Viewpoint

Integrated Child Development Services Programme - Need for Reappraisal

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There has been deep concern, but not much action for the past several decades, about the prevalence of malnutrition among young children in India. Most observers and policy makers have tended to attribute it to the prevalence of poverty, and since alleviation of that is a herculean task, they have just not faced upto the basic nature of the problem, but found recourse in supplementary nutrition programmes, of which the Integrated Child Development Services Programme (ICDS), is the most important one.

Considerable data has now become available regarding 6 months to 2 years being the most vulnerable age concerning malnutrition (l-4), even though the fact has been well known to anyone working with children. I called this period as one of perpetual hunger, because the child was dependent on someone else to feed him/her and this person did not have the knowledge and awareness (or time) regarding how much food this child needed and how often and that poverty was not the primary cause as was commonly assumed(5). The National Family Health Survey (NFHS) has shown that the pattern of malnutrition is the same in every state even though the extent varies.

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The mid-decade goal for malnutrition reduction in India, was to reduce the prevalence of severe and moderate malnutrition among two year old children by 20% of the 1990 level by end 1995. This has clearly not been achieved. NFHS has identified stunting in 52.0% and wasting in 17.5% children under four years of age.

While the essence of management is breastfeeding and the improved complementary feeding practices in children 6 months onwards at the household level, for which there is need for proper knowledge and awareness of the family regarding dietary requirements of the young child, the emphasis instead has seen on supplementary nutrition programmes.

The risk of death from common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child and may be as high as eight times for a severely malnourished child. For a malnourished child, every infection is a potentially fatal illness. This has relevance to the goal set for the reduction of infant and under five mortality for the year 2000.

The Integrated Child Development Services (ICDS) programme was initiated in 1975 as a small beginning in 33 blocks and now after twenty years, covers almost 4000 blocks out of the 5239 blocks *i.e.,* 75% of the country, and will cover the whole country during the Ninth Five Year Plan. It is considered to be the biggest child welfare programme in Asia and probably in the world. The emphasis is on the low socioeconomic group families, scheduled castes and scheduled tribes.

The package of services consists of

supplementary nutrition to children and to pregnant women during the last trimester of pregnancy as well as to lactating mothers, immunization, health check up, referral services and non-formal education and Nutrition and Health Education (NHE) to enhance the capability of the mother to look after the health and nutrition needs of the child through proper nutrition and health education.

The Anganwadi Center (AWC) is a focal point for the delivery of services for mothers and children and for convergence of services of various sectors like health, education, rural development, *etc.* Community mobilization and participation has been considered to be of vital importance for achieving the objectives of ICDS.

This innovative programme has attracted a lot of attention of the World health community and evaluations have been done every few years by the donor agencies as well as by Indian researchers and scientists. For an ongoing documentation, evaluation and training, a Central Technical Committee (CTC) was set up to encourage the medical college Faculty members as well as the district health officers to participate in the scheme.

Obviously the programme has contributed a great deal in creating awareness regarding health and nutrition of mothers and children and child development. The convergence of health services at the AWC has improved the immunization status of pregnant women and children, increased health check-ups and improved the management of morbidity. But it has failed to have the kind of impact that was envisaged. It was basically looked upon as a programme for improving nutrition of preschool children, but the programme caters mainly to children 3-6 years. The aim should have been to prevent malnutrition for which the priority group is 6 months to 2-3 years, rather than the older age group, when malnutrition has already set in and while the various constituents of the programme can help to ameliorate the situation to a certain extent, it cannot and has not made a basic difference. It has been reported by nearly all reviewers and programme managers that the participations of younger children is minimal. That is a difficult age group to reach, and the only way to do that is to mobilize the community. Obviously the programme for them cannot be entirely AWC based. However, community participation is by and large absent. At the time of the initiation of the programme it was envisaged that in ten years time, the community will be empowered to take over the programme. This hope has not materialized and the participation is limited to providing some space for AWC here and there and contribution towards fuel, when necessary. It is looked upon as a government programme and all the shortcomings are laid at government's door. Even after twenty years, the helper goes out every morning to collect the children for AWC. One of the objectives of the programme *viz.,* to enhance the capability of the mother and the family to look after the health and nutrition needs of the child through community interaction and relevant nutrition and health education remains largely unfulfilled.

