

ICDS - a turning-point of Indian public Health.

Prof. F.U. Ahmed MD, FAMS

Introduction: The International Conference on health in 1978 at Alma Ata marked a new era in the field of contemporary Public Health. The conference identified primary health care as “the key to achieve an acceptable level of health throughout the world in the foreseeable future as part of social development and in the spirit of social Justice”. India’s tryst with primary health care started with the adoption of the “magnacarta” of the health service development in Independent India.; - the Report of Health Survey and development Committee (1943-46) popularly known as “Bhore Committee report” The recommendation emphasized “the need for social orientation of medical practice, a high level of public participation to lay special emphasis on preventive work and consequent development of environmental health. It also stressed on Intersectoral approach to health service development.” (1) The main features of the recommendation included the element of universal availability, accessibility & equity of a comprehensive health care package to be delivered through a regionalized graded service infrastructure of sub centre, primary health centre duly supported by secondary and tertiary health institution. The other important landmark in laying down the foundation of primary health care concept was the initiation of the Community Development Program in 1952 where health was considered as a part of community development. In the pilot project of Community Development program Health service was one of the major components.(2) Unfortunately to address the acute health needs of the nation viz. combat diseases like Malaria and other communicable diseases in epidemic proportion without a wide network of infrastructure and adequately trained manpower, it was not possible for the health services to deliver its services as per the scheme. Health services was compelled to take emergency containment measures and simultaneously develop the infrastructure and trained manpower in a planned way as a standalone service department in the community. Gradually in the later years there was expansion of health service network and development of a well trained committed health workforce. And it was possible to attain the next mile stone in the history of Public Health of India in 1975 - the eradication of a dreaded disease like small pox.

Integrated Child Development Scheme a Unique Public Health Program: (3 &4) In 1975 on 2nd. October a unique health related project was launched as a pilot project in 33 places all throughout India. The project is “Integrated Child Development Scheme.” The unique project was conceived with sound public health concept of delivering an **integrated package** of services consisting of health care with other **health related non health services viz. nutritional, environmental and social services**. The **strategy** adopted was of **converging & delivering the services** to the identified **beneficiaries in continuum throughout their specified life cycle period** by a **process of intersectoral coordination** at different levels and **community participation** through a community based **outlet “Angan Wadi Centre” (AWC)**. ICDS project is unique in many ways. Some of the observations are hereunder:

- It is for the first time an important agenda of Child Health is delinked from the cure dominated Ministry of Health. The nodal ministry for the ICDS scheme is the Department of Social welfare under the **ministry of Human Resource Development**. The program defines the **primary goal as health development and is conceptualized with a life cycle approach**. **Starting from the period of adolescence in a girl & the program covers women throughout the reproductive period with special service during pregnancy, child birth, lactating and also covering the child from birth to the 6th Year in continuum; and** focusing on healthy development rather than on cure/repair. The main objective defined is to lay the foundation for overall development of

child, (which included not only physical component but included social and psychological component) and to improve the nutritional health status of children below the age of six years.

