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MINISTRY OF WOMEN AND CHILD DEVELOPMENT AND MINISTRY OF HEALTH AND FAMILY WELFARE

(MALNUTRITION IN INFANTS AND MOTHERS)

COMMITTEE ON ESTIMATES

(2013-2014)

TWENTY SIXTH REPORT

FIFTEENTH LOK SABHA

LOK SABHA SECRETARIAT

NEW DELHI

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(MALNUTRITION IN INFANTS AND MOTHERS)

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Presented to Lok Sabha on 06.09.2013

LOK SABHA SECRETARIAT

NEW DELHI

06 September, 2013/Bhadrapada 15, 1935(S)

EC No. ____

Price Rs.____

Published under Rule 382 of the Rules of Procedure and Conduct of Business in Lok Sabha (Eleventh Edition) and Printed by the Manager, Government of India Press, Minto Road, New Delhi.

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INTRODUCTION

I, the Chairman of Committee on Estimates (2013-14) having been authorized by the Committee to submit the Report on their behalf, present this Twenty Sixth Report (Fifteenth Lok Sabha) on the subject 'Malnutrition in Infants and Mothers' pertaining to the Ministry of Women and Child Development and the Ministry of Health and Family Welfare.

2. The Committee took oral evidence of the representatives of the Ministry of Women and Child Development and the Ministry of Health and Family Welfare on the subject held on 22.10.2012..

3. The Report on the subject was considered and adopted by the Committee at their sitting on 04.09.2013.

4. The Committee wish to express their thanks to the representatives of the Ministry of Women and Child Development and the Ministry of Health and Family Welfare who appeared before them and placed their considered views on the subject. The Committee also wish to thank the Ministry of Women and Child Development and the Ministry of Health and Family Welfare for furnishing the information required in connection with examination of the subject.

NEW DELHI;
5 September, 2013
Bhadrapada 14, 1935(S)

FRANCISCO SARDINHA,
CHAIRMAN,
COMMITTEE ON ESTIMATES.

PART – I

BACKGROUND ANALYSIS

Chapter I

Introductory

1.1 Nutrition is an important indicator of human development affecting lives of individuals and families, productivity and ultimately National development and growth. Importance of nutrition during infancy as well as during pregnancy remains unchallenged over a period of time.

1.2 There is substantial evidence that giving children the best start to life and nurturing them over the early childhood years will have long-term benefits for their future life and learning. The early years of life are a critical period in which the foundations of competence and coping skills that affect long-term learning, behavior and health are established. It is critical to prevent under-nutrition, as early as possible, across the life cycle, to avert, irreversible commutative growth and development deficits that compromise maternal and child health and survival, achievement of optimal learning outcomes in primary education and gender equality.

1.3 Poor nutrition starts before birth and generally continue into adolescence and adult life and can span generations, often with irreversible situations. The inter-generational cycle of under-nutrition ensures that an undernourished and anaemic mother gives birth to a low birth weight baby, more susceptible to infections, and more likely to experience growth failure, who goes on to become

an undernourished and anaemic child, experiencing cumulative growth and development deficits, which are largely irreversible.

1.4 Malnutrition means imbalance in nutrition and includes both under nutrition and over nutrition. Under nutrition is a multifaceted problem and it is an outcome of complex and interrelated set of factors. From a health perspective, the immediate causes of malnutrition are inadequate dietary intake and repeated episodes of infections. The underlying causes at household level includes insufficient access to food, inadequate maternal and child care practices, poor waste management and sanitation practices and inadequate health and social services.

1.5 The consequences of under nutrition are low resistance to infections, High levels of anaemia and low weight gain during pregnancy resulting in low birth weight of new born babies. Further consequences may be limited learning and cognitive abilities leading to poor school performance, low work productivity, leading to low income and poverty. This ultimately erodes human capital and national human resource base with ultimate reduction in the GDP

1.6 Under-nutrition is a specific condition of malnutrition, though frequently it is used interchangeably for malnutrition. It is characterized by inadequate calories and protein consumption alongwith deficiency of micronutrients. Under-nutrition is identified using three indices as per WHO standards *i.e.* ***stunting, under weight and wasting*** for children. For mothers, WHO prescribes the Body Mass Index to check malnutrition. According to the Ministry, each index provides different information about growth and body composition which is used to assess nutritional status as enumerated below:

(i) **Stunting**- it measures height for age. This index is an indicator of linear growth retardation and cumulative growth deficits.

(ii) **Underweight**- this represents weight for age and reflects failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illness.

(iii) **Wasting**- measures weight for height and depicts malnutrition of acute onset.

(iv) **Mid-Upper Arm circumference (MUAC)** Further, the Ministry have also referred to another indicator i.e.MUAC prescribed by WHO to assess severe acute malnutrition in under five children. Because of its simplicity, MUAC is a especially useful measurement in situations where other information is not available or when birth dates are not precisely known.

(v) **Body Mass Index (BMI)**- For measuring malnutrition in mothers, WHO prescribes BMI as an index of weight for height. It is used to classify underweight, overweight and obesity in adults.

1.7 Malnutrition has been recognized as a major threat to social and economic development and casts an adverse impact on children, adults, women and entire workforce of the country. Poor nutrition starts in embryo and extends throughout the lifecycle, amplifying the risks of low resistance to infections, increased rates of morbidity, mortality and contributes to impaired cognitive and social development and poor school performance. The undernourished adults get functionally impaired, chronically vulnerable to illness and intellectually disabled leading to low productivity and inefficiency in society. For women, the inter generational cycle of under nutrition ensures that an undernourished and

anaemic mother, gives birth to low birth weight baby, has greater risk of obstructed labour, adverse impact on pregnancy outcomes, lactation, death due to post haemorrage and illness for herself and the baby. The cycle is perpetuated with anaemic girls facing gender discrimination, early marriage, early and frequent child bearing, being locked in a cycle of multiple deprivations, gender inequality, social exclusion and poverty. At the familial level, Malnutrition linked disability and illness places increased costs and pressures, especially for poor families, and the said losses, replicated millions of times at the societal level, produce staggering drain on global development. Besides, malnutrition in the population diminishes the effectiveness of the resources spent on families to have access to basic health, sanitation and basic education.

1.8 The rationale for investing in Malnutrition-both as a development imperative and as central to the fulfillment of human right, has been globally well recognized. In this context, based on consolidated written and oral information from the Ministry of Women and Child Development and the Ministry of Health and Family Welfare, which undertake several schemes and programmes to tackle malnutrition (Appendix-I), the Committee examined the subject in detail and identified certain critical issues as enumerated in the succeeding chapters of this Report.

CHAPTER – II

MALNUTRITION SCENARIO IN THE COUNTRY

(i) Malnutrition Data

2.1 The National Family Health Survey (NFHS) which is a multi round survey in a representative sample of households throughout India, conducted by the Ministry of Health and Family Welfare, collects data on nutritional status of women, men and children by anthropometric measurements to measure the prevalence of underweight, stunting and wasting in children, underweight and overweight in men and women and anaemia in all the three categories. Information on Iron folic acid and Vitamin A supplementation in children along with dietary intake of different food items is also collected.

2.2 So far, three rounds of NFHS i.e NFHS-I in 1992-93, NFHS II in 1998-99 and NFHS III in 2005-06 have been conducted. The NFHS IV is proposed to be conducted in 2014. The third round of NFHS was conducted way back in 2005-06 and as such, there is no recent set of data on malnutrition.

2.3 It has been stated in a proposal for the 12^{th} Plan that there is no national system of nutrition monitoring, mapping and surveillance in the country. District level disaggregated data are not available from existing surveys. District Level Health Survey (DLHS) remains inadequate in its coverage. There is a need to generate reliable District level disaggregated data so that the progress made on under-nutrition can be monitored.

2.4 It has been proposed that an innovative health and nutrition monitoring and surveillance system should be put in place. It can be used as a major enabler

for performance management including financial management through real time data flow to the health system and for the restructured ICDS. It should have a vibrant community based monitoring component, which will function in partnership with civil society organizations, women/community groups and Panchayati Raj Institutions. The development of an e-health database with health-ID cards capturing complete digital histories will be planned.

2.5 The Ministry of Women and Child Development in their background note on the nutrition scenario stated as under:

- The National Family Heath Survey (NFHS-III), (2005-06) reflects that even during the first six months of life, when most babies are breast fed, 29.5% of infants are under weight. Thereafter, the prevalence of underweight increases with child's age. Age–wise prevalence of underweight children upto 4 years is as follows:

Less than 6 months of age	29.5 %
6-8 months	34.7 %
9-11 months	36.7 %
12-17 months	40.2 %
18-23 months	45.9 %
24-35 months	44.9 %
36-47 months	45.6 %
49-59 months	44.8 %

Other findings were as under:

- 42.5% of children under 5 are under- weight and 15.8 % are severely underweight. Stunting and wasting in children is 48 % and 19.8 % respectively.
- The level of underweight had declined from 42.7% in 1988-99 (NFHS-II) to 40.4% in 2005-06 (NFHS-III) for children below 3 years of age.
- Anaemia in children (6-59 months) is 69.5%
- Anaemia in women (age 15-49) is 56.2% and during pregnancy and lactation is 58.7% and 63.2% respectively.
- Chronic energy Deficiency (CED), measured as Body Mass Index (BMI) which identifies malnutrition in adults, is approximately 35%
- Nearly 22% newly born children have Low Birth Weight (LBW) i.e. below 2.5 kg.

2.6 A comparative chart as per NFHS II & III showing percentage of malnourished children less than 5 years with break-up of underweight, stunted and wasted children, as provided by the Ministry of HFW is given as under:

	NFHS-I (1992-93)	**NFHS-II (1998-99)**	**NFHS-III (2005-06)**
Proportion of underweight children under five years	No Information	47%	42.5%
Proportion of stunted children under five years		46%	48%
Proportion of wasted children under five years		16%	19.8%

2.7 Malnutrition in mothers is also measured by Body Mass Index (BMI), as prescribed by WHO as an index for weight for height. The percentage of women in age group 15-49 years having BMI less than 18.5 has gone up from 33% (as per NFHS II) to 35.6% (as per NFHS III). The State-wise Nutritional Status of Women (15-49 years) with Chronic Energy Deficit as per NFHS-III is given in Appendix-II.

2.8 A survey was conducted by Nandi Foundation in the year 2011, an idea triggered by the Citizen's Alliance against malnutrition. The survey named 'HUNGaMA – Fighting hunger and malnutrition' – was carried out in 112 rural districts in six States *viz.* Bihar, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh, capturing the nutrition status of about 1,09,000 children. 100 districts were selected from the bottom of a child development district index (developed by UNICEF); and for comparison, 1 best performing district from each of these 6 states and 2 districts each from three best performing states (Kerala, Tamil Nadu and Himachal Pradesh) was taken. The survey used indicators as per WHO Standards and measured malnutrition in terms of underweight, stunting and wasting in children up to 5 years of age. Besides, weight for height and height for age, HUNGaMA also measured MUAC of children and classified accordingly.

2.9 Findings of HUNGaMA Survey Report of 2011:-

- In the 100 High Focused Districts (HFDs), the prevalence of child underweight (using WHO Standards) has decreased from **53.1** per cent (District Level Household Survey – II in 2002-04) to **42** per cent (HUNGaMA 2011) making decrease of 20.3 per cent to over 7 years period with an annual rate of reduction of 2.9 per cent.

