Viewpoint

Integrated Child Development Services Scheme: Need for Reappraisal

We read with great interest the recent 'Viewpoint' on this subject(l). Dr. Ghosh, a renowned pediatrician and academician with vast experience in the field of Maternal and Child Health (MCH), has reviewed the various components of the ICDS programme as implemented in the country. She has described specific deficiencies of the programme and has suggested remedial measures which should be incorporated into the scheme for its improvement. However, we would also like to share our experiences of the ICDS programme in this context.

One of the critical issues of debate in the ICDS programme has been distribution of supplementary nutrition (SN) to the beneficiaries. This has been discussed in almost all forums in which this scheme is a part of the agenda. As per the Government of India guidelines, while selecting the location for an ICDS project, preference is to be given to those areas which are: (i) predominantly inhabited by underprivileged, vulnerable and weaker sections of society (scheduled castes, scheduled tribes); (ii) economically backward areas; *(iii)* drought prone areas; and *(iv)* areas in which the development of social services requires strengthening(2). In India, where about 40% of the population lives below the poverty line, it is expected that the families, particularly mothers and children, in the above mentioned areas will be at the maximum disadvantage as far as availability of food is concerned. Hence, rightly the programme managers in 1975 decided to have SN as a programme component. The prime concern of mothers and children in such a group is availability of food, to bridge the gap of dietary inadequacy, rather than the taste of the SN which becomes a secondary concern. Due to the democratic set up in our country. ICDS projects have also been initiated in population groups which are not recommended in the inclusion criteria and therefore issues of taste and acceptability of the SN have been correctly voiced by the beneficiaries. The National Nutrition Monitoring Bureau (NNMB) data shows that inspite of all developmental programme activities, the deficit of calories continues in the low income group(3). To discontinue SN for the entire ICDS scheme therefore may be detrimental to the services provided to the most disadvantaged mothers and children. However, in areas which are economically better, where beneficiaries do not require SN, a selective approach of discontinuation of SN may be considered.

Dr. Ghosh has mentioned that Anganwadi Centers (AWCs) are closed when food supplies are exhausted. There are more than 3 lakh AWCs which are functioning in this country(2). No hard data is available to indicate how many AWCs remained closed, when SN is not available. There are many Anganwadi Workers (AWWs) who have been undertaking innovative activities for the holistic development of the child even without SN.

We agree with Dr. Ghosh that growth monitoring (GM) is not being conducted in a way as it was conceptualised. However, these negative findings on GM in the ICDS projects have been reported recently(4,5).

We learn from our field experiences. The Government is considering modification of the technical components of the programme and GM is one such activity.

The ICDS scheme has been reviewed, monitored and evaluated concurrently by a large number of independent agencies. Based 011 the feedback received, several mid course corrections have been undertaken to improve the programme implementation. The training programme of the Child Development Project Officers (CDPOs). Supervisors and AWWs has been revised more than three times to make it more realistic and as per the job requirements of these functionaries. In the preplacement training programme, the health and nutrition components have been given more emphasis for the AWWs while special session on managerial aspects has been included for the CDPOs(6).

Only broad guidelines are provided by the Government of India for the programme implementation and therefore a flexibility exists in the states for programme implementation. In India, health is a state subject, five out of six services of the ICDS scheme, directly belong to the health sector. This means that each state government can modify the programme according to its own priorities and needs. The states of Kerala, Tamilnadu, Andhra Pradesh, Karnataka, Maharashtra and Gujarat have adapted the programme according to their local needs and have achieved a higher success in implementation of the ICDS programme and thereby in the promotion of MCH.

There are several research studies which have documented the positive impact of ICDS programme on MCH(7). There are also studies who have not documented the same. The ICDS scheme is the largest outreach programme aimed at the promotion of MCH and has helped in strengthening the implementation of various components of the MCH programme of the health department like immunization, distribution of iron folic acid and vitamin A, antenatal care, *etc.* The ICDS scheme provides a venue for undertaking all MCH activities in a village by the ANM. AWW being a local resident is available at the village. This is the most important reason why today all MCH promoting programmes invariably include AWWs into their programme activities.

Protein energy malnutrition is a problem of multi-factorial origin. It starts from the intra-uterine stage when a undernourished woman becomes pregnant and delivers a low birth weight baby. The problem of underweight is further aggravated by faulty weaning and rearing practices prevalent in our country. The weaning foods in India are largely based on cereals which do not have adequate caloric density. The young child has a small stomach and therefore requires frequent feeding for which adequate time is not available with the mother. These mothers are usually engaged in work within the household or outside to fight for their own survival and existence. The ICDS scheme is the only programme in which an attempt has been made to prevent undernutrition from intra-uterine period. The pregnant mothers are provided with SN as soon as they found to be pregnant.

We agree that due to certain inherent socio-cultural and economic reasons the "under three" children who require ICDS services the most are not able to avail them. Concrete efforts are being made by the Government of India and State Governments to provide high priority to the coverage of "under three" children.

