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Integrated Child Development Services (ICDS) Scheme in India: A Review

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Abstract

ICDS is a centrally sponsored flagship scheme for holistic development of children.Indian children have underprivileged childhoods starting from birth. The infant mortality rate of Indian children is 44 and the under-five mortality rate is 93 and 25% of newborn children are underweight among other nutritional, immunization and educational deficiencies of children in India (UNICEF, 2011). India is lagging behind the other developing countries of the world in this respect. Given such a daunting challenge, ICDS was first launched in 1975 in accordance to the National Policy for Children in India (Kapil, 2002).It is implemented through the concerned States/UTs with the funding by the Government in the ratio of 50:50 for supplementary nutrition (90:10 in NER) and 90:10 for other operational components between the Centre and the States. The Scheme provides a variety of services for the development of child and women such as immunization, supplementary nutrition, health check-up, referral services, pre-school non-formal education and nutrition and health information.ICDS today is the world's largest community based outreach program for early child development, reaching out to over 9.65 crorebeneficiaries of which 7.82 crore is children under 6 and 1.83 crore is lactating mothers. The objective of this paper is to highlight the working of ICDS and the need of convergence of services under ICDS with schemes of other departments.

Key words: ICDS, Women development, AWC, CAG Report, Convergence.

Introduction

Pt. Jawaharlal Nehru said, 'you can tell the condition of a nation by looking at the status of its women'. The Constitution of India recognized the importance of secured childhood and protection of children's rights as crucial components for laying the foundations of India's democracy. Article 39(f) of the Constitution states that 'Children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against moral and material abandonment.' Integrated child development services (ICDS)scheme is one of such community

development programme in response to the challenge of meeting the holistic needs of the women and children (*NIPCCD, 1992*).The Integrated Child Development Services (ICDS) Scheme was initiated in India on 2nd October 1975 with the objectives toimprove the nutritional and health status of children in the age-group 0-6 years, lay the foundation for proper psychological, physical and social development of the child, reduce the incidence of mortality, morbidity, malnutrition and school dropout, achieve effective co-ordination of policy and implementation amongst the various departments to promote child development, enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education. It is a comprehensive program designed to ensure the holistic development of children. It is one of the largest childcare programs in the world and has been in operation for more than three decades. The ICDS scheme integrates several aspects of early childhood development and provides supplementary nutrition, immunization, 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 age group of 3-6 years and health and nutrition education to women in the age group of 15-45 years.

Functioning of ICDS Scheme

In India, ICDS was initiated in 1975 in 33 blocks and used Below Poverty Line (BPL) as criteria for delivery of services. Out of the various services, the non-formal pre-school education and supplementary nutrition are provided by the Anganwadi Worker (AWW) and Anganwadi Helper (AWH). The other services such as immunization, health check-up, referral services and nuitrition and health education are provided with the help of medical personnels mainly with ANM (Nurse cum Midwife). The ICDS scheme consists of the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs). Anganwadi Worker, a lady selected from the local community, is a community based frontline honorary worker of the ICDS program. Besides, the medical officers, Auxilary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

