INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) PROGRAMME IN THE CONTEXT OF URBAN POOR AND SLUM DWELLERS IN INDIA: EXPLORING CHALLENGES AND OPPORTUNITIES

SANJEEV KUMAR AND SAINATH BANERJEE

The article examines the challenges and issues related to Integrated Child Development Services (ICDS) programme in urban settings with specific reference to urban poor and slum population in India. For example, Anganwadi Centres (AWCs) in slums or in urban areas are confronted with multiple issues ranging from infrastructural constraints (buildings, space, water and sanitation facilities); inadequate rental provision to run the AWC properly; unmapped and unrecognised slums and squatters; left out and drop out; increasing migrant and mobile population; difficulty in identifying and reaching out to migrant and working population; lack of convergence with health and allied departments and local bodies, and inadequate access and poor quality of services ;lack of knowledge and capacity among service providers; absence of an effective primary health care system in urban areas; lack of awareness and community participation, issues of gender and self-identity, etc. Further, the article attempts to explore opportunities and next steps to be taken as suggestive recommendations for ICDS programme that may strengthen the actual implementation of ICDS programme in urban areas.

INTRODUCTION

INDIA CONTINUES to have the highest rate of malnutrition and the largest number of undernourished children in the world. This is true, in spite of various policies at national and state levels, and the constant efforts of several international and national voluntary organisations, including that of bilateral and donor agencies (Kumar, 2009). Almost 43 per cent of children under five years of age in India are underweight and 48 per cent are reported as stunted (National Family Health Survey (NFHS-3). The urban poor population (including the slums in urban areas) has a high

prevalence of under-nutrition as almost 47 per cent of urban poor children are reported to be underweight and 54 per cent as stunted with almost 60 per cent of urban poor children miss total immunisation before completing one year (NFHS-3). Further, the Infant Mortality Rate (IMR) of India, is still considered as high as 40 per 1,000 live births (Sample Registration System (SRS), 2013) while the Under-5 Mortality Rate (U5MR) is as high as 52 per 1,000 live births (SRS, 2012).

India is home to 121 crore people, out of which 37.71 crore people, who constitute 31.16 per cent of total population reside in urban areas. This is for the first time since Independence, that the absolute increase in population is more in urban areas than in rural areas. Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other squatter settlements. India is home to the world's largest child (0-6 years) population of 158.8 million of which 41.2 million reside in urban areas (Census 2011). The child population in urban areas increased by almost 3.9 million (10.32%) as compared to 2001 Census. The Planning Commission, poverty estimate for 2011-12 (based on the *Tendulkar* method) designates 13.7 per cent (52.8 million) urban population as 'poor', i.e. living below the official poverty line (Planning Commission, 2013).

The main purpose of this policy research article is to examine the challenges and issues related to Integrated Child Development Services (ICDS) Programme in urban settings with specific reference to urban poor and slum population in view of growing urbanisation trend in India. Further, this article also attempts to review the effectiveness of ICDS in addressing the challenges around prevalence of child malnutrition. At the same time, the article attempts to explore opportunities and next steps as suggestive recommendation or a way forward that may strengthen the actual implementation of ICDS programme in urban areas with specific reference to slum and urban poor population.

The nutritional status of children has become an important indicator of the development status of the country. Today, ensuring good nutrition is a matter of international law. This is being fully expressed in the Convention on Rights of Child (1989) which specifies that States must take appropriate measures to reduce infant and child mortality and to combat malnutrition through the provision of nutritious foods. The Constitution of India, in Article 47 shares similar concern as it says that "the state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and in particular, the state shall endeavour to bring about prohibition of the consumption except for medicinal purposes of

intoxicating drinks and of drugs which are injurious to health." In Article 39 (f) of Constitution there is an emphatic emphasis on children when it says that "children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment". The commitment of India to the cause of nutrition can be seen from its ratifying the Convention on the Rights of Child and Signing the World Declaration on Nutrition, at the International Conference on Nutrition held in December 1992 at Rome. Many judicial pronouncements in this regard are noteworthy. The Supreme Court's order dated November 28, 2003 in this regard is a glaring example. The court, through that order, had appointed a Commissioner to review government social security schemes.

Historical Perspective: An Overview of ICDS Scheme in India

India's concern to address the needs of children is evident from the First Five-Year Plan itself when the Planning Commission of India adopted a planned approach by introducing child welfare programmes in the country. Since then, various child welfare programmes were introduced related to education, health, nutrition, welfare and recreation in subsequent Five-Year Plans. Special programmes to meet the needs of children with special needs, destitute and other groups of children were also undertaken. Some of these programmes were related to the growth and development of children, especially children belonging to the pre-school age group of below six years. However, such child care programmes with their inadequate coverage and very limited inputs could not make much dent in the problems of children. As comprehensive and integrated early childhood services were regarded as investment in the future economic and social progress of the country, it was felt that a model plan which would ensure the delivery of maximum benefit to the children in a lasting manner should be evolved. Accordingly, a scheme for integrated child care services named as ICDS was initiated for implementation in all states (Lok Sabha Secretariat report, 2011).

