
SITE VISIT: India—Integrated Child Development Services (ICDS)

By The Consultative Group Secretariat, 1993.

In 1974 India adopted a National Policy for Children to ensure the delivery of comprehensive child development services to all children. One of the first targets for the effort were the poorest children found in urban slums and rural areas, particularly children in scheduled castes and tribes. Beginning in 1975 with 33 projects, Integrated Child Development Services (ICDS) has grown to 2696 projects (more than 265,000 centres) in 1992, reaching about 16 million children under 6 years of age.

The overall goals of the programme are: to provide a comprehensive range of basic services to children, to expectant and nursing mothers, and to other women aged 15-45; to create a mechanism at the village level through which the services can be delivered, and to give priority to India's low-income groups, including the underprivileged tribes and scheduled castes. The specific objectives of the ICDS programme are:

- to lay the foundations for the psychological, physical, and social development of the child;
- to improve the nutritional and health status of children, 0 to 6;
- to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- to enhance the capability of mothers to look after the needs of the child;
- to achieve effective co-ordination among agencies and departments involved in child development.

The integrated package of ICDS services works through a network of Anganwadi (literally, courtyard) Centres, each run by an Anganwadi Worker (AWW) and helper, usually selected from the local village. The AWW undergoes a three-month training in one of the more than 300 training centres run by voluntary and governmental agencies. Responsibilities of the AWW include: non-formal preschool education, supplementary feeding, health and nutrition education, parenting education through home visiting, community support and participation, and primary maternal and child health care referrals. Support is provided to the AWW by a supervisor (1 per 20 AWW) and a Child Development Programme Officer (1 per 5 supervisors) who is directly responsible for the implementation and management of each ICDS project.

All families in the area to be served are surveyed to identify the poorest. Those families with children under 6 and/or where the woman is pregnant or lactating, are served in the Anganwadis.

Regular examinations are provided by Lady Health Visitors and Auxiliary Nurse Midwives. Children and pregnant women are immunized on a scheduled basis. Three hundred days a year food is distributed, the menu prepared in accordance with local foods and traditions. Families are encouraged to bring the children to the centres for regular feeding. Children's weight and height are monitored. Those with severe malnutrition are given additional food supplements, and acute cases are referred to medical services.

A pre-school programme has been developed for 3-6 year-olds who attend the centre three hours a day. The AWW is encouraged to develop activities that stimulate the child. An additional service is non-formal training in nutrition and health organised for mothers and pregnant women. These sessions are open to all women, aged 15-45, with priority given to pregnant and nursing women and women whose children suffer from repeated malnutrition.

Funding for the programme has come from both governmental and non-governmental sources. The initial costs of establishing a programme are provided by the Ministry of Social Welfare. The costs of the supplementary feeding programme are borne by the state; and the on-going operational costs are the responsibility of the Central government. International donor agencies have also been involved in funding aspects of the programme: UNICEF assisted in planning and implementation beginning in 1975. Since 1982 other international agencies, for example, the World Food Programme, the Aga Khan Foundation, CARE, NORAD, USAID and the World Bank, have been contributing in a variety of ways.

The ICDS programme uses existing services of diverse governmental departments and of voluntary agencies for the training of ICDS workers. Overall administration lies with the Department of Women and Child Development within the Ministry of Human Resource Development. ICDS is monitored by the Ministry as well as the All India Institute of Medical Science and the National Institute for Public Cooperation and Child Development. The annual unit cost per child per year was estimated at approximately US\$10.00.

Although the programme often operates at a minimum level of quality, it has nevertheless had important effects on the under-six population. For instance, a review of nearly 30 studies of the nutritional impact reveals nearly unanimous results documenting a positive outcome. A 1984-86 comparative study done in a number of locations showed ICDS/non-ICDS infant mortality rates of 67 vs. 86 in rural areas and 80 vs. 87 in urban areas. In a comparative study of effects on schooling, one researcher found that those with ICDS backgrounds had a higher primary school enrollment rate (89 vs. 78 percent), were more regular in primary school attendance, had better academic performance and scored significantly higher on a psychological test (Raven Colour Matrices), than non-ICDS children. Furthermore, the difference in enrollment rates was accounted for by differences among girls. In another study, it was found that primary school dropout rates are significantly lower for ICDS vs. non-ICDS children from lower and middle caste groups (19 vs. 35 percent for lower castes and 5 vs. 25 percent for middle castes).

The ICDS, the largest programme of its kind, illustrates the power of political commitment to achieve significant rates of coverage in integrated programmes of attention to children, ages 0 to 6, with important effects on health and education and at a reasonable cost per child.

What is impressive about ICDS is that when it was conceived in 1974 there was a clear understanding of the importance of delivering comprehensive services to meet the multiple needs of young children. Structurally the programme has always included a focus on health, nutrition and education of the young child and the mother. While the programme has certainly demonstrated positive benefits for both women and children, they are not of the magnitude that one would hope for. This is due primarily to the difficulty of assuring quality because of the scale on which the programme has been implemented. It may also be due to having such a comprehensive mandate.

References:

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