About the Author(s)

Aasha Kapur Mehta is Professor of Economics, Indian institiute of Public Administration, New Delhi and Member, Working Group of Feminist Economists constituted by the Planning Commission of India.

Sanjay Pratap and Akhtar Ali are Research Officers at Indian Institute of Public Administration, New Delhi.

UN Women
South Asia Sub Regional Office,
19A, Rajdoot Marg, Chanakyapuri
New Delhi – 110021, INDIA
Voice: +91-11-26119128/20/24/29
www.unwomensouthasia.org
www.unwomen.org

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Integrated Child Development Services:

Identifying critical gender concerns

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Author(s): Aasha Kapur Mehta, Sanjay Pratap and Akhtar Ali.
Editorial Inputs: Anne F. Stenhammer, Sushma Kapoor, Yamini Mishra, Sharmistha Sinha, Navanita Sinha, Bhumika Jhamb
Copyeditor: Urmila Dasgupta

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I. Executive Summary[1]

The Approach to the Twelfth Plan reiterates the need to "break the vicious cycle of multiple deprivations faced by girls and women because of gender discrimination and under-nutrition[2]". It draws attention to the fact that every third woman in India is undernourished and every second woman is anaemic. Further, it stresses the need to radically restructure the Integrated Child Development Scheme (ICDS) "to focus on reaching pregnant and lactating mothers, and also the more vulnerable children in the 0-3 age group."

Maternal undernourishment can lead to the birth of underweight babies, who may be more prone to illness as children and adults[3]. Hence, effective delivery of ICDS nutrition related services has tremendous significance for all children under the age of six, pregnant women, lactating mothers and adolescent girls who benefit from the scheme.

This Policy Brief outlines key policy recommendations to address critical shortcomings in delivery of services and identifies gender concerns in the ICDS Scheme. It challenges the assumption that schemes meant largely for women and children are inherently gender responsive and need no scrutiny from a gender perspective.

Based on implementation and evaluation evidence, it draws attention to gaps in policy, implementation and budgets. It highlights the need for attention to factors constraining coverage and access; quality of service delivery; and challenges faced by key functionaries. It also suggests concrete policy recommendations for better provisioning of nutritional support to women and children through the ICDS. The purpose is to address key policy and implementation gaps as well as set benchmarks for the provision of such services.

II. The Context

High prevalence of nutritional deficiency among women is evident from NFHS-3 (2005-06) estimates–33 per cent of ever-married women between 15 to 49 years of age (and 28.1 per cent of men) have a Body Mass Index (BMI) less than 18.5 or are undernourished. More than half of the ever-married women in this age group (56.2 per cent) and almost one-quarter of men (24.3 per cent) are anaemic. Pregnant women are more likely to be anaemic (57.9 per cent) than non-pregnant women (55 per cent)[4].

Childhood is the formative stage that governs the well-being and development of the child into a healthy and productive adult. Low birth weight (LBW) among newborn babies has serious adverse implications, including stunting and reduced intellectual development[5]. "Maternal deprivation adversely affects the health of the fetus, which in turn leads to long-term health risks that extend not just into childhood but into adulthood as well."[6]

[1]This Policy Brief is based on a review of the literature and on valuable inputs received from the many experts who participated in the UN Women – IIPA Workshop on "Reviewing Flagship Programmes from a Gender Lens: ICDS" held at IIPA on 29th February 2012. Dr.Syeda Hameed, Dr. N.C. Saxena, Dr. Rakesh Hooja, Ms. Anne Stenhammer, Ms. Sushma Kapoor, Dr. Shreeranjan, Ms.Deepika Shrivastava, Prof. Dolly Arora, Ms. Yamini Mishra, Ms.Sudha P. Rao, Dr.Mukta Arora, Shri Sushanta Kumar, Shri Rajkishor Mishra, Dr. Steve Collins, Dr. S.P. Pal, Ms. Bhumika Jhamb, Ms. Roopa Dutta, Dr. Sarojini Adhikari, Shri Biraj Patnaik, Ms. Dipa Sinha, Ms. Devika Singh, Ms. Vasanti Raman, Dr. Sandhya Vyas, Ms. Savita and her ICDS team from Delhi Government, Ms. Suman Sharma, Ms. Archana Kaushik, Ms. Lakshmi Durga, Ms. Sejal Dand, Ms. Monica Banerjee and Ms. Farheen Khurhid provided valuable inputs. We are grateful to them for their many contributions that include inaugurating the workshop, sharing insights, making presentations, chairing and forthright discussions. Also, gratefully acknowledged are IRRAD and Ms. Punima Menon for sharing inputs. Support provided by UN Women is gratefully acknowledged.
[2]See Page 88, Planning Commission, *Faster, Sustainable and More Inclusive Growth: An Approach to the Twelfth Five Year Plan,* October 2011.
[3]Amartya Sen, *Hunger: Old Torments and New Blunders, The Little Magazine,* Vol II, Issue 6. Available at http://www.littlemag.com/hunger/aks.html. Accessed on 27th October 2012.
[4]Arnold, Parasuraman, Arokiasamy and Kothari, 2009.
[5]Swaminathan, 2004; Mehta and Shepherd, 2004.
[6]Osmani and Sen, 2003.

India is one of four countries with the highest prevalence of underweight children under five. In 2005–06, about 44 per cent of Indian children under age five were underweight and 48 per cent were stunted[7]. 42 per cent of the world's underweight children and 31 per cent of its stunted children live in India[8].

Under-nutrition is caused by a large number of factors that include lack of access to medical care and health services; high disease load; lack of access to food, nutrition and health education; early marriage, pregnancy and non-spacing of children; anaemia among women; low birth weight babies; poor cultural practices regarding feeding of colostrum and breast feeding; poor quality of water and sanitation; and migration and mothers having to go for work leaving children at home[9]. In addition to the factors listed above, there are several latent socially constructed factors that determine nutritional and health outcomes of women, many of which are ignored. For instance, provision of the required calorific intake through take-home rations, aimed at improving nutritional and health status of women, ignores intra-household inequalities and realities. Availability of food may increase at the level of the household but may not reach the women for whom it is intended.

The ICDS Scheme is one of the world's largest outreach programmes for early childhood care and development. It was launched on 2nd October 1975. It seeks to directly reach out to children below six years through an integrated programme of early childhood education, health and nutrition and to expectant and nursing mothers. A package of six services is provided under the ICDS Scheme. These include supplementary nutrition; non-formal pre-school education; immunization; health check-up; referral services; and nutrition and health education.

