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## *Editorial*

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### **ICDS - Past, Present and Future**

The Central Government dedicate to the nation a unique programme for children of India on the birthday of Mahatma Gandhiji. The Intergrated Child Development Services (ICDS) was started on 2nd October, 1975 as an experimental programme in 30 blocks of rural and tribal population and 3 large urban slums. The ICDS document(1) stated the following goals and details of programme: (i) Improve the nutritional and health status of children in the age group 0-6 years; (ii) Lay the foundation for proper psychological, physical and social development of the child; (iii) Reduce the incidence of mortality, morbidity, malnutrition and school dropout; (iv) Achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and (v) Enhance the capability of the mother to look after the normal health and nutrition needs through proper nutrition and health education.

A historical decision was taken by Principals and Professors of Community Medicine and Pediatrics on 19th November, 1975 in the boardroom of All India Institute of Medical Sciences, New Delhi, to provide following support to ICDS as moral obligation to the children of India: (i) Training of ICDS functionaries; (ii) External evaluation and research; and (iii) Support to monitoring. A new chapter of active participation of 'Academicians', in National Development began and a system of Honorary Consultants from medical faculty was established for specified functions for successful implementation of ICDS.

ICDS has now completed 21 years and expanded its operation to 5102 projects from a meagre start of 33 projects. Its Central Budget has increased from Rs 1.54 Crores in 1975 to Rs 568.38 Crores in 1996-97. The number of functionaries and coverage has increased as shown in *Table I*. Besides the functionaries listed in *Table I*, a number of paramedicals of the health department and staff of the medical colleges from the Departments of Pediatrics and Community Medicine form the family of honorary workers for ICDS.

The expansion of ICDS has been based on performance audit and critical review by the Government and appropriate community of academicians. The number of beneficiaries of ICDS services has increased as shown in *Table II*.

What have been the achievements of ICDS? The details have been published in the document entitled "Integrated Child Development Services-Survey, Evaluation and Research 1975-1995"(2). The summary of the results and conclusions are as following:

#### **Nutritional Services Coverage**

The coverage of preschool children by the nutritional services, namely, supplementary nutrition, iron and folic acid tablets and vitamin A has remained extremely low without the added components of ICDS. In operational projects of ICDS, the coverage has recorded a progressive and highly significant increase over the initial 10 years of the scheme; thereafter the coverage reached a plateau or registered a decline except the distribution of iron and folic acid tablets. The nutritional services coverage has been maximum in tribal projects

TABLE I—ICDS Honorary and Full Time Functionaries Sanctioned in 1976-77 and 1996-97.

Functionary	Category	1976-77	1996-97
Anganwadi Workers	Honorary	259	400314
Mukhya Sevika	Employee	123	20071
Child Development Project officer (CDPO)	Employee	29	4314
Consultant	Honorary	29	192
Senior Consultant	"	0	15
State Coordinators	"	0	29
Senior Advisers	"	0	19
Data Analysis Officers	"	0	23
Regional Advisers	"	0	504
Chief District Advisers (Chief Medical Officer)	"	0	2804
Project Advisers (Medical Officer Incharge, Community Health Center)	"	29	1053

TABLE II—ICDS Beneficiaries (in Lakhs)

Beneficiary	1976-77*	1996-97 (September 96)
Preschool children	2.3	90.9
Pregnant women & Lactating mother	0.79	3.3
Reproductive age women	2.31	20.0

though a significant improvement is also evident in rural projects and urban slums.

The management of quality of food, its uninterrupted supply to anganwadis and motivation of mothers to bring their young children to the anganwadi needs further strengthening to ensure improvement for coverage by nutritional services.

### Immunization Coverage

The immunization coverage of children has steadily improved with the implementation of EPI and UIP by the Ministry of Health and Family Welfare. The overall performance, however, has remained unsatisfactory. The addition of ICDS compo-

nent had made a significant positive impact on the immunization coverage. In non-ICDS projects, the coverage of 0 to 6 year children was BCG-25.5%; DPT-18.3% and Polio-16.4% in 1982 while the ICDS covered children recorded BCG-39.6%; DPT-35.0% and Polio-37.3% in projects which were 5 years old. In 1991, the complete immunization coverage of 1 to 2 year old children from non ICDS areas was 43.8% in comparison to 56.8% and 60.5% in 5 year and 10 years old ICDS projects.

