INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME

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ABSTRACT

Integrated Child Development Services (ICDS) scheme is world's largest community based programme. The scheme is targeted at children upto the age of 6 years, pregnant and lactating mothers and women 16-44 years of age. The scheme is aimed to improve the health, nutrition and education (KAP) of the target community. Launched on 2 October 1975, the scheme has completed 25 years of its operational age. The article describes in brief, the organisation, achievements and drawbacks of this national programme. It also suggests various thrust areas for its betterment and further improvement.

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Introduction

Paediatric malnutrition has always been a matter of national concern. The various vertical health programmes initiated by the Government of India (GOI) from time to time did not reach out to the target community adequately. In 1974, India adopted a well-defined national policy for children. In pursuance of this policy it was decided to start a holistic multicentric programme with a compact package of services. The decision led to the formulation of Integrated Child Development Services (ICDS) scheme - one of the most prestigious and premier national human resource development programmes of the GOI.

The scheme was launched on 2 October 1975 in 33 (4 rural, 18 urban, 11 tribal) blocks. Over the last 25 years, it was expanded progressively and at present it has 5614 (central 5103, state 511) projects covering over 5300 community development blocks and 300 urban slums; over 60 million children below the age of 6 years and over 10 million women between 16 and 44 years of age and 2 million lactating mothers [1]. The total population under ICDS coverage is 70 million, which is approximately 7 percent of the total population of one billion.

The main thrust of the scheme is on the villages where over 75 percent of the population lives. Urban slums are also a priority area of the programme.

Objectives

The main objectives of the scheme are [2] :

- i) Improvement in the health and nutritional status of children 0-6 years and pregnant and lactating

mothers.

- ii) Reduction in the incidence of their mortality and school drop out
- iii) Provision of a firm foundation for proper psychological, physical and social development of the child.
- iv) Enhancement of the maternal education and capacity to look after her own health and nutrition and that of her family
- v) Effective co-ordination of the policy and implementation among various departments and programmes aimed to promote child development.

Beneficiaries

The beneficiaries are :

- i) Children 0-6 years of age
- ii) Pregnant and lactating mothers
- iii) Women 15-44 year of age
- iv) Since 1991 adolescent girls upto the age of 18 years for non formal education and training on health and nutrition.

Services

The programme provides a package of services facilities [3] like :

- i) Complementary nutrition
- ii) Vitamin A
- iii) Iron and folic acid tablets
- iv) Immunization
- v) Health check up
- vi) Treatment of minor ailments

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- vii) Referral services
- viii) Non-formal education on health and nutrition to women
- ix) Preschool education to children 3-6 year old and
- x) Convergence of other supportive services like water, sanitation etc.

The services are extended to the target community at a focal point 'Anganwadi' (AWC) located within an easy and convenient reach of the community. AWC is managed by an honorary female worker 'Anganwadi Worker' (AWW), who is the key community level functionary. She is a specially selected and trained woman from the local community, educated upto high school. She undergoes 3 months training in child development, immunization, personal hygiene, environmental sanitation, breastfeeding, ante-natal care, treatment of minor ailments and recognition of 'at risk' children. She gets a small honorarium as an incentive. The presence of AWW in the community has a synergistic effect as she liaises between health functionaries and the community. Convergence with health helps achieve better maternal and child health, enhances awareness regarding family planning services, treatment of morbidity and reduction of mortality. AWC serves as a central point for immunisation, distribution of vitamin A, iron and folic acid tablets and treatment of minor ailments and first aid. AWC is also the venue for health related activities carried out by auxiliary nurse-midwives (ANM). Each AWC looks after a population of approximately 1000 in rural and urban areas and 700 in tribal areas. Presently on an average there is 125-150 AWCs per project/block [4].

Complementary Nutrition

6 months to 6 year old children, pregnant and lactating mothers belonging to low income group families are entitled to avail the facility of CN for 300 days in a year. 300 calories and 8 to 10 g proteins are given to all children below 6 years including those with mild (grade I & II) malnutrition while pregnant (3rd trimester) and lactating mothers (first 6 months of lactation) are given 600 calories and 20 g proteins per day as CN. The type of food varies from state to state. Usually it consists of a hot meal cooked at AWC. It contains a combination of pulses, cereals, oil, vegetables and sugar. Some AWCs provide a 'ready-to-eat' meal while some other agencies like CARE, World Food Programme (WFP) are implementing a 'take-home' strategy for 2-4 weeks at a time for children under 2 years and pregnant and lactating women. While the 'take-home' practice solves the problem of daily attendance and saves considerable time of the AWW, there