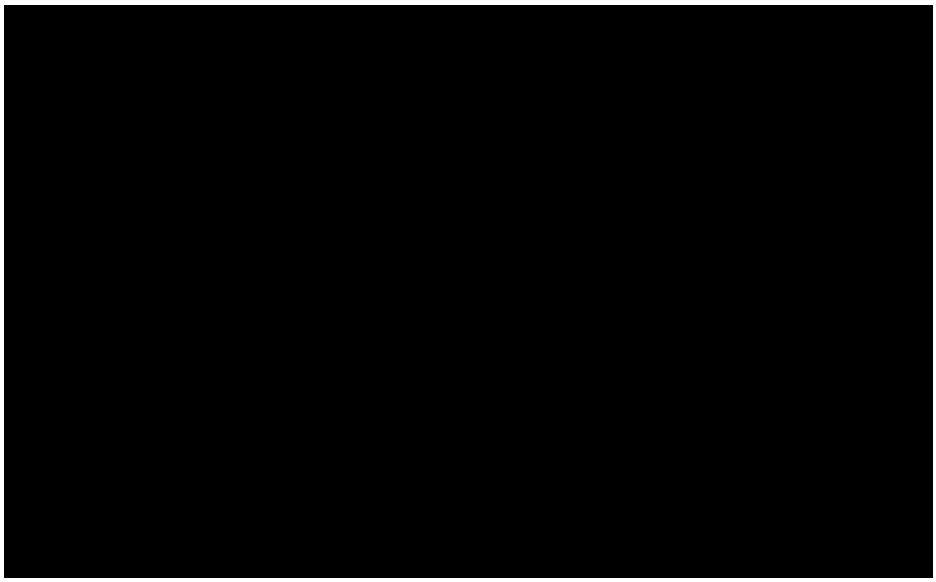
This programme finally has reached out to 15 million expectant and nursing mothers and 70 million children under 6 years of age with over 1.2 million AWCs (*UNICEF, 2011*).The scheme aims to improve the nutritional and health status of vulnerable groups including pre-school children, pregnant women and nursing mothers. A key element of this programme is that all the services are provided under one roof i.e the anganwadi centre (AWC). The Ministry of Women and Child Development is the nodal department for UNICEF, which has provided essential

supplies to the ICDS Scheme since 1975. In India, following a Supreme Court order, ICDS was expanded in 2005 to cover the entire country. Further, in 2008, the Government of India adopted the World Health Organization (WHO) standards for measuring and monitoring the child growth and development, both for the ICDS and the NRHM. However, various studies on ICDS revealed that the working of ICDS in India was far from expectation. While the scheme has been revised since 2005, in 2009 the United Nations Development Programme and the PlanningCommission stated that India had made insufficient progress inimproving nutritional status of children.

Community participation was not significant because of various reasons such as low awareness level of the benefits and facilities provided to pregnant women and children, irregular visit by the AWW, low quality of food provided etc. (*Banerjee,1999*).Activities based on community participation and maintaining liaison with other institutions were given medium level of priority by the AWWs. It was found that the NHE program was irregular and teaching was not satisfactory because of poor contents of classes and inconvenient timing of classes(*Barman, Nibha Rani ,2001*). Although a higher percentage of women were aware about the need of this program, but they were ignored about the various activities that were carried out at AWCs and extent of their participation was woefully inadequate (*Dutta , 2012*). 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 (*Gupta. A et al, 2013).*

Despite the fact that ICDS has been in operation for more than three decades, states have made limited progress in tackling under nutrition. 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. Table 1 depicts the present status of number of operational projects, AWCs, nutrition & education beneficiaries.

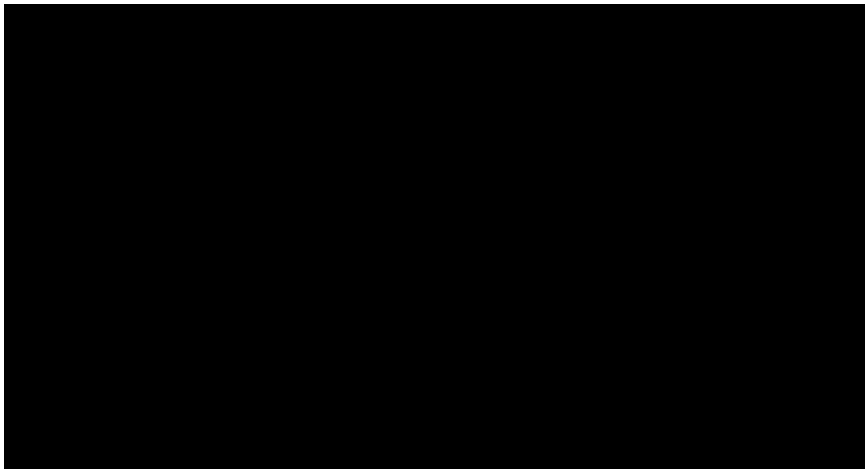
Table 1: Present Status of number of operational projects/AWCs/Nutrition & Education Beneficiaries



Source: Planning Commission, Evaluation Report on Integrated Child Development Services (ICDS) released in March 2011.

