

## Integrated Child Development Services (ICDS) Scheme :A Journey of 37 years

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### Abstract

**Background:** Malnutrition is currently one of the biggest challenges facing the modern world. In India, the Integrated Child Development Services (ICDS) scheme was started with the objective of improving child health, nutrition and development. Since its inception in 1975, the outreach of ICDS services has increased enormously, and now the goal is universalization of ICDS. In recent years ICDS has been evaluated by many agencies which have resulted in numerous changes to achieve the objectives.

**Methods:** This paper reviews the functioning and progress of Integrated Child Development Services and attempts to identify the programme bottlenecks

**Results:** Since its inception, ICDS has expanded rapidly in its scope and coverage, and today it covers approximately 7.6 million pregnant women and lactating mothers and around 36 million children less than six years of age. Although there had been vast increase in ICDS blocks, it was seen that there is lack of infrastructure and basic amenities. Though immunization activities under ICDS have appreciable credibility, however, non-formal pre-school, nutrition and health education are not fully functioning in the way they were planned to be.

**Conclusion:** The ICDS has a huge potential as a platform to provide comprehensive maternal and child services. Although there is a wide coverage under the ICDS blocks, many of them are not functioning optimally. Infrastructure and basic amenities, and training components need to be strengthened.

**Key words:** Integrated Child Development Services, children, women, Anganwadi, Malnutrition

### Introduction:

Malnutrition is currently one of the biggest challenges facing the modern world<sup>1</sup>. According to the WHO Global Database on Child Growth and Nutrition, the prevalence of malnutrition among under-five children in rural India fell from over 70% in the late 1970s to below 50% at the end of the 1990s, for both underweight and stunting measures<sup>2</sup>; however, as per NFHS III survey, malnutrition has decreased only marginally from 47% in 1998-99 to 46% in 2005-06.

The Integrated Child Development Services (ICDS) scheme is a large programme which was started with the objective of improving child health, nutrition and development. This paper reviews the functioning and progress of Integrated Child Development Services (ICDS) scheme in India and attempts to identify the programme bottlenecks.

### Historical Evolution of the ICDS in India

In the early seventies, various programmes and non-governmental organizations were involved in providing supplementary nutrition, and other related activities. An

inter-ministerial survey in 1972 revealed that child care programmes in India were not having the desired impact owing to resource constraints, inadequate coverage, and a fragmented approach<sup>3</sup>. To ensure that all young children, from all sections of society have access to their basic rights, the Integrated Child Development Services (ICDS) scheme was launched on 2nd October, 1975 (5th Five year Plan) in pursuance of the National Policy<sup>4</sup>. During the Eighth, Ninth and Tenth Five Year Plan periods, the outreach of ICDS services increased enormously, and now the goal is universalization of ICDS<sup>5</sup>.

ICDS is a centrally sponsored programme implemented by the Department of Women and Child Development and Ministry of Human Resource Development of the Government of India.

The Objectives of the Integrated Child Development Services (ICDS) Scheme were to improve the nutritional and health status of children less than six years, to lay the foundation for proper psychological, physical and

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social development of the child, to reduce the incidence of mortality, morbidity, malnutrition and school dropouts, and 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<sup>4</sup>. Anganwadi is the focal point for delivery of ICDS Services. The word Anganwadi is derived from the Hindi word "Angan" which refers to the courtyard of a house. It is mainly run by an Anganwadi worker supported by a helper. Beneficiaries under ICDS scheme are pregnant women, nursing mothers, children less than 6 years, and adolescent girls. Since its inception, ICDS has expanded rapidly in its scope and coverage, and today it covers approximately 7.6 million pregnant women and lactating mothers and around 36 million children less than six years of age<sup>4</sup>.

### Review of infrastructure of ICDS

The ICDS was started on an experimental basis in 33 development blocks in 1975. In the next fifteen years, the outreach of ICDS services increased to 2426 blocks. This was nearly doubled during the next decade. Presently there are around 6000 blocks<sup>6</sup>. It is recommended that there should be one anganwadi centre (AWC) per 1000 population in rural/urban areas and per 700 populations in tribal area. Under the direction of Honourable Supreme Court of India in 2004, population norms for sanctioning an AWC were relaxed. Revised norms are one AWC per 800 populations in rural/urban areas and 500 population in tribal area<sup>4</sup>. Since 2005-06, there has been a 73% increase in the number of AWCs/mini AWCs operating in India. As of November 2011, there were 13 lakh AWCs/mini AWCs operational in India, which is 95 % of the sanctioned number. However in 2004, a review from Bihar showed that ICDS is operational in only 44 % of the blocks in the state<sup>7</sup>.

