, abdomen, perineum and pelvic organs to ensure that 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 spacing the next birth or for limiting the family size, as the case may be. The findings of the post-natal examination and the acceptance of the family planning method should be entered in the antenatal delivery card of the mother.

iii) Care of children under six years of age :

The following activities are proposed :

1. Serial recording of the height and weight of children with a view to keeping close watch over their nutrition status.
2. Watch over other mile-stones in the growth and development of the child.
3. Provide all the immunization according to the policy enunciated.
4. Provide general check-up every three/six months in order to detect diseases and other evidences of malnutrition or infection.
5. Provide treatment for the widely prevalent diseases like diarrhea, dysentery, upper respiratory-tract infections, skin diseases, eye diseases like trachoma, conjunctivitis etc.
6. Deworming against the prevalent parasitic infections, round-work, hookworm, threadworm etc.
7. Prophylactic measures against diseases of nutritional origin like anaemia, vitamin deficiencies, marasmus etc. through distribution of drugs and diet supplement.
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, with a view to educating and sustaining their interest in the health of their small children and make them avail of the services offered by the project.

Referral Services :

Pregnant mothers and children, with problems requiring specialized treatment will be referred to the upgraded PHC/Sub-division/District Headquarters Hospital, as the case may be. The medical officer of PHC will refer such cases with a referral slip prescribed for the purpose. The hospital after completing the treatment will refer the mother/child back to the Primary Health Centre with

notes of treatment given and further treatment! advice to be followed.

Records **and** Registers:

1. Register of DPT/Tetanus immunization
2. Antenatal card
3. Delivery card
4. Child's card over 5 years
5. Child's card under five years of age
6. Referral card
7. Nominal Register.

APPENDIX – C

REVISED COST ESTIMATE OF PROJECT (ONE YEAR)

Sl. No.	Item	Rural Project	Urban Project	Tribal Project	Remarks
1	2	3	4	5	6
1	A. STAFF Child Development Project Officer	18,000	18,000	18,000	One CDPO in each project in the same pay scale as that BDO.
2	Assistant	9,000	9,000	9,000	One Assistant in each project in the scale of UDC or LDC.
3	Supervisors	50,000	40,000	30,000	Five, Four and Three supervisors in each rural, urban and tribal project respectively, in the pay scale as that of Mukhyasevikas in the States.
4	Clerk-Typist	7,500	7,500	7,500	One in each project.
5	Anganwadi Workers (Honorarium @ 225-325 p.m.)	3,30,000	3,60,000	1,65,000	
6	Driver	7,500	7,500	7,500	One Driver in each project
7	Helpers @ Rs. 110 p.m	1,32,000	1,32,000	66,000	100 in each rural/urban project and 50 in each tribal project.
8	Peon	6,000	6,000	6,000	
9.	Statistical Assistant	9,000	9,000	9,000	
	Total	5,69,000	5,89,000	3,18,000	
Strengthening of Staff in HC/Sub Centres					
1	Doctor (Preferably with diploma in child health	20,000	20,000	20,000	i) One Doctor in each urban project. ii) One Doctor in each

					rural/tribal project sanctioned upto 1981-82; one in rural/tribal projects sanctioned form 1982-83 onwards.
2	Lady Health Visitor/ Public/ Health Nurse / HA (Female)	20,000	-	20,000	Two LHV/PHN in each rural / tribal projects sanctioned from 1981-82; none in projects sanctioned from 1982-83 onwards.
3.	A.N.M./HW (Female)	60,000	30,000	30,000	i) Eight and four ANM if each rural and tribal project respectively sanctioned up to 1981-82; none, in rural/tribal projects sanctioned from 1982-83 onwards. ii) Four in each Urban Project.
4.	Health Staff	1,00,000	50,000	70,000	For projects sanctioned upto 1981-82.
		-	50,000	-	For projects sanctioned from 1981-82 onwards.
	Total	6,69,0006	89,000	3,88,000	For projects sanctioned from 1982-83 onwards.