Table 1 shows the increase in thenumber of operational projects, AWCs, nutrition & education beneficiaries at a CAGR of 4.41, 9.67, 11.32 and 9.92 percent respectively. Table 2 indicates that the overall performance of ICDS Scheme was higher in Karnataka (PI 0.728) followed by Maharashtra (PI 0.716) and Andhra Pradesh (PI 0.689).

Table 2: State-wise Performance of ICDS Scheme



Source: Planning Commission, Evaluation Report on Integrated Child Development Services (ICDS) released in March 2011

CAG Report on ICDS Scheme

The Comptroller and Auditor General of India's performance audit of the Integrated Child Development Services (ICDS) Scheme contain results of performance audit conducted between 2006-07 and 2010-11. The CAG audit reveals lapses in ICDS implementation. It is reported that India has registered higher infant and child mortality rates than Sri Lanka and Bangladesh. Further the country's position on the measure of the percentage of underweight and severely underweight children during the period 2006-10 was more than twice than that in the Sub-Saharan African region.On diversion of money meant for ICDS, the audit report notes that Rs. 57.82 crore was diverted to activities not permitted under the scheme in five of the test-checked States and Rs. 70.11 crore was parked in civil deposits and personal ledger accounts/bank accounts/treasury, resulting in the blocking of funds.Pointing out the shortage of staff and key functionaries at all levels, the audit notes that 61 per cent of the test-checked anganwadis functioning under the ICDS scheme did not have their own building and 25 per cent were functioning in semi-pucca/ kachcha buildings, or open/partially covered space. Worse, poor hygiene and sanitation was noticed due to the absence of toilets in 52 per cent of the anganwadis.Further, medicine kits were not available in 33 to 49 per cent of the anganwadis due to failure of the State governments in spending funds released to them by the Centre. Also functional weighing machines for babies and adults were not available in 26 per cent and 58 per cent of the centers respectively. The essential utensils required for providing supplementary nutrition to the beneficiaries were also not available in many places.(Source*: Performance Audit of ICDS Scheme, Report No. 22 of 2012-13)*

Challenges of ICDS Scheme

The ICDS Scheme has been suffering from the following bottlenecks:

- 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 under nutrition and malnutrition were the ones that received the least funds and coverage under ICDS.

- 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*).

- 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*).

- 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 immunized was less than anticipated because of stiff resistance from certain sections of communities resulting from inadequate awareness about the advantages of immunization. Inadequate infrastructure, including shortage of AWCs and staff, also affected immunization rates (*CAG, 2005*).

Conclusion

ICDS Scheme is a flagship programme of the Ministry of Women and Child Development. In order to achieve its objectives in full, an integrated approach along with appropriate actions becomes the need of the hour. ICDS should target children in the age group of 0-3 years, instead of focusing primarily on children in the 4-6 year age group, when malnutrition may have already set in.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.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, female foeticide, and infanticide is a problem that is prevalent in large parts of the country. To counter this, ICDS could incorporate awareness campaigns to encourage people to care for girls as well as boys.In order to fulfill the objectives of the scheme the level of co-ordination between the welfare, health and other related departments should be enhanced.Emphasis should be given to involve ICDS functionaries in the planning of the programmes at all stages. Also a system of providing incentives to ICDS functionaries needs to be developed.The Government agencies are responsible for the implementation of the programme and, therefore, required to organize some publicity campaign to create awareness and carried out a sense of confidence and zeal in the minds of the target group to come forward and reap the benefits of the programme. There is need to strengthen the system of supervision for improving the quality of better services.Sufficient training should be given to ICDS functionaries from time to time.

ICDS scheme envisages an integrated delivery of a multiplicity of services which are handled by different departments at different levels. Three of the six services under ICDS viz. immunization, health check up and referral services are delivered through public health infrastructure under the Ministry of Health and Family Welfare.

The convergence among departments and programmes for the delivery of ICDS, constitution of co-ordination committees at the Central, State , Block and village level to review the progress of the ICDS scheme under State Level Co-ordination Committee (SLCC), joint meeting of the State Nodal department with NRHM functionaries is required to be held in every quarter to discuss about different health aspects of ICDS and to gather inputs on and other health concerns of the ICDS from state on regular basis .

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