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THE ROLE OF INTEGRATED CHILD DEVELOPMENT SERVICES PROGRAMME IN PROMOTING FOOD SECURITY

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ABSTRACT

Poliicies to tackle Food insecurity is caused by three interlinked factors viz. availability of food, access to food, and utilization of food. In India, the first problem has been taken care of fairly well but much needs to be done with respect to the second and third aspects. An intervention scheme like the Integrated Child Development Services for the pre-school children deals with these aspects by providing a combination of supplementary feeding, health and nutrition education and regular health check-ups to improve the quality of food intake and its absorption by the body at the initial stages of growth. The evaluation studies indicate that the impacts of this program have not reached the target groups effectively and the operational efficiency of the program is not satisfactory. The key to malnutrition reduction lies in decentralization of the scheme, community participation, along with education and empowerment of women as is observed in the case of the Tamilnadu Integrated Nutrition Program. This would go a long way in creating a good human resource that can take advantage of the process of liberalization and globalization.

KEYWORDS :Food security, nutrition, child development.

INTRODUCTION :

Both quantity and quality of food intake affects the nutritional status of an individual and inadequacies in either or both of these have adverse impacts on health, cognitive ability and school achievement. All of these determine the productivity of an individual thereby affecting the income earning abilities and hence the standard of living.

The magnitude and prevalence of under-nutrition is so widespread in the developing countries that only state intervention can help tackle this problem. Many of these countries have several food safety net programs to address the issue of malnutrition particularly among vulnerable sections of the population. The success rates of the safety net programs implemented by the state in reducing

undernutrition levels has not been very good mainly due to problems of effective management. Emphasis on decentralized management with increased community participation seems to improve the effectiveness and efficacy of the service delivery wherever the programs have been successful. These issues gain importance in an era of globalization and liberalization both of which may not be beneficial to the poor in the beginning.

The decade of 1990s saw major changes in the economic environment mainly that of economic liberalization for better economic management and entering the process of globalization by opening up of markets. It is widely debated that these changes will affect absolute and relative poverty due to reductions in resource allocation to social sector in a period of economic restructuring and higher unemployment levels and increase in prices of essential commodities affecting the purchasing power of the poor particularly in the initial phases of globalization. In India, studies have shown reduction in allocation of resources to social safety net programs in the first half of 1990s with increases in subsequent years. But the evidence on increase in poverty or decrease in levels of human development due to liberalization and globalization is weak.

OBJECTIVES OF THE STUDY

1.To study the origin and development of Integrated Child Development Services programme in India.
2.To assess the role of the Integrated Child Development Services programme in promoting of food security.

METHODOLOGY

The data for the present study is collected purely from secondly sources. The data was collected from various governmental reports, statistical abstracts, articles, books etc.

EVOLUTION OF THE ICDS PROGRAM

The Integrated Child Development Services (ICDS) is India's flagship programme for early childhood development. The program was started as a pilot project in 33 blocks of the country in Oct, 1975. The impact of the ICDS service on the Health status was first assessed after 21 months of implementation and was reported in Lancet. "That BCG immunization coverage increased from 11.3 percent to 49.3 percent in rural projects, 20.9 percent to 55.4 percent in tribal projects, and 47.4 percent to 74.1 percent in urban projects. Coverage by diphtheria, pertussis, and tetanus (DPT) immunization increased considerable, but overall coverage remained low since the baseline figure was very low. Distribution of vitamin A and supplementary food increased significantly, and the nutritional status of the children improved considerably. The prevalence of severe malnutrition decreased from an overall figure of about 22 percent to 11.2 percent in rural, 5.5 percent in tribal and 6.1 percent in urban projects. Analysis by age-groups showed that services did reach to younger children, with resultant improvement in nutritional status and health status. The prevalence of severe malnutrition in children younger than age 3 decreased from 25.5 percent to 9.7 percent and that of normal and grade I nutritional status increased from 48.2 percent to 61.3 percent." The success was acknowledged nationally and internationally. This was followed by two major evaluations in 1978 and in 1982. On the basis of a positive result Government of India decided for its universal coverage throughout the country. Concurrent to the success of the ICDS project the ministry of health started "selected service and specific beneficiary based' service program with different International agency like World Bank funding keeping the basic service delivery framework of ICDS. It can also be said that this HRD sponsored health program is a fore runner of many other health program sponsored by Health ministry.