Sl. No.	Item	Rural Project	Urban Project	Tribal Project	Remarks
1	2	3	4	5	6
B. OTHER EXPENSES Recurring					
1	Contingencies for Anganwadis	18,000	18,000	9,000	100 Anganwadi in each rural/urban project and 50 Anganwadis in each tribal project.
2	Rent for Anganwadis (@Rs.120 p.m. for urban project)	-	1,44,000	-	
	@Rs.25 p.m. for rural/tribal	30,000	-	15,000	
3	Medicines	30,000	30,000	15,000	@ Rs.300 per Anganwadi.
4	POL maintenance	30,000	15,000	25,000	
5	Contingencies at block level (stationery etc.)	5,000	5,000	5,000	

6	Rent of buildings* for medical and para-medical staff.	6,000	24,000	3,000	
	* In respect of rural/tribal projects sanctioned upto 1981-82 only.				
		1,19,000	2,36,000	72,600	For projects sanctioned upto 1981-82.
		1,13,000	2,36,000	69,000	For projects sanctioned from 1982-83 onwards.
Non-recurring					
1	Equipment for Anganwadis (as per enclosed list)	1,00,000	1,00,000	50,000	For 100 Anganwadis in each rural/ urban project and 50 Anganwadis in each tribal projects.
2	Furniture etc. at block/MIC level	8,000	7,500	7,000	
3	Refrigerator	-	-	-	**one in each project
4	Van, Typewriter, Duplicator, Slide projector etc.	-	-	-	
		1,08,000	1,07,500	57,000	
(1)	(2)	(3)	(4)	(5)	(6)
Total Project Expenditure					
1	Recurring Non-recurring	7,88,000 1,08,000	9,25,000 1,07,500	4,60,600 57,000	In case of projects sanctioned uptp 1981-82.
2	Recurring Non-recurring	6,82,000 1,08,000	9,25,000 1,07,500	3,87,000 57,000	In case pf projects sanctioned from 1982-83 onwards
**** These articles are being supplied by UNICEF and hence provision not suggested.**					

List enclosed with Appendix – C
Basic Equipment for Anganwadis under ICDS Programme
(About Rs.1,000 per Anganwadi)

I. For General Use :

1. Small mats or durries
2. One closed shelf (for storage equipment) 1 or 2 racks
3. Low wooden choki with a low table for the Anganwadi Worker
4. First Aid Box
5. A National Flag
6. One vessel with lid for keeping drinking water (locally made mud pot)
7. Files, Registers and Records
8. Health Cards
9. Mud wall area for painting

II. Kitchen Equipment — To be met under Special Nutrition Programme.

1. Tumblers, Plates and Spoons
2. Two to three vessels with lid for cooking
3. Wick stove (kerosene)

III. Bathroom Equipment :

There should be a separate bathroom and lavatory.

1. 2 buckets or vessels for storing water
2. Mugs – one or two
3. Soap containers – 1 or 2
4. Towels (4)
5. Disinfectant Fluid
6. Brooms, brushes and other claim cleaning material

} To be met from recurring or miscellaneous

IV. Indoor Play Equipment :

1. Building blocks 9wooden or different sizes)
2. Counting frames
3. Paints and brushes and coloured chalk sticks
4. Dholak 1
5. Scissors 3-4

APPENDIX – D

Diagrammatic Representation of flow of Administrative Control in the Implementation of Integrated Child Development Services project in Rural Areas

	Administrative set up	Co-ordinating Machinery
CENTRE	Ministry of Human Resource Development, Department of Women and Child Development, Government of India	Frequent interministerial discussion are held at various levels as required from time to time
STATE	Department of Social Welfare or the nodal Department for ICDS as decided by the State Government.	A Co-ordination Committee with the concerned Minister or the Chief Secretary as Chairman and including representatives of all other concerned departments (e.g. Health Education, Welfare, Water Supply, Agriculture, Rural Development etc.) Chairman SSAWB, SCCW and Voluntary Organisations should be the members.
DISTRICT	The District Level Officer in charge may be the collector/	A co-ordination Committee wit6h District Magistrate/Dy. Commissioner/ Chief Executive Officer of
	DDO/ Dy. Commissioner/ District Social Welfare Officer / District	the Distt. Panchayat/DDO as the case may be as Chairman of the District Branch of CSWB as Vice-
	Women and Child Welfare Officer etc.	Chairman, ICDS Programme Officer or Distt. Social Welfare as convener, and district level officers of the Departments concerned representatives of ICCW, CSWB and other Voluntary organisations as members.
PROJECT	CDPO in charge of ICDS project.	Project level committee including CDPO, BDO, MO, other officials, non-officials etc.