is bound to be sharing of the food and the index beneficiary at best gets only a part of it. Food sharing strengthens the family bonds though it will delay recovery from malnutrition. Cooking and serving hot meal at AWC, on the other hand, provides a good opportunity to develop a close rapport with the local women and indulge in non-formal education on health and nutrition. This also provides a good opportunity for community mobilisation and participation, though it definitely adds to AWW's workload. A flexible approach to suit the local needs appears to be the answer. Improper storage facilities, poor quality and shortages of CN, erratic food supplies, bad communication, pilferage and other such logistic problems in certain states have been noticed and require corrective administrative measures.

Immunization

AWW helps organise fixed day immunization sessions. Primary Health Care Centre (PHC) and its infrastructure carry out the immunization of infants and expectant mothers as per the national schedule. AWW assists in the exercise; maintains records and follows up the recorded cases to ensure complete coverage. Her services are also being utilised for special drives and campaigns like pulse polio and family planning drive. Such activities, it has been seen, adversely affect her other duties and dilute her commitment to the ICDS programme.

Health Check Up and Referral Services

The health check up activity includes care of all children below 6 years, ante-natal care of pregnant women and post-natal care of lactating mothers. AWW and PHC staff work together and carry out regular check-up, body weight recording, immunization, management of malnutrition, treatment of diarrhoea, deworming and other minor ailments. At AWC, children, adolescent girls, pregnant women and lactating mothers are examined at regular intervals by the lady health visitor (LHV) and auxiliary nurse-midwife (ANM). Malnourished and sick children who cannot be managed by the ANW / AWW are provided referral services through ICDS. All such cases are listed by the AWW and referred to the medical officer.

Growth Monitoring Promotion (GMP)

It is an important tool to assess the impact of health and nutrition related services. Children below the age of 3 years are weighed once a month and those over 3 to 6 years are weighed every quarter. AWW usually uses the fixed day immunization sessions or 'take-home' ration collection days for growth monitoring

activities. Growth is charted to detect growth delay or malnutrition, if any. This activity, unfortunately has not been very successful due to many reasons. Some of which are poor understanding of this activity by the AWW as well as the mother, erratic method of weight taking; non availability of weighing machine/growth charts; lack of knowledge about weight recording and paucity of time at the disposal of AWW. It is to be appreciated that this activity needs a great deal of time, training, supervision and support. Unless these are forthcoming, it becomes just a wasteful time consuming ritual [5,6].

Nonformal and Preschool Education

Nonformal nutrition and health education given by the AWW is aimed at empowerment of women in the age group of 15-44 year to enable them to look after their own health and nutrition needs as well as that of their children and families. The education is imparted through participatory sessions at AWC, home visits and small group discussions. Basic health and nutrition messages related to child care, infant feeding practices, utilisation of health services, personal hygiene, environmental sanitation and family planning are usual components covered by AWW.

Early childhood care and preschool education is yet another important activity of ICDS programme. This focuses on the total development of the child upto 6 years. It also promotes early stimulation of younger children (< 3 year) through intervention with mothers. At this tender age, mother is the best teacher. In 1991, school dropout and other adolescent girls in the age group of 11-18 year have also been included in the ICDS orbit for health and nutrition education, literacy, recreation and skill formation. At present this scheme is available in 507 projects only. Preschool education has contributed a great deal in child development. It encourages school enrolment and retention. It also helps ICDS beneficiary children achieve higher psychosocial development. This was abundantly clear in two separate studies conducted by Central Technical Committee (CTC)-ICDS [7]. In the one carried out by the National Institute of Nutrition (NIN) in 1993 in Andhra Pradesh, Kerala and Tamil Nadu, under supervision of CTC-ICDS, a revealing observation was that higher psychosocial development benefit was more applicable to the younger age group (36-47 months) than the older group (48-72 months). Both the groups, though had far better score than the non-ICDS group. On the basis of this very significant observation, the possibility of introducing an age specific curriculum needs to be explored.

Presently, preschool education in ICDS is aimed at 3-6 year age group. The younger children are educated through their mothers. Non-formal education for mothers is an attempt to improve upon their KAP. It has been argued that as intellectual development gets established by 3 1/2 to 4 years, some sort of direct education could be imparted to 2-3 year old children at AWC. This needs a detailed discussion in view of already over burdened AWW's present commitments and several child psychologists opinion against group teaching at very young and tender age.