Supplementary Nutrition

This is considered to be the core of the programme and a great deal of time of AWW is spent on the various activities concerned with this-recording, storing, cooking, distribution *etc.,* with the objective of improving the nutrition status of children. However, the food supplies are erratic and there are large gaps in the feeding programme according to several reports(6) and personal discussions with workers. Besides, the food is considered of poor quality

and not tasty. Acceptability is much better in tribal areas. Often the food has deteriorated and is not fit for consumption, and many digestive problems are attributed to it. The quantity is often far below the stipulated amount. Whether it is a supplement or a substitute is also not clear.

The participation of pregnant and lactating women in the supplementary food programme is very low. There are many reasons offered-the food is not palatable, women do not have the time to come to the AWC, *etc.* But often it is because they feel that it is not dignified and while it does not matter in the case of children they say, the women cannot bring themselves to do that. The off take of food for children and women is better in tribal areas because of lower economic level.

AWC is closed when the food supplies run out which could be days or weeks. This is inevitable because the AWW looks upon this as the core of the programme and according to her the children do not come if there is no food. The supervisory staff are aware of it and have not tried to change this practice. Surely this can be overcome with community mobilization and awareness creation. Why should the other vital activities such as preschool education, health inputs, nutrition and health education and awareness creation not be continued with greater vigour, because with the absence of the activities concerned with supplementary nutrition, there is more time for these? Indeed in personal discussions, several families have said exactly that. The preschool education component is the one they seem to value.

Pre-School Education

Whatever the quality of pre-school education (and it has scope for tremendous improvement), it has contributed a great deal to child development and has encouraged school enrollment and retention(7). Even in the absence of suitable play material and equipment (often the education material is used for display rather than used by children), children have benefited a great deal, but the AWW's schedule is so stretched that she cannot devote sufficient time to it. Unfortunately this activity is by and large limited* to children"3-6 years, and younger children on whom the impact of this activity would be far greater, are not in the programme. The crucial age of lVi-3 years is thus left out. According to child psychologists, 50% of the variance in intelectual development is established by 4 years of age. The young children could participate in small groups of 5-10, even 2-3 days a week with the help of the community members. On the whole the programme is by and large not geared to catering to the younger children.

Growth Monitoring and Promotion (GMP)

A great deal of time is spent in weighing children-growth monitoring and promotion (GMP), and recording their weight on growth charts. There is no interaction with the mother at all. The weight is usually written on a piece of paper or in a notebook, and entered on the growth chart as and when AWW has the time. So it becomes a mere record and ritual with no understanding of the value of GMP and no involvement of the mother at all. Not all AWW's are adequately knowledgeable in weighing and recording the weight on the growth chart and interpreting it. The level of education of many is not sufficient for this activity. The P part of the GMP is totally forgotten and neither the AWW nor the mother can respond to it. The child is graded according to the grade of malnutrition and not whether there is growth or the lack of it. The growth charts used in the programme too emphasize grades and that

is what AWW is expected to report every month. This activity needs a great deal of time, training, supervision and support, and unless that is forthcoming, it becomes a waste of time. Child nutrition will not improve by just weighing the children. And yet this activity is going on all over the country without a serious thought having been given to its usefulness or to modifying it in some way. Even the evaluation of USAID funded Panchmahal and Chandrapur programme(8) where training and on the job supervision was very good, showed that while AWWs could plot the weight accurately they could not or did not have any communication with the mother regarding this. UNICEF which was a great supporter of this strategy has now come to realize that by and large it does not work in the field situation (9,10). Gopalan and Chatterjee(11) had emphasized that several years earlier and there have been several other reports as well(12-14). GMP is a useful activity if it provides information that is useful for assessment and analysis of the cause of growth faltering followed by affordable actions appropriate for each of these causes.

Training and Supervision

Another component that is lacking is supervision and on the job training both by the supervisors and the CDPOs. The supervisor cannot or does not visit AWC once a month as is stipulated and hardly ever visits the community. It is an inspection rather than supportive supervision and I am afraid is at times done long distance! Supervisors could help organize Mahila Mandals and interact with panchayats and thereby help community participation in the programme. CDPO is too busy with the paper work and meetings and does not have much time for meaningful field visits either. Besides, vacant posts add to the problems. So AWW has to be content with the basic training which is unsatisfactory. The 300 odd centers where this training is carried out are ill-staffed and ill-equipped and do not prepare AWW for the work ahead of her. There is no in-service training and so AWW, who is the kingpin of the programme, carries on with whatever knowledge she imbibed initially. It is remarkable how so many of them manage to do what they do! However, their knowledge regarding infant and young child feeding is rudimentary at best. They have no idea of the nutritional requirements of the young child, benefits of exclusive breastfeeding and what supplementary home based food they would advise a child of 5-6 months onwards when breastfeeding alone is not adequate.