ICDS is centrally sponsored and implemented through state governments/Union Territories (UTs)[10].

In 2001, the Supreme Court directed that ICDS be 'geographically universalized', that is, there must be an *Anganwadi* in each settlement. Every child under six, adolescent girl, pregnant woman and lactating mother, is entitled to supplementary nutrition under ICDS. The ICDS administrative unit is the community development block in rural areas, the tribal block in tribal areas and the ward or slum in urban areas. The population norms for setting up an *Anganwadi* Centre (AWC) and mini-centre have been lowered in an effort to increase outreach. In rural and urban areas the norm is now one AWC for a population size of 400 to 800 and a mini-AWC for 150 to 400 persons. In tribal, riverine, desert, hilly and other difficult areas the norm is lower with one AWC for a population size of 300 to 800 persons and a mini-AWC for 150-300 persons.

III. Critique of Policy Option(s)

Coverage, Utilization and Key Challenges in delivering the ICDS

In March 2012, 7,075 ICDS projects and 13.7 lakh AWCs had been sanctioned and 6,908 ICDS projects and 13.05 lakh AWCs were operational. Supplementary nutrition (SNP) was availed of by 1,82,43,484 pregnant women and lactating mothers and 7,90,05,328 children. Pre-school education benefited 1,82,53,384 boys and 1,75,68,322 girls[11]. However, estimates of coverage by the ICDS scheme vary depending on the data source used. For instance, NFHS-3 estimates that while 81 per cent children below six in India live in areas covered by an AWC, only 28.4 per cent received any service from an AWC in the year preceding the survey[12].

On the other hand, NCAER (2011)[13] estimated that ICDS covered 62 per cent eligible children (6-72 months) and 49 per cent of those in the delivery register. Further, of the children recorded in the delivery register, 64 per cent received supplementary nutrition and other services (not necessarily as per norms), 12 per cent received only supplementary nutrition and 24 per cent did not receive any benefits. Around 78 per cent pregnant women and lactating mothers and 42 per cent adolescent girls whose names are found in the delivery register received SNP benefits. Further, they estimated that effective coverage[14] was 41 per cent for children, 38 per cent for women and 10 per cent for adolescent girls at the national level.

Three standard indices of physical growth that describe the nutritional status of children are presented in the NFHS-3 report – height-for-age[15] (stunting); weight-for-height[16] (wasting); and weight-for-age (underweight). Each of the three nutritional status indicators is expressed in standard deviation units (Z-scores) from the median of the reference population.

Weight-for-age[17] estimates as per ICDS records, as on 31st March 2012, are that 62.8 per cent of children below the age of 6 who were weighed in AWCs were normal (so the rest were malnourished). While the highest levels of malnourishment are estimated to be in Bihar, independent verification is needed regarding data provided by other states prior to concluding that malnourishment is lower in other parts of the country. For instance, NFHS data (Table 1) show that:

- The BMI of 33 per cent women is below normal.
- The proportion of anaemia among ever-married women aged 15 to 49 has increased from 51.8 to 56.2 per cent.
- Almost 80 per cent children between 6 and 35 months of age are anaemic. The prevalence of anaemia among them has increased from 74 percent in NFHS-2 to 79 percent in NFHS-3.
- This increase is largely due to a sharp increase in anaemia among young children in rural areas[18].
- More than 43 per cent of children below three years of age are underweight.
- Stunting affects 38.4 per cent children below three years of age.
- Wasting is also a serious problem in India, affecting 19.1 per cent children under three years of age.
- Estimates of wasting and underweight among children below the age of 3 have worsened between NFHS-2 and NFHS-3.

[7]WHO, cited in International Food Policy Research Institute (IFPRI) 2010: 21, 2010.
[8]UNICEF, cited in IFPRI, 2010: 21, 2010.
[9]This is based on a presentation made by Dr N.C. Saxena at the UN Women-IIPA workshop.
[10]For more details about the scheme see http://wcd.nic.in/.
[11]Available at http://wcd.nic.in/.
[12]National Family Health Survey - 3, Volume 1, page 254, September 2007.
[13]The analysis is based on data collected from 19,500 households listed in the ICDS Survey Register as well as 1500 AWCs located in 300 Projects in 100 districts of 35 States/UTs.
[14]The proportion of registered beneficiaries receiving supplementary nutrition benefits * proportion of days (out of 300 days/year).
[15]The height-for-age index is an indicator of linear growth retardation and cumulative growth deficits. Children whose height-for-age Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered short for their age (stunted) and are chronically malnourished (those below -3 SD are severely stunted). Height-for-age represents the long-term effects of malnutrition in a population and does not vary according to recent dietary intake.
[16]The weight-for-height index measures body mass in relation to body height to describe the current nutritional status. Children whose Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered thin (wasted) for their height and are acutely malnourished (those below -3 SD are severely wasted). Wasting represents the failure to receive adequate nutrition in the period immediately preceding the survey and may be the result of inadequate food intake or a recent episode of illness causing loss of weight and the onset of malnutrition.
[17]Weight-for-age is a composite index of height-for-age and weight-for-height. It takes into account both acute and chronic malnutrition. Children whose weight-for-age is below minus two standard deviations from the median of the reference population are classified as underweight (those with weight-for-age below -3 SD are severely underweight).
[18]NFHS-3 Summary of Findings, page xxxix.

Table 1: Some Indicators of Under-nutrition (NFHS-2 and NFHS-3)

Indicators of Malnutrition	NFHS-2	NFHS-3
Women whose body mass index (BMI) is below normal (per cent)	36.2	33
Men whose body mass index (BMI) is below normal (per cent)	NA	28.1
Ever-married women age 15-49 who are anaemic (per cent)	51.8	56.2
Children aged 6-35 months who are anaemic (per cent)	74.2	79.2
Children under 3 years who are wasted (per cent)	15.5	19.1
Children under 3 years who are underweight (per cent)	42.0	43.5
Children under 3 years who are stunted (per cent)	45.5	38.4

Source: National Family Health Survey, 1998-1999 and 2005-2006

Additionally,

- The proportion of children who are severely undernourished (-3 SD) is 24 per cent according to height-for-age and 16 per cent according to weight-for-age[19].
- Overall, girls and boys are about equally likely to be undernourished[20].
- Under-nutrition is substantially higher in rural areas. Even in urban areas, however, 40 per cent of children are stunted and 33 per cent are underweight[21].
- Spatial disparities exist with high levels of underweight children in Madhya Pradesh, Bihar and Jharkhand; high levels of stunting among children in Uttar Pradesh, Bihar, Meghalaya, Chhattisgarh, Gujarat and Madhya Pradesh; and wasting in Madhya Pradesh, Jharkhand and Meghalaya[22].
- Anaemia is very common in India. Almost 7 in 10 children age 6-59 months are anaemic. It is so common that in all but four states (Goa, Manipur, Mizoram and Kerala) more than half of children are anaemic. In India, anaemia is primarily attributed to poor nutrition[23].