- In the 100 HFDs, 42 per cent of children under five are underweight and 59 per cent are stunted.
- There is no change in the underweight children since last 7 years. Also, the data represents unacceptably high occurrence of stunting at 59 percent which is a cause of grave concern.
- The prevalence of severe wasting (<-3 SD) in children aged 0-59 months is **3.3** per cent in the 100 focus districts, which are ranked the lowest on child development index. This prevalence is lower than the national average of Severe Acute Malnutrition (SAM) estimated at **6.4** per cent in NFHS III (2005-06).

2.10 The data in NFHS – III and HuNGAMA Survey are not comparable as the former is National Survey while the latter is restricted to only high focused districts in only six States.

2.11 On the issue of the latest data on malnutrition among different categories of people, the Annual Report of the Ministry of Health and Family Welfare states that they have decided that one integrated survey should be conducted in place of different surveys to provide data at the district level and it would be named as NFHS IV. This would provide comparative data with earlier round of NFHS and the periodicity of the NFHS would be three years. In order to initiate the work of NFHS-IV in 2013-14,the Ministry has designated Indian Institute of Population Studies (IIPS,) Mumbai as the nodal agency. Two Meetings of Technical Advisory Committee (TAC) have been organized to deliberate on the technical aspects including content, coverage, design etc of NFHS IV.

2.12 The Ministry of Health and Family Welfare launched Annual Health Survey (AHS) from the year 2010-11 aiming to provide feedback on the impact of the schemes under NRHM in reduction of Total Fertility Rate, Infant Mortality Rate and the Maternal Mortality Rate at the regional level. The Survey was conducted in 284 districts of 8 Empowered Action Groups (EAG) States. The field work of second round of AHS has been completed in 2012-13. Under the AHS, a separate component of data on height and weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households would also be collected during 2012-13.

2.13 With regard to the issue of challenges being faced in tackling malnutrition, Secretary, Ministry of Women and Child Development stated while briefing the Committee on 22.10.2012 as under:

> "India is still faced with the daunting task of reducing under-nutrition among children as two out of five children roughly are still underweight and every second child is likely to be stunted. Although there are indications of improvement in recent years from results of independent and State-level surveys, ensuring better nutritional status for women and children in the country remains still an unfinished agenda".

2.14 With regard to children born with low birth weight, the NFHS III indicates that nearly 22 percent of newly born children have low birth weight i.e. below 2.5 kg. These underweight babies contribute significantly to underweight/stunted children. During the briefing meeting on the subject held on 22.10.2012, the Secretary, Ministry of Health and Family Welfare stated as follows:

> "As compared to a normal healthy baby, a low birth weight baby, which is around 22 per cent in the country, has a greater chance of infection, premature retinopathy, or about the mental growth and development, it has a high risk. It also has less resistance and consequently growth and development is affected".

(ii) Infant and Child mortality rates

2.15 The National Population Policy (NPP) 2000, the National Health Policy 2002 and the Eleventh Five Year Plan (2007-12) and National Rural Health Mission (NRHM – 2005-2012) have laid down the goals for child health. Child Health Goals under Reproductive and Child Health programme (RCHII) / NRHM and Millennium Development Goal (MDG) are as under-

Child Health Indicator	**Current status (per 1000 live births)**	**RCH II/NRHM 2010-2012**	**MDG 2015**
IMR (Infant Mortality Rate)	47	<30	28
Neonatal Mortality Rate	33	<20	-
Under 5 Mortality Rate	59	-	<38

Source: Sample Registration System (SRS) 2010 & 2011

The strategies for child health intervention focus on improving skills of the health care workers, strengthening the health care infrastructure and involvement of the community through behavior change communication.

2.16 As per the information furnished by the Ministry of Women and Child Development, malnutrition is not a direct cause of death but it can increase morbidity and mortality by reducing resistance to infections. As per the Report on 'Causes of Death – 2001-03 in India' by Registrar General of India, nutritional

deficiencies are responsible for only (i) 2.8% death of children aged 0-4 years; and,(ii) 1.8% in the age group 5-14 years. The Ministry of Health and Family Welfare, in a note furnished to the Committee have stated that the achievement of Millennium Development Goals (MDGs) is indirectly linked with problem of malnutrition among infants and mothers in our country, as Malnutrition is one of the important underlying causes for under-five mortality.

2.17 In 1990, when the global Under five Mortality Rate (U5MR) was 87 per 1000 live births, India carried a much higher burden of child mortality at 114 per 1000 live births. In 2010, India's child mortality (59 /1000 live births) almost equals the global average of 57/ 1000 Live births. Further, during 2005-10, India's decline in U5MR has accelerated to an average of 7.5% each year. Five Indian States (Kerala, Delhi, Tamil Nadu, Maharashtra and West Bengal) have already achieved Millennium Development Goal for U5MR target, while many states viz. Assam, Madhya Pradesh, Uttar Pradesh, Odisha, Rajasthan and others are in striking distance. Overall, India is expected to achieve the target of U5MR reduction much ahead of the 2015. In this context, the Secretary, Ministry of H&FW, appearing before the Committee on 22 October, 2012 stated as under:

> "The good thing happened is the latest SRS data was made available last Friday and the IMR has dropped down by another three points. In the last two consecutive years, we have a drop of three points in the IMR. This time, it has come down from 47 to 44. Some of the high focus States like Bihar, Odisha, Uttar Pradesh and Rajasthan and even in Sikkim, they were dropped by four points. That is one improvement. Earlier, between 2005 and 2007, it used to remain almost static or drop by one or two points, but in the last two years, it dropped by three points each."

(iii) Interventions by the Ministries

2.18 The problems of malnutrition are complex, multi-dimensional and inter-generational in nature. According to the Ministry of Women and Child Development, the approach to dealing with the nutrition challenges has been two pronged. The first is the Multi-sectoral approach for accelerated action on the determinants of malnutrition in targeting nutrition in schemes/programmes of all the sector. The second approach, is the direct and specific interventions targeted towards the vulnerable groups such as children below 6 years, adolescent girls, pregnant and lactating mothers.

2.19 The Ministry of Women and Child Development has further stated that the Government has accorded high priority to the issue of malnutrition and is implementing several schemes/programmes of different Ministries/Departments through State Governments/UT Administrations. The schemes/programmes include the Integrated Child Development services (ICDS) Scheme, National Rural Health Mission (NRHM), Mid Day Meal Scheme, Rajiv Gandhi scheme for Empowerment of Adolescent Girls (RGSEAG) namely SABLA and Indira Gandhi Matritva Sahyog Yojana (IGMSY) as Direct targeted interventions. Besides, indirect Multi- sectoral interventions include Targeted Public Distribution System (TPDS), National Horticulture Mission, National Food Security Mission, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), Total Sanitation Campaign, National Rural Drinking Water Programme etc. All these schemes have potential to address one or other aspect related to Nutrition.

2.20 Pointing out that malnutrition is multidimensional and intergenerational and requires interventions through various Ministries to address its many

underlying causes in different stages of the life cycle, the Ministry of Health and Family Welfare stated that under National Rural Health Mission (NRHM), funds are provided each year for carrying out following set of activities:

> "Promoting appropriate infant and young child feeding practices that include early initiation of breastfeeding and exclusive breastfeeding till 6 months of age.
>
> Management of malnutrition and common neonatal and childhood illnesses at community and facility level by training service providers in IMNCI (Integrated management of neonatal and Childhood Illnesses) training.
>
> Treatment of children with severe acute malnutrition at special units called the Nutrition Rehabilitation Centres (NRCs), set up at public health facilities. Presently about 550 such centres are functional all over the country.
>
> Specific programme to prevent and combat micronutrient deficiencies of Vitamin A and Iron & Folic Acid. Vitamin A supplementation for children till the age of 5 years and Iron & Folic Acid supplementation for children 6 to 60 months.
>
> Supplementing iodine through National Iodine Deficiency Disorders Control Programme.
>
> Nutrition Education through VHNDs (Village Health and Nutrition Days) to increase the awareness and bring about desired changes in the dietary practices including the promotion of breastfeeding".

2.21 Both MoHFW and MoWCD focus on reducing malnutrition in mothers and children by providing supplementary nutrition and iron folic acid supplementation; undertaking regular growth monitoring of children up to three years and providing nutrition through Village Health and Nutrition Days. Mother and Child Protection Card is the joint initiative of the two Ministries that provide an opportunity to monitor the growth of children and address the nutrition concerns in children and pregnant and lactating mothers.

CHAPTER – III

SCHEMES OF THE MINISTRY OF WOMEN AND CHILD DEVELOPMENT (MWCD)

(i) Integrated Child Development Services(ICDS) Scheme

3.1 The ICDS scheme is the flagship programme of MWCD and reportedly represents one of the world's largest programmes for early childhood development. It is one of the most important interventions of the Government of India aimed at holistic development of children and for proper nutrition and health education of pregnant and lactating mothers. The objectives of ICDS scheme are as follows:-

(i) to improve the nutritional and health status of children in the age group 0-6 years;

(ii) to lay the foundation for proper psychological, physical and social development of the child;

(iii) to reduce the incidence of mortality, morbidity, malnutrition and school dropout;

(iv) to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and

(v) to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

3.2 The Ministry of Women and Child Development in their note submitted that the Integrated Child Development Services (ICDS) Scheme is being

implemented through State Governments /UT Administrations. The scheme provides a package of six services namely supplementary nutrition, pre-school non-formal education, nutrition & health education, immunization, health check-up and referral services. The Integrated Child Development Services (ICDS) Scheme has been universalized with special focus on SC/ST and minority habitations.

3.3 The revised WHO Child Growth Standards have been introduced under ICDS as well as NRHM for growth monitoring promotion of children upto three years of age. Further, the Joint Mother and Child Protection Card, an extremely important tool for not only monitoring the growth of children but also education tools for mothers have been introduced to the States. The States are in the process of roll out for distributing these cards under ICDS/NRHM.

3.4 It has been stated that population norms for setting up of AWCs and Mini-AWCs have been revised to cover all habitations, particularly keeping in view those inhabited by SC/ST/Minorities. The revised population norms of the ICDS scheme are stated to be as under:

For AWCs in Rural/Urban Projects

400-800	1 AWC
800-1600	2 AWCs
1600-2400	3 AWCs
Thereafter in multiple of 800	1 AWC

For Mini-AWC

150-400	1 Mini-AWC

For Tribal/Riverine/Desert, Hilly and other difficult areas/Projects

300-800	1 AWC

For Mini-AWC

150-300	1 AWC

Anganwadi on Demand (AOD)

Where a settlement has at least 40 children under 6 but no AWC

It is observed that as per Census 2011, the number of villages in India is 6,40,930 and the child population in the age group of 0-6 years stands at 1,645 lakhs. Children under six constitute less than 13.6 per cent of the total population of 121 crore.