- The service package is mainly constituted of **Health education, supplementary nutrition, health care & referral**. This package of services not only include all the levels of prevention viz. promotive, preventive, curative & rehabilitative but other “**social determinants**” influencing Mother & child Health like preschool non formal education for assuring social & psychological development in childhood like safe drinking water, environmental sanitation, nutritional supplementation, and adult literacy. All the above services were not new; it existed and was delivered in a fragmented way by different ministries and department.
- Convergence of health and health related service as an effective implementation strategy was the high light of the program. The strategy envisaged dove tailing the different programs for the welfare of women and Child sponsored by different ministries and department. “Convergence of Health and Health related service” in addressing the health needs was envisaged to be achieved through a system of Intersectoral coordination between implementing departments at the centre, state, district, and block and finally down to the Anganwadi Centre.
- The service delivery strategy in the community is also unique. The services are to be delivered as per the need of the targeted beneficiaries through a process of community participation comprising of identifying and engaging a community based worker “Anganwadi” by the community who will be the interface of the community and workers of different service departments -the nodal person for convergence at the grass root.
- The other unique component in the service delivery was “Capacity Building” among the care givers for effective sustainability through a process of enhancing the capability to look after the health, nutrition and educational needs of the child and also empowering them to look after their child’s health need. On the above context it can be said that ICDS fulfills all the criteria of a good “Health Promotional Program” addressing the concept of positive health and the “Social determinants”. On the above context we can presume that initiation of ICDS scheme in India ushered in the era of adoption of “Primary Health Care” Strategy ahead of the formal declaration of “Alma Ata” and with the adoption of the strategy by WHO and other members of the United Nations India’s Health service development got its *de-facto* approval of its ingenuity.
- The other highlight of the program is the involvement of the Academics in the major project activities like training & monitoring under “Central Technical Cell”; a unique concept of “**Academics to Services**” This concept emphasizes the involvement of teachers and students from teaching institution like medical college (Academics) which also act as the referral centre in providing services through the peripheral health institution up to the “Anganwadi level” (land). Under this strategy teachers of Medical colleges from the departments of Community Medicine, Pediatrics and Obstetrics and gynecology are involved in providing training of different categories of project personnel and also monitoring the implementation of the program and to conduct concurrent evaluation periodically. The teachers were designated as “Honorary Consultant” and provided marginal support in the form teaching aids, contingency for travel, academic forum like workshop, seminars, annual meets etc. The institutional department also provided specialist and referral services to the needy beneficiary of the service area. The institutional involvement in service delivery brought the Public Health Academicians & clinicians close to the community which they serve and was able to have an insight in understanding the natural history, observe

the influence of different determinants on health & disease and appreciate the constraints in implementing a well designed health programs. Almost all the existing medical colleges were involved. This exposure consequently helped these departments to modify their curriculum and teaching priorities accordingly. This is the only health program in the country which made it practically possible to bring some reorientation of the “Medical Education in the Country” more so in the field of teaching and training of Public Health. The erstwhile “ROME” program provided the physical inputs but ICDS made it truly operational. As a proof one can find out how many thesis or papers were published based on the studies conducted in ICDS blocks in that period. No other program till that period linked Health services to Academics except in period of emergency.

Evolution of the ICDS program: 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 (5). “That BCG immunization coverage increased from 11.3% to 49.3% in rural projects, 20.9% to 55.4% in tribal projects, and 47.4% to 74.1% 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% to 11.2% in rural, 5.5% in tribal, and 6.1% in urban projects. Analysis by age-groups showed that services did reach younger children, with resultant improvement in nutritional status. The prevalence of severe malnutrition in children younger than age 3 decreased from 25.5% to 9.7% and that of normal and grade 1 nutritional status increased from 48.2% to 61.3%.” The success was acknowledged nationally and internationally.(6) **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. (7 JE Park on ICDS). 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.

Role of civil Society & Law in Governance of ICDS: There are never enough human and financial resources for health promotion, but there are always innovative ways to organize the community by any pro active group to increase options. One of such option is to create awareness in the civil society through advocacy for good governance. And one of the Governance concerns is the ways in which people organize themselves to achieve common goals that collectively promote and protect health. It is also a fact that one of the most powerful instruments of social change is Law. Gostin (8) points out that most of the 10 great public health achievements in the 20th. Century in the USA was realized in part through law reform or litigation”. The following litigation in the Supreme Court of India is one such example. The case has been significant in not only catalyzing an India-wide movement for implementation of various food schemes but it has also become widely discussed in the global right to food movement. It gives enough scope to a public Health practitioner to improve the equity & effective delivery of health & welfare services in convergence to improve the quality of life. The litigation is popularly known as “PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001” 2001. People’s Union for Civil Liberties (PUCL) a NGO based in Rajasthan submitted a writ petition to the Supreme Court of India seeking enforcement of the right to food. The basic argument is that “the right to food is an aspect of the fundamental “right