Key Issues and Challenges[24]

While recognising that ICDS is one out of several interventions that are required to address malnutrition, it is important to draw attention to problems with regard to its effective functioning. The ICDS is delivered primarily by women workers at various levels. Yet, there is lack of gender sensitivity in the work conditions of the women who are the pivot in the endeavour to reduce malnutrition. The amount paid to *Anganwadi* Workers (AWWs) and *Anganwadi* Helpers (AWHs) is below the minimum wage rate and is carefully termed honorarium and not remuneration or wage. The work is regarded as voluntary and work conditions are ad hoc or casual. The assumption is that the army of women AWWs and AWHs will volunteer for this task despite the ad hoc nature of the work and low honorarium associated with it.

Despite the large number of women working for the ICDS, there is no provision for ensuring their safety and security. For instance, Supervisors are required to monitor several AWCs, many of which are at distant geographical locations with poor connectivity. Hence, they are required to walk for several kilometres to monitor AWCs in remote and unsafe environments. There is lack of provisioning for transport for Supervisors.

Other key issues needing attention include:

(a) Design, infrastructure and convergence related challenges:

- lack of emphasis on the thousand-day window[25] ;
- limited inclusion of adolescent girls;
- location of AWCs in upper caste localities within villages thereby creating access barriers for *Dalit* mothers and children;
- lack of monitoring of nutrition practices within the home and access to food for pregnant women and lactating mothers as well as domestic child care and feeding practices;
- non-convergence of health and nutrition services;
- lack of community/*Panchayat* participation;
- poor quality provisioning of supplementary nutrition;
- poor or no infrastructure;
- lack of funds for regular use items such as weighing scales for babies as well as for adults, charts, medical kits, mats, stationery, brooms, tables and chairs, etc.;
- unrealistically low budgetary provisioning for rent, leading to lack of space for the required indoor and outdoor activities;
- lack of basic facilities such as toilets, running water and safe drinking water;
- unsanitary conditions in and lack of regular cleaning of public spaces in slums and *jhuggi jhompris* (squatter settlements).

(b) Supervision and delivery related challenges:

- scattered geographical coverage;
- shortage of staff at various levels;
- overloading of staff with non-ICDS tasks;
- lack of training, skills and motivation of AWWs and AWHs;
- need for capacity building and motivation of staff.

(c) Inadequate budgets and delayed fund flows:

Severe budgetary constraints add to the poor performance of the ICDS. Both at the level of aggregate as well as at the level of unit cost, the allocations for ICDS remain grossly inadequate[26]. The quantum of funds required for universalising ICDS with quality based on a 'two *Anganwadi* worker' model, was estimated at around Rs.75,000 Crore. This is manifold the amount of current allocation for ICDS of Rs.15,850 Crore, which is an increase of 12.8 per cent from 2011-12 revised estimates. This is also way below the target average annual amount of Rs. 36,600 Crore recommended by the Working Group on Child Rights for the Twelfth Five Year Plan for ICDS[27]. If what is envisaged is an AWC-cum-Crèche, then the funding requirements would be far higher. The flexible fund that is available at the disposal of the AWW is just Rs.1,000.

Delays occur in the flow of funds from the Centre to the States for several reasons. For instance, the Department of Women and Child Development (DWCD) expects the districts to provide an estimate of the funds that will be required for implementation of ICDS but not many districts are well-equipped to furnish budgetary proposals and this leads to delays.

With poor facilities and infrastructure, design flaws, delayed fund-flow, overworked

[19]See National Family Health Survey–3, page 269.
[20]ibid, page 272
[21]ibid, page 272
[22]ibid, Table 10.2, page 273
[23]ibid, page xxxix
[24]Based on N.C Saxena, 2009; FOCUS 2006; Mehta and Ali, 2008; and Sinha and Jhamb, 2010.

[25]This is based on a recommendation from the Office of Supreme Court's Commissioners that the first thousand days is the "window of opportunity" that ICDS is missing out now, despite overwhelming evidence that much of the malnutrition manifests itself during this period. It stresses on targeted action and investment to improve nutrition for mothers and children in the 1,000 days between a woman's pregnancy and her child's second birthday when better nutrition can have a life-changing impact on a child's future and help break the cycle of poverty.
[26]Sinha and Jhamb, 2010.
[27]CBGA, 2012,page 19.

supervisors, scattered geographical coverage, overloading of staff with non-ICDS tasks, poor supervision owing to non-ICDS-related demands on time, low and delayed payment of honorarium and lack of training, skills and motivation of workers and helpers, it is hardly surprising the programme has not made a dent in malnutrition.

IV. New initiatives in delivering ICDS

However, notwithstanding the weaknesses noted above, many AWCs do work. Several factors influence the demand for the ICDS. For instance, women belonging to poor households use the ICDS as a means to access SNP for children of poor families. Women daily wage earners/domestic workers use AWCs as crèches. The AWC also enables access to services like immunization, pre and post natal care and health services where these are not easily accessible through the primary health care system. Proximity of the AWC to the settlement also matters[28]. Additionally, several successful initiatives have been taken to reduce malnutrition and improve delivery of services through the ICDS. A few of these are described below.

Naandi Foundation *Bachpan* Model – Changing lives through public-private partnerships (PPP)[29]

The Naandi foundation has used the PPP model to strengthen ICDS in Bajna block of Ratlam district in Madhya Pradesh. The five-fold strategy and associated key interventions adopted by the *Bachpan* model are outlined below.

