

# **Child Development in India & the ICDS**

**By  
Anuska Kalita  
Shilpa Deshpande<sup>1</sup>**

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<sup>1</sup> Anuska Kalita ([anuska.kalita@icchn.org](mailto:anuska.kalita@icchn.org)) and Shilpa Deshpande ([shilpa.deshpande@icchn.org](mailto:shilpa.deshpande@icchn.org)) are with the ICICI Centre for Child Health and Nutrition. The views expressed in this note are entirely those of the authors and do not in any way reflect the views of the institutions with which they are associated.

Children herald the future of every society and nation. They are the harbingers of societal development and evolution. Child welfare reflects how well a society or country protects, cares for and nurtures its most vulnerable members. It is therefore not surprising that globally, indicators of children's well being are used to understand the development status of different countries, such as in the Human Development Index or the Millennium Development Goals.

India, as a country unfortunately does not fare very well in this framework. Indian children, in their most formative and developmentally sensitive years are some of the most undernourished, unhealthy and neglected children in the world. Nearly a third of them are born undernourished and by the age of three almost 46 percent are underweight for their age while the physical growth (height for age) of 38 percent has been irreversibly affected. More than half of our two year olds are not fully immunized against debilitating illnesses, nearly 80 percent of our under threes are anaemic and only some 20 percent receive any Vitamin A supplementation<sup>2</sup>.

These grim statistics emerge from a macro-economic context of rising growth rates, an increasing number of Indian millionaires and billionaires and widespread urban prosperity. They are indicative of the uneven nature of Indian development and the inability of economic prosperity to automatically translate into the wellbeing of all. And yet, not all the children who are undernourished belong to poor families. As per the second National Family Health Survey (1998-99), while 57 percent of children belonging to the low socioeconomic index were underweight, surprisingly nearly 47 percent of children from the middle and 27 percent from the high socioeconomic index were also underweight. In fact, India stands out as a country with much higher levels of child undernutrition relative to its level of poverty, a characteristic termed the ' South Asian Enigma'. What then are the reasons?

According to the authors of 'the South Asian Enigma', the poor status of Indian women is an important variable influencing child development. This is hardly surprising. Most Indian women are undernourished and overworked with limited role in decision making, poor access to information, services and support for child rearing. This understandably impacts their health, the development of their babies in the womb and their capacity to care for children.

A third of Indian women in the reproductive age group are chronically undernourished and more than half have some form of anaemia. They give birth to an average of 5 children in their lifetimes often with intervals of less than 24 months between two pregnancies. Only a half use any method of contraception, less than 50 percent receive three antenatal visits by health service personnel during pregnancy and only a fourth consumed the required amount of iron and folic acid supplementation. Forty three percent pregnant women report excessive fatigue during pregnancy and a significant number barely gain 5 kg of weight. Most women have fairly heavy workloads right upto delivery which in more than half the cases is conducted at home and without trained birth attendants. Maternal mortality in India is therefore high and birth outcomes poor –

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<sup>2</sup>National Family Health Survey 3 (2005-06)

one in every three children is born premature or undernourished and every seventeenth child dies before completing one year of life.

The above scenario is further complicated by the prevalence of inappropriate infant feeding practices relating to colostrum feeding, early initiation of breastfeeding and exclusive breastfeeding during the first six months. Influenced often by traditional notions of infant and post natal care, only 23.4 percent of babies are breastfed within the first hour and more than 50 percent are not exclusively breastfed in the first five months. Complementary feeding is another problem area with nearly 45 percent of 6-9 month olds not receiving any solid or semi-solid food along with breast milk. However, these statistics and the resulting poor development of our babies and infants cannot simply and entirely be attributed to the lack of appropriate knowledge amongst families and communities. Certainly, accurate knowledge would help and it has done so wherever approached in a contextually sensitive and dialogue oriented way. However, it is also important to take into account the multiple roles played by women, their subsequent workload and its impact on child care for which again they are primarily responsible.

In any society, both men and women are involved in processes of production as well as reproduction but their contributions in these spheres are acknowledged and/or emphasised in varying degrees. Indian society, which is deeply patriarchal, tends to acknowledge women's contribution only in the reproductive realm even choosing to frame women and their entire lives through this lens. Men, on the other hand, seem to be identified purely with the productive function. This implies that women's work both in the private as well as the public spheres is largely overlooked and also that they receive limited or no support from the household or society for the rearing of young children.

