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INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME- OBJECTIVES, ORGANISATION AND IMPLEMENTATION

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There have been significant achievements in India in all spheres of development in last 3 decades. Nevertheless, various problems concerning child welfare are still of fairly large dimension. The incidence of morbidity, mortality and malnutrition among children continues to be high. Various surveys in our country have indicated that the incidence of severe malnutrition amongst preschool children is as high as 15-20%. The infant mortality rate varies in different parts of the country and is influenced among others, by social factors and level of socio-economic development of the community.

An integrated approach to early childhood services including nutrition supplement was adopted and in pursuance of National Policy for Children the scheme of ICDS was sanctioned in plan of social welfare sector. On 2nd of October, 1975, the Government of India launched the scheme in 33 community development blocks with following objectives:-

1. to improve the nutritional and health status of children in the age group 0-6 years;
2. to lay the foundations for proper psychological, physical and social development of the children;
3. to reduce the incidence of mortality, morbidity, malnutrition and school drop-out;
4. to achieve effectively coordination of policy and implementation amongst the various departments to promote child development; and
5. to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

It was decided to provide a package of following essential services to children 0-6 years, nursing and expectant women and women in 15-44 years age group.

i) Supplementary nutrition
ii) Immunization
iii) Health check-up
iv) Nutrition and health education
v) Referral services
vi) Non-formal education

On account of the key role of protected water supply efforts were also made to improve the rural drinking water supply through UNICEF and other Government Agencies.

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One anganwadi has been established for a unit of 1,000 population, which is the focal point for delivery of the entire package of child development services. The anganwadi worker is a female worker recruited from the village. She is assigned the responsibilities of non-formal education to preschool children, supplementary nutrition and health education while 3 other services of the package are rendered by the Auxiliary Nurse Midwife (ANM). The surveillance of growth and development of children is inbuilt in the package. The treatment of common ailments during childhood was later introduced realising the availability of anganwadi worker in the village all the time.

ORGANISATIONAL STRUCTURE AND WORK LOAD

The administrative unit for the location of ICDS project was chosen as a community development block in rural areas, tribal development block in tribal areas and slums in the urban areas. In selection of projects priority was given to areas backward in developmental services, nutritionally deficient and predominently inhabitated by the scheduled castes and tribes. Initially the 33 projects were placed in 11 tribal, 18 rural and 4 urban areas. In the years 1978-1980 the ICDS scheme has been expanded to 150 projects (56 tribal, 70 rural and 24 urban). Each project has approximately following number of beneficiaries per 1000 population.

Children 0-6 years	-	170
Pregnant women	-	30
Lactating women	-	70
All women of child bearing age (15.44 years)	-	200

To strengthen the health services, an additional doctor, 2 lady health visitors and 8 ANMs have been sanctioned in these projects, so as to make 1 ANM available for 5000 population at the periphery.

The entire package of services has been envisaged to be delivered by the social welfare and the health functionaries of the block through guidance from the respective authorities from district and state. The flow-chart at the end illustrates the administrative arrangements in an ICDS project.

Training of personnel: The anganwadi workers have been given basic training for 3 months at anganwadi training centres and a continued inservice training is given by the PHC physicians on all pay days with demonstrations at the maternal and child health and family welfare planning clinics and subcentres in groups of 8-10 anganwadi workers.

Monitoring and evaluation: The evaluation of organisation and implementation of the scheme has been entrusted to the PEO Cell of the Planning Commission, and periodic monitoring and evaluation of health and nutrition was undertaken by All India Institute of Medical Sciences through annual surveys which were conducted by the medical college consultants.

Role of medical colleges: To provide technical guidance, supportive supervision and training to various grades of functions of the programme, it was deemed necessary to appoint paediatricians as consultants to projects nearest to the medical colleges. To conduct periodic surveys for assessing the impact of services on health and nutrition, graduate interns were mobilised and in 15 projects it was possible to conduct 3 surveys within 2 years.

In the expanded programme, taking the distance of projects from the medical colleges and propagative nature of work, and also easy mobility of district staff, the paediatricians and the health officers of the respective district headquarters were appointed as consultants to the ICDS projects. Presently 54 consultants are the paediatricians or teachers of preventive and social medicine from medical colleges, while 35 consultants are officers from the districts.