- Increasing community awareness to create demand for ICDS services through folk performances, community meetings and house to house visits as well as distribution of booklets about government schemes.
- Formation and strengthening of Community Based Organizations (CBOs) and initiation of community based monitoring mechanisms. These include the formation of *Ekta Samuha* comprising elected *Panchayat* members, village-level government service providers and citizens; development of user-friendly Community Monitoring Tools for collecting, collating and analysing data; and formulation of village level micro plans with specific focus on women and child issues.
- Building convergence between government departments and *Panchayati Raj* Institutions (PRIs) in planning and service delivery through establishment of district, block and cluster-level forums at which government department officials and *Bachpan* team members exchange monitoring data and collectively identify gaps in services. These findings are incorporated in village level micro plans in the gram sabha.
- Forums for interface among CBO representative, PRIs and service providers include the Village Level- *Ekta Samuha*, *Panchayat* Level-*Panchayat* Core Committee (PCC) and Block Level- Block Core Committee (BCC).
- Volunteerism is nurtured through promoting a cadre of change agents among community and service providers. At the village level, a cadre of volunteers (*Gram Mitra*) are trained. Monthly review and planning meetings with the *Gram Mitra* are held at the cluster level. The best performing AWWs are trained and the best performing *Gram Mitra*, AWWs, Auxiliary Nurse Midwives (ANMs), Supervisors and communities are felicitated.

[28]NCAER,2011
[29]This section is based on a presentation by Sushanta Kumar, Naandi Foundation at the UN Women-IIPA workshop.

These strategies and key interventions under the programme have significantly improved the functioning of ICDS in the block. Attendance of children increased from 20 per cent in 2007 to 69 per cent in 2011, registration of pregnant women from 10 per cent to 93 per cent, regular weekly functioning of AWCs from 9 hours to 22 hours and SNP distribution from 23 per cent to 97 per cent. 23 AWCs have been developed as model AWCs.

The Marathwada Initiative and Rajmata Jijau Mother-Child Health and Nutrition Mission Aurangabad, Maharashtra[30]

Reports of fourteen child deaths in Bhadali village, Aurangabad during 2000-2001, allegedly due to malnutrition, led to the launch of the Malnutrition Removal Campaign on 14th March 2002 in eight districts of Aurangabad Division, Maharashtra. This initiative identified three key problems[31]:

- Under reporting of malnutrition by ICDS. Hence, the first critical step was that all children in the 0 to 6 age group, including those living outside the coverage of the *Anganwadi* area, were surveyed, registered, weighed and classified into normal or Grade I to IV categories of malnourishment.
- Nearly exclusive focus on food support by ICDS at the cost of other objectives such as growth monitoring. The issue of lack of availability of weighing scales and monthly weighing of children, especially those suffering from severe malnutrition, was addressed.
- Lack of coordination between ICDS and health departments. Hence, both departments were made jointly responsible for reducing malnutrition.

According to the pre-Campaign ICDS records, 7,867 children in the 0 to 6 age group were in Grade III and IV stages of malnutrition in Aurangabad Division in July 2002. However, the improved survey and weighing efficiency showed that the number of Grade III and IV malnourished children was 10,705 in July 2002. The campaign led to reduction in the number of Grade III and IV levels of malnourishment in children to less than 4000 by early 2004. Regular medical check-ups for children in the 0 to 6 age group also showed a distinct improvement after the commencement of the campaign.

The significant reduction in malnourishment occurred through:

- Training and motivation of staff at all levels as well as appreciation, competition and encouragement to take a proactive approach in solving the problems confronting them.
- Monitoring and detailed block level reviews at the Divisional Commissioner level and regular follow up visits.
- The existing ICDS machinery was motivated to perform to its fullest potential and devise local workable solutions to resolve problems.

In order to prioritize malnutrition reduction and removal, the State of Maharashtra, decided to replicate the Marathwada model in a mission mode by establishing the Rajmata Jijau Mother-Child Health and Nutrition Mission on 11th March 2005. Child Treatment Centres (CTCs) are among the pioneering initiatives launched by the Mission. Mothers staying at the centres with their children being treated are compensated for their loss of wages. The Mission uses funds from the National Rural Health Mission (NRHM) to run both CTCs and Village-level Child Development Centres (VCDCs). Gradually, it became a socially-led rather than a purely government-managed programme.

The Mission stressed the importance of sensitizing the ICDS functionaries and

[30]Inputs provided by Mr. Ramani regarding the Rajmata Jijau Mother-Child Health and Nutrition (RJMCHN) Mission are gratefully acknowledged.
[31]Bhattacharya, 2011.

improving their knowledge and skill sets. Above all, convergence between the ICDS and health departments had to be ensured if child malnutrition was to be effectively tackled.

The *Mitanin* in Chhattisgarh and Odisha

During 1998-2005 (between NFHS-2 and NFHS-3), the proportion of underweight children declined from 54 per cent to 44 per cent in Odisha and from 61 per cent to 52 per cent in Chhattisgarh[32]. Further, the proportion of children receiving services from AWCs was over 65 per cent in these two states, or twice as high as the national average; and six times higher than in Bihar (9.9 per cent). Therefore, Odisha and Chhattisgarh may still have high malnutrition and may be 'among the poorest states but they are the best ICDS performers and most successful at reducing under-nutrition' (see Box 1).

Box 1: *Mitanin*– A Success Story

The trigger for change in Chhattisgarh was the *mitanin* ('friend') programme launched in 2002[33]. Odisha used a similar approach. The *mitanin* is chosen by the local community and trained and supported by a block training team, the ANM and the AWW. Saxena and Srivastava (2009) point out that, 'what has worked in the *mitanin* model has been its outreach rather than a centre-based approach which helped provide services at the doorstep of all rural families of the state'. In Chhattisgarh, for example, the *mitanin* sensitizes and counsels the entire family when she comes to weigh children and explain the significance of the malnutrition grades. They also argue for independent verification of records, as AWWs 'have too many registers to complete and are reported to be under pressure to enter "correct" rather than accurate data[34]'. Additionally, they recommend packaged foods be banned, involvement of *panchayats* and mothers' groups be increased and access to water and sanitation be monitored.

Anganwadi services in Odisha post decentralization[35]

On 7th October 2004, the Supreme Court, ordered that "Contractors shall not be used for supply of nutrition in *Anganwadis* and preferably ICDS funds shall be spent by making use of village communities, self-help groups and *Mahila Mandals* for buying grains and preparing meals." In September 2009, the Government of Odisha introduced partial decentralization of procurement policy in all *sadar* (district headquarter) blocks. There was resistance from many quarters, especially from the AWWs union. Decentralized procurement of SNP, Emergency Feeding Programme (EFP) and Mid-Day Meal (MDM) were rolled out in the state with effect from 1st April 2011.

