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INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME BRIEF

ICDS is a comprehensive programme designed to ensure the holistic development of children. It is one of the largest childcare programmes in the world and has been in operation for more than three decades. This scheme brief examines the salient features of the scheme and the extent to which it has been effective in addressing still-widespread malnutrition among children in India.

BACKGROUND

The Integrated Child Development Services (ICDS) scheme integrates several aspects of early childhood development and provides supplementary nutrition, immunisation, health check-ups, and referral services to children below six years of age as well as expecting and nursing mothers. Additionally, it offers non-formal pre-school education to children in the 3-6 age group, and health and nutrition education to women in the 15-45 age group. ICDS was initiated in 1975 in 33 blocks and used Below Poverty Line (BPL) as a criteria for delivery of services. Following a 2004 Supreme Court order, ICDS was expanded in 2005 to cover the entire country.

Funding ICDS Initially the scheme was 100 percent funded by the centre except for nutrition supplements, which were funded by states and union territories. In response to resource contraints faced by many states, the central government increased fiscal support to cover half of the supplementary nutrition costs in 2006. For 2009-10, the central government has proposed that the sharing ratio be modified to 90:10 and 50:50 for general assistance and supplementary nutrition, respectively, for all states (except the North-eastern ones) and 90:10 for all components for North-Eastern states.

How does it work? The programme adopts a multi-sectoral approach incorporating both health and education interventions. The Ministry of Women and Child Development (MoWCD) is responsible for coordinating ICDS and working with state governments to monitor and evaluate the scheme's performance. In many states, panchayats have also been actively involved in the implementation and monitoring of ICDS since the 73rd Amendment Act was passed in 1992.

In 2004, the Supreme Court stated that BPL could not be used as an eligibility criteria for providing supplementary nutrition under ICDS. Accordingly, the revised guidelines stipulated that states were to identify and register beneficiaries by monitoring health and nutrition of children and women regularly. ICDS services are delivered through anganwadi centres (AWCs)[1] , each of which is staffed by anganwadi workers (AWWs) and anganwadi staff. These are supervised by Child Development Project Officers at the block level, who in turn report to District Programme Officers at the district level. To promote convergence of health services, three of the eight services under the ICDS scheme – immunisation, health check-up and referral services – are delivered through existing public health infrastructure: health sub-centres, and primary and community health centers operating under the Ministry of Health and Family Welfare.

Ministry	Ministry of Women and Child Development
Department	Department of Child Development
Sector	Health
Goal	Improve health and nutrition of children aged 0-6 years Preventing malnutrition among children aged 3-6 years Improve health and nutrition of women, particularly adolescent girls and pregnant women
Output/ Scheme Indicators	Infant mortality rate Weight and height of child Weight gain during pregnancy
Funding	Shared by centre and states in the ratio 90:10
Year of Inception	1975
Expiration date	None
2009-2010 Budget outlay	Rs.6,026 crore

Table 1: ICDS at a glance

1 Anganwadi centres are community child development centres.

Children become malnourished when they do not receive the adequate nutrients their bodies require to resist infection and maintain growth. When nutritional deficiencies become too significant, a child will begin to 'waste' – to consume his/her own tissues to obtain needed nutrients. nutrients. Wasting is a sign of acute malnutrition. Interventions that address immediate causes of undernutrition are sustainable only if they simultaneously correct the underlying determinants of malnutrition such as poverty, hunger, gender inequity, and lack of access to health care facilities. For example, female illiteracy has been strongly linked to child malnutrition and mortality. Consequently, a combination of services has the potential to have a greater impact than if the services were offered individually.

PROGRESS

In India, malnutrition is responsible for more than 50 percent of child deaths. Since the common assumption is that food insecurity is the major cause of malnutrition, almost completely ignoring the contribution of infection and inappropriate feeding practices, policy inputs have been skewed towards food-based interventions.

The objectives of ICDS are directly related to the Millennium Development Goal (MDG) of reducing child mortality by two-thirds between 1995 and 2015. The Government of India had stated that ICDS would be its main tool to achieve this target. A World Bank assessment[2] of the ICDS hailed it as an ambitious and well-designed program but stated that the scheme had compromised quality service delivery for broad coverage. Moreover, it noted that the programme focused more attention on providing food supplements rather than on changing family-feeding and child care behaviour. While the scheme has been revised since 2005, in 2009 the United Nations Development Programme and the Planning Commission stated that India had made insufficient progress in improving nutritional status of children and declared that it was unlikely that India would meet the goal by 2015[3].