Strengthening and Restructuring of ICDS

3.5 Integrated Child Development Services (ICDS) Scheme, one of the flagship programmes of the Government of India has been in operation since 1975. Over 35 years of its operation, ICDS has expanded from 33 community development blocks to cover almost all habitations and become universal through 7076 (approved) projects[*] and about 13.72 lakh sanctioned AWCs[†]. The rapid universalisation, however, 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 levels. Consequently, an Inter Ministerial Group (IMG) led by the Member, Planning Commission (In Charge of WCD) was constituted to suggest Restructuring & Strengthening of

[*] 7025 projects operational as on 31.01.2013

[†] 13.31 lakh AWCs operational as on 31.01.2013

ICDS. Accordingly, the proposal to strengthen and restructure the ICDS Scheme through a series of programmatic, management and institutional reforms, including putting ICDS in Mission mode, was formulated on the basis of the report submitted by the IMG. The proposal after consideration has been approved by the Government of India with an over-all budget allocation of Rs. 1,23,580 crore for 12th Five Year Plan (2012-17) with the following components:

(i) Repositioning AWC as a "vibrant ECD centre" to become the first village outpost for health, nutrition and early learning -minimum of six hours of working, focus on under-3s, care and nutrition counseling particularly for mothers of under-3s, identification and management of severe and moderate underweight children through community based interventions 'Sneha Shivirs', decentralized planning and management, architecture-flexibility to States in implementation for innovations, strengthening of governance including PRIs, partnerships with civil society introducing Annual Programme Implementation Plan (APIP) and MoUs with States /UTs etc.

(ii) ICDS will be implemented in Mission mode with establishment of a National Mission Directorate.

(iii) Restructured and strengthened ICDS will be rolled out in three years as under:

  (a) In 200 high burden districts in the first year (2012-13);

  (b) In additional 200 districts in second year (2013-14) (i.e. w.e.f. 1.4.2013) including districts from special category States (J&K, Himachal Pradesh and Uttarakhand) and NER.

  (c) In remaining districts in third year (2014-15) (i.e. w.e.f. 1.4.2014);

(iv) Cost norms of Supplementary Nutrition Programme per beneficiary per day have been revised, as per details given below on an existing cost sharing of 50:50 (NER 90:10):

Category	**Existing Norms (w.e.f. 16.10.08)**	**Proposed Norms effective form the date of approval (per beneficiary per day) as per phased roll out.**
(i) Children (6-72 months)	Rs. 4.00	Rs. 6.00
(ii) Severely underweight children (6-72 months)	Rs. 6.00	Rs. 9.00
(iii) Pregnant women and nursing mothers	Rs. 5.00	Rs. 7.00

However, the revised rate would follow the phasing of the programme.

(v) Cost norms of other existing components such as medicine kits, PS kits, rent for AWC buildings, uniforms & badges, procurement of equipment/furniture (non-recurring), administrative expenses, etc. have also been revised.

(vi) Additional human resource will be provided at different levels.

(vii) Introduction of following new components under the ICDS Mission on a cost sharing pattern of 75:25 between the Centre and the States (NER 90:10) to be implemented in a phased manner as per the roll out plan:

(a) Construction of 2 lakh AWCs building during 12th five year plan, funding for which would be provided @ Rs. 4.50 lakh per unit.

(b) Provision for maintenance of AWC buildings housed in a government building has been introduced.

(c) With a view of address the menace of malnutrition in those districts where it is prevalent most, a Nutrition Counsellor cum Additional

Worker (per AWC) would be provided in 200 high burden districts on demand by the concerned State. A link worker to be provided in other districts on demand. The incentives proposed for link workers including ASHA would be linked to outcomes.

(d) 5% of the existing AWCs would be converted into AWC-cum-Creche. States/UTs will have the flexibility in choosing such AWCs

(e) It has been decided to re-design and strengthen the package of six services. This is a in view of transforming AWC as a vibrant ECD Centre. The components under the re-designed and strengthened package, inter-alia, include Early Childhood Care, Education & Development (ECCED) ECCE/Pre-School Non-formal education and supplementary nutrition), Care & nutrition Counselling (IYCE Promotion & Counselling, maternal care and counseling, care, nutrition, health & hygiene education, Community based care and management of underweight children, health services immunization and micronutrient supplementation, health check up and referral services and Community Mobilization, Awareness, advocacy & IEC (IEC, campaigns and drives etc.).

(f) Roll out of Mother and Child Protection Cards prepared by using new WHO child growth and development standards would be universalized.

(g) It has been decided to assign management and operation of upto 10% projects to PRIs and separately to NGOs/voluntary organizations.

(h) Further, management of moderately and severely undernourished children (Sneh Shivirs), IEC/Advocacy, promoting Infants and Young Child Feeding (IYCF) practices, strengthening monitoring and evaluation and MIS & ICT, grading and accreditation ofAWCs and reward scheme would also be undertaken.

(i) In respect of health check up of beneficiaries at the AWC, NRHM would provide the doctors preferably on monthly basis but at least once in a quarter.

(viii) Training and capacity building would be strengthened.

(ix) Institutional Arrangements for ICDS Mission

(a) A National Mission Steering Group (NMGS) under the Chairpersonship of Minister in charge of MWCD will be constituted. NMSG will be the apex body for providing direction, policy and guidance for implementation of ICDS.

(b) An Empowered Programme Committee (EPC) under the Chairmanship of Secretary, MWCD would be formed at the national level for effective planning, implementation, monitoring and supervision of ICDS Mission.

(c) Decentralized planning and management will be ensured through Annual Programme Implementation Plan (APIP) and MoUs with flexibility to States for innovations

(d) State Child Development Society will be set up at the State level with powers to set up its District Units. Fund transfer of the ICDS Mission will be channeled through the Consolidated Fund of the State. In the

event, the State fails to transfer the fund within 5 days, it will be liable to pay interest on the amount on the pattern of releases for the Finance Commission funds.

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

3.6 As per the Outcome Budget 2013-14 of the Ministry of Women and Child Development, a Project, namely, 'World Bank Assisted ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP)', has been designed and made effective on 26.11.2012, to supplement and provide value addition to the ICDS Programme through system's strengthening for better service delivery and to allow selected 162 districts in 8 States (i.e. Bihar, Chhattisgarh, Jharkhand, M.P., Maharashtra, Rajasthan, U.P., and Andhra Pradesh) to experiment, innovate and conduct pilots of potentially more effective approaches for ICDS so as to achieve early childhood education and nutrition outcomes. As per the Ministry, ISSNIP is an important dimension of the Ministry's overall efforts to strengthen and restructure the ICDS Programme. The total size of the Project is Rs. 2893 crore with 70 % IDA share of Rs. 2025 crore over 7 years. States will be bearing 10 % of the cost while 20 % would be met by the Government of India. The Project will be implemented in two distinct phases – a preparatory phase of 3 years with clearly defined benchmarks and a 4 years full-scale implementation phase upon meeting all the agreed benchmarks.

3.7 With regard to the ICDS scheme, the Secretary, Ministry of Women and Child Development during the briefing meeting held on 22.10.2012 stated as under:

> "Our biggest and flagship programme still remains the Integrated Child Development Services Scheme which though is quite old in nature but its expanse has really increased from 1975 to now 2012. The programme was universalized in the year 2008 and we are now taking the services to the whole country. This is the largest outreach programme for nutrition, health and early learning for the children under six years and expectant and nursing mothers. This also aims at reducing the incidence of under-nutrition, mortality and morbidity in India."

Beneficiaries under ICDS

3.8 All children below 6 years of age, pregnant and lactating women are the beneficiaries under the scheme. BPL is not a criteria for beneficiaries under the scheme. A list of target groups for different services and the service provider is as under:

Services	Target Group/Beneficiaries	Service Provided by
Supplementary Nutrition	Children below 6 years, Pregnant & Lactating Mother (P&LM)	Anganwadi Worker and Anganwadi Helper(MWCD)
Immunization*	Children below 6 years, Pregnant & Lactating Mother (P&LM)	ANM/MO (M/o H&FW)
Health Check-up*	Children below 6 years, Pregnant & Lactating Mother (P&LM)	ANM/MO/AWW (M/o H&FW)
Referral Services	Children below 6 years, Pregnant & Lactating Mother (P&LM)	AWW/ANM/MO (M/o H&FW)
Pre-School	Children 3-6 years	AWW

Education		MWCD
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO MWCD/(M/o H&FW)

*AWW assists ANM in identifying the target group.

Physical Progress/Performance

3.9 The programme currently reaches out to 927.66 lakh beneficiaries under supplementary nutrition and 346.66 lakh 3-6 children under pre school component as on 31.01.2013. Trends in coverage during X and XI plans is as under :

Year ending	**no of operational Projects**	**No of operational AWcs**	**No. of Supplementary nutrition beneficiaries**	**No. of pre-school education beneficiaries**
31.03.2002	4608	5,45,714	375.10 lakh	166.56 lakh
31.03.2003	4903	6,00,391	387.84 lakh	188.02 lakh
31.03.2004	5267	6,49,307	415.08 lakh	204.38 lakh
31.03.2005	5422	7,06,872	484.42 lakh	218.41 lakh
31.03.2006	5659	7,48,229	562.18 lakh	244.92 lakh
31.03.2007	5829	8,44,743	705.43 lakh	300.81 lakh
Achievement during X Plan	**1221**	**2.99.029**	**330.33 lakh (88.06%)**	**134.25 lakh (80.60%)**
31.03.2008	6070	10,13,337	843.26 lakh	339.11 lakh
31.03.2009	6120	10,44,269	873.43 lakh	340.60 lakh
31.03.2010	6509	11,42,029	884.34 lakh	354.93 lakh
31.03.2011	6722	12,62,267	959.47 lakh	366.23 lakh
31.03.2012	6908	13,04,611	972.49 lakh	358.22 lakh
Achievement during XI Plan	**1079**	**4,59,868**	**267.06 lakh (37.85%)**	**57.41 lakh (19.09%)**

Sanctioned and Operational Projects

3.10 There were 7076 sanctioned ICDS projects out of which 7025 projects were operational as on 31/1/13. Further, out of the 13.72 lakh AWCs/mini AWCs sanctioned, 13.31 lakh are operational across the country. The State-wise number of sanctioned, operational ICDS Projects and Anganwadi centres (AWCs) and number of beneficiaries (children 6 months- 6 years and pregnant & lactating mothers (P&LM)) under ICDS Scheme as on December 2012 is given in Appendix III

3.11 In written reply as to the reasons for not operationaising all the sanctioned ICDS projects, the Ministry of Women and Child Development stated that since ICDS scheme is implemented through the States/UTs, the remaining 40,000 AWCs are to be operationalised by the States/UTs wherever pending. The Ministry, from time to time, in the national reviews and other meetings, has been impressing upon the States/UTs to give priority to the opening of the remaining AWCs. However, these centres could not be put in operation due to variety of reasons as informed by the States/UTs which include delay in recruitment of AWWs/AWHs, pendency of court cases, difficulty in selection of location of the AWCs, non-availability of land, etc.

Status of Physical Infrastructure of AWCs

3.12 The status of infrastructure as on 31/01/2013 of the 12.03 lakh AWCs is as under:

- 84.26% AWCs are running from pucca buildings and 15.74 % from Kutcha buildings
- 71.05% AWCs have drinking water facilities within the premises
- 50.28% AWCs have toilet facilities

    - 30.08% running from Government owned buildings
    - 22.33% running from School premises
    - 3.94% running from Panchayat buildings
    - 32.89% running from rented buildings including 5.24% from AWWs/ AWHs house
    - 9.58% running from others
    - 1.18% running from open space

3.13 Approximately 14,200 AWCs are running from open space. Further, around 7 lakh AWCs are functioning without drinking water facilities and 12 lakh are operational without toilet facilities. The above data also indicate that approx. 3.97 lakh AWCs are functioning from rented buildings. In this connection, the Secretary, Ministry of Women & Child Development during the course of briefing on the subject, held on 22.10.2013 stated as under:

> "Particularly there was a complaint that they are not getting proper buildings in the rural areas and urban areas because the allowance for rent is quite low. So, it has been increased quite a bit."