In an effort to understand the impact of decentralization on the status of SNP and pre-school activities and growth monitoring, a network of civil society organizations working on child rights, Voice for Child Rights in Orissa (VCRO), visited AWCs between August and October 2011 to collect information. The data revealed that out of 56 *Anganwadi* Centres, 48 had already constituted *jaanch* (enquiry) committees for local (village) level monitoring of ICDS. Post decentralization, the services of village communities, self-help groups and *Mahila Mandals* are being used for buying grains and preparing meals. Additionally, the weekly menu for hot cooked meal and morning snacks has been standardized for the entire state based on the prescribed calorie and protein norms. Decentralization has promoted local procurement as 66 per cent AWWs have started procuring the hot cooked meal from the same village. Similarly, for managing morning snacks 57 per cent AWWs procure food items from the village itself.

The availability and serving of cooked food at AWC level has encouraged attendance of pre-school children and regularity in pre-school activities as 87.5 per cent of the respondents were of the opinion that the pre-school activities are being conducted for six days a week; 91 per cent of the sampled pre-school respondents said that they play in the AWC; 70 per cent reportedly sang songs and 61 per cent learnt to dance. With decentralization and strengthened accountability towards the community there is mandatory display of entitlements and other details at the AWC level. Some of the AWCs have provided toll free numbers for grievance redressal.

Further, in almost all the *Anganwadi* centres, a joint account had been opened in the name of the *Anganwadi* worker and the Ward member by September 2011. Availability of funds has always been a major problem in implementing SNP and other programmes. This continues to be a problem with only 37 per cent AWWs stating that funds were received regularly for managing their respective AWCs. More than half (54 per cent) of the AWWs said that the fund flow is irregular, while funds were delayed by between 3 to 5 months in 9 per cent AWCs. Hence, regularity in flow of funds needs urgent attention.

The overall impact of a decentralized procurement process is a paradigm shift in the quality of SNP and in addressing the nutrition issues by curbing malnutrition. It has checked corruption; streamlined governance related issues; and encouraged active participation of women through SHGs and PRIs. Decentralization has helped in creating a demand for local products. Indirectly, it has contributed to the promotion of kitchen gardening, which could yield income as well as supplement household level nutrition needs. Finally, the local procurement of food-grains has contributed to women's empowerment and participation in the implementation of ICDS.

Government of Rajasthan's efforts at improving delivery of ICDS[36]

Several initiatives have been taken by the Government of Rajasthan to strengthen ICDS. Initially, decentralization of SNP was started through self-help groups with one SHG group providing SNP to one AWC. However, this was not viable and hence small clusters were created. Instead of one group making SNP for one AWC, clusters of ten groups were made in Udaipur and this gave a boost to the programme. In view of the Supreme Court decision for Maharashtra regarding 'zero human interaction', the Rajasthan Government was exploring mechanisms for automation within the decentralized process[37]. A big plant may be set up through a federation of SHGs.

Malnutrition treatment centres were started in seven districts. This was later extended to all districts. In district hospitals, a special ward is earmarked; special staff has been deputed and are being trained to treat malnourished children. Plans are being put in place for developing 100 Community Health Centres (CHCs) as malnutrition treatment corners.

[32]Saxena and Srivastava, 2009
[33]Saxena and Srivastava, 2009 cited in Mehta et al, India Chronic Poverty Report: 86, 2011.
[34]ibid.
[35]This section is based on a presentation by Shri Rajkishor, Odisha State Advisor to the Commissioners of the Supreme Court of India, at the UN Women-IIPA workshop.

[36]This section is based on a presentation by Ms. Mukta Arora, Executive Director, WSHGI cum Additional Director, SHG, Department of Women and Child Development, Government of Rajasthan at the UN Women-IIPA workshop.
[37]ibid

Another initiative taken by the Rajasthan State Government in 2004 was deputing *Sahyogini* as a third worker to monitor the health and nutrition status of children under 3 years, pregnant women and lactating mothers, by visiting the families in their homes and motivating them to get immunized on Mother and Child Health and Nutrition (MCHN) Day and providing counselling on Infant and Young Child Feeding (IYCF). MCHN Day is organized on a fixed day each month, at every AWC. After the introduction of NRHM, it was seen that the role of Accredited Social Health Activist (ASHA) and *Sahyogini* was, more or less, the same, so the two were merged in 2006. The Government of Rajasthan took the initiative of appointing the *Sahyogini* or third worker at the AWC under ICDS as an ASHA worker under NRHM and re-designated her as ASHA-*Sahyogini*.

Anaemia Control Programme for out-of-school adolescent girls has also been introduced in the State. Inadequate space is a constraint faced by AWCs. To address this, funds for construction of buildings are being allocated in the Plan budget and the Department of School Education and DWCD have jointly decided to shift AWCs to school buildings as far as possible. In schools where a separate room is not available, funds for construction of a room for an AWC will be made available through the *Sarva Shiksha Abhiyaan* (SSA). Around 12,000 AWCs have been shifted to schools.

In backward areas and some tribal areas, some of the AWWs are illiterate and cannot impart pre-school education. To strengthen pre-school education, in last year's budget, the Government announced that 500 trained nursery teachers would be deputed to tribal areas.

There are four projects that are being run by Non-Governmental Organizations (NGOs) in the State. Sterlite Foundation is partnering in around 1,000 AWCs by providing additional resources, like utensils, and participating in beautification of the AWCs or providing some nutritional components. Health check-ups are being provided in partnership with Fortis Hospital in Jaipur. *Akshaya Patra* Foundation is distributing hot meals in some of the Centres.

On 2nd October, 2010, powers were transferred to PRIs up to the district level. Now, the Departments of Medical and Health, Women and Child Development, Education, Revenue, Forest, and Rural Department and *Panchayati Raj* Department have come under the PRIs. Hence, the selection of AWW, AWH, ASHA-*Sahyogini, Sathin* etc. is through the *Gram Sabha*. Among the problems faced in recruitment is the deviation from established norms and criteria; or inability to remove insincere workers as they may have the support of PRI members. Hence, it is important to build the capacity of PRIs and sensitize them to the importance of delivering ICDS related services.

Early Warning Systems for preventing Severe Acute Malnutrition[38]

Severe Acute Malnutrition (SAM) is a major contributor to child mortality under five years of age. ICDS provides an opportunity for early diagnosis because AWWs and AWHs can be trained to identify children with SAM who need urgent treatment and to recognize children with associated complications who need urgent referral. Treatment of SAM is usually provided in nutritional rehabilitation centres for thirty days. However, Collins et al (2006) draw attention to several weaknesses of a centre-based approach, that include the high opportunity costs associated with the care giving mother having to leave the family for thirty days. They argue that children with SAM without medical complications can be treated with ready-to-use therapeutic foods (RUTF) or other nutrient-dense foods at home, provided cases are detected early. Ingredients required for manufacture of RUTF are in the public domain.