Note :	It is, however, left to the State to have committees at other levels in addition to these three levels, if they consider them also necessary. Village level committees may be formed, not stressing institutional structure too much but emphasizing functional aspects.

APPENDIX – E

Annual Budget for the Training of Anganwadi Workers

(3 1/3 courses for 3 months duration)

	Recurring	Amount (in Rs.)
1	(a) Salaries and allowance (b) Part time instructors (c) Honorarium to visiting Lectures	64,000
2	Stipend to trainees (Rs.325 p.m. to matriculates and Rs.275 p.m. to non-matriculates)	1,50,000
3	Rent	18,000
4	Trainees' Kits (at the rate of Rs.100 x 50 trainees per course)	17,000
5	Conveyance and field trip	10,000
6	Contingencies (at the rate of Rs.24 x 50 trainees per course)	4,000
7	Travelling allowance per annum per centre	45,000
Non-recurring (Once only)		
1	Equipment and Furniture	30,000
2	Literature	8,000
3	Miscellaneous	4,000
	Total	**42,000**

ICDS Scheme

Addendum

The information given below may be added in the relevant para indicate against them.

1. Introduction

Indian Population (1991) is 837 million according to 1991 census about 40% population consisted of children upto 14 years of age. Children under to years of age constitute about 17.5% of population and are about 15 crores in numbers.

Package

10. In the year 1991, Adolescent Girls Scheme was also introduced in selected ICDS Projects to broaden its scope. A copy of the scheme is at Annexure I.

12. Adolescent Girls in the age group of 11-18 years who are not covered in any programme and are in need of appropriate initiation into adulthood are now included in the ICDS Programme.

Types of Beneficiaries		Services	
6.	Adolescent Girls (11-18 years)	(i)	Supplementary Nutrition
(i)	Scheme I (11-15 years)	(ii)	Immunisation
(ii)	Scheme II	(iii)	Health Check up
		(iv)	Refferal Services
		(v)	General Education and Literacy Training, Training for Motherhood & Skill Development

Supplementary Nutrition

15. All the A WW s and Helpers have to be given supplementary nutrition equivalent to pregnant mothers.

20. All the adolescent girls have to be provided immunization.

21. Health check up of all the adolescent girls has to be done at regular intervals and referral services will be also provided to them.

25. The AWWs will be provided training according to sandwich pattern in three phases. First phase of two months institutional training will be followed by second phase of four months actual work in Anganwadis and four weeks follow up training at the training centre in Phase III.

26. Some additional job responsibilities given to AWWs include assisting primary school teacher in conducting village level educational survey of all households

ii) associating herself with OWACRA group meetings and surveys under OW ACRA for identification of beneficiaries wherever applicable

iii) providing support f-or demonstration on NHEO by Nutrition and Extension Centres in Anganwadis

iv) providing information to supervisors for filling up community growth chart and assisting for providing education throught its use.

v) informing and motivating women to open accounts under Mahila Samridhi Yojana and utilise services and funds available under Rashtriya Mahila Kosh and Indira Mahila Yojana

vi) assist in the activities of village Bal Vikas Samiti to monitor Child and Women related activities and programmes

vii) act as village rehabilitation worker so as to create awareness for early detection of disability, its prevention and making appropriate referrals

viii) involve adolescent girls in ICOS scheme & provide services to them under the adolescent girls scheme

38. Bal Vikas Samiti will be constituted at village, Block and District Levels with representation from Women Panchayat members, NGOs and ICOS functionaries for integrated community based monitoring of all programmes for Women and Children-especially ICOS. The Gram Panchayat and Bal Vikas Mahila Samiti would play an increasingly crucial role in ICOS, similarly in the urban setting; people's representatives of urban local bodies will play a major role.

Personnel

45. Larged ICDS projects will also have assistant child development project officers (ACDPOs). There no. will be determined by number of Anganwadis in each rural/ tribal project as follows

No. of Anganwadis		No. of ACDPOs
Rural	**Tribal Project**	
> 150	**> 100**	1
> 200	**> 150**	2
> 250	**> 200**	3
> 300	**> 250**	4

UNICEF/Bilateral Aid

53. World Bank is providing assistance to ICDS Projects in the States of Andhra Pradesh, Bihar, Madhya Pradesh and Orissa.