As per the 2001 census, nearly 30% of India's workforce comprises women. Ninety percent of these 120 million women work in the unorganised sector without specific access to maternity benefits or any child care facilities. Most of this work is unskilled, physically arduous and time consuming located largely in the agricultural sector and involving activities such as weeding, transplanting and seed selection. Such female labour contributes to 55-66% of farm production. Women are also involved in the care of livestock especially in gathering and preparing fodder in addition to the sole responsibility for all household work including fetching water, fuel (often over long distances), cleaning and cooking. In these circumstances most women and especially those from poorer households struggle to provide adequate child care.

This gender differential is not as apparent in early child development, girls are only slightly more likely than boys to be wasted, underweight and stunted, but as they grow older it begins to impact their access to nutrition, education and health care fueling an intergenerational cycle of undernutrition such that they grow into shorter, smaller women giving birth to small, undernourished babies.

All of the above does not imply that poverty is not an important determinant of poor child nutritional status in India. Contexts of poverty exacerbate the difficulties, constraining the resources available for child care including the quality and quantity of food as well as access to timely and effective health services. There are calorie deficits

amongst Indian adults. These are the cases in which poor families often go hungry – the most stark and direct impact of poverty. In a significant number of cases there are enough calories in the household to meet the requirements of a small child. However, a majority of this energy is from cereals which children due to their small stomach capacity are not able to eat in the quantities required for nourishment. In addition, children need proteins, vitamins and fats for optimal growth and development which poor parents are not able to either access or afford. Most importantly, little children need to be fed several small meals a day, they need to be cleaned, cared for and loved. Their illnesses and infections need to be identified in a timely fashion and treated and they need immunisation. Poverty limits the time parents can spend looking after their children with consequent detrimental impacts.

### **The case for intervention**

The poor status of India's young children demands urgent attention. There is a need to ensure that their mothers are born healthy, receive the necessary health and nutrition in their growing years, are able to plan their pregnancies and families, get nutrition, rest and care during pregnancy, have safe deliveries and joyful birth outcomes. We need to ensure that children are born in safe environments, are fed, immunised and cared for such that they grow to attain their developmental potential. These outcomes call for a comprehensive set of interventions working with communities as well as service providers. An indicative list is as follows:

<b>Women (15-45 years), especially pregnant and lactating women</b>	<b>Infants (6-12 months) and children (1-3 years)</b>	<b>Children (3-6 years)</b>	<b>Adolescent girls (11-18 years)</b>
Nutrition	Nutrition	Nutrition	Nutrition
Health services including immunisation and referral	Health services including immunisation and referral	Health services including immunisation and referral	Health services including referral
Fetal growth promotion	Growth promotion	Growth promotion	Growth promotion
Vitamin A tablets	Vitamin A drops	Vitamin A drops	Vitamin A tablets
Iron & Folic supplement	Iron & Folic supplement	Iron & Folic supplement	Iron & Folic supplement
Antenatal, delivery & postnatal care	Crèche facilities	Non-formal pre-school education	Nutrition & health education
Nutrition & health education		Crèche facilities	Life Skills Education
Family Planning & other Reproductive Health care services			

But how are these interventions to be implemented? Should the focus be on private incomes or public services?

## **Role of the State in Child Care & Development**

The Indian state has through numerous policy documents affirmed its commitment to child development. However these affirmations have till date not translated into the scale of investments, institutions and systems required to make a significant difference to the status of the young child in India. The Integrated Child Development Services (ICDS) programme launched in 1975 was expected to provide pre-school education, growth monitoring, supplementary nutrition and health services to 0-6 year old children. For pregnant and nursing mothers, supplementary nutrition, health services and health and nutrition education was to be provided. The programme was supposed to function from a centre located in the community through a local woman trained to provide these services and most importantly to mobilise communities for early child development.

However, even after 30 years, the programme has not been effectively universalised with some of the most vulnerable communities deprived of these services. Its one volunteer-worker is poorly trained and indifferently supported bearing the entire responsibility and blame for child development. Certain service components especially pre-school education and nutrition and health education are nearly entirely absent and the growth monitoring provided is of poor quality with very few mothers even aware of the weights of their children. The snack given is quite inadequate both in terms of quantity and quality and cooked fairly infrequently. Very few mothers and adolescent girls receive any services from the ICDS and its convergence with other programmes, especially for the provision of health services is largely lacking. For the ICDS programme to deliver its promise, it needs to be approached as a system rather than a programme. It needs both greater financial investments as well as investments in its people and institutions. In the context of the many reasons and factors leading to poor child development in India, its design needs to be critically re-examined to ensure that the services it provides meet the real requirements for child care and development. Reforming and rehauling the ICDS to improve child development, most importantly requires renewed political will and commitment.