However, concerns have been expressed[39] regarding multinational interest groups seeking entry in commercially produced RUTF. Hence, it is especially important that the Health Ministry formulates both the community-based protocol as well as the facility-based protocol for treatment of SAM, so that early treatment and management are effective in preventing the deaths of hundreds of thousands of children. It is important to take cognisance of guidelines for community and home-based treatment of SAM formulated by a large group of experts and supported by the Indian Academy of Paediatrics[40].

V. Policy Recommendations: Key Gender related and other issues needing attention

(a) Access, Coverage and Outreach

- Provide access to AWCs in each village or slum by opening functional AWCs based on population norms.
- Use spatial mapping to identify the districts and blocks with high levels of under-nutrition among women and low sex ratio. Give priority to opening new AWCs and strengthen the functioning of existing AWCs in such blocks.
- Within each village and slum, give priority to locating new AWCs in the poorest areas of the village.
- Ensure that the process by which decisions are taken regarding location etc. of the AWCs includes women from the poorest households in the village.
- Strengthen outreach activities to ensure the ICDS functionaries do not miss out on the critical 0 to 2 age group and their families in their homes. If needed, provide a third functionary at the AWC to facilitate this.
- Give special attention to the 1000 day window of opportunity, which is extremely critical for improving nutrition that spans "the period from -9 to +24 months (that is, the 1,000 days between conception and a child's second birthday). This is the period when children are not only in the greatest need for adequate amounts of nutritious food for healthy development, but also when interventions are most likely to prevent under-nutrition from setting in. After the age of two, the effects of under nutrition are largely irreversible[41]."
- Note that "children who are undernourished during the thousand-day window risk experiencing lifelong damage, including poor physical and cognitive development, poor health, and even early death. These children are likely to grow up to be short and thin, as well as less productive and healthy than they might have been. Furthermore, when poorly nourished girls grow up, they tend to give birth to underweight babies, perpetuating the cycle of under nutrition, quite apart from the toll that undernourishment takes on their health and well-being. This means that the well-being of mothers is a critical element of the solution[42]."
- Supplementary Nutrition Programme (SNP): Support women care givers and their families through home visits and outreach activities. Provide information and counselling regarding issues such as the quality of nutrition and number of times that feed is to be provided to the child as well as the kind of nutrients required for tackling malnutrition among women and children and food sources from which they can be obtained.

[38]This section is based on a presentation by Dr. Steve Collins at the UN Women-IIPA workshop and other literature cited below.

[39]See reference to the meeting organized at AIIMS in November 2009 on Nutrition Therapy in SAM, in Beesabathuni and Natchu, 2010.
[40]Working Group for Children under Six, 2009.
[41]Ruel, 2010, cited in IFPRI 2010, page 21.
[42]IFPRI, 2010:2.

(b) Functioning of AWCs and Quality of Services

- Identify gaps that need to be addressed in the functioning of AWCs and Primary Health Centres (PHCs).
- ICDS can play a critical role in reducing the care burden borne by women and girls through providing child care. Increase the duration for which the AWC is open so that it functions as an AWC-cum-crèche, in order to make it more gender responsive through meeting the care needs of women with children below the age of 6, and to release girls from having to provide sibling care so that they can attend school/go to work. This is especially important in view of declining family support systems and migration.
- Work with nutritionists to identify effective nutritionally balanced ingredients that can be used to prepare supplementary nutrition made from local ingredients and prepared under rigorous quality control. Facilitate participation of women's self-help groups in preparing these nutritionally balanced hot cooked meals and thereby generate local employment and income earning opportunities.

(c) Working Conditions and Staff Capacity

The Child Development Project Officers (CDPOs), Supervisors, AWWs and AWHs are directly responsible for implementing the ICDS Scheme and most of these posts are held by women. Hence issues pertaining to working conditions and staff capacity are directly relevant for women.

- Address issues such as vacancies of key field personnel, low motivation and skills and lack of supportive supervision.
- Fill all vacant posts of ICDS functionaries at least through contract posts if there are factors constraining regular appointments.
- Streamline systems so that ICDS functionaries are not burdened with non-ICDS related tasks and participation in non-ICDS events.
- Prepare a perspective training plan and annual plan for training ICDS staff at all levels. Provide training and skills to ICDS staff to enable motivation and inclusion of members of the community who are not using AWCs.
- Provide job security and minimum wages to ICDS functionaries, most of whom are women.
- Prevent exploitation and manipulation that is suffered by AWWs, helpers and other ICDS functionaries.
- Rationalize the workload of ICDS functionaries, viz., CDPOs and Supervisors and AWWs, AWHs and *Sahyoginis*. Limit the number of registers and indicators that are required for tracking malnutrition.
- Support, encourage and guide ICDS functionaries to work effectively. Undertake regular fact finding field-based reviews, especially in poorly performing blocks, to identify and fill the gaps through supportive supervision.
- Motivate better implementation of ICDS by felicitating best performing ICDS functionaries and communities.
- Provide transport facilities where needed to enable supervision and monitoring of AWCs located in remote areas.

(d) Linkages with the community and PRIs

- Break the notion that ICDS support is only for mothers and children. Make communities aware that the support that is being provided benefits the entire family. Initiate actions to facilitate behavioural change at the level of the household and the community. Involve men, women and the community in the task of addressing malnutrition in all its aspects so that they own the programme.
- Provide nutrition and health counselling for the entire household and supportive measures for change. This will ensure equitable distribution of nutritional resources and allow women to partake in their share.
- Reduce women's care burden by increasing community awareness to create demand for ICDS services through use of folk performances, community meetings and house to house visits, booklets about government schemes to disseminate information about child development and government programmes/services for children.
- Formulate both the community-based protocol as well as the facility-based protocol for treating severe acute malnutrition. Take cognisance of guidelines for community and home-based treatment of severe and acute malnutrition formulated by a large group of experts and supported by the Indian Academy of Paediatrics.
- Provide mechanisms so that the *panchayat* reviews the functioning of ICDS and their task is not limited only to appointing the AWW or AWH.
- Initiate community based monitoring mechanisms through formation of Committees comprising elected *panchayat* members, village-level government service providers and citizens at the village level as well as Oversight Committees at the *panchayat* and block levels. Ensure the gender sensitivity of these Committees. Through these Committees enable convergence between government departments and PRIs in planning and service delivery through reviewing progress and identifying gaps in services.
- Support the formulation of village level micro planning with specific focus on women and child issues.