Burdened with paper work a large number of registers mostly focussing on inputs with little attention to impact or use of data to improve impact, current training and supervision is disproportionately titled towards records and reports instead of quality assessment, support and continuing education. This problem has been debated for the past decade or more but the modality remains the same.

I have a good opportunity of meeting several CDPOs when they come for refresher training to the National Institute of Public Co-operation and Child Development (NIPCCD). Very few of them understand the concept of growth or addition of home food to the diet. They seem only interested in records and reports. I learn **a** lot about programme constraints from them—too many AWCs per supervisor, job vacancies, gaps in food supplement, quality of food, reluctance of women to come for food, interference by politicians and in some cases non-receipt of pay and emoluments. The more knowledgeable ones among them, do offer some suggestions for improvement of the services, but "who

listens to us?" is a common refrain.

The basic premise of the programme should be to prevent malnutrition and keep children healthy. However, the most critical period for malnutrition is 6 months to 2 years, when almost 60% children become malnourished and stunted. So by the time they get attention at the ICDS programme, they are already moderately to severely malnourished and so the ICDS becomes concerned with managing malnutrition rather than preventing it. Mary Ann Anderson, a nutritionist with USAID, had highlighted the prevalence of stunting among these children more than a decade ago (paper presented at a NIPCCD workshop). The tragedy is that these children are a part of the programme and yet they are not truly in the programme. The interventions are carried out much too late with very marginal benefit, and yet this malnutrition could have been prevented by right advice regarding feeding and timely management of morbidity. Repeated infections contribute significantly to malnutrition and to the high mortality.

In a vast country like India with more then 5000 blocks, the same norms and rules apply from Kashmir to Kanyakumari with no local variation or innovation. The level of development, population density, roads, transport, *etc.* and people's attitudes and beliefs vary from one place to another and we cannot apply the same norms everywhere. In densely populated large villages, one AWW could look after more than 1000 population while in some sparsely populated areas, even 500 population may be too much. Centralized planning has failed to fulfill the special need of difficult areas. In tribal areas and remote villages, it is difficult even to find a literate AWW. Recently some innovation has been done in a tribal area to have a mini AWC for each hamlet.

Nutritional Status Evaluation

One of the largest evaluation was carried out by NIPCCD (6) in 100 blocks in 1990-92. This comprised 9% sample of ICDS programme of which 54 were rural, 28 tribal and 18 urban. Approximately 28,000 households were included in the study. The nutritional status according to the evaluation is depicted in *Table I.*

Tandon in 1989(15) reported on the nutritional status in ICDS blocks after they had been functional for 3-5 years and 8 years and compared this with the non-ICDS blocks at 10 years interval *(Table II).* There was considerable improvement in the non-ICDS areas during this period, as has also been shown by the National Nutrition Monitoring Bureau (16, 17). However, there was no difference between this and the ICDS blocks which had been functional for 8 years.

An evaluation by the National Institute of Nutrition (18), also found no difference in the nutrition status between ICDS and non-ICDS areas in the 5 states studied. Immunization and vitamin A coverage was much better in the ICDS area. There were vast differences between the States, *e.g.,* vitamin A coverage was 45% in Andhra Pradesh and only 11% in Bihar. AWC acted as a nodal point for these activities. Another significant observation was that most

TABLE I- *Nutritional Status in the NIPCCD Evaluation*

Age group	ICDS %	Non ICDS %
0-3 years		
Moderately malnourished	22.4	23.7
Severely malnourished	6.8	8.6
3-6 years		
Moderately malnourished	21.3	24.7
Severely malnourished	4.0	5.5

TABLE II–*Comparison of Nutritional Status(15).*

Nutrition Status	Non ICDS (%)		ICDS (%)	
	1976	1985	3-5 years	8 years
Normal and grade I	47.2	69.5	74.6	72.6
Grade II	27.0	19.7	17.3	19.8
Grades III & IV	19.1	8.4	6.4	6.3

AWWs in Madhya Pradesh and Bihar could not plot weights.