In ICDS covered areas, the children who attended Anganwadis showed better immunization status (67.3%) than those who did not attend (53.4%). There was a disparity in favor of male children compared to their female counterparts.

### Antenatal Services

The evaluation and research activities have shown that the coverage of MCH services has progressively increased from 1976 onwards even in those areas where ICDS scheme is not available. The coverage, however, is far better in ICDS projects where the increase was progressive and highly significant in the initial 2 to 10 years

of the programme but slowed down in the later years. The utilization of antenatal care, tetanus immunization and maternity assistance by trained personnel was maximum in the urban project, while the distribution of iron and folic acid tablets and supplementary nutrition was maximum in the tribal areas. Comparative study of ICDS and matched control non ICDS group of pregnant women showed that significantly higher proportion of ICDS women used trained paramedical personnel for antenatal care and maternity assistance. Their immunization status, consumption of supplementary nutrition and iron and folic acid tablets has been also higher compared to non-IGDS women.

### Postnatal Services

The coverage of lactating women by the postnatal services registered a significant improvement in both ICDS and non-ICDS projects. Maximum improvement is evident in 5-10 years old ICDS projects where it was significantly better than in non-ICDS areas. The overall coverage in rural women, however remains around 32 to 54% and in tribal women it is about 55%. These results though better than the baseline data call for more concerted efforts to achieve success in future.

### Nutritional Status of Preschool Children

The nutritional status of preschool children in both non-ICDS and ICDS areas has shown an improvement. Compared to the baseline (1976) nutritional status there was an evident decline in the undernutrition among non-ICDS preschool children (from 20.5% in 1976 to 7.3% in 1987). Thereafter there has been a marginal decline. The percentage of normal nutritional status preschool children was 75.8% and the percentage of severely malnourished children was only 5.8% in over 5 year old projects. The factors responsible for better nutritional

status of ICDS children are the availability of health care facilities, supplementary nutrition and other ICDS components at the anganwadi. There was all round improvement in the nutritional status of children staying in rural, urban and tribal areas and belonging to depressed and deprived sections of the community.

The prevalence of severe malnutrition in both male and female children living in ICDS projects was significantly lower than in the non-ICDS projects. Female children were behind their male peers in both ICDS and non-ICDS projects. The disparity was significant. More attention and better impetus is required to be given to improve the nutritional status of the girl child.

### Special Research Studies and Their Conclusions

Special studies on ICDS projects have provided information related to the outcome of ICDS. The salient findings of each study are given below:

1. *Management of severely malnourished children by Anganwadi Workers*

The ICDS functionaries at the village level, supported by the infrastructure of the Primary Health Center, were able to reduce the morbidity and mortality rates. The mortality rate of severe malnutrition at anganwadi (3.8 to 5.8% maximum) is much less than what is generally reported from hospital population (nearly 15 to 35%). The ICDS is able to save the lives of millions of children with malnutrition and associated infection at the onset of the illness. The mortality rate indeed can be further reduced by improving the management of diarrhea (with oral rehydration therapy) and respiratory infections at the village level.

2. *Morbidity amongst preschool children in ICDS and non-ICDS population*

The morbidity of the common child-

hood diseases was found to considerably more in both rural and urban non-ICDS control preschool children when compared to ICDS experimental projects.

### 3. *Assessment of vitamin A among preschool children*

(i) Out of total of 6696 mothers, less than 50% mothers (2270) were aware of vitamin A supplementation programme in surveyed population; (ii) Majority of children (86%) contacted by the vitamin A teams were administered vitamin A; (iii) Only 1.4% of 15268 children surveyed were detected to have difficulty in seeing at dusk (iv) Conjunctival lesions were present in 7.9% and corneal lesion in 0.92% children; and (v) 0.08% children were blind due to vitamin A deficiency.