(e) Infrastructure

- Address the problem of space constraint faced by AWCs. Provide a permanent building or built facility for the *Anganwadi*. Where permanent structures cannot be built, provide adequate allocations for rent or where possible, locate the AWC in a school.
- Provide adequate infrastructure facilities required to carry out activities in AWC.

(f) Monitoring and Evaluation

- Conduct monthly review meetings based on data generated by the AWCs and health staff. Analyse and disseminate the monthly reports generated by AWCs to related district level officials to improve the quality of programme interventions in terms of addressing under-nutrition of women, adolescent girls and children.
- In view of the massive gaps between data reported from the field through the government system and data that is generated through independent evaluations, stress the criticality of reporting accurate sex disaggregated data for tracking progress on nutritional outcomes. Put systems in place for regular verification of the data reported from the field.
- Review the number and spread of AWCs that are to be supervised as close monitoring is critical to the success of the programme. Where AWCs are located in remote areas with poor connectivity, address safety concerns of Supervisors by making adequate arrangements for transport facilities.

(g) Accountability Mechanisms

- Provide grievance redressal mechanisms with clear stipulations regarding response time. Ensure the inclusion of women in overseeing the implementation of grievance redressal.

- Provide opportunities for making ICDS participatory, flexible, based on bottom-up planning and participation, with effective grievance redressal systems and community-based monitoring mechanisms. While including women in effectively monitoring the ICDS ensure that the onus of monitoring ICDS is not only on them.

(h) Budget

- Provide accountability mechanisms to ensure regular and timely fund flow and payments to ICDS functionaries.
- Provide resources for travel for supervision.
- Give ICDS priority allocation of adequate funds based on meeting unit costs as per norms. Address budgeting and fund flow issues that constrain the performance of this programme.
- Provide flexi-funds that are placed at the disposal of AWWs and Supervisors.

(i) Convergence

Recognise that malnutrition is a function of large number of variables, of which access to food is only one. Other important aspects that must be addressed for better outcomes are access to medical attention; access to preventive, promotive and curative health care; nutrition counselling; safe water and sanitation; feeding of colostrum; breast feeding and complementary feeding and education. Hence, it is crucial to enable convergence across ministries and departments such as PRIs, Health, Education, WCD and Water and Sanitation to track and achieve progress in reduction of malnutrition.

VI. Conclusion

The ICDS Scheme is one of the world's largest outreach programmes for early childhood care and development and has been functioning since 1975. A critical objective of this flagship programme is improving the nutritional and health status of children below 6 years and reducing malnutrition. Using standard indicators of nutritional status, NFHS - 3 provides evidence that is alarming – 33 per cent of ever-married women between 15 to 49 years of age are undernourished and more than half of the ever-married women in this age group are anaemic; almost 80 per cent of children between 6 and 35 months of age are anaemic; more than 43 per cent of children below three years of age are underweight; 38.4 per cent are stunted; and 19.1 per cent are wasted. Taking cognisance of the gravity of the nutritional situation facing the nation the Supreme Court has given a large number of directions to improve compliance with the obligations of the ICDS.

An Inter Ministerial Group (IMG) was constituted for restructuring and strengthening the ICDS, led by Dr. Syeda Hameed, Member, Planning Commission. After several discussions and consultations with stakeholders, the IMG submitted a Report to the Prime Minister's Office. Based on this, the ICDS restructuring submission of the Ministry of Women and Child Development was formulated and submitted for restructuring the ICDS Scheme through a series of programmatic, management and institutional reforms, changes in norms, including putting ICDS in Mission mode. Information regarding Strengthening and Restructuring the ICDS Scheme was conveyed to Chief Secretaries of all States/UTs and concerned officials in a document dated 22nd October 2012.

The restructured ICDS is being rolled out in 200 high burden districts in 2012-13, 200 districts including special category States and North East Region (NER) in 2013-14 and the remaining districts in 2014-15. Some of the important initiatives taken for strengthening and restructuring the ICDS Scheme are listed in Annex 1. These include repositioning the AWC as a "vibrant Early Childhood Development (ECD) centre", joyful learning, universal Mother and Child Protection Cards that use the new WHO child growth and development standards, revisions in cost norms for supplementary nutrition, new AWC buildings, revisions in budgets for rented accommodation, allocation of funds for infrastructure, flexi funds, extended timings for functioning of AWCs, Anganwadi cum Crèche/Day Care Centres on experimental basis, inclusion of children with special needs and efforts at convergence and involvement of PRIs and other agencies. While the restructured ICDS takes cognisance of many of the policy recommendations made in the literature as well in presentations and discussions at the February 2012 Workshop, some significant recommendations listed in Section V still need attention. A few of these are mentioned below.

Firstly, spatial mapping can be usefully used to ensure that priority is given to locating AWCs in the poorest areas of a village or slum and to ensure that the number of AWCs in a habitation is as per population norms. Second, mechanisms are needed for ensuring that women from the poorest households in the village are included while taking decisions regarding functioning of the AWCs, timings, etc. Third, ICDS functionaries are critical to successful delivery of the programme. As many as 32 per cent posts of CDPO/ ACDPO, 34 per cent Supervisors, 8 per cent AWW and AWH are vacant as per the strengthening and restructuring ICDS document, which mentions the need for a dedicated cadre and team for ICDS functionaries and tenure stability and disengagement of ICDS functionaries from non - ICDS related activities. While the document states that a comprehensive Human Resource Policy would be developed to strengthen the human resources under ICDS, no concrete commitments are made. Women appointed as AWWs and AWHs are denied job security and minimum wages through use of terms such as honorarium and voluntary work. This makes them vulnerable to exploitation and manipulation as well as leads to low levels of accountability. In the interest of better delivery of the ICDS as well as gender justice, these long-standing unmet demands need urgent action.

Fourth, systems must be put in place for regular verification of the data reported from the field due to the massive gaps between data generated through official systems and those collected by independent surveys. Fifth, while a cluster approach is suggested in the document, the number of AWCs to be covered by a Supervisor ranges from 17 to 25. Since close monitoring is critical to the success of the programme and is a major weakness in the present system, the number of AWCs to be monitored by a Supervisor needs to be reduced significantly so that Supervisors are able to support AWWs and AWHs in effectively implementing the programme. Where AWCs are located in remote areas with poor connectivity, safety concerns of Supervisors must be addressed and transport arrangements made.