Impact evaluation of CARE programme, 1994(19), stressed that ICDS focusses most on rehabilitation of the severely malnourished child than on identifying and preventing growth faltering. There was hardly any difference in the nutritional status. of ICDS and non-ICDS groups. A recent evaluation of ICDS III in Maharashtra(20), came to the same conclusion and stressed the fact that there was no evidence to suggest that supplementary nutrition in ICDS has had any impact on the prevalence of severe malnutrition. There was a demand from the community for better pre-school education activities.

Convergence of Services

One of the major benefits of ICDS has been convergence of health and the activities of A We. Even though the ANM does not in all areas visit A WC as frequently as proposed, but still it has made a difference. Antenatal care and immunization coverage is much better in the ICDS blocks as the data from Tandon(21) 'and NIPCCD evaluation(6) shows. Iron and vitamin A coverage is also better. There is some evidence of early response to illness and of course the drug kit with A WW has also proved useful. If only ICDS could have formed the convergence point of basic health inputs and of health and nutrition education and preschool activities instead of being bogged down with food supplements, the results would have been far better. Food distribution is visible, and once started, it is difficult to give it up. It is perfectly logical to give a snack to the children with the active participation of the community (we all give a snack to our children when they go to nursery schools because they get hungry) but this is not supplementary nutrition. Unfortunately the health ministries too have not been very forthcoming in having a joint plan and strategy.

Kennedy and Slack(22) in their review of several studies related to ICDS pointed out that there is an increased convergence of services (health, supplementary nutrition and preschool education) when ICDS participants are compared to non-ICDS individuals in the same areas. Bulk of the time of A WW is devoted to food related activities, and next to this is time spent on record keeping and pre-school education. There seems to be very little home visitation by the AWW. Vitamin A and iron distribution is better but still disappointing. According to them few earlier studies reported use of any type of statistical testing and thus it is difficult to say whether the differences if any are significant. It would seem that it is the integrated package of services within ICDS that is responsible for the observed nutritional improvements. Pregnant women and children under three do not get adequate attention, according to the review.

Some studies better have shown

psycho-social development, school enrollment and retention. One gets this impression also while talking to community members. Concentrating on and further strengthening these activities rather than making supplementary nutrition the center-piece of activities and objectives would pay dividends. It is high time, therefore, that some rethinking is done in this regard. It can be initiated by giving more freedom to the states to devise their own priorities regarding ICDS. Involving more NGOs will also help to devise new strategies.

Kapil and Tandon (23) have in a recent publication listed twenty areas which need strengthening. Most of them have been commented upon ever since ICDS has been in existence, and yet no midcourse correction or strengthening of the areas of weakness have been carried out by and large.

The ICDS blocks have kept multiplying without any serious evaluations of design, content, methodology, training, supervision *etc.* No lessons have been learnt from the shortfalls because no one in authority has seriously wanted to look into these and make any mid-course changes as if what was envisaged twenty years ago, will stand the test of time. However, the government has agreed to try out some innovations in a few blocks and some projects have been given to NGOs to manage and some innovations are proposed to be tried in some others.

There can be no argument about ICDS being beneficial for women and children, nor is the argument regarding the amount of money spent. Much more money is spent in areas which yield much less dividends. But can't we make better use of money and the infrastructure? Time has come to have a second look at the functioning of the programme, make mid course changes, weed out what dose not work, improve training, supervision and better interaction with health and other women's development programmes, and make it a truly community participatory programme. The obsession with it being a nutrition improvement programme must give way to it becoming a maternal and child health and development programme and children under 3 years must come center stage. Tandon (24) has rightly stated that co-ordination between various groups of functionaries and convergence of the services offered by different social sector departments needs to be strengthened. On the other hand, we must be wary about AWW becoming everybody's hand maiden and being pulled in different directions.

There is evidence lately of an eagerness to reassess the implementation of ICDS, particularly in view of the high rates of malnutrition between 6 months to 2 years. Unfortunately the emphasis still seems to be on identifying a suitable supplement for them rather than the crucial input of community education and participation in the well-being of their children with the active support of the ICDS and health functionaries. Some thought should be given to having 2 AWWs per AWC and strengthening the infrastructure for better community mobilization and convergence.

Overtime the image of the programme needs to change-from a food disbursement programme to a development programme for adolescent girls, women and children with active involvement of the community. AWW is a tremendous resource. We need to strengthen her and prioritize her job responsibilities.

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