They were selective service and beneficiary oriented vertical program like Universal immunization, ARI control, Diarrhea control and later CSSM I, CSSM II, RCH I and finally RCH II program. The culmination of the above vertical program was "National Rural Health Mission". But unfortunately effective linkage of health program with the existing ICDS network could not be materialized leading to a gradual drift of ICDS institution in the delivery of health packages.

The importance of ICDS somewhat faded between 1975 and 1990 and there were a spate of surveys and reports drawing attention to India's failure to reduce malnutrition among children. Advocacy for ICDS gained momentum when the Right-to-Food case was filed by the People's Union for Civil Liberties vs the Union of India in 2001. As a result of this the Supreme Court passed an order which culminated in the universalisation of ICDS.

SUPREME COURT JUDGMENT

In a landmark order dated 28 November 2001, the Supreme Court, in a Public Interest Litigation (PIL) by the People's Union of Civil Liberties, directed the central and state governments to:

"Implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under:

- Each child up to 6 years of age to get 300 calories and 8-10 grams of protein;
- Each adolescent girl to get 500 calories and 20-25 grams of protein;
- Each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein;
- Each malnourished child to get 600 calories and 16-20 grams of protein;
- Have a disbursement centre in every settlement.

The Supreme Court, vide its subsequent order dated 29.4.2004, issued the following directions to the Government of India in relation to the implementation of the ICDS Scheme:

- We direct the Government of India to file within 3 months an affidavit stating the period within which it proposes to increase the number of AWCs so as to cover 14 lakh habitation;
- We notice that norm for supply of nutritious food worth Re. 1 for every child was fixed in the year 1991. The Government of India should consider the revision of the norm of Re. 1 and incorporate their suggestion in the affidavit.

Supreme Court in its further order-dated 7.10.2004, has, inter-alia, directed that BPL shall not be used as an eligibility criteria for providing supplementary nutrition under the ICDS Scheme.

ICDS AND THE WORLD BANK

Total government expenditure on the program has grown sharply over time. An average of 700 million rupees was spent per year on the program between 1975 and 1992, but this amount rose more than six-fold to average 4,542 million rupees per year between 1992 and 1997. For 1999-2000, the budgetary allocation for the program was over 8,557 million rupees and more than US$400 million have been allocated under India's Tenth Five-Year Plan (2002-2007). The program has been supported by several donors, including UNICEF, SIDA, WFP, CARE and NORAD.

The World Bank has supported efforts to improve nutrition in India, in general, since 1980 through six projects. With an overall investment of US$ 712.3 million in the sector, India accounts for the largest volume of Bank Group lending devoted specifically to nutrition programs. Support to ICDS, in particular, has been provided in four overlapping phases:

- Phase I in which the Bank supported the Tamil Nadu Integrated Nutrition Project (TINP) as an alternative to the standard ICDS in the state of Tamil Nadu (TINP I, 1980-89; TINP II, 1990-1997);
- Phase II in which support was extended to the standard government ICDS programs, as well as some additional activities (ICDS I in Orissa and Andhra Pradesh, 1991¬1997, and ICDS II in Bihar and Madhya Pradesh, 1993-2000); and
- Phase III in which the primary emphasis has moved from expanding coverage to improving quality of services (through an ICDS component in the Andhra Pradesh Economic Restructuring Program, 1999-2004, and the Woman and Child Development Projectb, 1999-2004).
- Phase IV: The World Bank has completed three phases in support of the ICDS programme since 1980 with an overall investment of over US$ 700 million in an effort to contribute to improving malnutrition and early childhood development in India. The Government of India has now expressed strong interest in continuing the World Bank support for the next five-year cycle, which is referred as the ICDS IV project to be implemented during 2008-09 to 2012-13. Although, the previous investments in ICDS have not yielded the desired level of impact, the rationale for continued Bank involvement is that nutrition and early child development investments, if efficiently designed and implemented, are estimated to be among the best buys in development.