Appendix A

Immunization schedule (Revised) in the text

Appendix B

v) Health check up a 'Referral services

iv) (i) Adolescent Girls will undergo health check up at regular intervals (every six months)

(ii) Watch over menarcher will be kept

3. All the immunisation according to policy will be provided if not provided earlier

4. Treatment for minor ailments will be provided

5. Deworming, if required would be done

6. Prophylasis against anemia, goitre, Vitamin deficiencies etc. would be done

7. Will be provided referral to PRC/District Hospital in case of acute need.

Referral Services

Adolescent Girls with problems requiring specialist treatment will also .be provided referral services.

Annexure I

Department of Women & Child Development, Ministry of Human Resource Development

Scheme for Adolescent Girls in ICDS

In the context of the objective of the ICDS Programme, the Women and Child have to be looked upon as an integral and composite unit. While this concept is so obvious, a serious gap has existed. This gap is represented by the adolescent girl, who bridges the child and the woman, and who, in a sense, is a child and a woman all at once, she, again, is as much a resource as child or a woman. Also, in the context of the various shortcomings observed, an important strategy by way of answer to these shortcomings would obviously be through the utilization of all available human resources, particularly at the village level, among whom one of the most critical resources is the adolescent girl. Therefore, while grappling with the problems of 'Women and Child Development'. We should examine what her needs and potential are in the context of the Nation's urgent needs, including population control.

2. The ICDS has, for its target,· children in the age group of 0-6 years, pregnant women and nursing mothers. For children in the age group of 6 to 11 years, i.e. in the age group for enrolment for primary education, the responsibility lies at present with the Ministry of Education through the State Governments. Some of the states in the country have programmes for providing services like Mid-Day Meals and School Health for children in the primary schools. Thus, while children upto the age of 11 or 12 are looked· after through the ICDS and the primary school/non-formal school structures, and again the pregnant women and nursing mothers are taken care of by the ICDS programme, girls in the crucial age group from about 11 years to around 18 years who are in need of appropriate initiation into adulthood are not covered by any programme at present in terms of their crucial needs. In other words, there is no structured programme to meet their needs. However, we have to look at the Adolescent girl not merely in terms of her own needs (nutrition, nutrition education, health education, training for adulthood, training for acquiring skills as the base for earning an independent livelihood, training for motherhood etc.) as an adolescent girl. We have also to look at her as an individual, who is a member of the village community and who has the potential to offer the community her leadership as a constituent of the village youth power. Encowed with these possibilities, she, as a member of the community, has the capability to act as a bridge between the community and the changes that the ICDS philosophy wants to bring about in the lives of children and women and, through them, of the entire community, including men. Thus, the adolescent girl is a treasure house of enormous· possibilities in the ICDS scheme of things in the context of the community. It is, therefore, proposed that the adolescent girl should be brought into the focus of the 'Women and Child Development' package.

3. While, in the Indian context, the adolescent girl can be generally conceived only in the. age group 11 to 15 years, we have to go beyond this concept and include girls upto the age of 18 years. So that we find comprehensive answers to the problems of the essential services that a girl needs in terms of nutrition health and education and the rights of the child to grow into a girl; and then into a woman, before she is called upon to take the responsibility associated with her reproductive role, in other words, the girl child must grow into adulthood, untrampelled by

economic or social constraints such as an early marriage. It, therefore becomes necessary that we look at the adolescent girl in 'the age span of 11 to 18 years. Any programme for the adolescent girl should embrace a whole range of ,activities, such as nutrition, health education, health' and nutrition education, recreation, upgradation of home-based skills and promotion of the decision-making capability

4. With this background, schemes for the adolescent girls, with the following objectives are proposed, as a part of the ICDS programme

(i) to cover girls in the age group of 11 to 18 years;
(ii) to improve the nutritional and health status of girls in this age group;
(iii) to provide to them the required literacy and numeracy skills, through the non-formal stream of education, to stimulate a desire for more social exposure and knowledge and to help them improve decision making capabilities;
(iv) to train and equip the girls to improve and upgrade home-based skills;
(v) to promote awareness of health, hygiene, nutrition and family welfare, home management and child care, to take all the measures as would facilitate the marrying only after attaining the age of 18 and, if possible, even later.

5. The two institutions which would be involved virorcusly in the achievement' of these objectives would be

i. the Mahila Mandal; and
ii. the Anganwadi.