Funding pattern

3.14 Funding pattern between the Centre and the State for supplementary Nutrition (SNP) is 50:50 and for ICDS (General) is 90:10 for all the States except

NER. For NER the funding pattern is 90:10 for all the components. Funds are provided under two heads i.e. ICDS (General) and ICDS (SNP). ICDS (General) consists of salary, honorarium, TA and all project related expenses where as ICDS (SNP) consists of expenditure incurred on supplementary nutrition on approved cost sharing basis. The funds are paid in four instalments quarterly.

Budgetary allocation and utilisation

3.15 The budgetary allocation for the scheme during the X, XI and XII Plan is as given below:

Plan	**Budgetary Allocation**
Xth	10,391.75 crore
XI Plan	44,400.00 crore
XII Plan	1,23,580.00 crore

3.16 The details of Plan Allocation, Budget Estimates, Revised Estimates, actual expenditure and utilization of allocated amount under ICDS Scheme during the Eleventh Plan and 2012-13 is given below:

S.No.	**Year**	**Budget Allocation BE (Rs.in Crores)**	**Revised Allocation RE (Rs.in Crores)**	**Expenditure (Rs.in Crores)**	**%age with reference to BE.**	**%age with reference to RE.**
1	**2007-08**	5293.00	5396.30	5257.09	99.32%	97.42%
2	**2008-09**	6300.00	6300.00	6379.36	101.25%	101.25%
3	**2009-10**	6705.00	8162.00	8157.76	121.66%	99.94%
4	**2010-**	8700.00	9280.00	9763.11	112.22%	105.20%

	11					
5	**2011-12**	10,000.00	14048.40	14272.21	142.72%	101.59%

Further, for the first year of the XII Plan i.e. for 2012-13, Rs. 15,850 crore has been allocated for ICDS Scheme. As on 8th March 2013, an amount of Rs. 14,550.86 crore (92% of allocation) has been released to the States/ UTs.

3.17 As per the Outcome Budget (2013-14) of the Ministry, the unspent balances with the various grantee institutions are being reviewed from time to time. Release of further grants is subject to utilization of grants released earlier. Release of grants is linked to the availability of funds with the implementing agencies and unspent balances lying with them. As per the Outcome Budget, the provision of unspent balances with the States/partner as on 31st December, 2012 is Rs. 3017.17 crore

Monitoring

3.18 The Government has introduced a 5-tier monitoring & review mechanism at National, State, District, Block and Anganwadi Levels and has issued the guidelines on 31.03.2011. For the Committees at the State level and the District level, Members of Parliament (MPs) and Members of Legislative Assemblies (MLAs) have been given representations. Five MPs and five MLAs have been included in the State Level Committee on a rotational basis, whereas all the MPs & MLAs of the District are members of the District Level Committee. At the grass root level Anganwadi Level Monitoring & Support Committee (ALMSC) is created. This committee comprises of Gram Panchayat member (preferably women) as chairperson, 2 members of mahila mandal, ASHA, 2 members of community

based organization, 3 members from community e.g. parents of AWC children, teachers etc., Sakhi under 'Sabla' (if any) and the Anganwadi worker. This Committee organizes regular monthly meetings to discuss various issues relating to functioning of AWCs. The Status of Constitution of 5 tier monitoring mechanism by various states is as under:-

1	J & K	- To be constituted within one month
2.	Jharkhand	- Not reported
3.	Kerala	- Under process for Constitution.
4.	Maharashtra	- to be constituted
5.	Mizoram	- State level constituted. Other levels not constituted.
6.	Punjab	- State level constituted. Other levels not constituted.
7.	Rajasthan	- constituted excluding block level
8.	Tamil Nadu	- in process
9.	U.P.	- issued. Not done for State level
10.	Delhi	- Committee constituted at state level only
11.	D & N Haveli	- State Distt., and Anganwadi level constituted
12.	Lakshadweep	- Constituted at Distt and Project levels.

The Ministry informed that States/UTs were required to notify the full 4 tier Monitoring and Review Committees without further delay.

(ii) Indira Gandhi Matritva Sahyog Yojana (IGMSY)

3.19 In India, due to various economic and social responsibilities, women continue to work till the end of the pregnancies and resume work immediately after delivery. Inadequate rest and continuous work by the pregnant women lead to malnutrition among mothers and their children. To address these issues, the Indira Gandhi Matritva Sahyog Yojana (IGMSY) scheme was introduced by the Ministry in October 2010, as a centrally sponsored scheme.

3.20 IGMSY is a Conditional Cash Transfer Scheme for pregnant and lactating women to contribute to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and nursing mothers. The Scheme envisages providing cash to Pregnant and Lactating (P&L) women during pregnancy and lactation in response to individuals fulfilling specific conditions. It addresses short term income support objectives with long term objective of behavioural and attitudinal changes. The scheme attempts to partly compensate for wage loss to Pregnant and Lactating women both prior to and after delivery of the child.

3.21 The beneficiaries are paid Rs. 4000 in three installments per P&L women between the second trimester till the child attains the age of 6 months. The cash transfer takes place only through beneficiaries' bank/post office account. The modes of cash transfer include – Nationalized Bank, PO, Cooperative Bank, Business correspondent model of bank etc. The scheme is now covered under Direct Benefit Transfer (DBT) programme under which 9 districts have been included under first phase of the implementation (where **Aadhaar** enabled cash transfer is to take place).

3.22 Targets and achievement of the scheme during 2011-12 and 2012-13 is indicated below:

Quantifiable deliverables	2011-12		2012-13	
	target	achievement	target	Achievement as on 31/12/12
No of beneficiaries covered	12.5 lakh	0.61 lakh (5 %)	12.5 lakh	1.60 lakh (12.8 %)

3.23 IGMSY is a Centrally Sponsored Scheme under which amount is given as grant-in-aid to State Government/Union Territories. The Budgetary allocations, revised Estimates and utilization since 2010-11 is as follows:

(in crore)

Year	**Budget Estimate** *(Rs in Crore)*	**Revised Estimate** *(Rs in Crore)*	**Actual Expenditure (Release to the States)** *(Rs in Crore)*	**Fund Utilized (as reported by states)**	**Percentage of Utilization**	
					vis a vis BE (%)	**vis a vis RE (%)**
2010-11	390	150	117.95	23	30.24	78.63
2011-12	520	403	293.83	121.18	56.50	72.91
2012-13	520	84	75.21	143.04	15.83	98.01

3.24 As per the Outcome Budget (2013-14) of the Ministry, an amount of Rs. 225.39 crore is the position of unspent balance as on 31.12.2012. With regard to basic factors/comments on the performance of the scheme, the Ministry in their Outcome Budget have stated that funds constraint may impact the effective implementation of the scheme.

3.25 On the issue of impact of the scheme on the targeted sections of the society, the Ministry in their response have stated that an evaluation of the scheme is currently being undertaken by them. The impact of the scheme in

combating malnutrition among the target groups may be commented based on the report of the evaluation study. The Ministry further stated that further course of action with regard to extension of the scheme will be taken on the basis of findings of the evaluation.

(iii) Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – 'Sabla'

3.26 **'Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – Sabla'** is a comprehensive scheme introduced in 2010 for the holistic development of adolescent girls. The unmet needs of girls (especially adolescent girls) in terms of nutrition, health (mainly reproductive health) and education are sought to be achieved through the 'Sabla' scheme in order to lead to a healthy and more productive women work force and help break the intergenerational cycle of malnutrition. '**Sabla'** is being implemented in 205 selected districts across the country, using the ICDS platform.

3.27 'Sabla' aims at an all-round development of adolescent girls (AGs) of 11-18 years by making them self reliant by improving their health and nutrition status, promoting awareness about health, hygiene, adolescent reproductive and sexual health, facilitating access to learning about public services through various interventions such as counseling and vocational training etc. It also aims at mainstreaming out-of-school girls into formal/non formal education.

3.28 The scheme has two major components -Nutrition and Non-Nutrition. Nutrition is being given in the form of Take Home Ration or Hot Cooked Meal for 11-14 years to out of school girls and 14 -18 years to all AGs (out-of-school and in

school girls). Each AG is given 600 calories and 18-20 grams of protein and micronutrient per day for 300 days in a year. The out of school AGs (11-14 years) attending AWCs and all girls (15-18) are provided supplementary nutrition in the form of Take Home Ration/Hot Cooked Meal. The nutrition provided is as per the norms for pregnant and lactating mothers. In the Non Nutrition Component, the Out of school Adolescent Girls (11-18 years) are being provided Iron and Folic Acid (IFA) supplementation, Health check-up and Referral services, Nutrition & Health Education, Counselling / Guidance on family welfare, Adolescent Reproductive Sexual Health (ARSH), child care practices and Life Skill Education and accessing public services and 16-18 year old AGs are also being given vocational training.

3.29 'Sabla' has replaced the nutrition programme for AG (NPAG) and Kishori Shakti Yojana (KSY). In non-Sabla districts, KSY continues as before. 'Sabla' is being implemented through State Governments/UTs with 100 per cent financial assistance from Centre Government for all inputs other then nutrition provision for which 50 per cent central assistance is provided to States.

3.30 On the issue of progress of the scheme, the Ministry informed that as reported by States/UTs, the progress under Nutrition component has been satisfactory. However, non-nutrition component of the scheme has six sub components requiring convergence with various Ministries/Departments at all levels. Therefore, the progress for this component is slow.

3.31 The number of beneficiaries covered under 'Sabla' since 2010-11 is as follows:-

Year	**Beneficiaries covered for nutrition**
2010-11	4,44,42,674
2011-12	1,00,77,363

2012-13	88,76,975 (as on 31.12.2012)

3.32 The target and achievement in terms of number of beneficiaries is as under:

Quantifiable deliverables	2011-12		2012-13	
	Target	achievement	Target	Achievement (as on 31.12.2012)
No of beneficiaries covered for nutrition under Sabla	100 Lakh	100 Lakh	100.77 Lakh	87.23 lakh
No of beneficiaries covered for non nutrition under Sabla	49.16 lakh	37.81 lakh (77 %)	69.02 lakh	33.19 lakh (48%)

3.33 'Sabla' is being implemented through the State Government/ UTs with 100 per cent financial assistance from the Central Government for all inputs other than nutrition provision. The utilization of allocated amounts under the scheme is as under:

(Rs. in crore)

Year	**Budget Estimates**	**Revised estimates**	**Actual Expenditure (amount released to States)**	**Funds Utilized as reported by States/UTs**
2010-11	1000	340	296.73	52.11
2011-12	750	750	561.11	522.02
2012-13	750	504	496.56*	300.15#

***** As on 15.03.2013 # As on 31.12.2012

Besides, unspent balance as on 31.12.12 stood at Rs. 494.13 crore.