ACHIEVEMENT OF I C D S:

1. Establishment of infrastructure: Despite the difficulties in the system of appointments a very large proportion of health and non-health staff (81% and 99% respectively) is on the ground in projects of first phase, of which more than 88% of staff has undergone formal training.

2. Training of functionaries and supportive supervision: The basic training of anganwadi workers, mukhyasevikas and child development project officer was arranged by the National Institute of Public Co-operation and Child Development. All the physicians placed at the ICDS project and their supervisors at the district were trained regionally at the medical colleges by the consultants. The All India Institute of Medical Sciences introduced the in-service training of anganwadi workers and the ANMs within PHC with emphasis on primary health care and monitoring of maternal and child health and nutrition. The orientation is conducted by the physicians at the PHC or at sub-centres.

3. Co-ordination: The Child Development Project Officers and the PHC physicians are the key persons in the implementation of the programme. The experience at the projects shows that medical college consultants have been successful in introducing environment of team approach by participating in various activities of anganwadi through coordinated supervision, re-organisation of the services of administration, referrals and establishing an information system through regular data collection. The services to highrisk-mothers and children were intensified, both at village and health centre level.

4. Results of the surveys: Three surveys were conducted in 28 projects at three different points at an interval of approximately one year on a sample of 10% anganwadis. Data from 15 projects has been compiled, which shows that there is a progressive increase in coverage of population of women and children regarding their enrolment, supplementary nutrition, antenatal and postnatal checkup, immunisation and distribution of vitamin 'A' and folifer tablets. Further, there is remarkable improvement in the nutritional status of children with almost 50% reduction in Grade III and Grade IV malnutrition.

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SPECIAL BENEFITS OF THE ICDS PROGRAMME:

1. The blocks where an ICDS project is running have also been selected for upgrading the PHC under the minimum needs programme. The ICDS programme has ensured the supply of refrigerators to these PHCs thereby helping in the immunization programme. Sufficient amount of medicines including folifer tablets and vitamin 'A' have been given to these projects with additional budget for medicine from ICDS. These projects were given the transport at a priority basis. Rural electrification and water supply programmes have also been augmented in this project areas.

2. Anganwadi-worker as an agent of health care delivery to mothers and children:

The anganwadi worker has been envisaged as a caretaker for growth and development of young children and education of young mothers. Their selection from the local community and ability to render the package of service at the anganwadi has proved to be an asset. The fact, that she is the only available and accessible health worker at the village level became a compelling need to train her in giving treatment for common ailments at first contact. Her training in primary health care and first aid has been found extremely beneficial to the community and complementary to work of ANMs. The health care has now been included in the syllabus of anganwadi workers' basic course and continued training at the PHC and the sub-centres aims at making them proficient in treatment of 'at risk' children and mothers.

3. Active involvement of paediatricians and teachers of community medicine has installed an academic impetus to the performence of health functionaries and management of severely malnourished children. Continuous training of various level workers has ensured better standards. The participation of graduate interns in the health surveys has proved to be an interesting field exercise which is hopefully expected to motivate them in the MCH work in their future practice. The consultants from the medical colleges have also been able to mobilise members of other disciplines in training and surveys. Most of the medical colleges are currently participating in this national programme.

4. The state directorates of health services have taken special interest in ICDS recognising the approach as an alternative strategy to delivery of health care.

WHAT SHOULD BE BETTER ACHIEVED IN ICDS

1. Children in age group 1-3, particularly the ones who are suffering with severe degree of malnutrition still remain inadequately covered. A system to establish nutrition therapy for such children at home or at sub-centre and PHC needs to be developed, though high calorie therapeutic food has been made available for treatment of those affected.

2. The referral system from anganwadi to the PHC and onwards needs support from the administration.

3. Inspite of renewed emphasis, the nutrition and health education activities remain low in service priority.

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4. The improvement in water supply and sanitation has also not picked at a faster pace.

CONCLUSION

The comprehensive approach of child development is well conceived in ICDS projects and preliminary programme in 150 areas shows promising results. The ICDS programme is an example of unified efforts of Social Welfare and Health Departments leading to fulfilment of needs of those, who are deprived and neglected.

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