All adolescent girls of the village would form the youth wing of the village's Mahila Mandal, to be organized by the Anganwadi Worker where issues of their mutual interest will receive main attention. Their practical training in the areas of management of health, nutrition, education and health and nutrition education would come from the Anganwadi Centre, in the actual running of which these girls will have a significant role, sharing work and decision-making responsibilities with the workers and helpers.

6. Coverage

It is expected that, in a village with 1000 population, there will be 70 adolescent girls in tile age group 11-18. This gives us a figure of 7% of the total population. The total adolescent girl population in the country would be around 5.6 crores. In the presumptive population of 1 lakh in a block, or an ICDS Project, the number of adolescent girls will. be 7,000. Of them, 4,500 will be in the age group of 11-15 years and 2,500 in the age group of 15-18 years.

7. Eligibility Criteria

All unmarried adolescent girls in the age group of 11-18 years and belonging to families whose income is below 6,400/- per annum in the rural areas will be eligible to receive services under the schemes. This would mean that each village would have, approximately 28 (40%) adolescent girls from such households. Of these, 18 would be in the age group 11-15 years and 10 in the age group 15-18 years. Common services, mentioned in paragraph 8 below, however, will be available to all adolescent girls, irrespective of their family income.

8. Common Services

All adolescent girls in the age group of 11-18 years will receive the following common services:

i. Watch over menarcher;
ii. Immunization;
iii. A general health check up every six months;
iv. Treatment for minor ailments
v. Deworming;
vi. Prophylaxis measures against anaemia goitre, Vitamin deficiencies etc; and
vii. Referral to PHC/District Hospital in case of acute need

9. Additional Services

While the above mentioned health and educational services will be provided to all adolescent girls, additional services will be provided to those in the age group 11-15 and 15-18 years as mentioned in the succeeding paragraphs.

10. Scheme-I: Girl to Girl Approach (for Girls in the Age Group of 11-15 years

i. In each selected Anganwadi area, three girls in the age group of 11-15 years will be identified. These adolescent girls would be provided, at the Anganwadi itself, a meal on the same scale as the pregnant women or nursing mother, namely one that would provide 500 calories of energy and 20 gms of protein. The 3 girls so identified will receive in-service training at the Anganwadi from the worker and Supervisor over a period of six months to become fully equipped individuals, capable of managing the centre on their own, so as to fully realize the objectives of the scheme. Thus, the adolescent girls would be trained in all aspects of the Anganwadi Work, including management of stories, organization of the feeding programme, immunization schedules, weighment of children, home visits, preschool activities etc.

ii. Training : The identified adolescent girls will receive, in batches of 30, initial training of 3 days at the sub block level (Supervisor's head quarters), followed by one-day continuing education sessions every month. Time-table of the 3 days initial training Course and curricula of the 3-day initial Course and 1-day monthly courses are given in Annexures I, II and III.

iii. The cost of organizing 3-day initial training programme for a group of 300 adolescent girls selected in a project block, followed by 6 one-day monthly refresher training programmes, to be organized over a period of six months, would be as indicated below :-

Trainee's Training		Rupees
1.	Cost of organizing the 3-day initial training for 300 girls in batches of 30 each at the rate of Rs.1660 per batch	16,600
2.	Cost of organizing 6 one-day refresher training programmes (once every month) for 300 girls in batches of 30 each at the rate of Rs. 300 per batch	23,400
	Total	40,000

Assuming 100 Anganwadis in a block, 300 adolescent girls can be given this training in a block every six month, or 600 adolescent girls per block per annum.

iv. Break-up of the unit costs of Rs.1660 for the initial 3-day training and Rs.390 for subsequent. I-day refresher training is given in Annexure-IV.

v. Supplementary Nutrition

These girls will be provided supplementary nutrition in the same manner as that to a pregnant woman or nursing mother, vis. 500 calories and about 20 gms of protein. While each girl will be attached with the Anganwadi worker for two fu;11 days each week, each of them will get supplementary nutrition for all the six working days of the week. Cost of supplementary nutrition for 300 girls in 100 Anganwadis will be Rs.1,03,500 (Rs.1.15x300x300) per annum.