3.34 On the issue of monitoring, the Ministry informed that the monitoring and supervision mechanism set up under the ICDS Scheme at the National level, the State level and the Community level is used for this Scheme also. Quarterly and Annual Progress Reports, both Physical and Financial, are furnished to the Ministry by States/UTs. Based on the reports received from States, the physical and financial achievements are assessed against the targets and the States/UTs are intimated to take remedial action. The progress of the scheme is also reviewed in the review meetings organised with States/UTs.

3.35 Monitoring committees for '***Sabla***' are set up at National, State, District, Block and Village level. These Committees meet and take stock of the progress of the Scheme as also strengthen the coordination and convergence between concerned departments at all levels and ensure smooth functioning of the scheme at the ground level. The Committees also consider the bottlenecks faced in the implementation and suggest modifications required for improving the implementation. The National level Monitoring and Supervision Committee for '***Sabla'*** has been set up under the chairmanship of Secretary, Ministry of Women and Child Development. The Committee meets to ensure effective convergence of services with various schemes/programmes of Health, Education, Youth Affairs, Labour & Employment and PRI for smooth implementation of the Non-Nutrition component under '***Sabla'***.

Chapter – IV

SCHEMES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (MHFW)

4.1 The Ministry of Health & Family Welfare, under the 'National Rural Health Mission (NRHM)' is involved in three pronged manner i.e. development of technical guidelines in consultation with experts, providing funds for strategies developed including training of health personnel and tracking physical and financial progress. These are done specifically for the management of sick children with Severe Acute Malnutrition (SAM) and supplementation of nutritional deficiencies with micronutrient supplementation/fortification (iron, folic acid, vitamin A, iodine etc) along with promotion and IEC activities. Apart from this, the Ministry also engages in promotion of appropriate infant and young child feeding practices. The States are responsible for implementation of these programmes.

Specific action taken by MHFW under NRHM are limited in scope as it does not include any special schemes for direct feeding or supplementary nutrition.Organizing of Village Health and Nutrition Day (VHNDs) at Anganwadi center at least once every month to provide ante natal/post partum care for pregnant women, promote institutional delivery, immunization, Family Planning and nutrition are the part of various services being provided during VHNDs. More than 3.7 Crore Village Health and Nutrition Days (VHNDs) have been held at Anganwadi Centres (NRHM – MIS) since the launch of NRHM.

I. Micronutrient Supplementation

Vitamin A Supplementation

4.2 According to the Ministry of Health and Family Welfare, the Policy for Vitamin A supplementation was revised in 2006 to decrease the prevalence of Vitamin A deficiency to levels below 0.5 per cent. The Annual Report (2012-13) of the Ministry of Health and Family Welfare state that the strategy being implemented is:

- 1,00,000 IU dose of Vitamin A is being given at nine months
- Vitamin A dose of 2,00,000 IU after 9 months at six monthly intervals upto five years of age
- All cases of severe malnutrition to be given one additional dose of Vitamin A

4.3 Biannual rounds are conducted in many States to supplement children between 1-3 years and 3-5 years with Vitamin A and to administer deworming syrup/tablets.

4.4 The percent of children of 9 months and above, who have received atleast one dose of Vitamin A has improved from 24.8 percent as per NFHS III (2005-06) to 55 percent as per DLHS III (2007-08) and further to 65.4% as per CES, 2009.
is given as under:-

Coverage with at least One dose of Vitamin A for children of 9 months and above	NFHS III (2005-06) 24.8%	DLHS III (2007-08) 54.5%	CES (2009) 65.4%

4.5 The State wise details of coverage as per District Level Household Survey (DLHS) III and (CES) 2009 is given in the chart below

STATES	Percentage of children (age 9 months and above) received at least one dose of Vitamin A supplement	Percentage of children age 12- 23 months who received at least one dose of Vitamin A
	DLHS-III (2007-08)	**CES 2009**
India	54.5	65.4
Himachal Pradesh	85.6	92.7
Goa	83.9	87.8
Karnataka	69.4	87.1
Andhra Pradesh	78.8	84.7
Maharashtra	70.5	84.5
Sikkim	86.8	82.6
Mizoram	72.1	74.6
West Bengal	78.3	74.1
Punjab	65.1	73.4
Assam	67.9	71.1
Orissa	71.6	71
Gujarat	56.2	69.3
Kerala	68.1	68.2
Tripura	53.6	68
Delhi	55.1	67.7
Chhattisgarh	65.1	67.3
Jharkhand	61.6	63.3
Jammu & Kashmir	53.4	61.6
Uttarakhand	67.6	60.8
Rajasthan	50.8	60.5
Meghalaya	38.5	58.8
Haryana	46.3	58.1
Tamil Nadu	73.0	56.6
Bihar	49.9	49.4
Uttar Pradesh	32.2	49.1
Madhya Pradesh	39.5	48.8
Manipur	31.6	48
Arunachal Pradesh	45.1	43.1
Nagaland		29.9

Iron and Folic Acid Supplements

4.6 An important cause of malnutrition in iron deficiency. Low dietary intake and poor iron and folic acid intake are major factors that contribute to high prevalence of anaemia in India. Anaemia refers to the low level of hemoglobin/decreased oxygen carrying capacity in human body which is an important cause of malnutrition in India. Poor bioavailability of iron in Indian diet aggravates the situation. In girls, deficiency of iron is further aggravated with higher demands with onset of menstruation and also due to the problem of adolescent pregnancy and conception.

4.7 The comparative data for anaemia among children and women, as per NFHS II and NFHS III is enumerated as under:

	NFHS II (1998-99)	**NFHS III (2005-06)**
Children under 5 years who are anaemic	74 %	69.5%
Children (6-35 months)	74.3%	78.9%
All women(15-49 years)	51.8%	55.3%
Ever married women	52 %	56.2%
Pregnant women	49.7%	58.7%

4.8 To manage the widespread prevalence of anaemia in the country, the policy has been revised (Annual Report 2012-13):-

- Infants from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 20mg elemental iron and 100mcg folic acid per day child for 100 days in a year.

- Children 6-10 years of age shall receive iron in the dosage of 30mg elemental iron and 250mcg folic acid for 100 days in a year.
- Children above this age group would receive iron supplements in the adult dose.

4.9 MH&FW stated in a note that more recent change has been the introduction of IFA syrup for children. Paediatric IFA tabllets/syrup and deworming tablets were being supplied as part of Kit A to all sub-centres. twice a year, till the financial year 2011-12. Anaemia in mothers and children can only be assessed through surveys. No recent surveys have been conducted since NFHS III to show if there is an impact on anaemia levels.

4.10 In the recent Annual Health Survey (AHS) conducted in 9 States for the first time, collected data on the coverage with Iron and Folic acid. The data provided for children aged 6-35 months indicate wide variation across States and also intra district variation.

4.11 The M/o HFW informed the Committee in a written reply dated 12.02.2013 that Weekly Iron and Folic Supplements (WIFS) programme has been launched in Adolescent age group by NRHM, as an effective strategy for implementation of iron supplementation in programme mode. In this programme Iron and Folic Acid Supplement are to be distributed free of cost on weekly basis to the target groups. Approx 13 crore rural and urban adolescents will be covered through the platform of Government/ Government aided and Municipal schools for school going children and Anganwadi Kendras for out of school adolescent girls.

National Iodine Deficiency Disorder Control Programme (NIDDCP)

4.12 Iodine is an essential micronutrient required daily at 100-150 microgram for the entire population for normal growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, still birth, deaf mutism, loss of IQ and various types of goiter.

4.13 On the recommendations of Central Council of Health in 1984, the Government took policy decision to iodate the entire edible salt in the country by 1992. The programme started in April, 1986 in a phased manner. The Central Government is implementing ban notification on the sale of non-iodated salt for direct human consumption under Prevention of Food Adulteration Act, 1954 with effect from 17th May, 2006.

4.14 The NIDDCP is continuing programme and the goals of 11th Plan were not achieved. The proposed goal of 12th Plan as nutritional Iodine Deficiency Disorders is related with Millennium Development Goal 1 & 4 directly and country is signatory to achieve these goals by 2015.

4.15 It is stated in a note submitted to the Committee that on the basis of the surveys conducted by the Directorate General of Health Services, ICMR and State Health Directorates, it has been found that out of the 324 districts surveyed covering all the States/UTs, 263 districts are endemic i.e. with more than 10 per cent IDD. It is estimated that more than 71 million people are suffering from goiter and IDD. No State/ UT is free from IDD.

4.16 The Government of India is implementing a 100 per cent centrally assisted National Iodine Deficiency Disorders Control Programme (NIDDCP) with the following objectives:-

- Surveys to access the magnitude of Iodine Deficiency Disorder (IDD) in districts.
- Supply of iodised salt in place of common salt.
- Resurveys to access Iodine Deficiency Disorder (IDD) and impact of iodised salt after 5 years in districts.
- Health education and Publicity.

4.17 With regard to the physical achievement under the scheme, out of the 16,97,941 salt samples tested by salt testing kit (upto Feb, 2013), 10,51,118 (62%) salt samples were found conforming to the standards for ensuring the quality of iodized salt. For estimation of iodine content at the consumption level, it has been mentioned that 85 per cent, 28,857 out of 35,054 samples have been found conforming.

4.18 Some of the achievements under NIDDCP are stated to be as follows:-

- Notification banning the sale of non iodized salt for direct human consumption in the entire country is already issued under Food Safety and Standards Act 2006 and Regulations 2011.
- Consequent upon liberalization of iodated salt production, Salt Commissioner has issued licenses to 824 salt manufacturers out of which 532 units have commenced production. These units have an annual production capacity of 120 lakh metric tones of iodated salt.

- Annual production/supply of iodated salt has been raised from 5 lakh MT in 1985-86 to 59.00 lakh MT in 2011-12.
- For effective implementation of NIDDCP 31 States/UTs have established IDD Control Cells in their State Health Directorate. 30 States/UTs have already set up IDD monitoring laboratories which the remainign States are in the process of establishing the same.
- In order to monitor the quality of iodated salt and urinary iodine excretion, the State Governments are also provided grants for Iodine Deficiency Disorders Control Cell, Iodine Deficiency Disorders Monitoring Laboratory, Survey and IEC activities.

Physical Achievement under NIDDCP (2007-08 to 2011-12)

(figures in lakh MT)

Year	Production/Supply of iodated salt
2007-08	48.64
2008-09	49.23
2009-10	54.88
2010-11	60.19
2011-12	59.77

S. No.	Item	Target	Achievement
1	Production and distribution of iodated salt	55.00 lakh MT	55.00 lakh MT
2	IEC activities through Doordarshan, AIR, S&D Division, Dte. Of Field Publicity and DAVP	Telecast of daily/bi-weekly/weekly IDD spots through DD & AIR	Telecast of IDD spot as per schedule

		Special interactive programme through S&D Division and Dte. Of Field Publicity	Programme as per annual action plans
3	Establishment of IDD Cell in States/UTS	35	31
4	Establishment of State IDD Monitoring Labs	35	30
5	District IDD survey	270	42
6	Supply of Salt Testing Kits at district level for creating awareness about IDD and promotion of consumption of adequately iodated salt.	All districts of 35 States/UTs	Activity initiated in 2007-08, 50 lakh STK supply was made at district level to all States/UTS in 2008-09 and 2009-10. Supply of STK has now been decentralized; States/UTs will procure the same under NIDDCP for creating awareness through ASHA.