Until recently, food insecurity was viewed as the primary cause of malnutrition in India. However, research shows that exposure to repeated infections, inadequate utilization of health services, poor sanitation, inappropriate child feeding/caring practices, especially in the first two years of life, and the low status of women are among the key factors contributing to the high malnutrition in India.

The proposed International Development Association (IDA) support from the World Bank to the ICDS programme is expected to: (a) bring in greater focus and targeting of interventions in terms of both age specific developmental needs of children (below three years and 3 to 6 years); (b) intensive support to high burdened districts in terms of malnutrition and early childhood education; and (c) introduce substantial reforms in implementation. In addition, the revised project design will learn from the many technical and managerial “best practices” that have evolved during the ICDS implementation in some States over the last three decades and will aim to take these to scale as feasible and appropriate. The specific Development Objectives of the ICDS-IV project are:

- to reduce child malnutrition through expansion of utilization of nutrition services and awareness and adoption of appropriate feeding and caring behaviors by the households of 0-6 years of age; and
- to improve early childhood development outcomes and school readiness among children 3 to 6 years of age; in selected high burden districts of the eight States.
- Special focus would be given on the girl child and children from disadvantage sections of the society.
- The design of the ICDS Programme and the underlying causes of child undernutrition

The Integrated Child Development Services (ICDS) program is potentially well-poised to address some of the underlying causes of persistent undernutrition, identified in the framework.

The programme adopts a multi-sectoral approach to child well-being, incorporating health, education and nutrition interventions, and is implemented through a network of Anganwadi centers at the community level. The Department of Women and Child Development’s (DWCD) emphasis on a

"life-cycle approach" means that malnutrition is fought through interventions targeted at unmarried adolescent girls, pregnant women, mothers and children aged 0 to 6 years. Eight key services are provided, including supplementary feeding, immunization, health checkups and referrals, health and nutrition education to adult women, micronutrient supplementation and preschool education for 3 to 6 year olds. As the program has developed, it has expanded its range of interventions to include components focused on adolescent girls' nutrition, health, awareness, and skills development, as well as income-generation schemes for women. The table 1.1 gives a clear view of various services provided under ICDS scheme.

Table-1.1
Range of services that the ICDS seeks to provide to Children and Women

Description of services	Children under 6	Pregnant women	Lactating women
Health check-ups, and treatment	Health check-ups by AWW, ANM, LHW Treatment of diarrhea Deworming Basic treatment of minor ailments Referral of more severe illnesses	Antenatal check-ups	Postnatal check-ups
Growth-monitoring	Monthly weighing of under-threes Quarterly weighing of 3-6 year olds Weight recorded on growth cards		
Immunization	Immunization against poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles	Tetanus toxoid immunization	
Micronutrient supplementation	IFA and Vitamin A supplementation for malnourished children	IFA supplementation	
Health and nutrition education		Advice includes infant feeding practices, child care and development, utilization of health services, family planning and sanitation	Advice includes infant feeding practices, child care and development, utilization of health services, family planning and sanitation
Supplementary nutrition	Hot meal or ready-to-eat snack providing 300 calories and 8-10g protein Double rations for malnourished children	Hot meal or ready-to-eat snack providing 500 calories and 20-25g protein	Hot meal or ready-to-eat snack providing 500 calories and 20-25g protein
Preschool education	Early Childhood Care and Preschool Education (ECCE) consisting of "early stimulation" of under-threes and education "through the medium of play" for children aged 3-6 years		

Source: Department of Women and Child Development, Government of India, 2004

However, ICDS has the potential to address many of the underlying causes of malnutrition, there are a number of mismatches between design and implementation within the program (especially with respect to targeting), as well as some serious problems with the quality of implementation. ICDS will, therefore, need some strategic changes for it to effectively combat malnutrition in India.

Description of Services provided by the ICDS

Supplementary nutrition

Adequate food is the most important requisite for the healthy growth of a child. The basic requirement of a child pertains to energy, usually calories. Besides calories, the nutritional needs of children include adequate fats, proteins, vitamins and minerals. The need to provide Supplementary nutrition (SN) arises from the fact that many children are unlikely to be well fed at home owing to a number of factors. The SN also includes supplementary feeding, growth monitoring and as a prophylaxis against Vitamin A deficiency and control of nutritional anaemia. It is provided to bridge the nutrient gap. This supplement is provided to bridge the protein - energy gap between the recommended dietary allowance and the dietary intake (which depends on availability) of children and women.