to life" enshrined in Article 21 of the Indian Constitution. In its earlier judgements Supreme Court observed that Right to Life should be interpreted as a right to "live with dignity", that includes "right to food and other basic necessities". (Maneka Gandhi v. Union of India AIR 1978 SC 597,). (Focus of six) The case is still continuing but pending final judgement the Supreme Court has issued a series of "interim orders" aimed at safeguarding various aspects of the right to food. The first major order, dated 28 November 2001, directed the government to fully implement nine food-related schemes following the official guideline which included ICDS program. This order converted the benefits of these schemes into legal entitlements. In case of ICDS the court further directed the Government to "universalize" the programme by providing a functional AWC in each hamlet and specific ICDS services should be extended to every child under six, every pregnant or nursing mother, and every adolescent girl. Unfortunately the directives did not yield the results as expected till several hearing on ICDS was held in the Supreme Court in April & October 2004. Following hearing, this time the court explicitly directed the Government to expand the number of "Anganwadis" from 0.6 million to 1.4 million, to ensure that every settlement is covered.(9) Following the Supreme Court directive in May 2004 "universalization of ICDS" was included in the National Common Minimum Programme of the UPA government. The National Advisory Council submitted detailed recommendations for achieving "universalization with quality" in October 2004, as well as follow-up recommendations in February 2005. This was reflected in the Union Budget of 2005-6. In the budget the expenditure of the Central Government on ICDS was nearly doubled. However, there has been relatively little progress in terms of the situation on the ground. The expansion of ICDS is quite slow, and in most states there is little evidence of substantial quality improvement. This reflects the fact that Supreme Court orders and budget allocations are not enough. Ultimately, what is required is a broad based movement for the universalization of ICDS, involving not only the government but also the public at large.

Current Status of the ICDS Scheme (10,11) Since its inception in 1975, many evaluation studies have been conducted by organizations and individuals to assess the effectiveness of ICDS programme, Most of the evaluations were process evaluation limiting to service coverage, availability of infrastructure and type of services delivered and number of beneficiaries receiving various services. The results of the two latest NCAER & and the NFHS3 Survey are reviewed here for studying the current status of the functioning and the outcome. National Council of Applied Economic Research (NCAER) carried out a nationwide evaluation of ICDS covering nearly 60,000 Anganwadi Centres and 1.8 lakh beneficiary households in the country. Main findings of report (1996-2001) are as follows:

- **Distance of beneficiary households from the AWC** was unlikely to affect attendance at the AWC during inclement weather. Observation: Most of the AWCs across the country were located within 100-200 meters from beneficiary households. A majority of the beneficiary households was within 100 metres of the AWC. Only 10 per cent were about 150-200 meters away and the rest were beyond 200 meters.;
- **Location and safety of AWC** against any natural hazards: Most of the AWCs in the country, except those in Tamil Nadu, Kerala, Karnataka and Orissa were functioning from community buildings. Of those sampled, about 40 per cent were functioning from pucca buildings. Nearly 50 per cent AWCs reported adequate space, especially for cooking.
- **Capacity & Training of the AWW:** One out of two AWWs was found to be educated at least up to matriculate level across the country. Though about 84 per cent of the functionaries were reported to have received training, the training was largely pre-service training. In-service training remained largely neglected.
- **Day to day functioning** of the AWC is a critical indicator of the effectiveness of the ICDS programme: On an average, an AWC functioned for 24 of 30 days in a month. On a given day, the AWC functioned for about 4 hours. By and large, environmental factors did not affect the functioning of the AWC.
- **Beneficiaries enrolled:** On an average nearly 66 per cent of eligible children and 75 per cent of eligible women were registered at the AWCs. Participation of beneficiary women and adolescent girls in AWC activities was reported to be low.

- **Attitude of the Community:** Community leaders were generally positive about the functioning of the AWCs (more than 80 per cent in all states) while more than 70 per cent found the programme to be beneficial to the community.

The highlights of the observation is that the community based AWW centres are well accepted by the community and are mostly accessible and are functioning 24 days of 30 days and on an average for 4 hours.. The AWCs are manned by trained AWW without any continued training. The coverage is poor among the children but mostly the adolescence and pregnant and lactating mother.

