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Integrated Child Development Services Scheme (ICDS) In India: Its Activities, Present Status and Future Strategy to Reduce Malnutrition

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ABSTRACT

In 1975, the Indian Government launched a comprehensive strategy to provide health care, nutrition, and education services to underprivileged communities in villages and urban slums through centers. Each center was managed by a local part-time female worker (anganwadi) with an assistant, who was compensated with an honorarium.

The Integrated Child Development Services Scheme (ICDS) combines all essential services for enhanced childcare, early stimulation and learning, health and nutrition, water and environmental sanitation, targeting young children, expecting and nursing mothers, other women, and adolescent girls in a community. The scheme aims to enhance the nutritional and health status of children aged 0-6 years; decrease mortality rates, morbidity, malnutrition, and school dropout rates; ensure effective coordination among different departments to promote child development; establish a proper foundation for psychological, physical, and social development of children; and improve mothers' abilities to care for their children's health and nutritional needs.

ICDS services are delivered through village-based centers called Anganwadi centers that provide supplementary nutrition, immunization, health check-ups, referral services, treatment for minor illnesses, nutrition and health education for women, preschool education for children, as well as support for water supply and sanitation. Numerous government departments collaborate at the village, block, district, state, and central levels to ensure efficient service delivery. Anganwadi workers represent the grassroots-level personnel responsible for implementing program services in their communities.

ICDS has shown better outcomes in projects led by capable leaders. Although the program has some shortcomings that need addressing for future initiatives targeting disadvantaged populations improvement. To enhance ICDS efficiency further operational research in diverse areas has been proposed.

KEY WORDS -Nutrition, Knowledge, Anganwadi, Child Development, Health

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. 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

- Improvement in the health and nutritional status of children 0–6 years and pregnant and lactating mothers.
- Reduction in the incidence of their mortality and school dropout.
- Provision of a firm foundation for proper psychological, physical and social development of the child.
- Enhancement of the maternal education and capacity to look after her own health and nutrition and that of her family.
- Effective co-ordination of the policy and implementation among various departments and programmes aimed to promote child development.

Beneficiaries

The beneficiaries are:

- Children 0–6 years of age
- Pregnant and lactating mothers
- Women 15–44 year of age
- Since 1991 adolescent girls up to the age of 18 years for non-formal education and training on health and nutrition.

Services

The programme provides a package of services facilities

Complementary nutrition

- Vitamin A
- Iron and folic acid tablets
- Immunization
- Health checks up
- Treatment of minor ailments
- Referral services
- Non-formal education on health and nutrition to women
- Preschool education to children 3–6-year-old and
- Convergence of other supportive services like water, sanitation etc.

The services arc 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 up to 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

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 1 & 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-mid-wife (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

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.

Non-formal and Preschool Education

Non-formal 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 series, 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 up to 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. 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 overburdened AWW's present commitments and several children psychologists' opinion against group teaching at very young and tender age.

CONCLUSION

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.

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.

Enhanced collaboration and synchronization among various departments, non-governmental organizations, and groups concerned with mother and child development are essential to eliminate redundancy and unnecessary expenditure. The CTC-ICDS proposed the implementation of fixed-day immunization sessions as a platform for fostering interaction between ICDS, health officials, and the community. CARE, along with other NGOs, has promoted the idea of designating a specific day every 10-15 days, during which the community can actively engage with and communicate with ICDS personnel and healthcare professionals.

Having an effective coordination mechanism among stakeholders is indispensable for streamlining efforts towards the common goal of mother and child development. Ensuring that limited financial resources are judiciously utilized not only protects against wastage but also promotes efficiency in delivering vital services. In this regard, fixed-day immunization sessions have been suggested as a means of fostering better communication between different agencies involved in the process.

Moreover, several non-governmental organizations such as CARE have been pivotal in encouraging the observance of a special day once every 10-15 days. This innovative approach allows for direct interaction between the community members, ICDS authorities, and healthcare providers. This ensures that feedback can be gathered from those on the ground while also providing essential information to targeted beneficiaries.

In summary, it is crucial for greater harmony among various entities involved in mother and child development programs to prevent overlap of efforts and maximize their impact. Collaborative initiatives like fixed-day immunization sessions and observance of special interaction days go a long way in enhancing communication among stakeholders and ensuring optimal resource utilization.

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.

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