4.19 The expected outcomes of NIDDCP at the end of the 12th Five Year Plan are stated to be as follows:-

1. The prevalence of iodine deficiency disorders in all districts of the country will be reduced below 5%.
2. The visible goiter in the country will disappear.

3. No cretin due to nutritional iodine deficiency will be borne in the country.
4. The nutritional iodine status will improve significantly to prevent still birth, perinatal death, physical and mental retardation in children.

(ii) Management of Severe Acute Malnutrition (SAM)

4.20 The Ministry of Health and Family Welfare is concerned with management of SAM in facility based settings. SAM is an important contributing factor for most deaths amongst children suffering from common childhood illnesses such as diarrhoea and pneumonia . The National Family Health Survey-III revealed that 6.4 percent of all children under-five years of age are severely wasted. Children with (SAM) have nine times higher risk of dying than well-nourished children. Around 10 percent of these children with SAM suffer from complications or other illness and require facility based management.

4.21 Under National Rural Health Mission, Nutrition Rehabilitation Centres (NRCs) have been set up at health facilities for facility based management of SAM children under 5 years of age who have medical complications. In these facilities, sick children with SAM are being admitted along with the caregivers and in addition to medical and nutrition management and psychological stimulation of these children, their care givers are also counselled, provided nutrition education and wage compensation for the period of their stay at the facility. There is also provision of follow up of these children and linking them with the Anganwadis for further nutrition management. Accredited Social Health Activists (ASHA) are being provided incentives for referral of sick children with SAM to the NRCs and follow up of these children after discharge.

4.22 The Annual Report (2012-13) of the MH&FW states that about 650 NRC's are planned in 14 States. The MH&FW have informed that currently 604 NRC are operational in 14 States and UTs. The State wise list is given in Appendix IV**.**

4.23 With regard to future plans and projections for Twelfth plan, the MH&FW stated that facility based management of sick children with Severe Acute Malnutrition would be strengthened, with the target of operationalizing at least one Nutritional Rehabilitation Centre in each high burden district. To complement facility based care, community Based management of Severe Acute Malnutrition in children is being conceptualized

(iii) Infant and Young Child Feeding (IYCF) Practices

4.24 According to the MH&FW, there are several entry points into the health system when mothers and children have contact with the health service providers especially during pregnancy and the first two years of the life of the child. Actions to promote infant and young child feeding are being taken at the following three levels: (1) at health facilities (2) during community outreach activities and (3) during community and home based care. The IYCF practices for infants and young children include:

(i). Timely initiation of breastfeeding.

(ii). Exclusive breastfeeding during the first six months of life (no other foods or fluids, not even water).

(iii). Timely introduction of complementary foods, at six months, while breastfeeding continues until 24 months and beyond.

(iv). Frequent, appropriate and active feeding for children during and after illness, including oral rehydration with zinc supplementation during diarrhoea.

4.25 Appropriate feeding practices in children under 2 years are crucial for their survival, health growth, intellectual and physical development. According to the Lancet, 2008, the world's leading general medical journal, if breastfeeding (Including exclusive breastfeeding for the first six months and continued breastfeeding for the next six months) was universalized it will reduce death at 36 months of age by 9.1%. NFHS III reveals that overall, only 21 percent of children aged 6-23 months are fed according to all three quality parameters of IYCF practices recommended by WHO (timely, adequate and safe). Only 44 percent of breastfed children are fed at least the recommended minimum number of times (NFHS 3), but only half of them consume food from three or more food groups. Feeding recommendations are even less likely to be followed for non-breastfeeding children age 6-23 months. As per the Ministry of WCD, the feeding practices in India are far from optimal and continue to pose a serious challenge.

4.26 Statement of progress in adherence to the recommended IYCF practices is as under :

Indicators	NFHS-III (2005-06)	DLHS-III (2007-08)	CES (2009)
Children under three years breastfed within an hour of birth	24.5%	40.2%	33.5%
Children 0-5 months exclusively breastfed	46.3%	46.4%	56.8%
Children age 6-35 months breastfed for at least 6 months		24.9%	

4.27 Annual Health Survey (AHS) 2010, which provided an assessment of IYCF practices in 7 Empowered Action Group (EAG) States shows improvement. Nevertheless, the rates of initiation of breastfeed within an hour of birth leaves much to be desired with low rates in States like Bihar, Jharkhand and Uttar Pradesh as enumerated below:

State	Breastfeeding initiated within 1 hour of birth (%)	
	DLHS-3 (07-08)	AHS 2010
Assam	65.7	69.6
Bihar	16.2	30.3
Chhattisgarh	50	63.9
Jharkhand	34.6	37.9
Madhya Pradesh	43	61.5
Odisha	63.7	71.5
Rajasthan	42	48.6
Uttar Pradesh	15.4	32.9
Uttarakhand	63.4	63.2

4.28 One of the very important factors leading to malnutrition in children is not introducing semi-solid food along with breast milk after 6 months of age. As per different surveys, the introduction of semi-solid food at 6 months of age is improving with time as shown below:

Indicators	NFHS-3 (2005-06)	DLHS-3 (2007-08)	CES 2009
Introduction of complementary feeding upon completion of 6 months, along with continued breastfeeding for 2 yrs	53% (6-8 months)	56.9 % in the age group of 6-9 months	62.6% (started semi-solids)

4.29 The HuNGAMA Survey report states that in the 100 Focus Districts, 51 per cent mothers did not give colostrum to the new born soon after birth and 58 per cent mothers fed water to the infants before 6 months.

Chapter V

INFORMATION, AWARENESS AND COORDINATION

5.1 The Ministry of Health & Family Welfare develops Information, Education and Communication (IEC) material on various health topics through experts for dissemination to States to be used as promotional materials. The IEC material is targeted towards promotion of health initiatives for improving reach and acceptability of the programmes and also behavioural change by providing appropriate health messages. Dedicated funds are also allocated in this regard to the State and UTs for comprehensive IEC plans.

5.2 Health and Nutrition Education is one of the important components of ICDS for which funds are provided under the Scheme. This is done through nutrition and health counselling, home visits by Anganwadi Worker (AWW) who are part of awareness campaign at grass root level. The frontline workers at community level i.e. AWW, ASHA and Auxillary Nurse Midwife (ANM) workers play a vital role in creating awareness among people on nutrition issues

5.3 Malnutrition is a manifestation of several underlying factors and causes which are economic, environmental, geographical, and cultural and governance related. The Ministry of Women and Child Development (MWCD) have stated that several of the States are yet to constitute the State Nutrition Councils and formulate the State Action Plan on nutrition..

5.4 The Ministry of Women and Child Development in their replies furnished to the Committee have stated that the institutional arrangement of both ICDS and NRHM have coordination mechanism. Village Health and Nutrition Day (VHND)

are organised jointly at the Anganwadi Centres (AWC). The coordination is ensured right from training to implementation of the Mother and Child Protection Card (MCPC) from top to bottom. Joint training sessions are also organised at ground level for ANM, ASHA and AWW

5.5 As per the XI Plan document, poor sanitation leads to high incidence of diarrhoeal diseases in the early years, undermining whatever little nutrition the infant taking in; hence the Total Sanitation Campaign (TSC) must force its pace.

5.6 The proposal for XII Plan states that one initiative should be the effective linking of AWC's with health sub centres as well as with drinking water and sanitation services.

5.7 Intervention and coordination with agriculture sector is also imperative. As per the XI plan document, per capita availability of cereals has declined and share of non cereals in food consumption has not grown to compensate for the decline in cereal availability. It has been stated that significant sections of population do not have the purchasing power to diversify their food consumption away from cereals. In this context MSP, Food Procurement Policy and PDS become significant.

5.8 Drinking Water and sanitation facilities are being provided in convergence with the schemes of the Ministry of Drinking Water Supply and TSC. Such convergence has been advocated from Central and State levels. The Ministry of Rural Development has also reportedly been addressed to provide potable water at the AWCs under the Rajiv Gandhi Drinking Water Mission.

PART – II

Observations/recommendations of the Committee

1. **Malnutrition has been recognised as a major threat to social and economic development and casts an adverse impact on children, adults, women and entire workforce of the country. The Committee are surprised to note that in the modern era of information technology, there is no recent official data on malnutrition. What is available is seven year old, outdated National Family Health Survey (NFHS) – III data of 2005-06. It is only now, the Ministry of Health and Family Welfare (MHFW) has proposed to conduct NFHS – IV and also decided to slash the periodicity of NFHS to three years. The Committee wonder why no efforts have been made so far to computerise the Anganwadi Centres (AWCs) in villages/habitations connected by broadband/internet and ensure real time data flow for nutrition monitoring. The Committee would urge the Ministry of Women and Child Development to prepare an action plan in this regard for time bound implementation under intimation to the Committee.**

2. **According to HUNGaMA survey of 2011, carried out on private initiative, the prevalence of child underweight has considerably decreased from 53.1 per cent in 2004 to 42 per cent in 2011. The Committee are, however, concerned to note that among children under five, 59 per cent are stunted and 3.3 per cent face severe wasting in the 100 focus districts which ranked the lowest on childhood development index in six States viz. Bihar, Jharkhand,**

Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh. Malnutrition is one of the underlying causes of under-five mortality. The Committee are disappointed to note in this connection that the aim of the National Rural Health Mission (NRHM) to bring down infant mortality rate to <30 per 1,000 live births by the year 2011-12 has not materialised and it remains as high as 44 per 1,000 live births as of October, 2012. Further, going by the past experience, the Committee doubt whether the Millennium Development Goal (MDG) to bring IMR down to 28 per 1000 live births by 2015 will be achieved. All these call for accelerated and vigorous implementation of nutrition related programmes with active co-operation and full involvement of State Governments.

3. With regard to the status of malnutrition among women in the country, the Committee note from the available data of NFHS – II and NFHS – III that the percentage of women in the age group of 15-49 having Body Mass Index (BMI) of less than 18.5 has risen from 33 per cent in 1999 to 35.6 per cent in 2006. During the same period, anaemia among married women has risen from 52 per cent to 56 per cent and among pregnant women from 49.7 per cent to 58.7 per cent. For want of data, the Committee are not in a position to comment whether there has been any improvement or further deterioration in the nutritional status of women during the last seven years. Though NFHS – IV, which is underway, would bring out the factual position in this regard, the Committee hope that the last seven years would have

registered an improvement in the nutritional status of women as in the case of children.

4. The Integrated Child Development Services (ICDS) scheme, commenced in 33 community development blocks in 1975 and universalised in the year 2008, is primarily aimed to improve the nutritional and health status of children in the age group of 0-6 years. The scheme has reportedly covered almost all habitations through 7076 approved projects and about 13.72 lakh sanctioned Anganwadi Centres (AWCs). The Committee regret to point out that nearly four decades of implementation of the scheme have not eliminated malnutrition of children which remains high as brought out in preceding paragraphs. In order to redress the management gaps, the ICDS is reportedly being implemented in Mission Mode by introducing Annual Programme Implementation Plan (APIP) and Memorandum of Understandings (MoUs) with States/UTs and rolling out the restructured ICDS in 200 high burden districts in 2012-13, in 200 additional districts in 2013-14 and in remaining districts in 2014-15. Though these steps are in the right direction, the Committee feel that unless specific targets to bring down the cases of malnutrition are fixed and AWCs and monitoring agencies held responsible for shortfall, the much desired results may continue to elude. The ICDS Mission for the Twelfth Five Year Plan 2012-17 has set the goal of preventing and reducing child undernutrition by 10 percentage points and reduction of anaemia prevalence in young children,

girls and women by one fifth. The Committee hope that these elements will be incorporated in the APIPs and MoUs. The Committee would like to be informed of the position in this regard and also of the achievements during 2012-13. Compensation and other facilities given to Anganwadi Workers (AWCs) and Accredited Social Health Activists (ASHAs) should be periodically revised to meet the increase in cost of living. The Committee desire that centralized guidelines regarding nutritional requirement and hygiene standards be issued to AWCs for strict adherence. There should be no experiments and compromise on quality of nutritional food to children.