At this stage, it may be pertinent to reexamine what should be the role of the state in child care and development in terms of the importance of early child development, the nature and responsibilities of a democratic state, and how child care is provided in other countries.

A significant body of literature has established that the early years of a person's life form the building blocks for future growth and development. They play a formative role in influencing physical, cognitive and social development. Investing in these years is therefore important for ensuring a child's right to life and development. It benefits society by creating greater ability and capacity amongst its members to contribute to the greater good. Economists have estimated that the returns to investments in early childhood care and education programmes are even greater than other education investments.

Most importantly, interventions in the early years can help to reduce the effects of existing social and economic inequality on the vulnerable and growing young child. They

can complement the care being provided to children by their families addressing whatever gaps may exist because of poverty. In addition, they can minimise the effects of intra household inequality due to gender giving girls an equal opportunity to grow and develop.

Given that early childhood care and education is needed by each child to prosper and build a good life, especially those children whose families do not have the resources or those girls whose families and communities do not believe that they deserve such care , it has to be provided by the state. Markets which provide services in demand, those that people are willing to pay for can only perpetuate the existing inequality along the lines of religion, caste, class and gender. They cannot be expected to alter the values which underlie discrimination, determining the opportunities that individuals have to participate in economic progress. They cannot herald social change. But the state by definition espouses a certain vision of society and is mandated to work towards the achievement of this vision. Indian society has committed to ensure the 'equality of opportunity' for all and equal opportunity for early child care and development would be the beginning of fulfilling this commitment. One of the critical ways of providing effective and relevant early child care and development services would be by reforming the ICDS.

### **Nature of ICDS reform: universalisation of all services or better targeting?**

In the context of ICDS reforms, two schools of thought would need to be critically examined to determine the direction of reform. One school argues that poorest children as well as those that are already undernourished are in the greatest need of services. It therefore suggests that the programme should be targeted to the poorest communities or at least the supplementary nutrition component should be targeted to only the already undernourished children. The main argument in favour of targeting is that it allocates scarce resources to the most needy and hence is more efficient increasing the welfare effects for the programme as a whole.

But targeting the ICDS services or any particular service on the basis of poverty or undernutrition has many costs. To begin with targeting on the basis of undernutrition undermines the integrated character of the ICDS. It organises the programme around undernutrition rather than child development and it emphasises a management approach to undernutrition rather than a more desirable preventive approach. Undernutrition should be viewed as a temporary aberration, a problem that needs to be eliminated whereas promoting child development will always be an ongoing requirement. In fact promoting child development will in the long term prevent undernutrition.

Targeting on the basis of poverty, on the other hand has many administrative costs. Identifying the appropriate beneficiary and ensuring that the service is only accessed by them is in the Indian context unlikely to be more efficient than the provision of services to all. It creates many more opportunities for rent seeking and is equally likely to be cornered by the already powerful and resourceful in the community. It may lead to stigma which could influence the self perception of the children accessing these services

creating a sense of disadvantage among those that the programme specifically set out to advantage.

Given the above arguments, this paper takes the view that ensuring appropriate early child development requires the universalisation of the ICDS and all its services. It goes further to suggest some recommendations towards this end.

### **Reforming the ICDS: Some recommendations**

**Universal Coverage:** Currently in India, there are 8.5 lakh Anganwadi Centres (AWCs). Despite its universalisation under the ninth five-year plan the coverage of the ICDS has considerable gaps. According to the earlier norms of 1 AWC for 1000 population, the total number of AWCs and a population of around 1.2 billion in India indicates a shortfall of more than 5.5 lakh AWCs. This is further aggravated by the fact that in heterogeneous communities instances of differential treatment of children based on their caste and regional identities are noted. Compounded by a lack of outreach by the projects, almost one third of the cases of the target population are often not even aware of the services provided at the AWC.<sup>3</sup>

**How many AWCs are needed for universalisation?** To achieve the goal of universalisation of the ICDS, it is estimated that the need is for 14 lakh AWCs for the 8 crore 0-6 year old children in the country (implying approximately 60 children per AWC), 1 crore pregnant and lactating women, and around 5 crore adolescent girls.<sup>4</sup> This estimate takes into account the convenient access by each household to an AWC. Besides this, in congruence with the recent Supreme Court orders as a safeguard against possible failure to apply the "improved norms", rural communities and slum populations should be entitled to an "Anganwadi on demand" in cases where a settlement has at least 50 children under six but no Anganwadi.

**How can equity concerns be addressed?** In the process of extending the coverage of ICDS, priority should be given to SC/ST hamlets and urban slums. For rural areas, this would involve conducting a survey of SC/ST-dominated habitations and ensuring that all new AWCs are placed in these habitations until such time as universalisation has been achieved for this group. Special provisions should be made for the inclusion of marginalised children in the ICDS, including disabled children, street children, and children of migrant families.