Launched on October 2, 1975, ICDS scheme continues to be one of the largest and unique schemes in the world underpinning holistic development of under-six years of children in the country. Being implemented nationwide under the aegis of the Union Ministry of Women and Child Development (MWCD), the scheme is a powerful driving force designed to break the vicious cycle of child malnutrition, morbidity, reduced learning capacity and mortality. The scheme adopts multi-sectoral approach by integrating health; nutrition; water and sanitation; hygiene; and education into one package of services that primarily targets children below six years;

women including expectant and nursing mothers; and adolescent girls. The other key element of this scheme is that all the services under ICDS are provided through *Anganwadi* Centres (AWCs) established at the community level.

While the scheme was launched nationwide, only 42 per cent out of 14 lakh habitations were covered under the scheme by the Ninth Five-Year Plan in the country. With a view to universalising the scheme, the Supreme Court of India in its order of April 29, 2004, and reiterated in its order dated December 13, 2006, has *inter-alia*, directed the Government of India to sanction and operationalise a minimum of 14 lakh AWCs in a phased and even manner. To comply with the directions of the Supreme Court and to fulfil the commitment of the Government of India (GoI) to universalise the ICDS Scheme, it has been expanded in three phases in the years 2005-06, 2006-07 and 2008-09, so as to cover all habitations, including Scheduled Caste (SC) / Scheduled Tribe (ST) and Minority, across the country (Lok Sabha Secretariat report, 2011).

In pursuance to the order of Supreme Court, rapid universalisation of ICDS has been made across the country. Today, there is near universalisation of ICDS scheme in India, to the extent that the ICDS scheme covers nearly 7067 ICDS projects (99.89%) out of approved 7075 and almost 13.60 lakhs AWCs (97.14%) out of 14 lakh across states of India (MWCD, 2014, Consolidated Report).

While it was essential to universalise ICDS, the rapid expansion resulted into some programmatic, institutional and management gaps that needed redressal. These gaps and shortcomings have been the subject matter of intense discussions at various forums including the mid-term review of the 11th Five-Year Plan. It was felt that the programme needs restructuring and strengthening which was duly endorsed by the Prime Minister's National Council on India's Nutrition Challenges which decided to strengthen and restructure ICDS. Consequently, an Inter-Ministerial Group (IMG) led by the Member, Planning Commission (In-Charge of WCD), was constituted to suggest restructuring and strengthening of ICDS.

The Inter-Ministerial Group (IMG) after holding consultations with different stakeholders submitted the report on restructuring ICDS in 2011 (Hameed, 2011). Accordingly, the proposal to strengthen and restructure the ICDS scheme through a series of programmatic, management and institutional reforms, changes in norms, including putting ICDS in a Mission Mode was considered and approved by Gol for continued implementation of ICDS Scheme in the 12th Five-Year

Plan (MWCD, 2012,). In order to achieve the above objectives, ICDS has repackaged its services (relating to health; nutrition; water and sanitation; hygiene; and education) in an integrated manner with an aim to bring in larger impact on the beneficiaries. The new package of services has six major components; ten services and 52 core interventions (MWCD, ICDS Mission, 2012).

Context and Challenges

The Global Context

The global population reached seven billion in 2011 and will continue to grow, albeit at a decelerating rate, to reach a projected nine billion in 2050 (United Nations (UN), Department of Economic and Social Affairs, Population Division, 2011). "...For many countries, the current rate of expansion of urban agglomerations has brought about severe challenges for provision of basic services such as adequate housing, water and sanitation systems as well as provision of health clinics and schools. There are many factors specific to life in urban environments which impact household food and nutrition security" [Food and Agriculture Organisation (FAO), UN, 2010].

The United Nations Standing Committee on Nutrition (UNSCN) statement of 2012, which builds on the 2006 statement *(The double burden of malnutrition: a challenge for cities worldwide)* clearly reflects its view on nutrition security of urban population when it states that "Now more than half of the global population lives in cities which are therefore hosting more poor... growing urban populations increase vulnerability and the risk of humanitarian crises. All countries, high as well as low- and middle-income countries (LMIC), are experiencing the double burden of malnutrition which is rooted in poverty and inequality. Vulnerable households require social protection, adult education including nutrition education and legal protection to realise and protect optimal nutrition. A wide variety of local innovative initiatives is taking place, both in LMIC as in wealthy nations. But cities need to be empowered to do more, better and now. The UNSCN through this statement of 2012 calls for increased attention, awareness and research on urban nutrition as well as for an effective engagement and Inter-sectoral and Multi-stakeholder collaboration leading to an efficient use of urban resources. Rural-urban linkages need to be enhanced. Successful urban nutrition initiatives need to be better documented and more widely shared" (UNSCN Statement, 2012).

The National Context

As per the Census Report of 2011, India is home to 121 crore people, out of which, 37.71 crore people, which constitute 31.16 per cent of total population residing in urban areas. This is for the first time since independence, that the absolute increase in population is more in urban areas than in rural areas. The level of urbanisation has increased from 25.7 per cent in 1991 to 27.81 per cent in 2001 and 31.16 per cent in 2011. In fact, the proportion of rural population, declined from 72.19 per cent in 2001 to 68.84 in 2011 (Census of India, 2011). Within 25 years, another 30-40 crore people are expected to be added to Indian towns and cities (Planning Commission, 2010). The UN estimates that by 2030 about 583 million Indians will live in cities (United Nations, 2014). See Table 1.

TABLE 1: RURAL AND URBAN POPULATION OF INDIA (IN CRORE)

	2001	*2011*	*Differences*	*% Total*
India	102.9	121	18.1	
Rural	74.3	83.3	9.0	68.84
Urban	28.6	37.7	9.1	31.16

SOURCE: Rural Urban distribution of population, Provisional Population Tables, Census of India, 2011.

Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other squatter settlements. As per Census 2011, approx. 6.5 crore people live in slums as compared to 2001 census when 5.24 crore people lived in slums. Out of 4,041 Statutory' Towns in Census 2011, 2543 Towns (63%) were reported as Slums. The total Slum Enumeration Blocks (SEBs) in Census 2011 is about 1.08 lakh in the country and the largest number of SEBs are reported from the State of Maharashtra (21,359). Out of 789 lakh urban households, almost 137.49 lakh (17.4 % households) live in slums in India. Interestingly, out of these 52 lakh slums household (38.1%) reported to live in Millions Plus Cities, which are 46 in number, across India. The increase in urban poor population including people living in slums is putting greater strain on the urban infrastructure. (See Table 2).

Unlike in rural areas, urban poor economy is cash-based making an impoverished urban poor family more vulnerable to food insecurity. Poor environmental conditions in urban slums result in frequent episodes of morbidity, particularly diarrhoea, putting families especially children in a vicious cycle of malnutrition. As many of the urban poor live in

TABLE 2: NUMBER OF URBAN UNITS (TOWNS) IN INDIA

	Towns	*Statutory Towns*	*Census Towns*
2001	5161	3799	1362
2011	7935	4041	3894
Increase	2774	242	2532

SOURCE: Rural Urban Distribution of Population, Provisional Population Tables, Census of India, 2011.

temporary settlements and slums not included in the official government lists they are often excluded from basic amenities/government services and they constantly struggle for housing, livelihood and health care. Further, due to long delays in updating official slum lists many often remain unlisted/unrecognised for years. Being unrecognised they are not even entitled to basic health and nutrition services (Agarwal, Taneja, 2005). Improving health outcomes for urban populations is a challenge, particularly for residents of slum areas. In addition to the general level of poverty, unique factors contribute to poor health in urban slums and make the provision of health services in those areas more difficult. These include lack of regular employment, lack of tenure and the threat of eviction, migration, poor access to water and sanitation, extreme crowding, and a host of social issues including discrimination (Kamla Gupta, Fred Arnold, and H. Lhungdim. 2009). See Table 3.

An overview of State-wise ICDS Projects/Anganwadi Centres in Rural and Urban Areas of India

Though, originally designed to reach rural communities, ICDS now has a substantial presence in urban areas, particularly in poor slum settlements. AWCs are increasingly playing a crucial role in providing health and nutrition services to children and women in the urban landscape. Today, there is near universalisation of ICDS in India, to the extent that the ICDS scheme covers nearly 7067 ICDS projects (99.89%) out of approved 7075 and almost 13.60 lakh AWCs (97.14%) out of 14 lakh across states of India.

However, of these, there are just 755 ICDS projects and 11, 7411 AWCs sanctioned for urban areas across the country. The analysis of data mentioned in table 3 clearly depicts that the national average of urban ICDS projects in India is just about 11 per cent, whereas the urban population in India has reached up to 31 per cent. In fact, more or less similar is the situation of states except NCT of Delhi, where percentage of urban population is almost 97.50.

TABLE 3: STATE-WISE NUMBER OF SANCTIONED AND OPERATIONAL ICDS PROJECTS/ANGANWADI CENTRES IN RURAL AND URBAN AREAS IN INDIA

Sl. No.	*Country/State*	*Total No. of ICDS Projects*		*Rural/ Tribal*	*Urban ICDS Projects*	*Total No. of AWCs*		*No. of Rural/tribal AWCs*	*No. of Urban AWCs*	*% of Urban ICDS projects*	*% of Urban Population*
		Sanctioned	*Operational*			*Sanctioned*	*Operational*				
	India	7075	7067	6320	755	136085 6	1341770	1243445	117411	10.67	31.16
1	Andhra Pradesh	406	406	349	57	91307	90757	82661	8646	14.03	33.49
2	Arunachal Pradesh	98	93	94	4	6225	6028	6021	204	4.08	22.67
3	Assam	231	231	221	10	62153	62153	60437	1716	4.32	14.08
4	Bihar	544	544	539	25	91968	91677	87629	4339	4.59	11.30
5	Chhattisgarh	220	220	205	15	50311	49651	48274	2037	6.81	23.24
6	Goa	11	11	11	0	1262	1260	1262	0	0	62.17
7	Gujarat	336	336	315	21	52137	52065	46565	5572	6.25	42.58
8	Haryana	148	148	129	19	25962	25962	24027	1935	12.8	34.79
9	Himachal Pradesh	78	78	77	1	18925	18915	18925	0	1.28	10.04
10	Jammu & Kashmir	141	141	135	6	28577	28577	26625	1952	4.25	27.21
11	Jharkhand	224	224	212	12	38432	38167	35887	2545	5.35	24.05
12	Karnataka	204	204	192	12	64518	64518	61251	3267	5.88	38.57
13	Kerala	258	258	233	25	33115	33115	30725	2390	9.68	47.72
14	Madhya Pradesh	453	453	380	73	92230	91683	84050	8180	16.11	27.63
15	Maharashtra	553	553	449	104	110486	108010	94734	15752	18.80	45.23