11. Scheme II : Balika Mandal (For girls in the age group 11-18 years)

i. While it is essential to concentrate on the adolescent girl from the early stages, i.e. from 11 years onward, the crucial age from the point of view of her transformation to adulthood starts from the time she nears 15 years. We should therefore, focus more on social and mental development of girls mainly in the age group 15-18 years. Special emphasis would be laid to motivate and involve the uneducated groups belonging to this age group in non-formal education and improvement and up gradation of home-based skills.

ii. **Period of active enrolment**

The need is to provide non-formal education, develop literacy skills and upgrade and improve the home-based skills among adolescent girls. The period of an adolescent girl's active enrolment in the Balika Mandal would vary from one adolescent girl to another, depending upon her previous educational background, her power of grasp, her possession, if any, of a home based skill and allied factors. For the purpose of calculating the financial requirements, however, it may be presumed that, on an average, an adolescent girl may be on active role of a Balika Mandal for a period of six months. With an average attendance of about 20 adolescent girls, each Balika Mandal may cater to about 40 adolescent girls in a year.

iii. **Objectives**

The objectives would be to make the adolescent girl i understand and learn the significance of personal hygiene, environmental sanitation, nutrition, home nursing, first aid, health and nutrition education, family life, child care and development etc. apart from facilities for recreation and entertainment. In addition, efforts would be made to improve and upgrade thy home-based skills in trades popular, or having the potential, in the local. areas.

iv. **Focal Point**

The existing Anganwadi centre would be used for the activities of the Balika Mandal as well. if that centre does not have adequate space, efforts would be made to enlarge the centre, or to have a separate accommodation, with the

community's contribution, wherever practicable, or with assistance under the DWCRA, JRY etc. Timings of Balika Mandal will be other than those of Anganwadi and would be decided as per convenience of the participating adolescent girls,

v. **Instructor**

The village Anganwadi worker would be the regular honorary instructor for the Balika Mandal and would provide general education and literacy to. adolescent girls, apart from overseeing the work relating to skill improvement/up gradation. In most of the cases, local artisans with such skills would be available and one or more of them can be engaged, on a part time basis or as a guest lecturer for a few days in the month, to impart such skills. The Anganwadi worker, serving as regular honorary instructor for the Balika Mandal, will be paid an additional honorarium of Rs.150/- per month. The local artisan, working on a part time basis or as a guest lecturer, will be paid an honorarium of Rs.50/- per month. In addition, the State Government would endeavour to make available services of the Instructors of the ITIs/ vocational training centres and non-formal education for periodical visits to Balika Mandals for providing guidance. Services of the field units of the Food and Nutrition Board will also be available for periodical visits for the purpose of Nutrition Education and demonstration. Instructors of training Institutes like AWTCs, MLTCs and training centres of Health and FW Department will also pay visits to Balika Mandals from time to time to provide continuing education. Tie up arrangement with TRYSEM would also be made.

vi. The cost of a Balika Mandal is discussed below:

A. Non-recurring

Initital equipment and material like wooden planks, small tools, frames, paper, cloth, marking chalks, measuring tapes, needles, thread, brushes, colours, recreational instruments like dholak etc …….. Rs.1,000/-

B. Recurring

1	Replenishment of material at Rs.50 p.m.	Rs.600/-
2	Honorarium to Instructors (Rs.150 for Anganwadi workers and Rs.50 per guest lecturer) i.e Rs.200 p.m.	Rs.2,400/-
3.	Supplementary Nutrition to 15 girls at Rs.1.15 per head per day for 300 days	Rs.5,175/-
*	It is presumed that cut of about 20 girls/women enrolled for training at the centre, not more than 15 girls may need supplementary nutrition on any working day.	Rs.8,175/-
C.	**Total**	**Rs.9,175/-**

v. Assuming about 10 Balika Mandals in a block, the estimated expenditure per block will be as under :

Non-recurring	Rs.10,000/-
Recurring	Rs.81,750/-
Total	**Rs.91,175/-**

12. For a block, the estimated expenditure under different scheme for adolescent girls will be of the following order :-

	Estimated Expenditure (Rs.)					Number of beneficiary adolescent girls, per annum
	On Training		On nutrition		Total	
	N.R.	Rec.	Rec./ Annum	N.R.	Rec. P.A.	
Scheme I (Girl to girl approach)	-	80,000	1,03,500	-	1,83,500	600
Scheme II (Balika Mandal)	10,000	30,000	51,750	10,000	81,750	400
Total	**10,000**	**1,10,000**	**1,55,250**	**10,000**	**2,65,250**	**1,000**