Physical progress ICDS started in 33 development blocks of the country and was extended to the entire country in 2005. It is delivered through a network of over one million AWCs and reaches more than 70 million children and 15 million pregnant and lactating mothers (Figure 1). However, the third round of the National Family Health Survey (NFHS) conducted in 2005-06 found that only 80 percent of children in the 0-6 year age range were in areas covered by an AWC and that only 28 percent had received any service from an AWC in the year preceding the survey. Additionally, only one in five mothers in areas having an AWC received any services from an AWC during pregnancy or lactation period.

2 Gragnolati. Michele, Shekar. Meera, Das Gupta. Monica, Bredenkamp. Caryn and Lee. Yi-Kyoung. 2005. India's Undernourished Children: A Call for Reform and Action World Bank (Health, Nutrition and Population group)

3 UNDP-India http://www.undp.org.in/index.php?option=com_content&view=article&id=73&Itemid=157 (Accessed on February 15, 2010)

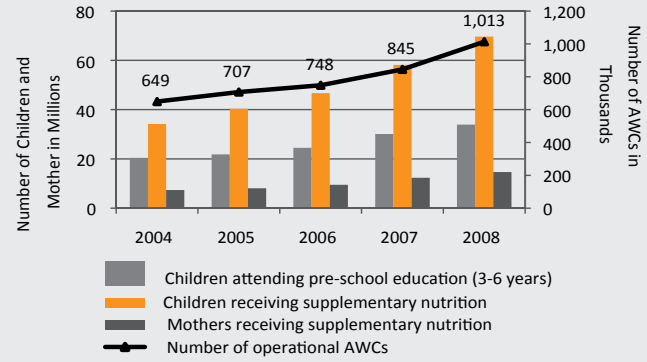

Figure 1: Physical progress of ICDS

Source: www.indiastat.com

How much money is being spent? Between 2000 and 2010 approximately Rs.35,000 crore has been allocated to ICDS by the union government. ICDS's status as a flagship programme is reflected in its place in successive union budgets: the programme secured between 75-85 percent of all funds allocated to MoWCD. The sudden increase in its share in 2001-02 (Figure 2) indicates an increase in

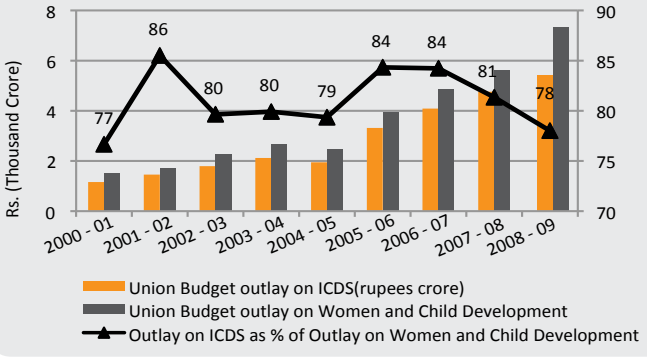

Figure 2: Budget outlays on ICDS

Source: Union Budgets 2000-2010

MoWCD's budget outlay which was allocated almost entirely to ICDS. Between 2002 and 2005 MoWCD increased its allocations to other child welfare components such as National Children's Board, National Awards for Child Welfare, Universal Children's Day, Indo-Foreign Exchange Programme, UN Contribution, National Fund for

ICDS scheme objectives

- To improve the nutritional and health status of children below the age of six
- To lay the foundation for the proper psychological, physical and social development of the child
- To reduce the incidence of mortality, morbidity, malnutrition and school dropouts
- To achieve effective coordination of policy and implementation among various departments to promote child development
- To enhance the capability of the mother to look after the normal health, nutritional and developmental needs of the child through proper community education

Child Care Services, Research Publications & Assistance to voluntary organisations for providing Social Defence, Mass Education & Information and National Commission for Children. Similarly, in 2008-09 MoWCD's budget made larger outlays to existing schemes that focused on improving women's welfare such as Working Women's Hostel, Training and Employment, and Rashtriya Mahila Kosh, a national fund to support micro-credit activities.