### Infrastructure and equipment

The National Council of Applied Economic Research (NCAER) study in 2001 reported that 40% of AWC had pucca structures, 50% had adequate cooking space, and 75% AWC reported to have weighing scales<sup>8</sup>. In 2006, a study by National Institute of Public Cooperation and Child Development (NIPCCD) found that around 75 % of AWC had pucca structure, more than 90% had weighing scales, but less than half had toilet facility and learning kits<sup>9</sup>. An evaluation in Jammu and Kashmir in 2009 reported that only one-third of AWC were in own pucca building, and majority had lack of basic amenities<sup>10</sup>. Similarly, other studies in Madhya Pradesh,

Uttar Pradesh, and West Bengal found that the presence of weighing scales and other inventories were inadequate<sup>11,12,13</sup>. In another evaluation done by NCAER 2009 it was found that 42.5% were owned AWC, and around 17% were rented. In the eight years since the first evaluation in 2001, it was seen that there was only a 5% increase in the number of AWC with proper cooking and storage space. Toilet facility was found in only 40% of AWC<sup>14</sup>.

### Human resources

The ICDS team is comprised of the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs) from grass root level to the district level. Besides these, people from health system form a team with the ICDS functionaries to achieve convergence of different services. The NCAER study in 2001 described that though more than half of the anganwadi workers were matriculate or above, but only one third had in-service training<sup>8</sup>. In 2004, a study from Andhra Pradesh reported that most of supervisors had average job performance<sup>15</sup>. A review in 2006 in Rajasthan found that there was shortage of nearly 30% CDPOs and supervisors, but all AWWs were in position<sup>16</sup>. In 2006, the NIPCCD reported around 80% AWWs were matriculate or above<sup>9</sup>. The Forum for Creche and Child Care Services (FORCES) in 2006, report from Orissa in 2007 and West Bengal in 2009 testify that there is wide gap in monitoring process of ICDS<sup>13,17,18</sup>. In 2007 a report from Gujarat found that nearly 70 % of CDPOs and supervisors were trained<sup>19</sup>. As on November 2011, 29% of supervisor posts and 30 % of CDPO/ACDPO (expand) posts were vacant<sup>20</sup>.

### Review of key components of ICDS

#### Supplementary nutrition and Growth monitoring

Supplementary nutrition and growth monitoring are the two important, high cost input activities of the ICDS programme. Supplementary nutrition is given for 300 days in a year. Growth monitoring is done to assess nutritional status. Severely malnourished children are given extra supplementary nutrition. Revised norms of energy and protein are: 500Kcal for children aged 6-72months; 600 kcal for a severely malnourished child and 800 Kcal for pregnant and nursing mothers per day; 12-15 grams of protein for children aged 6-72months, 20-25 grams for a severely malnourished child and 18-20 grams for pregnant and nursing mothers per day<sup>4</sup>.

Compared to mid-seventies in mid-eighties, supplementary nutrition resulted in decrease in severe malnutrition from 19.1 per cent to 8.4 per cent<sup>21</sup>. The NCAER study in 2001 reported that registration coverage was about 60%<sup>8</sup> and supplementary nutrition and growth monitoring is done for less than two thirds of registered children. Review in Rajasthan in 2005 found nearly 92% women are getting benefits from AWC but food being served was stale<sup>12</sup>. In 2006 NIPCCD reported similar registration rate as NCAER 2001 and SN coverage of 75%<sup>9</sup>. A study in New Delhi in 2006 showed 100% AWC had supply of supplementary nutrition. On the contrary, a review done in Bihar, reported inadequate provision of supplementary nutrition<sup>7</sup>. Evaluation in Jammu and Kashmir, West Bengal, Madhya Pradesh and Uttar Pradesh in 2009 reported that children were not weighed regularly and less than 60% coverage of supplementary nutrition. There too, food was of low quality in many places, and the condition was worst in Uttar Pradesh<sup>10,11,12,13</sup>. Evaluation report of planning commission showed that of the registered children, 64 % received food on an average of 16 days per month<sup>6</sup>.

### Immunization

In 2001, the NCAER study showed that immunization coverage in children was nearly 80% among ICDS beneficiaries. A similar report came from a survey in 2004 in Chandigarh; however, coverage of anti-tetanus toxoid in pregnant women was only 60%<sup>8</sup>. In 2005, a review from Rajasthan reported around 90% coverage of immunization, whereas the Centre for Childs Rights discovered that more than half of children were not fully immunized, and 14% were never immunized<sup>16</sup>. Socio-Economic and Educational Development Society (SEEDS) evaluation in Haryana and Himachal Pradesh reported that poor awareness of people, non-cooperation of health staff and disbeliefs are major hurdles in the path of 100% immunization<sup>22,23</sup>. In 2006, the NIPCCD found that 66% children were fully immunized for age. Coverage of BCG vaccination for children between 6 months and 3 years was 82.4% followed by 70.5% polio and measles, and 17.8% DPT booster dose. Reason for inadequate immunization was indifferent attitude of parents and disbeliefs<sup>13</sup>. An evaluation done by Citizen's Initiatives for the Rights of Children under Six (CIRCUS) and FORCES in 2006 mentioned that in Maharashtra, Tamil Nadu and Delhi, immunization services were well integrated with ICDS, however, these were lacking in states like Uttar Pradesh, Rajasthan and Chhattisgarh<sup>13</sup>. In 2009, an evaluation done in Jammu and Kashmir

found that 91% of children were immunized for polio and DPT, followed by 89% for BCG and 74% for measles; whereas in Madhya Pradesh, only 12% of infants and 24% of under-three children were being immunized<sup>110,11</sup>.