### **Service Provision**

**What are the calorie requirements for desired development of children under six?** Currently the supplement provided under the ICDS is 300 kcal. The recommended dietary allowances for children aged 1-3 years is 1240 kcals and that for children aged 3-6 years is 1690 kcals. However, recent data by the National Nutrition Monitoring Bureau (NNMB) show that the average intake varies between 687 kcals and 1020 kcals for

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<sup>3</sup> Dutta, V.,(2001)

<sup>4</sup>Gupta, A., et al. 2007. *Strategies for Children Under Six: A Framework for the 11<sup>th</sup> Plan*

children in these age groups, suggesting a deficit of 500 – 700 kcals.<sup>5</sup> Thus, the supplement of 300 kcals through the ICDS – consisting mainly of cereals, has often failed to impact nutritional indicators of underweight and wasting in the country. Besides calorie deficiencies, the country records extremely high degree of micronutrient malnutrition for children under six including anaemia at 79.2 percent, vitamin A at 57 percent.<sup>6</sup>

The design and implementation problems with the national prophylaxis programmes for these micronutrients have not been very successful for children. The need therefore, is to increase the calorific value of the supplement to atleast 500 kcals to address this deficit. National programmes for the prevention of Iron and Vitamin A deficiency should be implemented through ICDS. Appropriate doses and formulations should be specified by the Auxiliary Nurse Midwife (ANM). Iodised salt should also be used in all Anganwadis. A provision of at least Rs 3 per child per day (at 2006-7 prices) and 80 grams of grain should be made for SNP in the 3-6 age group. The supplementary nutrition component of the ICDS can be strengthened by setting up a baseline on nutritional status of the community that is owned by each level of the department including the AWW and the helper. This will not only show the impact of the interventions, but also provide formative information for planning and contextualising the interventions.

**What foods can best provide this calorie requirement?** While the quantity of the supplement at 300 kcal is itself inadequate as per this deficit, the problems with quality of the food and vested interests of suppliers and contractors are also present. Although the Supreme Court has ruled against the supply of food through centralised contractors, the trend still continues in most states. The ready-to-eat food (primarily consisting of biscuits, bread, peanuts and roasted gram) supplied by these sources are not nutritionally appropriate for young children. The move towards provision of cooked food in AWCs through local non-profit organisations and women's self help groups need to be implemented effectively. Use of locally available food items, vegetables, oils, energy dense and micronutrient rich foods should be integrated. A significant criticism of the supplementary nutrition component is the insufficient targeting of children in the 0-3 year age group. There is now ample evidence on the importance of this period of growth in the onset of malnutrition. However the food provided at the AWC is not conducive for consumption by younger children. Moreover as children in this age group cannot come to the centre, in most cases the food is given to the mothers. This is convenient for the AWWs also as they are busy with the pre-schoolers and often do not have physical space in the centre to accommodate so many children<sup>7</sup>. The AWW thus almost steps in after malnutrition has set in and is classified as moderate or severe. Although weaning food packets consisting of ground wheat, chana dal, peanuts, oil and sugar are available, they are not distributed effectively in the form of take home ration, and its preparation for feeding very young children is not clearly explained to the mothers. Effective and wider distribution of weaning foods, with clear instruction for its preparation to caregivers of children is recommended. Micro-nutrient deficiencies in India exist because of massive

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<sup>5</sup>The data has been taken from the National Nutrition Monitoring Bureau, 2006-07.

<sup>6</sup>National Institute of Nutrition (NIN), 2005 - 06

<sup>7</sup> Ghosh, S., 'Reaching the under threes in ICDS', <[www.nutritionfoundationofindia.org](http://www.nutritionfoundationofindia.org)>

macro-nutrient deficiencies, and if adequate food is supplied, most micronutrient deficiencies will disappear. The implications of this for the ICDS programme clearly are that we must focus on a meal-based strategy rather than a pill-based strategy for micronutrients. Ensuring supply of freshly cooked food to AWCs, and use of seasonally and locally available ingredients is important for consumption by children.

**How can the intergenerational cycle of undernutrition be broken?** It is well established that the health and nutritional status of the child is determined to a large extent by the health of the mother. A undernourished mother often gives birth to a low birth weight baby, who grows up to be an undernourished adolescent, which in the case of girls perpetuates the intergenerational cycle of undernutrition. To address this, it is important that the ICDS include supplementary nutrition for pregnant and lactating women and adolescent girls. The utilisation of the supplementary nutrition by pregnant and lactating women is not very high<sup>8</sup>, and there are several issues with the acceptability of the supplement. There is often a reluctance to accept and consume food in full view of other people. In several AWCs the food is therefore not consumed at the centre but taken home where it is most likely to be distributed amongst other members.<sup>9</sup> This component of service provision needs to be strengthened to meet its objectives and needs to be complemented with nutritional counselling for pregnant and lactating women.