16	Manipur	43	42	42	1	11510	9883	10706	804	2.38	30.21
17	Meghalaya	41	41	39	2	5864	5156	5674	190	4.87	20.08
18	Mizoram	27	27	26	1	2244	2242	2111	133	3.70	51.51
19	Nagaland	60	59	58	2	3990	3455	3758	222	3.33	28.97
20	Odisha	338	338	319	19	72873	71140	70192	2681	5.62	16.68
21	Punjab	155	154	146	9	26656	26656	24494	2162	5.80	37.49
22	Rajasthan	304	304	264	40	61119	60061	55873	5246	13.15	24.89
23	Sikkim	13	13	11	2	1308	1233	1209	99	15.38	24.97
24	Tamil Nadu	434	434	386	48	55542	54439	48823	6719	11.05	48.45
25	Tripura	56	56	41	15	9911	9911	8767	1144	26.78	26.18
26	Uttar Pradesh	897	897	824	73	188259	187997	171555	16704	8.13	22.28
27	Uttarakhand	105	105	100	5	23159	19291	21129	2030	4.76	30.55
28	West Bengal	576	576	500	76	117170	114391	107989	9181	13.19	31.89
29	A&N Islands	5	5	4	1	720	710	464	256	20	35.67
30	Chandigarh	3	3	0	3	500	500	0	500	100	97.25
31	Delhi	95	95	3	92	11150	10897	648	10502	96.84	97.50
32	Dadra & N Haveli	2	2	2	0	281	268	281	0	0	46.62
33	Daman & Diu	2	2	2	0	107	107	107	0	0	75.16
34	Lakshadweep	9	9	9	0	107	107	107	0	0	78.08
35	Puducherry	5	5	3	2	788	788	487	301	40	68.31

SOURCE: State-wise number of sanctioned, operational ICDS projects and AWCs as on the September 30, 2014, MWCD, GoI; Rural urban distribution of population and proportion of rural and urban population India/States/Union Territories: Census 2011 (provisional)

Emerging Issues and Gaps (Problem of Health and Undernutrition in Urban Areas)

India is home to the world's largest child (0-6 years) population of 158.8 million (Census 2011), of which 41.2 million reside in urban areas. The child population in urban areas increased by almost 3.9 million (10.32%) while the corresponding rural child population decreased by five million (7.04%) as compared to 2001 Census. Demographic trends indicate that urban areas will see exponential population increase over time. The Child Sex Ratio (0-6) in the country in Census 2011 has declined by 13 points from 927 in 2001. In Rural areas the fall is significant as it has declined by 15 points from 934 in 2001 to 919 in 2011 and in Urban areas the decline is limited to four points from 906 in 2001 to 902 in 2011. See Table 4.

TABLE 4: POPULATION FOR 0-6 YEARS INDIA (IN MILLIONS)

	2001	*2011*
Total population	163.84	158.8
Total urban population	37.35	41.2
Rural Sex Ratio	919	934
Urban Sex Ratio	906	902

SOURCE: Rural Urban distribution of Population, provisional Population Tables, Census of India, 2011.

The urban poor suffer from poor health and nutrition status (NUHM, MoHFW, 2013). Almost 43 per cent of children under five years of age in India are underweight and 48 per cent are reported as stunted (NFHS-3). The urban poor population (including the slums in urban areas) has a high prevalence of under nutrition as almost 47 per cent of urban poor children are reported to be underweight and 54 per cent as stunted with almost 60 per cent of urban poor children miss total immunisation before completing one year (NUHM, MoHFW, 2013; NFHS-3, 2005-06). Further, the Infant Mortality Rate (IMR) of India, is still considered as high as 40 per 1,000 live births (Sample Registration System (SRS), 2013) while the Under-5 Mortality Rate (U5MR) is as high as 52 per 1,000 live births (SRS, 2012). See Table 5.

The Global Hunger Index (GHI) Report, released in October, 2014, has reported that underweight children in India fell by almost 13 percentage points between 2005-06 and 2013-14, this means underweight in children in India stands as 30.7 per cent. India now ranks 55th out of 76 countries,

TABLE 5: NUTRITIONAL AND HEALTH STATUS OF URBAN POOR (CHILDREN & WOMEN) IN INDIA (IN PERCENTAGES)

	Urban Poor	*Urban Non-Poor*	*Overall Urban*	*Overall Rural*	*All India*
Children who are stunted (under 5 years)	54.2	33.2	39.6	50.7	48
Children Underweight (under 5 years)	47.1	26.2	32.7	45.6	42.5
Children Wasted (under 5 years)	-	-	19.1	24.1	22
Children with Anaemia (under 5 years)	71.4	59.0	63.0	71.5	69.5
Children completely immunised	39.9	65.4	57.6	38.6	43.5
Under 5 Mortality	72.7	41.8	51.9	81.9	74.3
Women age 15-49 with anaemia	58.8	48.5	50.9	57.4	55.3
Mothers who had at least 3 antenatal care visits	54.3	83.1	74.7	43.7	52
Mothers who consumed IFA for 90 days or more	18.5	41.8	34.8	18.8	23.1
Children under age 6 living in enumeration areas covered by an AWC	53.3	49.1	50.4	91.6	81.1
Women who had at least one contact with a health worker in the last 3 months	10.1	5.8	6.8	14.2	11.8

SOURCE: Urban Health Resource Centre: Key Indicators for Urban Poor in INDIA from NFHS-3 and NFHS-2, http://uhrc.in/downloads/Factsheet-lndia.pdf

before Bangladesh and Pakistan, but still trails behind neighbouring Nepal (rank 44) and Sri Lanka (rank 39). While no longer in the "alarming" category, India's hunger status is still classified as "serious", (GHI, 2014). Even if we go by this figure, this 30.7 per cent is still very high and much has to be done to contain malnutrition in India, without losing our focus from policy perspective. In fact, before arriving at any conclusion based on GHI report on reduction in malnutrition for India, one should also wait for National Family Health Survey-4 (NFHS-4) data to come out by Ministry of Health and Family Welfare (MoHFW) Government of India for clearer policy direction. See Table 6.