### 4. *Infant and early childhood mortality study*

The infant and early childhood mortality was less in ICDS covered population. This effect was evident in both rural and tribal areas and to a lesser extent in urban slums where the ICDS infrastructure requires further strengthening.

### 5. *Awareness of Pregnant and Lactating Women about ICDS facilities*

*Pregnant Women:* Pregnant women belonged to 18-40 years age group and were aware of AW in their locality. Majority (57.9%) were aware of the facilities at AW centers. However, 55.9% of pregnant women never visited AW due to various reasons.

*Lactating Women:* Lactating women belonged to 18-40 years age group and were aware of AW in their locality and the facilities at AW centers. However, 54.6% lactating women never visited the AW due to various reasons.

### 6. *Enhancing Participation of Pregnant and Lactating women and Children Below 3 Years in ICDS Programme*

The low utilization of ICDS services by pregnant and lactating women and children below 3 years age was due to AWW work schedule which does not permit enough time to make home visits for interaction with the community to enhance participation. It was also observed that substantial proportion of women (28%) were not satisfied with AWWs attitude. Services like referral services under the ICDS programme were not available as intended. The community awareness leaves much to be desired. Only 12% women were aware of all available services.

### 7. *Impact of non-formal preschool education component of ICDS on various psycho-social development parameters of children*

Children who had attended anganwadi were regular, the absenteeism was less as compared to AW-not attended children. The difference was statistically significant. AW-attended students performed significantly better academically than AW-not attended students. In Government schools, personal hygiene was better amongst children who attended AW. In public schools there was no significant difference in personal hygiene amongst AW-attended and not-attended children. Participation in school activities like school games and cultural programmes was significantly high amongst AW-attended school children.

### 8. *Integrated Child Development Services and Tamil Nadu Integrated Nutrition Project (TINP) II-A Comparative Study*

The two programmes have similar aims and objectives. However, there are some variations in the supplementary nutrition provided. In TINP, there is entry/exit policy for children below 3 years while in ICDS, supplementary feeding is universal

for children below 6 years who attend AW center. At the group level, both the programmes are functioning well and there were no significant differences in service utilization by the beneficiaries.

9. *Knowledge, attitude and practices of Aganwadi Workers in ICDS*

A vast majority of Aganwadi Workers presented a committed and dedicated attitude towards ICDS despite low financial return and heavy load of work. In 54 AWCs only 819 pregnant and lactating women and 6192 children below 6 years were registered, the average per AWC were only 15 and 115, respectively. Out of the registered pregnant and lactating women and children, 79% and 90%, respectively were ICDS beneficiaries.

The KAP of CDPOs, supervisors, AWWs and mothers with respect to growth monitoring, supplementary nutrition and immunization were adequate.

AWWs record revealed that growth monitoring and supplementary nutrition to children were provided to 90% and 79%, respectively; immunization coverage also ranged from 50-90% for various vaccines. The nutritional status of children was quite satisfactory. Pregnant and lactating women were adequately covered by ICDS services. The supervisors suggested reduced frequency of growth monitoring, more refresher courses to AWWs, distribution of raw food to mothers of children who are far away from AWC and organization of more educational camps with audio-visual facilities and distribution of pamphlets for better implementation of ICDS services.

### ICDS-Present and Future

The ICDS at present has reached to a very challenging situation of improving its performance and expansion of its activities. It has covered the whole country by administrative policy but operationalization of several hundred projects is still awaited. The network of health system of ICDS must be preserved and its enthusiasm maintained against the better financial temptations of adhoc programmes. Co-ordination between various group of functionaries and convergence of the services offered by different social sector departments is being attempted and it must succeed. Contribution by voluntary agencies is being enhanced and it must be done with a speed that it deserves.

The ninth plan is under finalization and the contribution of ICDS in human resource development is accepted. The future is bright if the present policy of co-ordination, expansion and self reliance is put in operation with unequivocal commitment.

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