**How can demand and awareness about child health and nutrition be generated?** Nutritional status at any given point is a function of the quantity and quality of intake and frequency, duration and severity of illness. Thus interventions in both health and nutrition are required for impact. Moreover, to ensure sustained impact these interventions need to go beyond supplementary food and curative care to improved knowledge, changed attitudes and the adoption of appropriate feeding and growth monitoring practices at the household and community level. The most neglected component of the ICDS is nutrition and health education (NHE), which is to be provided by the AWW through home visits, special campaigns and the use of mass media. The indicators for tracking this service are activity rather than outcome oriented, so the number of sessions conducted are tracked but not the process of behaviour change or the regularity of follow up. The NIPCCD<sup>10</sup> evaluation revealed that most AWWs do not have sufficient skills to conduct effective behaviour change communication. While some training has been included since then on this aspect and the number of beneficiaries accessing this service has risen<sup>11</sup>, its impact is as yet not clear. The nutrition and health education services provided through the programme are likely to have greater impact if the AWWs are trained in innovative behaviour change communication (BCC) methodologies. For this, more attention must be given to developing a strong capacity to contextualise ICDS services within an analysis of the community's needs, resources, perceptions, and local caring and early learning practices on a continuous basis. As a part of the behaviour change initiative, the AWW is required to organise mothers groups to generate discussion and thus initiate the process of behaviour change. In the absence

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<sup>8</sup> The percentage of expectant women utilizing the SNP has increased from 47.2% in the NIPCCD evaluation in 1992 to 62% in the 2001 NCAER study.

<sup>9</sup> This was gathered through a field visit to an Anganwadi Training Centre at Pune

<sup>10</sup> NIPCCD., (1992)

<sup>11</sup> NCAER., (2000)

of contextual and timely Nutrition and Health Education (NHE) with mothers and their families, desired behaviours such as timely initiation of exclusive breastfeeding and complementary feeding for 0-3 year olds are unlikely to be adopted accelerating the onset of malnutrition. Amongst the 3-6 year olds who do receive some supplementary nutrition, the feeding is not accompanied by suitable growth monitoring. Moreover both these activities are limited to the centre and lack parental involvement in the growth tracking and feeding. The intervention is thus not supported by the household leading to limited impact.

**What are the health services required for child development?** Due to the unavailability and inaccessibility of health services, there is inadequate management of leading causes of malnutrition in children such as diarrhoea, acute respiratory illness, malaria and vaccine preventable diseases. The utilisation of health services by both women and children from the AWC is low. Services such as distribution of IFA tablets, and provision of health check ups, tetanus toxoid injections and referral services<sup>12</sup> are usually non-existent. To address these issues, every AWC should have a medicine kit with basic drugs (including ORS and IFA tablets), to be distributed by the Anganwadi worker with appropriate training as well as guidance from the ANM (unless adequate provision has been made for the ASHA to provide this service). The procurement of medical kits should be decentralised (detailed guidelines should be prepared for this purpose).

**Early Childhood Education:** It is well established that pre-school education is very significant in helping children to prepare for formal schooling. Preschool education assists children both to enter school and to remain in the system. A child cannot fully realise her right to education unless she has access to quality early childhood care and education. The interventions required for children in the age-group of 3 to 6 years (until joining school) include a centre-based play-school facility with a teacher trained in conducting preschool activities. The pre-school component of the ICDS programme does not function as envisaged. There is no formal curriculum and scarce availability of play materials and AWWs inadequately trained in pre-school hinder the delivery of effective education. The problem is further aggravated by the presence of a number of younger children in the AWC due to which the pre-schoolers do not receive adequate attention. In some cases the AWCs function as a downward extension of formal education, with Class 1 skills being 'taught' in pre-school. To strengthen early childhood education within the ICDS, each AWC should have basic preschool education facilities including adequate space for indoor and outdoor activities (with clean and hygienic surroundings), appropriate charts and toys. Preschool education should receive higher priority in AWW training programmes, and also in the support activities of ICDS supervisors and CDPOs.