5. The Committee received an impression that scarce resources are frittered away in setting up numerous AWCs/Mini AWCs without much focus on uplifting children's nutrition. As against 6.4 lakh villages (as per Census 2011) in the country, about 13.74 lakh AWCs have been sanctioned. The population norm of one AWC for 400-800 people fixed by the Ministry of Women and Child Development appears to be flawed as is evident from the fact that children under six (1645 lakh) constitute less than 13.6 per cent of the total population (121 crore) in our country. In other words, one AWC is expected to handle just 50-100 children on an average in a month which translates into merely 2-4 children per day (if the average in number of visit by children is once a month). The ratio of children-AWC will further go down if we consider the number of supplementary nutrition beneficiaries which is less than 928 lakh as on 31.01.2013. Considering the huge

overhead expenditure involved in establishing and maintaining an AWC, the Committee feel that there is a need to have a fresh look at the population norm for AWC. The feasibility of introducing mobile AWCs on an experimental basis to cover the thinly populated habitations ought to be explored to ensure optimum utilisation of resources. The Committee would await the outcome of examination of these matters by the Ministry of Women and Child Development.

6. The Committee are dismayed to learn that approximately 14,200 AWCs are run from open spaces; 12 lakh AWCs function without toilet facilities and 7 lakh AWCs operate without drinking water facilities. The Committee would like to place on record their deep sense of shock and disapproval over the absence of basic facilities in AWCs and would like the Government to formulate an action plan to provide the much needed infrastructure to facilitate their effective functioning. Approximately 3.97 lakh AWCs are functioning from rented buildings. The Committee have been informed that strengthened and restructured ICDS is being rolled out in a phased manner for construction of 2 lakh AWCs during the Twelfth Five Year Plan @ ₹ 4.5 lakh per unit. The Committee emphasise that, as already recommended elsewhere in this report, computerization and network connectivity should form part of the ICDS strengthening. The Committee would like to be apprised of the targets achieved on strengthening and restructuring of ICDS during 2012-13 and the progress made in 2013-14.

7. The Committee regret to note that even after two years, none of the States has introduced the 5 Tier Monitoring and review mechanism at all levels as per MWCD's guidelines of 31.03.2011. In Mizoram, Punjab and Delhi, only State level Committee has been constituted while in Jammu and Kashmir, Kerala, Maharashtra, Tamil Nadu, Uttar Pradesh, etc., the 5 Tier mechanism is still under process of constitution. The Committee urge the Ministry of Women and Child Development to vigorously pursue with the State Governments and ensure that the 5 Tier monitoring mechanism is put in place within a stipulated time frame.

8. The Committee are distressed to note the very poor implementation of Indira Gandhi Matritva Sahyog Yojana (IGMSY) scheme introduced in October, 2010. The centrally sponsored scheme implemented by the State Governments is aimed at improving the nutrition and health of pregnant and lactating women by paying Rs. 4000 on a conditional cash transfer mode to the beneficiaries' bank/post office accounts. As against the target of 12.5 lakh beneficiaries, the benefit reached merely 61,000 women (constituting 5 per cent) in the year 2011-12 and just 1.6 lakh women (constituting 12.8 per cent till 31 December, 2012) in the year 2012-13. The Committee desire that reasons for this disastrous performance of the scheme be gone into expeditiously and the benefits delivered to the targeted number of women without fail, during the current year.

9. The Committee note with satisfaction that the nutrition component of the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (AGs) – Sabla introduced in 2010 in 205 select districts has fared as targeted. However, the number of beneficiaries under the non-nutrition component was 37.81 lakh i.e. only 77 per cent of the targeted 49.16 lakh beneficiaries during 2011-12 and 33.19 lakh (till 31 December, 2012) as against the targets of 69.02 lakh during 2012-13. The non-nutrition component having six sub-components (including health check-up and referred services, Nutrition and Health Education, Guidance on family welfare, Adolescent Reproductive Sexual Health, Life style education and vocational training) reportedly requires convergence with various Ministries and render the progress slow. The Committee suggest that the bottlenecks faced in the implementation of the scheme should be expeditiously overcome by ensuring effective convergence of services with the schemes of Health, Education, Youth Affairs, Labour and Employment and Panchayat Raj Institutions.

10. The Ministry of Health and Family Welfare is engaged in micronutrient supplementation under 'Child Health' component to address the issue of nutritional deficiencies, under which it provides Vitamin A supplements that has a promotive and preventive role in addressing malnutrition. The Committee are happy to learn that the coverage of children of 9 months

and above with atleast one dose of Vitamin A has shown a substantial increase during the period of 4 years from 24.8 % in (NFHS III) 2005-06 to 65.4 % in (CES) 2009. The Committee are, however, concerned to note that in some States viz. Uttar Pradesh, Madhya Pradesh, Manipur, Meghalaya, Haryana, Bihar and Arunachal Pradesh etc. the coverage was below 50 per cent. According to the Ministry of Health & Family Welfare, biannual rounds are conducted in many States to supplement children between 1-5 years with Vitamin A. The Committee desire that the Ministry of Health and Family Welfare must widely publicize through media, the Village Health and Nutrition Day on the lines of Pulse Polio campaign. Further, efforts should be made to have upto-date data regarding coverage of children with the Vitamin A through real time on line data.

11. According to NFHS-III (2005-06), 70 % of children between 6-59 months and more than half of the women (15-49 years) suffer from anaemia in the country. More disturbing is the fact that prevalence of anaemia in children between 6-35 months had increased significantly from 74.3 per cent in 1998-99 to 78.9 per cent in 2005-06. It has been stated that to manage the widespread prevalence of anaemia, the policy has been that infants from the age of six months to the age of five years shall receive iron supplements in liquid formulation for 100 days in a year and the paediatric IFA tablets/syrup supplied to all sub-centres twice a year. The Committee would like to know the achievement in reduction of anaemia during the last

five years among children upto age of five years, 5-10 years, adolescent children and pregnant women.

12. Iodine is an essential micronutrient for normal growth and development. The Committee are distressed to observe that though the Government took a policy decision in 1984 to iodate the entire edible salt in the country by 1996, the goal is yet to be achieved. The production of iodated salt is just around 60 lakh M.T. against the annual production capacity of 120 lakh M.T. There are 263 districts which are endemic in the country with more than 10% Iodine Deficiency Disorder (IDD). The Committee fail to understand why the National Iodine Deficiancy Control Programme (NIDDCP) which aims among other things, to supply iodised salt in place of common salt could not show desired results. The Committee have been informed that surveys conducted in various parts of the country reported significant reduction in the prevalence of IDD and visible goitre. The 12th Five Year Plan has targeted that the prevalence of IDD in all districts of the country will be reduced below 5% and the visible goitre in the country will disappear. The Committee desire that causes for past failures should be looked into for effective remedial action and the targets of 12th Plan achieved without fail.

13. The Committee note that 604 Nutrition Rehabilitation Centres (NRCs) are operational in 14 States which admit sick children with severe acute

malnutrition alongwith care givers with compensation for period of their stay. The Ministry of Health & Family Welfare has now targeted to operationalise at least one NRC in each high burden district during the Twelfth Plan. The Committee would like to know the norms set for these centres, their capacity, facility and achievements of these during each of the last three years.

14. According to NFHS-III 2005-06 only 21% of children aged 6-23 months are fed according to all three quality parameters of Infant and Young Child Feeding (IYCF) practices recommended by WHO (timely, adequate and safe) and only 44% are breastfed as per the recommended minimum number of times. As per the latest data available (CES 2009), only about 34% of children under three years are breastfed within an hour of birth. There has, however, been some improvement in the percentage of children exclusively breastfed for 6 months i.e. from 46.3% in 2005-06 to 56.8% as per CES 2009. HuNGAMA Survey indicates that in 100 high focus districts, 51% mothers did not give colostrum to the new born soon after birth. The Committee feel that desired practices in this regard can be universalized only by bringing about awareness. The media campaign to achieve this appears to be inadequate. The Committee desire that intensive and sustained media campaign regarding nutrition education and appropriate feeding practices through mass media/social media including private radio and TV channels should be resorted to.

15. Since the problem of malnutrition is intergenerational and multi factoral, which can be dented only through addressing multiple factors such as poverty, illiteracy especially female illiteracy, gender discrimination, environment, hygiene and food scarcity, it is imperative that convergence with other schemes/Ministries is effected at the ground level. The Committee are appreciative of the measures for convergence and coordination with various Ministries such as those concerning Drinking Water Supply and Sanitation, Rural Development, Human Resource Development, Panchayati Raj, etc. The Committee desire that innovative strategies such as aligning mid day meals with nutritional norms through convergence with Ministry of Human Resource Development, or with the Ministry of Food and Consumer Affairs (M/o FCA) along with current interventions should be designed and effectively implemented with adequate funding.

New Delhi
September, 2013
Bhadrapada, 1935 (Saka)

FRANCISCO SARDINHA
Chairman,
Committee on Estimates.

Appendix I

(vide Para no. 1.8)

Schemes/programmes implemented by Government for Mother and Infants at different stages of life are as given below.

BENEFICIARIES	SCHEMES	YEAR OF EXPANSION/UNIVERSALISATION
Pregnant and Lactating Mothers	Integrated Child Development Services (ICDS), Reproductive and Child Health(RCH)-II, National Rural Health Mission (NRHM) , JananiSurakshaYojana(JSY), Indira Gandhi MatritvaSahyogYojana (IGMSY) (52 districts)	NRHM (2005-06) JSY (2006-07) ICDS (2008-09)
Children 0 – 3 years	ICDS, RCH- II, NRHM, Rajiv Gandhi National Creche Scheme (RGNCS)	RGNCS (2005-06) ICDS (2008-09)
Children 3 – 6 years	ICDS, RCH- II, NRHM, Rajiv Gandhi National Creche Scheme, Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	TSC (2008-09)
School going children 6 – 14 yrs & Adolescent Girls 11 – 18 years	Mid Day Meals (MDM), *SarvaShikshaAbhiyan* Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG) in 200 districts, Kishori Shakti Yojna (KSY), Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	SSA (2002/2005-06) MDM (2008-09) RGSEAG (2010-11) NRDWP (2010)
Adults	Mahatama Gandhi National Rural Employment Guarantee Scheme (MGNREGS), Skill Development Mission,	NHM (2005-06) MGNREGS (2005-06) NIDDCP (1992)

	Women Welfare and Support Programme, Adult Literacy Programme, Targeted Public Distribution System, *Antodaya Anna Yojana, RashtriyaKrishiVikasYojana,* Food Security Mission, National Rural Drinking Water Programme and Total Sanitation Campaign, National Horticulture Mission, National Iodine Deficiency Disorders ContolProgramme (NIDDCP), Nutrition Education and Extension, *Bharat Nirman, RashtriyaSwasthyaBimaYojana etc.*	RSBY (2007) Bharat Nirman (2005)

Appendix II

(vide Para no. 4.19)

State-wise Nutritional Status of Women (NFHS-III) 2005-06

Percentage of women age 15-49 years with Chronic Energy Deficit

…….