The perusal of above data that relate to urban poor for slums and non-slums from cities, namely, Bhubaneswar, Jaipur, and Pune reflects that on an average only 32 per cent of children weights were measured across slums in these cities. Further, more than 60 per cent mothers of these children who were weighed in these slums reported that they have not been counselled. In fact, the issues of mother receiving supplementary

TABLE 6: UTILISATIONS OF RCH AND ICDS SERVICES AMONG CHILDREN UNDER THREE AND WOMEN AND HOUSEHOLD LEVEL WATER AND SANITATIONS SERVICES IN SLUM AND NON-SLUM IN THREE CITIES OF INDIA (IN PERCENTAGES)

	Bhubneswar		*Jaipur*		*Pune*	
	Slum	*Non-Slum*	*Slum*	*Non-slum*	*Slum*	*Non-slum*
Children under 3 whose weights were taken in last 12 months	39.3	64.4	23.6	35.3	32.3	21.9
Children under 3 who were weighed and whose mothers were counselled	63.6	43.8	46	17.4	20	17.5
Of children breastfed within an hour	93.8	72.7	37.5	28	76	62.7
Of children exclusively breastfed for six months	91.7	87.5	60.3	72.8	87.5	85.9
Of mothers who (in %) received any supplementary nutrition's from AWCs	37	7.5	21	4.6	22	7
Of married women who consumed IFA for 90 days or more in (%)	65.2	79.5	41.9	60.7	79.2	88.2
Of children aged 12-23 months who were fully immunised	31.6	62.2	32	47	64	55
Of households with access to water in their own dwelling	2.7	22.4	5.3	25.2	0	20.5
Of households without toilet facilities and use open spaces for defecation	23.2	3.5	13.5	0.7	5.9	0.2
Of married women who had interacted with AWW/ANM at AWCs	8.3	18.8	45.5	69.9	70	69

SOURCE: HUP Baseline Report, (2011), "Health of the Urban Poor Evidence from Bhubneswar, Jaipur and Pune" International Institute for Population Sciences (IIPS), Mumbai.

nutrition from AWCs is very low, on an average it is just 27 per cent across three cities except Bhubaneswar, where this percentage is 37. The data further reveals that only 42 per cent of children aged 12-23 months were fully immunised across slums in these cities. However, the data shows that on an average about 69 per cent of children were breastfed within an hour of birth of child except Jaipur where this percentage is just 37. Also, on an average more than 85 per cent of children were exclusively breastfed across these cities except Jaipur where the per cent is just 60. Further, almost 62 per cent of married women in these slums reported to have had consumed IFA for 90 days or more, except in Jaipur where this percentage is just 42. On the issue of community interaction with ICDS

and Health field functionaries, on an average, about 41 per cent of married women across slums in these cities reported that they had interacted with AWW and ANM at AWCs, as shown in Table 6.

The households in slum areas lack toilet facilities and use open spaces for defecation. For example, almost, 23 per cent of households in Bhubaneswar, 13 per cent in Jaipur and six per cent in Pune do not have toilet facilities and use open spaces for defecation. In fact, on an average only about three per cent of households in these slums across cities reported to have access to water in their own dwelling. However, in Bhubaneswar about 23 per cent, Jaipur, four per cent and Pune, 25 per cent of households in slums reported of getting drinking water from their own yards/plots. In fact, more than two thirds of the households source of drinking water is located elsewhere. Majority of slum households reported to storing of drinking water. (HUP, *Baseline Report*, 2011, IIPS, Mumbai).

The constraints of space, proper infrastructure, sanitation, town planning without giving adequate provision for childcare plague the functioning of urban ICDS. "The ICDS runs very poorly in urban slums areas, the urban *Anganwadis* are in terrible conditions... Whether winter or summer, they make the kids sit on a paper-thin *durrie* and even if they soil themselves they are made to sit like that for hours. All they get is a meal but no personal touch. Most women here who go out for work leave their children with private care providers... In urban slums, the problem of appallingly low rent allocations for hiring of spaces and non-availability of government buildings needs to be addressed urgently to fill the gap in universalising services for slum populations" (Saxena, 2012). Action Aid, a study done in 2010 on the homeless in Chennai and discovered that 66 per cent of children under five years were not availing of ICDS facilities. Many were opting for creches services of private players. The worst affected are those in the unorganised sectors-constructions workers, domestic helps, vendors and so on. They take their children along with them and make them work by pulling them away from schools (Saxena, 2012).

Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being "crowded out" because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits/ restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system when contrasted with the

rural network makes the urban poor more vulnerable and worse off than their rural counterparts (NUHM, MoHFW, 2013)

Poor environmental condition in the slums along with high population density makes them vulnerable to lung diseases like asthma, tuberculosis (TB) etc. Slums also have a high-incidence of vector-borne diseases (VBDs) and cases of malaria among the urban poor are twice as high as other urbanites ((NUHM, MoHFW, 2013). The multiplicity of providers, agencies, and programmes addressing similar developmental issues, often without synergy, is a complexity unique to urban areas, rendering some populations "over reached" and perhaps the most vulnerable populations, "under reached" (Urban Health Initiatives, India, 2012).

Overall urban health and well-being metrics is weak in terms of its ability to highlight inequities within urban areas. Practice of using simple tools to understand deprivations and of spatially mapping inequities and vulnerable pockets is yet to be adequately developed. Despite physical proximity of service delivery points, cities are the locus of inequitable access and reach of healthcare services. There is poor social cohesion and collective self-efficacy to seek essential services among the urban underserved. Coordinated efforts of multiple stakeholders in responding to urban inequities have been limited. While there is growing recognition of the magnitude, growth and significance of urban poverty in India, the response of governments, donors and other agencies in addressing urban health inequities has been lukewarm (Agarwal, Sethi, UHRC, 2012).

An order of Supreme Court dated October 7, 2004, with regards to urban slum and urban ICDS, stated that "Efforts must be made to ensure that all Scheduled Castes and Scheduled Tribes (SCs & STs) habitation in the country shall, as early as possible, have operational AWCs. Similar efforts shall also be made to ascertain that all urban slums have AWCs. Further, the order says: "All States and Union Territories shall make earnest efforts to ensure that slums are covered by the ICDS Programme" (Mander, 2012).

Mindful of all these growing problems and complex challenges in urban settings with specific reference to functioning of ICDS programme in urban areas, the MWCD, Gol, in July, 2012, organised a two-day workshop on *'Strengthening Maternal and Child Care, Nutrition and Health Services in Urban Settings'* attended by senior representatives of the allied department of Gol, several state governments including that of the representatives of Municipal Corporations, NGOs, etc. Probably, these challenges were discussed for the first time at such a national forum comprising of galaxy of participants and experts from different corners of the country. The MWCD during deliberations recognised and acknowledged that urban ICDS is faced with a multitude of constraints and further noted that "in view of

multidimensional challenges of providing maternal and child care nutrition and health services in urban settings, there is pressing need for identifying the key issues and to arrive at workable solutions along with short and long term strategies for ICDS programme in urban areas" (Workshop Report, MWCD, NIPCCD, 2012).

However, the recent policy decisions by Central Government with regards to drastic reduction in budget on ICDS and what impact it would have on ongoing ICDS restructuring and strengthening process initiated and mandated under 12th Five-Year Plan period requires some discussion. The budgetary allocation for ICDS scheme this financial year (FY) 15-16, by GoI is reduced to almost 50 per cent as compared to last two financial year period. This financial year, the allocation is just Rs. 8335.7 crore as GoI share, whereas, the budgetary allocation amount for FY 13-14 & FY 14-15 for the ICDS scheme was Rs. 16,312 crore and Rs. 16,561 crore respectively (Press Information Bureau, MWCD reply to *Rajya Sabha,* March 19, 2015).

The recent decision leading to drastic reductions in ICDS budget may impact the ongoing strengthening and restructuring of ICDS scheme which had already started a series of programmatic, management and institutional reforms, including putting ICDS in Mission mode as envisioned and approved under 12th Five-Year Plan period. Under 12th Five-Year Plan period, the total approved budget allocation for ICDS by Government of India for implementation of restructured and strengthened ICDS scheme in Mission mode was Rs 1,23,580 crore as GoI shares. In addition, the provision of funding from other sources and convergence with other programme/schemes including the Mahatma Gandhi National Rural Employment Guarantee Act was agreed to be pursued (MWCD, 2012, letter no.1-8/2012-CD-1, October 22, 2012).

However, Government of India maintains that the reduction in the Budgetary allocations in Financial Year 2015-16 for all planned schemes, including ICDS, have been made against the backdrop of the 14th Finance Commission 'recommendations of higher devolution of taxes to the tune of 42 per cent of the divisible pool to the states which in their view is much higher than the 32 per cent devolved to states in the previous five years. The GoI argues that this decision is made to give more flexibility to states in implementation of centrally sponsored schemes with higher share from the states (Expenditure Budget, Plan Outlay 2015-2016). But so far states have not come up with clearer response on that as whether they will really enhance their shares to these social schemes or in this case ICDS in line with objectives of restructured and strengthened ICDS and whether they will implement the programme in mission mode as envisioned. Further GoI,

should clarify that major activities under restructured and strengthened ICDS that was supposed to be undertaken at central level should be supported with required budgetary allocations to support the rolling out ICDS mission in effective manner.

Interestingly, the perusal of the draft concept note of widely discussed Smart City Scheme suggests that ICDS scheme is not incorporated in Smart City Strategy. Although, there is focus on health, sanitation and social infrastructure in draft proposal but without any reference of ICDS services or tackling of under-nutrition among urban poor and slum settlements (Draft Concept Note on Smart City Scheme, 3-12-14, MoUD, Gol).