**Crèche Facilities:** In the context of poverty and time constraints of women mostly engaged as agricultural labourers in rural areas, and in the unorganised sector in urban areas, optimal stimulation and care for comprehensive child development is often absent. Due to this, it is recommended that AWCs also provide Crèche facilities. Ensuring exclusive breastfeeding requires that mothers stay close to their infants during this period. However, many breastfeeding women, especially poor women, often need to

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<sup>12</sup> Ibid.

work outside the home, where they cannot take their infants with them. Crèches at/near workplaces to support frequent breastfeeding. Crèches must have trained workers, to ensure that children are provided with adequate care and development opportunities, especially if there are no adult carers at home. Crèches are also an important intervention in addressing malnutrition with the provision of cooked nutritious meals for poor children.

### **The need for structural reforms: How do we provide these desired quality services through the ICDS?**

All ICDS services are provided in an Anganwadi Centre (AWC) by an Anganwadi Worker (AWW), who is assisted by a Helper (AWH). Ideally a woman from the local community, the AWW is paid a monthly honorarium of Rs. 1000. An approximate number of 25 AWCs are supervised by one Supervisor or Parvekshak. Each project, with around 100 to 150 AWCs are supervised by one Community Development Programme Officer (CDPO). Supervisors and CDPOs are expected to play a supportive supervisory role and oversee the documentation and strategic planning of service delivery through the AW. While the Supervisor provides direction and support to the activities run out of around 20-25 AWCs, the CDPO is the project head and is responsible for the overall management of service delivery and arranges for the procurement and supply of equipment from the state government to the AW. The entire structure comes under the Ministry of Women and Child Development, Government of India. ICDS functionaries are a key to the delivery of services. However, they face several constraints that are demotivating and ultimately impact efficiency.

AWWs are part time workers with multiple responsibilities. Heavy workload has been identified as an important reason for the inadequate focus of the AWW on behaviour change among her target group. For the range of work expected from her the remuneration provided is not adequate. The AWW also does not receive sufficient supportive supervision from the CDPO and the Supervisor. The CDPOs are mostly involved exclusively in ministerial and administrative activities like record checking and the stock verification. An increasing amount of political interference acts as a disincentive and a deterrent in beginning new initiatives for several CDPOs. The inadequate training of the AWWs also acts as an impeding factor and hampers their communication with the CDPOs. Moreover, the system of a joint cadre of CDPO in the Department of Social Welfare mostly results in CDPOs being involved in work of other departmental schemes, unrelated to the ICDS. Also, intra-departmental transfers of CDPOs after a resources spent in a long induction training are very common. The specific recommendations for workforce rationalisation are mentioned below:

**How many workers are needed at the AWC?** Each AWC-cum-creche should have at least two “Anganwadi workers” (AWWs), and an “Anganwadi helper” (AWH). The primary responsibility of the one Anganwadi worker should be to take care of children under three and pregnant or nursing mothers, in collaboration with the local Accredited Social Health Activist (ASHA) if any. The responsibility of the other would be to conduct pre-school for children in the 3-6 years age group (including providing them with the mid-day meal).

**What are the related human resource policy reforms?** Urgent action is needed to address the shortage of ICDS staff at all levels. Programme management structures should also be strengthened by inducting subject-matter specialists (e.g. for pre-school education, health and nutrition) at the District, State and Central levels, especially women. Introduction of a separate dedicated cadre of personnel for ICDS from the level of the CDPO onwards. This is crucial to bring about a reduction in the workload of the functionaries by limiting their area to only the ICDS rather than other schemes of the department. This will also prevent the spending of valuable resources in training potential functionaries, who are then intra departmentally transferred to another scheme. Given the large shortfall of human resources for existing posts, timely recruitment and filling of vacancies for posts of supervisors and CDPOs are recommended. Addressing staff motivation is important to ensure effective service delivery. Regarding this, one of the most significant recommendation is supportive supervision at every level of the structure. A change in the current paradigm from strict monitoring of quantitative indicators to supportive supervision for problem solving by focusing on quality of processes is required. Time-and-motion studies for workload rationalisation of personnel at all levels to reduce overburdening and increase efficiency and effectiveness, as well as considering changes in incentives and honorarium structures can be undertaken.