We sincerely feel that the observations and findings of the international visiting scientists who spend one to two years and

at times few weeks only in the country, and publish research papers on the ICDS scheme implementation should be taken with a pinch of salt. Most of their findings are based on discussions held with academicians, planners, administrators and clinicians in metropolitan cities or district headquarters. Experiences and findings of dedicated scientists who are working at the field level in the village unfortunately, do not get published as multi-color monographs or in form of scientific reports. Our own personal discussions with such scientists like Director, Institute of Health Management, Pachod(8) confirms that ICDS scheme is effective if adapted according to the local needs of an area. This scheme significantly contributes in the promotion of MCH activities.

ICDS scheme is a social programme and should be viewed keeping this fact in mind. Percentages and decimals should not be a criteria for judging the success of the programme. The programme should be looked from the point of the overall social awakening created by it amongst community members and mothers in particular. Under the ICDS scheme, young children and mothers from different castes and religion consume food from the same kitchen under one roof. This has helped in breaking the age old caste barrier in rural India. What is the cost benefit of this social integration activity?

Dr. Ghosh's suggestion to give the ICDS programme to the community for its total management is highly commendable. Constant efforts are being made in this direction; however, limited success has been achieved. It is difficult to envisage that a large scale programme like the ICDS can be totally owned up by the community. In small projects targeting 40 to 60 thousand population, active community participation and partial ownership has been possible(9,10). This is largely due to the able leadership provided to these projects rather than the community getting united and coming forward to own the programme.

The involvement of adolescent girls has become an important component of ICDS programme. At present it is operational in 507 ICDS projects(2) in which they facilitate the work of AWWs and also receive nutrition and health education and SN. Attempts are being made to provide all the adolescent girls with iron folic tablets and give them family life education to prepare them for safe motherhood.

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Reply

I am glad to receive a response to my paper on the Integrated Child Development Services programme. This can facilitate a little more discussion on some points which were earlier omitted for the sake of brevity.

Kapil and Tandon in their paper in 1994(1) had identified twenty points, attention to which could make ICDS more effective. Several of these points were similar to what I have suggested in my paper.

It is quite correct to say that certain areas and communities are economically disadvantaged and for them supplementary nutrition is a great help and I have referred to this in my paper also. Not only this, they should be assured of food security at the household level through Public Distribution System (PDS) and the poverty-alleviation programmes. But there are large areas where the community does not bother about it because of several reasons which are well known. Even the poor and the deprived are discerning about the food they eat and its taste because they have so little. In Madhya Pradesh the World Food Programme has used several innovations to make the food more acceptable. It has also been done at a micro level by several programme implementers including the National Institute of Nutrition in urban and Mehtab Bamji in a rural blocks of Andhra Pradesh. Community involvement and interaction is a pre-requisite for such changes. There are good examples of this from Bangladesh and several other countries where the families contributed in the form of vegetables, spices and whatever else was possible and helped in cooking. Nutrition education and awareness creation (which is low key in ICDS) is an important part of nutrition improvement programmes, and not just food distribution.

In my paper I have referred to the positive aspects of convergence with health which has resulted in much better MCH coverage. However, there is tremendous scope for improving it with better collaboration between the two.

The authors agree that the most vulnerable group - the under three children in whom there is maximum malnutrition are not in the programme. It stands to reason

that every nutrition and development programme must give priority to this group. This can only be done at the community level, and one possibility as I have suggested is to have another AWW at least in a few blocks to begin with who could work at the community level. People's beliefs and prejudices can only be overcome with intense interaction and nowhere is this more true than in the case of young children.

The authors quote Director, Institute of Health Management, Pachod and I fully agree that ICDS scheme is effective if adapted to the special needs. I wonder if they perused his evaluation of the World Bank funded ICDS HI in Maharashtra which I have referred to in my paper. Several reports including those of the National Institute of Public Cooperation and Child Development (NIPCCD) and ICDS III Maharashtra have shown no difference in the nutritional status of ICDS and non-ICDS blocks. To say that foreigners come for a short time and write reports is not fair. Mary Ann Anderson was closely involved with ICDS in the tribal blocks of Chandrapur and Panchmahal and identified stunting as a serious problem. Kennedy and Slack reviewed a large number of publications on behalf of the World Food Programme and gave their evaluation. CARE has actually been working in this area for several years and evaluated its own programmes, so they cannot be reckoned as casual observers, whose findings need to be taken with a "pinch of salt". CARE has made several changes in the programme recently.

The debate can go on endlessly, but the point I wish to make is that ICDS is an excellent concept; let us see how we can make it more responsive to the needs of mothers and children, and among the children those under three who are the most vulnerable.

I was delighted to see the news item "Healthier Children" in the Times of India December 29, 1997 which highlights some new strategies to improve nutrition in younger children in ICDS as well as to improve food security. We need more such strategies if we have to improve nutrition status of the young children as well as the population in drought prone areas.

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