Conclusion and Recommendations

The foregoing discussion and analysis clearly depicts the challenges that ICDS programme in urban areas is presently confronted with and augur the need to strengthen the ICDS programme in urban areas. The analysis clearly reflects services related to ICDS in urban areas are not without serious limitation and challenges especially in the wake of increase in urban population and slum settlements and inclusion of new areas under urban settings. The discussion also brings forth the gap between the policy intentions of ICDS and its actual implementation at field and raises serious concerns on functioning of ICDS programme in urban areas. For example, the AWCs in slum or in urban areas is confronted with issues ranging from infrastructural constraints for AWCs (buildings, space, water and sanitation facilities, inadequate rental provision to run the AWC properly; unmapped and unrecognised slums and squatters; left out and drop out; increasing migrant and mobile population; difficulty in identifying and reaching out to migrant and working population; lack of convergence with health and allied departments and local bodies, lack of knowledge and capacity among service provider; absence of an effective primary health care system in urban areas; lack of awareness and community participation, issues of gender, self-identity and inadequate access and poor quality of services, etc.

In the context of foregoing analysis and objectives of this article, it is important to highlight some recommendations for ICDS programme, in urban areas that have emerged from discussion. Over all, the trend emerging out of this discussion in the form of immediate and intermediate recommendations are summarised in following points: There is a need to think about AWCs cum-day-care centres/Creche in urban settings to facilitate working mothers; establishing mobile AWC; mapping and reallocation of left-out listed slums; use of temporary structures such as Porta Cabins or other temporary structures as AWCs; co-location of AWCs in schools wherever feasible, provision of wage loss to mothers and collective efforts for services like water and sanitation; AWC rent options to be linked

to different categories of cities/towns and the rent approved under ICDS restructuring and strengthening under 12th Five-Year Plan should be strictly adhered to; ensure quality of service delivery to urban poor settlements and pockets with focus on highly vulnerable settlements.' Increased involvement of community in managing and organising AWC activities in urban settings; need for proper capacity building and skill development of ICDS staffs in the context of urban challenges; need for convergence and coordination and multi-sectoral partnership and need for co-micro planning with multi-sectoral agencies viz. MoHUPA to improve AWC infrastructure; with MoHFW to improve outreach points, mobile service teams, helplines and referral linkage; with community based organisations to improve household counselling and community mobilisation; with NGO partners to manage urban ICDS particularly delivery of supplementary nutrition and Early Child Education; with Urban Local Bodies (ULBs) to implement and monitor ICDS projects. Need for private sectors participation and leverage of CSR funds for strengthening of the ICDS in urban areas.

Further, there is need for the growth-monitoring activities at AWCs to be performed with greater regularity with an emphasis on using this process to help parents understand how to improve their children's health and nutrition and at the same time the monitoring and evaluation activities need strengthening through the collection of timely, relevant, accessible, high-quality information to inform decision, improve performance, quality and increase accountability.

Addressing the health and nutrition of urban poor children is both a right and an equity issue. In terms of long-term planning, there is an opportunity for policy makers to identify and explore for various localised models and workable solution along with existing best practices keeping in view the strengths of their reliability, which can support urban ICDS programme in effective and meaningful ways. There is pressing need to design and initiate urban pilot interventions aimed at improving the availability, accessibility and quality of child development services to effectively address the nutritional and health concerns in urban setting of the urban poor population.

Notes

Support Acknowledged

Mr. Gautam Chakraborty: Public Health Economist, Health of the Urban Poor Program, Population Foundation of India (PFI), New Delhi.

Dr. Sanjay Pandey: Director, Programmes, Population Foundation of India (PFI), New Delhi.

As Per Census 2011

Slum : Slum is defined, as a residential area where dwellings are unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of street, lack of ventilation, light, or sanitation facilities or any combination of these factors which are detrimental to the safety and health. For the purpose of Census, slums have been categorised and defined as of the following three types: Notified Slums; Recognised Slums; Identified Slums.

Statutory Town: All places with a Municipality, Corporation, Cantonment board or Notified town area committee, etc. (known as Statutory Town); Census Town: Places other than the Statutory Town, which satisfied the following criteria (known as Census Town): A minimum population of 5,000; At least 75 per cent of the male main workers engaged in non-agricultural pursuits; and a density of population of at least 400 per sq. km.

REFERENCES

Agarwal , Siddharth and Taneja, Shivani. "All Slums are Not Equal: Child Health Conditions among the Urban Poor," *Indian Pediatrics,* 42:233-44, 2005.

Agarwal, Siddharth and Sethi, Vani. "The Impact of Urbanisation on Public Health in India (presentations at 13th World Congress on Public Health, Addis Ababa, Ethiopia), Urban Health Resource Centre, Delhi, India, April 27, 2012.

Census of India, 2011, rural-urban distribution of population. Provisional Population Totals, India. Available at: http://censusindia.gov.in/2011-prov-results/paper2/dat a files/india/Rural Urban 2011.pdf.

Census of India, 2011 (provisional), Rural urban distribution of population and proportion of rural and urban population India/States/Union Territories.

Food and Agriculture Organisation (FAO) of the United Nations, *The Impact of Global Change and Urbanization on Household Food Security*, *Nutrition, and Food Safety,* FAO, Rome, Italy, 2010.

Global Hunger Index (GHI), 2014, "the Challenges of Hidden Hunger", by International Food Policy Research Institute (IFPRI), *Concerns Worldwide*, Welt Hunger Hilfe, p. 12, 2014.

Harsh Mander, (2012), *Food from Courts: The Indian Experiences, IDS Bulletin, Standing on the Threshold Food Justice in India*, Volume 43, Number S1, Special Issue, July, pp.15-24, 2012.