**How should the workers be selected?** The recruitment and selection of workers in the ICDS at all levels are currently centralised and conducted by the WCD Department. Experience of the last 30 years have shown the major problems with this as political appointments, nepotism, corruption, discrimination and exclusion. In order to counter some of these issues, the following table suggests some changes in the selection procedure of ICDS functionaries:

<b>Functionary</b>	<b>Current procedure</b>	<b>Proposed role of the WCD</b>	<b>Proposed role of the Panchayat</b>
AWW	Done by WCD Department at the State level	Set educational norms for the position and process to be followed for selection.	Selected by village Panchayat and vetted by the Gram Sabha. CDPO to ensure that minimum qualifications are being met before vetting/ consent by Gramsabha.
Supervisors	Done by WCD Department at the State level	Set educational norms for the position and process to be followed for selection. Empanel existing AWW for promotion to CDPOs.	Supervisor to be selected by a Committee which has CDPO, Project Director and ZP representatives.
DPOs	Done by WCD Department at the State level or the State PSC.	Set minimum educational qualifications (Masters in Social Work/ Child Development/) Exam at state level through	

Functionary	Current procedure	Proposed role of the WCD	Proposed role of the Panchayat
		the PSC or appropriate state level bodies for ICDS. A dedicated cadre of CDPOs should be developed for every State.	

**The need for training and capacity building: How do we build human resource capacity within the ICDS to achieve desired quality?** For the ICDS to achieve its programmatic objectives, it is crucial to have effective structures in place to orient and train the various functionaries, especially the community-based AWWs. NIPCCD has been assigned primary responsibility for the overall planning and monitoring of training of ICDS staff. The training is designed as a combination of pre-service and in-service programmes and includes components on planning, implementation and monitoring of service provision. The CDPOs attend a month long induction training course at NIPCCD located in Delhi, while Supervisors are trained in Middle Level Training Centres (MLTCs). All AWWs are expected to attend a 6 day long induction training course, a 26 day in-service training, and refresher training of 5 days after 2 years of service at Anganwadi Training Centres (AWTC).

The study conducted by NCAER (2001) indicates that a majority of ICDS functionaries have received some kind of training. However, for more than 75 per cent of the trained functionaries, this statistic represents pre-service training. According to this study, the in-service component of training is neglected. The report points out that the lack of sound in-service training is reflected in the poor quality of delivery of services such as growth monitoring and behaviour change communication. Some of the specific problems identified with training by the literature on ICDS are – highly process and input oriented, centralised curriculum and not context specific, improper balance between training on various components (health, nutrition and pre-school), low engagement with the field, extremely large batch sizes, lack of emphasis on continuous training, training curriculum not informed by research findings and innovative experiences. Besides this, while the lack of MLTCs presents a constraint for training of Supervisors, most CDPOs cannot be relieved for training due to under-staffing and over-burdening in the department. On the other hand, the AWTCs are underutilised, as they organise only a few training sessions throughout the year, causing a substantial drain on resources.

**What are the changes needed in training of ICDS workers?** The training inputs within the ICDS require significant strengthening, both in terms of curriculum content and design, as well as resource availability and capacity building of training institutions. Overall review of training curriculum and methodology, and assessing effectiveness of training by studying the impact on knowledge and ability in the personnel to translate knowledge to practice through objective evaluations can be undertaken by external agencies. More exposure to field level and practice oriented training is important for AWWs. Training for Supervisors and CDPOs can include content for sensitisation to field realities in order to facilitate supportive supervision of AWWs. Besides training on technical knowledge

related to health and nutrition, training can be undertaken on interpersonal skills, effective human resource management is essential.

Reinforcement of knowledge can be done by organising frequent in-service trainings rather one long induction training programme. Newer topics and innovative methodologies can be introduced to in AWW training. This can be informed by experiences in various parts of the country in training community health workers. Joint trainings with ASHAs, ANMs and medical officers should be conducted to facilitate smooth coordination of ICDS with health services as well as supportive supervision.

Optimal utilisation of training infrastructure, such as AWTCs, throughout the year is also a necessity. Related to this is the balanced distribution of training load amongst the different training institutions. The regularity and quality of AWW/AWH training programmes should be improved. Towards this end, a recommendation is to upgrade MLTCs and AWTCs to resource and research centres and provide the specific mandate to undertake area specific research into local practices and the context of child development. Such research could then inform the training and the programme content.

For training to be contextualised to local realities, it is necessary that training curriculum, approaches and material are developed at decentralised levels of the the State and District. Allocating AWTCs for capacity building in specific region at the District or Sub-District level can be done for ensuring that every AWTC builds familiarity with at least a district and provides contextually relevant training for all AWWs of that district. The AWTC would also then be able to conduct post training follow ups and build field and demonstration sites for better training. Decentralisation of training should also include training of CDPOs at the state level by the identified state technical institution on the basis of the guidelines provided by NIPCCD. Besides this, CDPOs and POs should be involved in training needs assessment and training review as a part of programme review and evaluation.

**The need for convergence: How do we address the issue of child development comprehensively?** There should be greater convergence between the ICDS and the National Rural Health Mission (NRHM) for prevention and management of malnutrition.