This supplementation is given to children between 6 months and 6 years of age. It is based on locally procured food. Every child availing the Supplementary Nutrition (SN) is entitled to a prescribed

nutrition intake according to age. The SN is provided for 300 days in a year. Besides children, pregnant and lactating mothers are also provided with the supplement. The calorie norms for the different categories under ICDS are given in Table 1.2.

Table 1.2
Calorie norms for different categories in ICDS, 2008

Category	Calorie (Kcal)	Protein (grams)
Children below 3	500	12 - 15
Children of 3 - 6 years	500	12- 15
Severely underweight	800	20-25
Pregnant and lactating women	600	18-20

Source: Ministry of Women and Child Development, Government of India, 2008.

As per the table 1.2 for below 3 year-old children, the SN is provided as a Take-Home Ration (THR) consisting of 500 calories and 12 - 15 grams of protein. However, in addition to the current mixed practice of giving either cooked or raw ration (Wheat and Rice), which is often consumed by the entire family and not by the child alone, the THR should be given in the form that is palatable to the child. The THR could be given in the form of micronutrient fortified food / or energy dense food that may be marked as 'ICDS Food Supplement' since a child below 3 years is not capable of consuming a meal of 500 calorie in one sitting. For the severely underweight children the supplementation provides for 800 calories of energy and 20-25 grams of protein/day in the form of micronutrient fortified food or energy dense food as THR. Those children requiring medical intervention may be given locally appropriate feeding and care under medical advice.

For 3 – 6 year old children, the nutritional supplement of500 calorie and 12-15 grams protein per child per day should be provided through hot cooked meal in AWC's and mini AWCs under the ICDS scheme. Since the process of cooking and serving a hot cooked meal may take time, the State Government and the UT's are expected to provide a morning snack in the form of milk/banana/egg/seasonal fruits/micronutrient fortified food before that to sustain the children. For the severely malnourished an additional 300 calorie and 8 - 10 grams of protein (in addition to 500 calories and 12 - 15 grams protein) is given at the AWC.

Pregnant and nursing women are to be provided food supplement of 600 calories of energy and 18 - 20 grams of protein per beneficiary/day in the form of micronutrient fortified food/ or energy dense food as THR. The THR will replace the current mixed practice of giving dry rations of wheat or rice.

Financial norms

The Government of India has recently, revised the cost of supplementary nutrition for different category of beneficiaries vide this Ministry's letter No. F.No. 4-2/2008-CD.II dated 07.11.2008, the details of which are given in the table 1.3.

Table- 1.3
Revised Financial Allocations under SNP

Sl. No.	Category	Pre-revised rates	Revised rates (per beneficiary per day)
1.	Children (6-72 months)	Rs.2.00	Rs.4.00
2.	Severely malnourished children (6-72 months)	Rs.2.70	Rs.6.00
3.	Pregnant women and Nursing mothers	Rs.2.30	Rs.5.00

Source: Ministry of Women and Child Development, Government of India.

Type of Supplementary Nutrition

Children in the age group 0-6 Months

For Children in this age group, States/ UTs may ensure continuation of current guidelines of early initiation (within one hour of birth) and exclusive breast-feeding for children for the first 6 months of life.

Children in the age group 6 months to 3 years

For children in this age group, the existing pattern of Take Home Ration (THR) under the ICDS Scheme will continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

Children in the age group 3 to 6 years

For the children in this age group, State/ UTs have been requested to make arrangements to serve Hot Cooked Meal in AWCs and mini-AWCs under the ICDS Scheme. Since the child of this age group is not capable of consuming a meal of 500 calories in one sitting, the States/ UTs are advised to consider serving more than one meal to the children who come to AWCs. Since the process of cooking and serving hot cooked meal takes time, and in most of the cases, the food is served around noon, States/ UTs may provide 500 calories over more than one meal. States/ UTs may arrange to provide a morning snack in the form of milk/ banana/ egg/ seasonal fruits/ micronutrient fortified food etc.

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