HUP Baseline Report, (2011), "Health of the Urban Poor Evidence from Bhubneswar, Jaipur and Pune" International Institute For Population Sciences (IIPS),Mumbai. (Health of Urban Poor (HUP) Program is implemented by Population Foundation of India (PFlHed consortium funded by USAID India).

Kamla Gupta, Fred Arnold, and H. Lhungdim. 2009. *"Health and Living Conditions in Eight Indian Cities".* National Family Health Survey (NFHS-3), India, 2005-06. International Institute for Population Sciences (IIPS) Mumbai; Calverton, Maryland, USA: ICF Macro.

Kumar, Sanjeev, (2009), High Malnutrition rate a cause for concern", *Hindustan Times*, July 16, 2009, Lucknow, p. 4.

Lok Sabha Secretariat, Eighth Report on Working Conditions of Anganwadi Workers, New Delhi, August, 2011. Ministry of Finance, Expenditure Budget, Vol.l, 2015-2016;

Part-lll, Plan Outlay, 2015-2016,Gol, available at : http://indiabudget.nic.in/ub2015-16/eb/po.pdf.

Ministry of Health and Family Welfare (MoHFW), 2013, *National Urban Health Mission (NUHM), Framework for implementation*, MoHFW, Government of India (Gol), May, 2013, pp-1.

Ministry of Women and Child Development (MWCD), 2012. A letter entitled " Strengthening and Restructuring of ICDS scheme", from MWCD to Chief Secretaries of all States & Union Territories on Strengthening and Restructuring of ICDS Scheme dated October 22, 2012 (Gol, letter no. l-8/2012-CD-l, 22nd October, 2012) New Delhi.

MWCD, 2012, *ICDS Mission: The Broad Framework for Implementation* MWCD, Gol, October, 2012, New Delhi.

MWCD (2014), *State wise number of sanctioned, operational ICDS projects And AWCs*, MWCD , Gol, New Delhi. (Consolidated report prepared based on information shared by state government and union territories as on 30th September, 2014).

MWCD & NIPCCD (2012) *Draft Report on Strengthening Maternal and Child Care. Nutrition and Health Services in Urban Settings,* July 18-19, 2012, National institute of Public Cooperation and Child Development (NIPCCD), MWCD, New Delhi.

MWCD & NIPCCD (2012), Presentation by Dr. Shreeranjan, Joint Secretary (Nutrition and Child Development), MWCD, Gol, at workshop on -"Strengthening Maternal and Child Care, Nutrition and Health Services in Urban Settings, July 18-19, 2012, MWCD, GoI, New Delhi.

Ministry of Urban Development , *Draft Concept Note on Smart City Scheme*, MoUD, Gol, New Delhi (Revised as on 03.12.2014-work under progress).

N.C. Saxena, (2012), "Hunger and Malnutrition in India", Standing on the Threshold Food Justice in India, *IDS, Bulletin*, Volume 43, Number SI, Special Issue, July, 2012, pp.8-14.

National Family Health Survey (NFHS)-3, India, 2005-06, MoHFW, Gol, New Delhi.

Planning Commission of India Mid-term appraisal of the 11th Five Year Plan, 2010, Chapter, 18, Urban Development, p.378: http://planningcommission.nic.in/plans/mta/llth_mta/chapterwise/chapl8_urban.pdf

Planning Commission of India (2013) Press Notes on Poverty estimates 2011-12, Press Information Bureau, Gol, July, 2013. Available at: http://planningcommission.nic.in/news/pre_pov2307.pdf.

Planning Commission, 1982, *Evaluation report on the integrated child development services project (1976-78) -1982*, PEO Study No.120, Planning Commission, Gol, and New Delhi.

Planning Commission, October, 2011, *Report of the working group on urban poverty, slums, and service delivery system*, Steering Committee on Urbanization Planning Commission, Gol, October, 2011, New Delhi.

Planning Commission, 2011, *Evaluation Study on integrated child development services (ICDS)*, Volume 1, Program Evaluation Organisation (PEO) Report no.218, Planning Commission, Gol, March, 2011, New Delhi.

Press Information Bureau, Government of India, *Budgetary allocations for ICDS*, 19th March, 2015 (a reply by MWCD in Rajya Sabha)

Sample Registration System (SRS) 2013, Office of Registrar General and Census Commissioner, Ministry of Home Affairs, Gol.

Sample Registration System (SRS) 2012, Office of Registrar General and Census Commissioner, Ministry of Home Affairs, Gol.

Syeda Hameed, 2011, *Report of the Inter Ministerial Group on ICDS Restructuring*, Planning Commission, Gol, September, 2011, New Delhi.

Urban Health Initiatives (UHI), (2012) "Accelerating Access to Health and Nutrition Services among the Urban Poor: ICDS shows the way" May 2012, available at www.uhi-india.org.

Urban Health Resource Centre (UHRC) "Key Indicators for Urban Poor in INDIA from NFHS-3 and NFHS-2", available at http://uhrc.in/downloads/Factsheet-lndia.pdf.

United Nations, 2014, *World urbanisation prospects: The 2014 Revisions*; Department of Economic and Social Affairs, New York, USA.

United Nations System Standing Committee on Nutrition (UNSCN) Statement, (2012), *Nutrition Security of urban populations: A call for attention and joint action*, UNSCN, 2012.

United Nations, 2011, Department of Economic and Social Affairs, Population Division, New York, USA.