Central Technical Committee (CTC)-ICDS

A Central Technical Committee (CTC) on health and nutrition was constituted on 30 June 1976 by the then Ministry of Social Welfare, Government of India to provide technical and scientific assistance to the department of Women and Child Development. A central cell was established at New Delhi :

- i) To assist the health departments in monitoring the health and nutrition of ICDS.
- ii) Monitor the motivational and continuing education activities of the ICDS
- iii) Evaluate the flow and availability of services and their impact on ICDS beneficiaries by undertaking annual surveys and research studies.
- iv) Conduct orientation and training courses for medical officers and health functionaries of ICDS.

The monitoring developed by the CTC encourages interaction of functionaries at different levels to ensure smooth programme implementation. An effective uniform syllabus for various categories of functionaries has been prepared by the CTC in consultation with experts. The training curriculum is aimed to provide a comprehensive training package which is flexible enough to meet the local needs. Besides the training schedules conducted by the CTC-ICDS, on the job training is also imparted to the supervisors and Child Development Project Officers (CDPO).

This training, regrettably, is disproportionately tilted towards record maintaining instead of quality assessment, support and education [8].

Survey, Evaluation & Research

ICDS is the only national programme which has a built-in "External Investigative" survey, evaluation and research component from its very inception. The senior faculty members from the departments of preventive and social medicine (PSM) and paediatrics of various medical colleges and institutions form the core of the component. They are designated as 'ICDS honorary consultants'. Presently, they are over 190.

Their contribution is extremely cost effective and observation unbiased and objective. The evaluation is done in the form of multicenter annual surveys or unicenter research projects. In 1993, research activities were further strengthened and 4 regions (Western, Eastern, Southern, and Northern) were identified. Till today 24 annual surveys and a large number of multicentric and unicentric research studies have been conducted from time to time. The results of these studies were published in a book form in 1995. This document contains a lot of original data and makes an excellent reference book [7]. The studies confirm that on the whole the programme has done exceedingly well. The nutritional status of ICDS children, their immunization, vitamin A and iron and folic acid coverage have improved and are better than those of the non-ICDS children. The services coverage among women in ICDS areas is again far better than that in non-ICDS areas. Their KAP about health and nutrition is also better. The programme performance however is not uniform. There are areas where ICDS progress is slow and in some other a 'plateau' effect is noticeable after the initial elevation.

This is explained by the vast size of the country with several variables like local customs, whims and fancies, poor community mobilisation and participation, inadequate logistic support, irregular supply position, discrepancies between sanctioned and positioned staff, indifferent and casual attitudes of AWWs and other ICDS functionaries, inequitable workload distribution, inappropriate time budgeting and erroneous understanding of the priorities of ICDS service components. Many other workers in the field have also spelt out weakness and lacunae in the programme [9-12]. Urgent corrective strategy requires to be worked out to further strengthen the programme. Some of the thrust areas for further research and innovative approaches are mentioned below.

Recommended Thrust Areas

Complementary Nutrition (CN) [7].

The benefit of the CN is seen to be limited in very young children aged 1/2 to 2 years. Their attendance at AWC and intake of CN are poor. Innovative approach is needed to draw them to the AWC. The young children probably need a special treatment regarding CN and better sensitization to health and nutrition education. Physiologically, in early childhood there are marked differences in food intake. Therefore, specific attention is required to be focused on narrow age groups to work out requirement and variety of CN e.g. nutritional needs and intake are differ-

ent in 4 to 6 months; 7 to 12 months and over 12 months old children. We personally believe that 4 to 6 months is the optimal age to introduce CN. However, there are many pediatricians who recommend exclusive breast-feeding for the first 6 months. This controversy requires more information to formulate a definite policy. We also need a firm policy regarding introduction of CN in low birth weight children. CN as designed presently must be wholesome, nutritionally and culturally acceptable with adequate micronutrients. This requires special care in small children 1/2 to 1 year of age as home foods are difficult to be consumed in large quantities by them. The timing of CN should be such as not to affect the breast milk intake. Hence probably the best time for the small children is to give it in between feeds. We prefer serving hot meal at the AWC. All the same there is no quarrel if 'carry home' dry rations or precooked packets are supplied to small children and pregnant and lactating women. Perhaps a controlled study could be done in some areas. Considering the experience with iron and folic acid tablets, it perhaps will be best if CN is fortified with micronutrients. The micronutrients requirements, calorie and components of CN for LBW and normal children require redefining in view of our updated knowledge in this field. Many a time during community survey, mothers complain of poor appetite of their children. Recent observation that asymptomatic presence of microbes in the gut, urinary or respiratory tracts is associated with anorexia and lack of appetite resulting in progressive weight loss and malnutrition requires detailed looking in for appropriate corrective steps.