How has the scheme performed? According to data from the NFHS 3 (2005-06), there has been a marginal decline in stunted[4] and underweight[5] children under 5 years of age of 6 and 3 percentage points, respectively. However, there was a 3 percent increase in wasted[6] children. During the same period, children affected by severe anaemia increased by 25 percent. Despite the moderate decline in infant mortality rates[7] over the three national survey periods (Figure 3), the data reveals that more than one in 18 children die within the first year[8] of life and one in 13 children die before they reach the age of 5[9] , with the Scheduled Castes and Scheduled Tribes experiencing greater mortality rates.

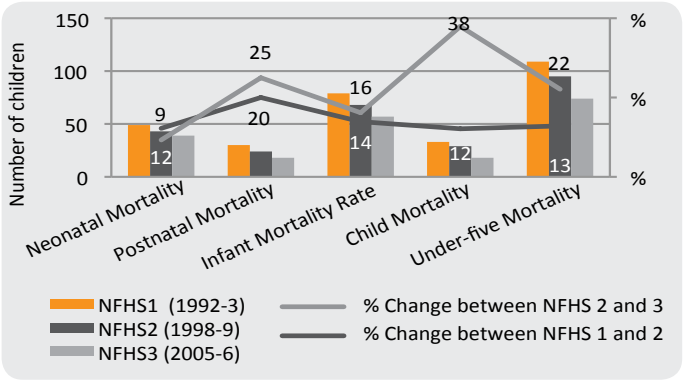

Figure 3: Trends in IMR (Number of infant deaths per 1000 live births)

Source: NFHS

India ranks among the worst performing countries with respect to the prevalence of child undernutrition. The high prevalence of undernutrition, close to 46 percent, is particularly foreboding for India's large child population. According to the 2001 census, India is home to approximately 160 million children making it one of the world's largest populations of malnourished children. Table 2 demonstrates how countries with comparable per capita GDP like the Philippines, Sri Lanka and Egypt have made better progress towards at reducing child mortality. In fact, Bangladesh and Eritrea, which have approximately half and quarter of India's per capita GDP, respectively, and had higher infant mortality rates to start with, have made commendable progress between 1990 and 2006.

State performance Despite the fact that ICDS has been in operation for more than three decades, states have made limited progress in tackling undernutrition. There is a large inter-state variation with the phenomenon being concentrated in a few states; Bihar, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Uttar Pradesh account for more than 80 percent of the cases of child malnutrition. In 2005, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh accounted for 43 percent of all under-weight children in India[10]. To focus additional resources on the worst performing states, the Government of India is partnering with the World Bank to increase ICDS progamming in 158 high-burden districts from eight states including Andhra Pradesh, Uttar Pradesh, Madhya Pradesh, Chhatisgarh, Rajasthan, Bihar, Jharkhand and Maharashtra. For the Eleventh Plan period the MoWCD has adopted an outcomes

4 Stunting: poor height for age; Stunting reflects failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illness. Height-for-age, therefore, represents the long-term effects of malnutrition in a population and does not vary according to recent dietary intake.

5 Underweight: poor weight for age.

6 Wasting: poor weight for height.

7 Infant Mortality: Probability of dying within first year of life.

8 Child Mortality: Probability of dying between first and fifth year of life.

9 Under-five mortality: Probability of dying before completing five years of life.

10 Gragnolati. Michele, Shekar. Meera, Das Gupta. Monica, Bredenkamp. Caryn and Lee. Yi-Kyoung. 2005. India's Undernourished Children: A Call for Reform and Action World Bank (Health, Nutrition and Population group)

Countries	Per Capita GDP	Under-five mortality rate		MDG target 2015	Average annual rate of reduction (%)		Progress towards the MDG target
		1990	2006		Observed 1990 - 2006	Required 2007 - 2015	
Eritrea	271	147	74	49	4.3	4.6	on track
Bangladesh	428	149	69	50	4.8	3.6	on track
India	**976**	**115**	**76**	**38**	**2.6**	**7.6**	**insufficient**
Pakistan	996	130	97	43	1.8	9.0	insufficient
Nigeria	1,169	230	191	77	1.2	10.1	insufficient
Philippines	1,639	62	32	21	4.1	4.8	on track
Sri Lanka	1,676	32	13	11	5.6	2.2	on track
Egypt	1,770	91	35	30	6.0	1.6	on track
Indonesia	1,869	91	34	30	6.2	1.3	on track

Table 2: Child Mortality statistics

Source: Unicef

approach for the implementation and monitoring of the programme, as opposed to the inputs approach that is typically used to monitor other government schemes. This will give states a framework to measure results and to monitor progress, and it is expected that the programme will deliver better results with restructuring, and improved design and implementation.