### Non-formal Pre-school Education

The early learning component of the ICDS through Non-formal Pre-school Education is a significant input for providing a sound foundation. The NCAER study in 2001 reported that only 60% of the eligible children were enrolled for pre-school education, and inadequacy of basic services was the main cause. More than two-third of the anganwadi centres provided pre-school education for more than 21 days in a month<sup>8</sup>. A study in 2004 in West Bengal reported that majority of parents send their children to anganwadi centres for food rather than pre-school education. A review in Bihar in 2005 identified community participation as a major force for success of pre-school education<sup>7</sup>. In 2006, NIPCCD found that only 37 % of eligible children were enrolled for pre-school education, which was much less than the NCAER 2001 report<sup>8</sup>. A report from Orissa in 2007 covering 12 villages found that pre-school education was present only in one village<sup>18</sup>. An assessment in 2008 in New Delhi revealed that more than 50% of AWC had complete pre-school education kit and toys<sup>24</sup>. Evaluation in the states of Jammu and Kashmir, West Bengal, Madhya Pradesh and Uttar Pradesh in 2009 showed that pre-school education was imparted only when nutrition was given, and few anganwadi centres had pre-school education and playing kits<sup>10,11,12,13</sup>. In 2011 an evaluation report by the Planning Commission showed that around 90% anganwadi centres across the country provide pre-school education, which is much higher than previous studies<sup>6</sup>.

### Health Check-up and referral

ICDS was perceived as provider for primary health services. NCAER study in 2001 nearly 75 % of the households reported regular health checkups<sup>8</sup>. A review in Rajasthan in 2005 mentioned that *sahyogini* are appointed to ensure that women and adolescent girls take medicines and come for health check-up regularly<sup>16</sup>. NIPCCD in 2006 found more than half of children under three had received health checkup<sup>19</sup>. A review by UNICEF and Gram Sabha in 2007 stated health checkups and distribution of medicines were irregular in Bihar<sup>25</sup>. In 2009, UNESCO found that referral and health checkups were the weakest link of ICDS due to lack of community

participation and health staff<sup>26</sup>. As per an evaluation by the Planning Commission in 2011 health checkups are provided by nearly 70% and referral by around 50 % anganwadi centres across the country<sup>6</sup>.

### **Nutrition health education**

Nutrition health education of adolescent girls, pregnant woman and mothers is one of the services provided under the ICDS. A study in Bangalore in 1996 reported only about 25% of anganwadi workers provided nutrition health education<sup>27</sup>. A review in Rajasthan in 2005 reported that there was a lack of active participation of women. They also found a positive correlation between literacy status of the women and attendance at anganwadi centre education talks<sup>16</sup>. Evaluation report of the planning commission also showed that only one quarter of women nationwide attend nutrition health education meetings<sup>6</sup>.

### **Conclusion:**

In recent years ICDS has been evaluated by many agencies which have resulted in numerous changes to achieve the objectives. Although there had been vast increase in ICDS blocks since 1975 but many of them are not functioning optimally. Infrastructure and basic amenities need to be strengthened. Coverage of supplementary nutrition needs to be increased with maintenance of continuous supply. Moreover quality of food is to be seriously addressed. Critical issues related to raw or cooked food supply need to be analyzed. Food should be given in accordance to the local taste, and above all food safety laws must be followed. Reconsideration of training component of ICDS scheme is a necessity. There ought to be reorientation of the workers. Accountability need to be developed in ICDS team. Supervision and monitoring components need to be reinforced. Immunization activities under ICDS have appreciable credibility. However, non-formal pre-school, nutrition and health education are not fully functioning in the way they were planned to be. Above all a better reporting system which is transparent and accountable needs to be put in place.

In the 12<sup>th</sup> five year plan, there are indications that the ICDS will receive a boost through increased allocation and revitalizing its activities. The Cabinet Committee on Economic Affairs approved a plan to bring about substantial strengthening and restructuring of ICDS with increased budgetary allocation<sup>28</sup>. The restructured ICDS will be rolled out in the next three years, starting with 200 high burden districts identified by the government. Thus, we hope that in the near future this programme

will be able to achieve its objectives as it was envisaged during its inception. In conclusion, the ICDS has a huge potential as a platform to provide comprehensive maternal and child services and should be strengthened.

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