Growth Monitoring And Growth Faltering

This activity has not served the purpose for which it was initiated. The available tools for weight taking and length/height recording require proper standardisation and knowledge. AWW, ANM and other functionaries must receive more training and education in this respect in case this activity is to be continued. Linear growth measurement is as important as body weight in view of the recent observation that in some children, linear growth falters before they start losing weight.

Convergence and Coordination

Better convergence and coordination among various departments, NGOs and groups involved in mother and child development is required to avoid duplication and avoidable expenditure. CTC-ICDS had recommended use of fixed day immunization sessions for interaction between ICDS, health functionaries and

the community. CARE and some other NGOs have encouraged the concept of observance of a special day in 10-15 days where community can actively participate and interact with ICDS and health personnel. Any approach, which facilitates convergence at all levels is welcome.

Community Participation

Despite all efforts, community participation has been substandard and far below expectation. To enhance this we recommend involvement of elders and the menfolk in the family, opinion makers in the community, women groups, adolescents, Swastha Sangathans, Mahila Mandals, Gram Panchayats etc. Their cooperation will indeed be very exciting and full of potentials for further community motivation, mobilisation and participation. Community involvement at planning stage may also prove useful and should be encouraged. AWW, the key player in ICDS, must have more time for community motivational visits and interaction at AWC. This is possible only if less time is spent in non-productive work.

Administrative Corrections

Better training to AWW and Mukhya Sevikas, more inputs, better supervision, rational and equitable workload distribution, better logistics and realistic community expectation will go a long way to make ICDS programme better. CTC-ICDS in their annual convention in 1977 had stressed at length the vulnerable areas in each state and proposed a number of corrective measures. These points have again been mentioned by Kapil and Tandon [3]. They deserve most serious consideration of the concerned authorities.

ICDS has been and is an excellent mother and child development programme. Its implementation has been good in most of the areas, outstanding in some, mediocre in other and poor in some other areas. Believing in overall outstanding performance rather than be content with small mercies in pockets of excellence we recommend an objective review and assessment of

the ICDS and strengthening the weaker links. This paper is aimed towards that.

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References

1. Ministry of Human Resource Development, Department of women and Development. Annual Report 1995-96 Part IV. Government of India Press New Delhi. 5-6
2. Sachdev Y, Tandon BN, Krishnamurthy KS, Kapil U. Evaluation, Research and training in ICDS, 1995;2-3.
3. Tandon BN, Kapil U. ICDS Scheme. A programme for development of mother and child health, Indian paediatrics. 1991;28:1425-8.
4. Kapil U. Monitoring and continuing education system in ICDS scheme. A module for National Health Programme, Indian Paediatrics, 1989;26:863-7.
5. Gopalan C, Chatterjee M. Use of growth charts for promoting child nutrition. Review of global experience. Special Publication Series 2 : Nutrition Foundation of India, New Delhi 1985.
6. Ghosh S. Second thoughts in growth monitoring, Indian Paediatrics. 1993;30:449-53.
7. Sachdev Y, Tandon BN, Gandhi N, Dasgupta J. Integrated Child Development Services, Survey, Evaluation and Research 1975-1995, Central Technical Committee - Integrated Mother and Child Development, New Delhi, 1996:149-52.
8. Gupta DB, Gambir A, Banarjee A. Strengthening ICDS programme, Key findings from pilot study. Margin 1998;30(2):77-106.
9. Tandon BN, Ramachandran K, Parmar BS et al. Impact of ICDS on infant mortality rate in India. Lancet 1984;2:157-8.
10. Tandon BN. Nutritional intervention through intervention through primary health care. Impact of ICDS projects in India. Bull. WHO 1989 67:70-80.
11. Sachdev Y et al. Integrated Child Development Services Scheme and Nutritional Status of Indian Children. Jr. Tropical Paediatrics 1995;41:123-8.
12. Kennedy E, Slack A, The integrated Child Development Services (ICDS) in India, Lessons learnt and implications for future policies. International Food Policy Research Institute, Washington DC 1993.