CHALLENGES

Inappropriate targeting Prior to 2005, ICDS assigned too much focus to children aged 4-6 years at the cost of younger children (0-3 years) who are at a more vulnerable stage in their development and where nutrition supplements have the most effect. Moreover states with the highest incidence of child undernutrition and malnutrition were the ones that received the least funds and coverage under ICDS[11].

Poor physical infrastructure More than 60 percent of the angawadi centres (AWCs) had no toilet facilities. Lack of space within the premises for conducting outdoor and indoor activities such as games and songs adversely affects the delivery of non-formal pre-school education. Approximately 49 percent of the AWCs had inadequate space for outdoor and indoor activities and 50 percent had no separate space for storage of materials. Similarly, the number of cooking and serving utensils was considered inadequate in 42 percent and 37 percent of AWCs respectively (CAG 2005).

Insufficient material Approximately 44 percent of the AWCs lacked pre-school education kits and about 37 percent reported non-availability of materials/aids for nutrition and health education (CAG 2005). Between 1999 and 2005 only Rs.1.79 crore was spent on procuring medicines for treatment of dysentry, diarrhea, respiratory tract diseases, and skin and eye infections compared to Rs.10.4 crore that was allocated for these purposes. Similarly, with respect to funding for de-worming medicines only Rs.0.27 crore was spent of the available Rs. 7.02 crore (CAG 2005).

Inadequate supplementary nutrition and immunisation The supply of nutrition supplements was irregular, with gaps in delivery ranging from one to seven months, and insufficient. Ready-to-Eat supplements provided to pregnant and lactating mothers were less than the norm. Some AWWs reported that the number of children fully immunised was less than anticipated because of stiff resistance from certain sections of communities resulting from inadequate awareness about the advantages of immunisation. Inadequate infrastructure, including shortage of AWCs and staff, also affected immunisation rates (CAG 2005).

RECOMMENDATIONS

Shift focus to changing behaviours To date, ICDS has focused on extending service to all blocks of the country and on providing supplementary nutrition with insufficient attention to changing feeding habits of families and child care behaviours. ICDS should target children in the age group 0-3 years, instead of focussing primarily on children in the 4-6 year age group, when malnutrition may have already set in.

Community participation Involving local communities in the delivery and monitoring of the scheme is widely held to be the best way to improve its performance. For instance, getting women from local Self Help Groups to cook for children and pregnant and lactating mothers may ensure that the beneficiaries are provided nutrients as prescribed within the programme.

Popularsing the programme and promoting gender equality The success of ICDS rests largely on communities accepting the services provided. Community uptake of ICDS services can be improved through awareness drives to raise consciousness of the community on issues related to women and children. In particular, discrimination against girl children, femal foeticide, and infanticide is a problem that is prevalent in large parts of the country. To counter this, ICDS could incorporate awareness campaigns to attempt to encourage people to care for girls as well as boys.

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11 Gragnolati. Michele, Shekar. Meera, Das Gupta. Monica, Bredenkamp. Caryn and Lee. Yi-Kyoung. 2005. India's Undernourished Children: A Call for Reform and Action World Bank (Health, Nutrition and Population group)

FOR MORE INFORMATION

www.wcd.nic.in
As the nodal Ministry for the advancement of women and children, the Ministry formulates plans, policies and programmes; enacts/ amends legislation, guides and coordinates the efforts of both governmental and non-governmental organisations working in the field of Women and Child Development.

www.nipccd.nic.in
National Institute of Public Cooperation and Child Development, popularly known as NIPCCD, is a premier organisation devoted to promotion of voluntary action research, training and documentation in the overall domain of women and child development.

www.worldbank.org
Source of socio-economic data, statistics and research publications on India

www.cag.gov.in
The Comptroller and Auditor General of India audits schemes and undertakings at the behest of the principal authority. The CAG Audit Report (Civil) for the year ended 2005 summarises the audit of the ICDS scheme.

www.wcd.nic.in/icds.htm
The official website of the ICDS scheme

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