At the village level the ASHA and the second Anganwadi worker can work together towards promotion of breastfeeding, nutrition counselling etc. Infant and Young Child Feeding (IYCF) counselling and support, while included under ICDS, should also be a mainstream intervention in RCH and NRHM, and listed as a child survival intervention along with "immunisation". The creation of "IYCF counselling and support centres", run by skilled women in a cluster of 5-30 villages, should also be considered.

Treatment of severely malnourished children must be the joint responsibility of the Health Department and the ICDS. While it would be the responsibility of the ICDS to identify severely malnourished children, the Health Department must make arrangements at the sub-centre and PHC level for treatment of such children. This requires setting up nutrition rehabilitation centres in PHCs in areas with high

malnutrition, training of ANMs on nutrition related issues, and authorizing the Anganwadi worker to refer malnourished children to the Health Department.

Further, the Health Department must also ensure that the national programmes of immunization, iron and vitamin-A supplementation are carried out and de-worming takes place. While the Anganwadi worker would play a role in motivating children for this, the Health Department must ensure adequate and appropriate supplies (such as pediatric formulations of iron). A drug kit with essential drugs must be provided at the village level with either the ASHA or the second Anganwadi worker.

Better interaction and convergence between functionaries of different schemes and departments, especially the Department of Health and Family Welfare, is important to ensure comprehensive services to the intended beneficiaries and to strengthen the component of health check-ups and referrals for pregnant women, mothers and children. This could be achieved through initiating joint-training sessions for ICDS and health functionaries, as well as convergence at the level of policy and programmatic decision making.

Related to this, caution has to be observed to prevent duplication of roles and responsibilities of field level functionaries – AWW, ASHA and ANM. The following table suggests role demarcations for these workers to achieve convergence where all the functionaries would be expected to work towards tracking development of each child so that the same can be suitably promoted and supported rather than focusing narrowly on their specific contributions:

<b>Focus Group</b>	<b>AWW 1 AWC based</b>	<b>AWW 2 AWC based</b>	<b>ASHA Community based</b>	<b>ANM Sub centre based with field visits</b>
Adolescents	Provision of IFA supplements & implementation of the Kishori Shakti Yojana		Working with adolescent girls for life skills education through the development of peer educators Working with families and communities on delaying marriage and first pregnancy, including promotion of spacing Ensuring Reproductive Health	Coming in as an expert for some sessions Providing contraceptives and enabling contraception Providing required services
Pregnant women	Growth Monitoring and Supplementary Nutrition		Working with women, families and the community to ensure adequate weight gain through appropriate	Ante Natal Care, Promoting delivery by Trained Birth Attendant,

<b>Focus Group</b>	<b>AWW 1 AWC based</b>	<b>AWW 2 AWC based</b>	<b>ASHA Community based</b>	<b>ANM Sub centre based with field visits</b>
			nutrition, reduction in workload, rest and accessing timely health services especially supporting clean and institutional delivery	Promoting and Supporting Institutional Delivery
Lactating women	Weighing at birth and recording birth weight, encouraging early initiation of breast feeding, Supplementary Nutrition		Post Natal Care, Encouraging Early Initiation of Breast feeding	Post Natal Care, Immunisation
0-6 months	Supporting exclusive breastfeeding through the creche facility, Providing the site for immunisation. Nutrition rehabilitation of severely undernourished children and referral		Providing new born care, supporting management of low birth weight and sick babies. Establishing exclusive breastfeeding as an accepted community norm, Establishing complete immunisation as a community norm. Counselling and follow up of families with severely undernourished children	Providing immunisation services and timely curative & referral services for sick new borns, Management of severely undernourished children
6 – 36 months	Growth Monitoring, Providing adequate nutrition & care through the creche and THR. Providing the site for complete immunisation, Vitamin		Positively influencing complementary feeding practices of families and at the community level, Encouraging adoption of hygienic practices regarding water and sanitation, Early detection	Providing timely curative and referral services. Management and referral of severely undernourished children

Focus Group	AWW 1 AWC based	AWW 2 AWC based	ASHA Community based	ANM Sub centre based with field visits
	Supplementation . Nutrition rehabilitation of severely undernourished children and referral		and management of childhood illness especially management of diarrhoea. Counselling and follow up of families with severely undernourished children	
3-6 years		Growth Monitoring, Providing Nutrition, Early Childhood Education and Care through the creche. Nutrition rehabilitation of severely undernourished	Identification and referral of sick children. Counselling and follow up of families with severely undernourished children	Health Check ups and curative services, Management and referral of severely undernourished children
Anganwadi Helper			Cook and serves food in the creche Help children and AWW in play activities	