State	Body Mass Index (BMI)* in kg/sq.m
	<18.5 (Total thin)❖
India	35.6
Delhi	14.8
Haryana	31.3
Himachal Pradesh	29.9
Jammu & Kashmir	24.6
Punjab	18.9
Rajasthan	36.7
Uttarakhand	30.0
Chhattisgarh	43.4
Madhya Pradesh	41.7
Uttar Pradesh	36.0
Bihar	45.1
Jharkhand	43.0
Orissa	41.4
West Bengal	39.1
Arunachal Pradesh	16.4
Assam	36.5
Manipur	14.8
Meghalaya	14.6
Mizoram	14.4
Nagaland	17.4
Sikkim	11.2
Tripura	36.9
Goa	27.9
Gujarat	36.3
Maharashtra	36.2
Andhra Pradesh	33.5
Karnataka	35.5
Kerala	18.0
Tamil Nadu	28.4

Appendix III
(vide Para no.)

State-wise number of sanctioned, operational ICDS Projects and Anganwadi centres (AWCs) and number of beneficiaries (children 6 months- 6 years and pregnant & lactating mothers (P&LM)) under ICDS Scheme as on December 2012

Sl. No.	State/UT	No. of ICDS Projects		No. of AWCs		Beneficiaries for Supplementary Nutrition					Beneficiaries for Pre-school Education		
		Sanctioned	Operational	Sanctioned	Operational	Children (6 months - 3 years)	Children (3 - 6 years)	Total Children (6 months - 6 years)	Pregnant & lactating Mothers (P&LM)	Total Ben.(Children 6 mo-6 years plus P&LM)	Boys (3 - 6 years)	Girls (3 - 6 years)	Total (3 - 6 years)
1	Andhra Pradesh	406	387	91307	88005	2631226	1615230	4246456	1311341	5557797	800866	807466	1608332
2	Arunachal Pradesh	98	93	6225	6028	112264	113819	226083	29789	255872	57175	56644	113819
3	Assam	231	231	62153	58699	1015405	1195597	2211002	400115	2611117	612120	602280	1214400
4	Bihar	545	544	91968	81829	1786099	1721778	3507877	710378	4218255	981475	955923	1937398
5	Chhattisgarh	220	220	64390	49317	1168980	881299	2050279	473773	2524052	437781	447459	885240
6	Goa	11	11	1262	1262	17528	35029	52557	17115	69672	9257	9208	18465
7	Gujarat	336	336	52137	50226	1799438	1319703	3119141	788789	3907930	680595	641646	1322241
8	Haryana	148	148	25962	25245	701684	392159	1093843	325844	1419687	206483	185745	392228
9	Himachal Pradesh	78	78	18925	18651	260245	162696	422941	100387	523328	73215	72310	145525
10	Jammu & Kashmir	141	141	28577	28577	251810	190787	442597	126611	569208	138510	128648	267158
11	Jharkhand	224	204	38432	38432	840312	1156819	1997131	662987	2660118	600500	675468	1275968

12	Karnataka	204	185	64518	63377	1986565	1669195	3655760	914590	4570350	838827	888035	1726862
13	Kerala	258	258	33115	33110	421540	464249	885789	195927	1081716	266363	224808	491171
14	Madhya Pradesh	453	453	92230	90999	3535797	3367269	6903066	1412698	8315764	1423618	1378423	2802041
15	Maharashtra	553	553	110486	106231	3084125	3162119	6246244	1222861	7469105	1626803	1498620	3125423
16	Manipur	43	42	11510	9883	175636	179540	355176	75010	430186	90343	89179	179522
17	Meghalaya	41	41	5156	5156	167428	188600	356028	63755	419783	75493	75222	150715
18	Mizoram	27	27	1980	1980	71637	57200	128837	37476	166313	27377	26793	54170
19	Nagaland	60	59	3515	3455	118133	106567	224700	53922	278622	64741	63209	127950
20	Orissa	338	338	72873	71134	1988773	1851288	3840061	806058	4646119	721730	708839	1430569
21	Punjab	155	154	26656	26656	600830	460668	1061498	288318	1349816	239791	220877	460668
22	Rajasthan	304	304	61119	61100	1719760	1078349	2798109	836405	3634514	563476	554752	1118228
23	Sikkim	13	13	1233	1233	5883	13387	19270	2191	21461	6701	6686	13387
24	Tamil Nadu	434	434	55542	54439	1119700	666847	1786547	664121	2450668	568780	550920	1119700
25	Tripura	56	56	9911	9906	143235	159212	302447	81946	384393	84849	79475	164324
26	Uttar Pradesh	897	897	187517	187347	10491712	8211478	18703190	4940615	23643805	4453669	4092798	8546467
27	Uttrakhand	105	105	23159	18427	91044	259192	350236	5681	355917	159983	137532	297515
28	West Bengal	576	574	117170	116390	3414775	3266415	6681190	1337366	8018556	1649331	1611639	3260970

29	A & N Islands	5	5	720	699	9258	5769	15027	3666	18693	2898	2871	5769
30	Chandigarh	3	3	500	420	22227	16287	38514	8689	47203	8141	8146	16287
31	Delhi	95	94	11150	10615	523829	373606	897435	170961	1068396	192297	181309	373606
32	Dadra & N Haveli	2	2	267	267	8453	6677	15130	2941	18071	3314	3363	6677
33	Daman & Diu	2	2	107	102	3258	2481	5739	1451	7190	1195	1274	2469
34	Lakshadweep	9	9	107	107	2503	2362	4865	1812	6677	1178	1184	2362
35	Puducherry	5	5	788	788	26398	5512	31910	9760	41670	2788	2724	5512
	All India	**7076**	**7006**	**1372667**	**1320092**	**40317490**	**34359185**	**74676675**	**18085349**	**92762024**	**17671663**	**16991475**	**34663138**
* Based on State level consolidated report sent by State Government and information sent in templates by State Governments/ UT Administration.													

Appendix IV
(vide Para no. 4.17)

Appendix IV

(vide Para no. 4.17)

Nutritional Rehabilitation Centres (NRCs) across States and UTs as on September 2012

State	**NRCs**
West Bengal	**10**
Assam	**4**
Chhattisgarh	**37**
Delhi	**11**
Gujarat	**79**
Jharkhand	**59**
Karnataka	**19**
Maharahstra	**6**
M.P	**275**
Odisha	**7**
Rajasthan	**40**
U.P	**16**
Bihar	**38**
Andhra Pradesh	**4**
	604

MINUTES OF ELEVENTH SITTING OF COMMITTEE ON ESTIMATES

(2012-2013)

The Committee sat on Monday, the 22nd October, 2012 from 1415 hrs. to 1600 hrs. in Committee Room 'E', Parliament House Annexe, New Delhi.

PRESENT

Shri Francisco Sardinha - Chairman

MEMBERS

2. Shri E.T. Mohammed Basheer
3. Dr. Sanjay Jaiswal
4. Dr. Thokchom Meinya
5. Smt. Ranee Narah
6. Shri Prabodh Panda
7. Dr. Vinay Pandey
8. Shri Rayapati Sambasiva Rao
9. Smt. Yashodhara Raje Scindia
10. Shri S. Semmalai
11. Shri M.I. Shanavas
12. Shri Jagdish Sharma
13. Shri Neeraj Shekhar
14. Shri Uma Shankar Singh

SECRETARIAT

1.	Shri A. Louis Martin	-	Joint Secretary
2.	Smt. Anita B. Panda	-	Director
3.	Dr. Yumnam Arun Kumar	-	Deputy Secretary

WITNESSES

Representatives of the Ministry of Health and Family Welfare (Department of Health)

	Name	Designation
1.	Shri P.K. Pradhan	Secretary, (Department of Health)
2.	Ms. Anuradha Gupta	AS&MD (NRHM)
3.	Dr. Rakesh Kumar	Joint Secretary (RCH)
4.	Dr. Ajay Khera	DC (CH&I)

Representatives of the Ministry of Women and Child Development

	Name	Designation
1.	Shri Prem Narain	Secretary
2.	Dr. Shreeranjan	Joint Secretary
3.	Dr. Dinesh Paul	Director, NIPCCD

2. At the outset, the Chairman welcomed the Members of the Committee and representatives of the Ministries of Health & Family Welfare and Women & Child Development to the sitting of the Committee convened to have a briefing on the subject 'Malnutrition in Infants and Mothers'. The Chairman, in his opening remarks, highlighted the gravity of the situation by quoting various facts and figures, especially those relating to India's position vis-à-vis other developing countries. He urged the representatives of both the Ministries to apprise the Committee about the underlying causes for persistently high rates of malnutrition and the strategies being chalked out by them to tackle it in a comprehensive and holistic manner.

3. Thereafter, the Health Secretary made a presentation on the subject highlighting their multi-pronged approach to check malnutrition which *inter-alia* included improving the antenatal check up, tracking of mothers and children through registered data base, focusing on minimizing neo-natal mortality, creation of more nutrition centres, etc. He also highlighted a three point drop in the Infant Mortality Rate lately and emphasized upon the need for convergence with other Ministries such as those handling Women and the Child Development and Drinking Water and Sanitation to ensure a better nutritional status for infant and mothers.

4. Thereafter, the Secretary, Ministry of Women and Child Development briefed the Committee on various facets of the problem and highlighted the significance of preventing malnutrition at the earliest in order to avoid its adverse impact on cumulative growth and development among children. He also explained the performance and restructuring of Integrated Child Development Scheme (ICDS), which is the biggest flagship programme for child nutrition. Certain other initiatives such as introduction of new WHO Child Growth Studies, Joint Mother and Child Protection Card under ICDS, the National Rural Health Mission (NRHM), role of Anganwadis, holding of Village Health & Nutrition Days etc. were also explained to the Committee.

5. The Members, thereafter, raised various issues and queries related to the subject and the representatives of the Ministries responded to the same. Some of these included setting up of a Monitoring Committee for each district headed by local MP for implementation of ICDS and efforts to improve the percolation of ICDS services in States like U.P. and Bihar, community involvement, fixing accountability of officials/ bureaucrats, more responsibility to panchayats to implement ICDS, bringing better awareness on malnutrition and other programmes/schemes for preventing malnutrition and taking further long and short terms measures by both Ministries. The representatives were asked to furnish replies in writing to the points raised by Members for which answers were not readily available during the course of discussion. The Members also made useful suggestions which *inter-alia* included improving dietary diversification, universal access to iodized salt and an increased community participation with highest concentration of malnutrition.

6. The Committee also decided to call the representatives of the Ministry of Human Resource Development to brief the Committee on various issues related to the subject especially the 'Mid-day Meal Scheme' at a later stage.

7. A verbatim record of the proceedings has been kept.

The Committee then adjourned.