As already noted, under-nutrition is caused by a large number of factors and requires convergence across several Government Ministries and Departments, elected representatives and communities. The ICDS Scheme is one of the world's largest outreach programmes and has tremendous significance for the nutritional status of women, children and adolescent girls as well as early development and learning outcomes of children. While successful achievement of the outcomes sought by the restructured ICDS depends on convergence of many factors, the motivation and commitment of CDPOs, Supervisors, AWWs and AWHs as well as regularity in flow of funds to AWCs are among the most critical requirements for its successful implementation.

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Annexure 1

Strengthening and Restructuring ICDS*

Recognising the programmatic, institutional and management gaps that needed redressal in the context of ICDS, an Inter-Ministerial Group (IMG) led by Member, Planning Commission was constituted for restructuring and strengthening it. After discussions and consultations with different stakeholders, the IMG submitted a Broad Framework of Implementation for restructuring the ICDS Scheme through a series of programmatic, management and institutional reforms, changes in norms, including putting ICDS in Mission mode. The restructured and strengthened ICDS scheme will be implemented with an overall budget allocation of Rs. 1,23,580 crore as Government of India share in the 12th Five Year Plan. Information in this regard was conveyed to Chief Secretaries of all States/UTs and concerned officials in a communication sent by MWCD dated 22nd October 2012.

The goal of the ICDS Mission is to attain three main outcomes, namely: (i) prevent and reduce young child under-nutrition (% underweight children 0-3 years) by 10 percentage points; (ii) enhance early development and learning outcomes in all children 0-6 years of age; and (iii) improve care and nutrition of girls and women and reduce anaemia prevalence in young children, girls and women by one-fifth.

Some of the main highlights of the strengthened programme are:

- Repositioning of the AWC as a "vibrant Early Childhood Care and Development centre" to become the first village outpost for health, nutrition and early learning with a minimum of six hours of working, focus on under-3s, care and nutrition counselling, particularly for mothers of under-3s, identification and management of severe and moderate underweight through community based interventions - Sneha Shivirs, decentralized planning and management, flexible architecture - flexibility to States in implementation for innovations, strengthening governance - including. PRIs, partnerships with civil society, introducing Annual programme Implementation Plan and MoUs with States/UTs, etc.
- ICDS will be implemented in Mission Mode with a National Mission Directorate and National Mission Resource Centre to become operational from the first year of 12th Five Year Plan.
- The programme will be rolled out in 200 high burden districts in 2012-13, 200 districts including special category States and North East Region in 2013-14 and the remaining districts in 2014-15.
- Revised cost norms for Supplementary Nutrition Programme (cost sharing ratio of 50:50 between the Centre and the State other than NER where it will be 90:10).
- Revised cost norms of other existing components such as medicine kits, PSE kits, monitoring, rent for AWCs and for the office of CDPOs, POL, IEC, purchase of vehicles, uniforms & badges, procurement of equipment/furniture (non-recurring), administrative expenses etc.
- Provision for additional human resource/ technical manpower support at different levels.
- Centre - State cost sharing pattern of all new components including staff salary for the new staff to be sanctioned would be 75:25 in the States other than NER, where it will be at 90:10.
- During the 12th Plan period, buildings would be constructed for 2 lakh AWCs @ Rs. 4.5 lakh per unit.
- Provisioning of maintenance cost @ Rs. 2000 per AWC per annum to all AWCs housed in a government building.
- A Nutrition Counsellor cum Additional Worker (per AWC) would be provided in 200 high burden districts.
- Provision has been kept for a link worker in other districts with incentives linked to outcomes.
- 5 per cent of the existing AWCs would be converted into AWC-cum-Crèche.
- With a view to repositioning the AWC as a "vibrant ECD centre" the components under the re-designed and strengthened package include:

a. Early Childhood Care Education & Development (ECCED) (ECCE/Pre school non-formal education and supplementary nutrition);
b. Care & Nutrition Counselling (Infant and Young Child Feeding Promotion & Counselling, maternal care and counselling, care, nutrition, health & hygiene education, community based care and management of underweight children);
c. health services (immunization and micronutrient supplementation, health check-up and referral services); and
d. Community Mobilization, Awareness, Advocacy & IEC (IEC, campaigns and drives, etc).

- Roll out of Mother and Child Protection Cards prepared by using new WHO child growth and development standards would be universalised. Funds for this purpose would be provided within the overall budgetary allocations.
- Management and operation of up to 10 per cent projects to PRIs and separately to NGOs/voluntary organizations.
- Management of moderately and severely undernourished children (Sneha Shivirs), IEC/ Advocacy, promoting 1YCF practices, strengthening monitoring and evaluation and MIS & ICT, grading and accreditation of AWCs and reward scheme.
- NRHM would provide the doctors for health check up of beneficiaries at the AWC, preferably on monthly basis but at least once in a quarter.
- Strategies for improving human resource management will be put in place, such as, an appointment and selection policy, prescribing minimum qualifications, a separate cadre for ICDS in States/UTs, permitting States to fill up vacant posts on contract basis, opening a cluster office at a strategically located AWC for managing a cluster of 17-25 AWCs by placing one Supervisor at the Cluster office, rationalizing appointment of AWWs as Supervisors, etc.
- Training and capacity building would be strengthened.
- A National Mission Steering Group (NMSG) under the Chairpersonship of Minister- in-charge of MWCD will be constituted as the apex body for providing direction, policy and guidance for implementation of ICDS. An Empowered Programme Committee (EPC) under the Chairmanship of Secretary, MWCD would be formed at the national level for effective planning, implementation, monitoring and supervision of ICDS Mission. Similar structures would be created at the State level under the Chairpersonship of Chief Minister and Chief Secretary respectively.
- ICDS Mission will report to Prime Minister's Council at national level and the State Mission will report to the Chief Minister of the State.
- A National ICDS Mission Directorate and State ICDS Mission Directorates will be established and District Mission Unit will be operationalized. District Cells will be set up in those districts where these are non-existent.
- A separate ICDS Budget head for National ICDS Mission will be opened to allow flexibility and integration within the child development and nutrition sectors and for convergent action with wider determinants of maternal and child under-nutrition.
- Decentralized planning and management will be ensured through Annual Programme of Implementation Plan (APIP) with flexibility to States for innovations.
- Fund transfer of the ICDS Mission will be channelled through the Consolidated Fund of the State. In the event, the State fails to transfer the funds within 15 days; it will be liable to pay interest on the amount on the pattern of releases for the Finance Commission funds.

**Source:* Strengthening and Restructuring of Integrated Child Development Services (ICDS) Scheme, Communication No. 1-8/2012-CD-1 dated 22.10.2012, Ministry of Women and Child Development, Government of India.

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