The other NCAER survey “**Facility Survey of Infrastructure at Anganwadi Centres (RFS-AWCs)**” was conducted as a Rapid Facility Survey on ICDS infrastructure in 2004. The result highlights are:

- Service provided at the AWC: More than 90 per cent Centres provided supplementary food, 90 per cent provided pre-school education and 76 per cent weighed children for growth monitoring;
- Only 50 per cent anganwadis reported providing referral services, 65 per cent health check-up of children,
- 53 per cent for health check-up of women and more than 75 for nutrition and health education;
- Average number of days in a month in which services are provided at the anganwadi centres are 24 for supplementary food, 28 for pre-school education and 13 for Nutrition and health education;
- More than 57 per cent of anganwadi centres reported availability of ready-to-eat food and 46 per cent availability of uncooked food at the anganwadi centres;
- Nearly three-fourth of the anganwadis have reported the availability of medical kits and baby weighing scale. On the other hand adult weighing scale has been reported only by 49 per cent of the anganwadis.

But the most revealing outcome results were observed in the NFHS3 study.

- According to the NFHS 3 study it is observed that 72% of the Enumeration area under the survey was covered by AWC of these 62 % are of 5 year or more duration that signifies that the during the last five year only 10% of the AWC was added. It is also not uniform in the states of Tripura, Tamil Nadu, Mizoram, Karnataka, and Nagaland 90% of EA are covered whereas less than half of EAs are covered by an AWC are Meghalaya (27%), Delhi, and Arunachal Pradesh (35% each).
- Although ICDS *coverage* is fairly high; Women with one or more children born in the 6 years before the survey when asked about benefits received from an AWC for their young children and benefits they themselves received during pregnancy and while breastfeeding, it was observed that only 28% of children under age 6 years received *any* service from an AWC in the last year. The services received by these children are also not satisfactory. Children receiving any service consisted of 33%. Only 26 and 23% beneficiaries received the services of supplementary feeding and preschool education.
- The coverage of health component of the services like immunization, health check up and referral is dismal only 20%,18% and 16% respectively.
- The coverage of the other beneficiaries’ viz. Pregnant and lactating women is further lower. **As much as 78% of pregnant mother and 83% of the lactating mother did not receive any services from the AWC.**
- Of those who received some services only 21% of the pregnant women and 17% of the lactating women received supplementary food, Health check up was received by 12% & 9% respectively

and Health education. Nutrition education was received by 11% & 8% of Pregnant and lactating mothers who received any services. (NFHS3).

- The nutritional outcome was meticulously assessed in NFHS3 and it is reported that of the children surveyed 45% are stunted, 40% underweight and 23% are wasted. The rate at which the nutritional status is improving can be observed while we compare the NFH2 & NFHS3 results. During the interval period of two surveys it was observed that there is a decline of proportion of stunted and wasted children from 51% to 45% in stunted group and from 43 to 40% in the wasted group. Paradoxically the wasted group has increased from 20 to 23 %.

The Citizens Initiative for the Rights of Children under six a NGO conducted an all India survey and the results were published in "Focus on Children under Six". (12)

- In the report they observed that the effective coverage of ICDS remains quite limited: barely one fourth of all children below six are covered under the supplementary nutrition component. About 11 crores (111million) children, out of a total of 16 crore (160 million) in the 0-6 age group, remain unreached.
- Throughout India the functioning of the ICDS program is not uniform some states are better than the others. Focus survey revealed that "at one end of the spectrum, Tamil Nadu is doing very well: anganwadis are open throughout the year, nutritious food is available there every day, regular health services are also provided, and even the pre-school education programme is in good shape. At the other end, a day in the life of a typical anganwadi in Uttar Pradesh is little more than a brief ritual, involving the distribution of a bland, monotonous "ready-to-eat" mixture (called panjiri) to the children and some hasty filling – or fudging – of registers. Between these two extremes, there are many shades of achievement and failure in different states."

While releasing the report Prof. Amartya Sen, the Nobel laureate said: "In the country as a whole, the population of underweight children has not gone down. Most of them are also anaemic." As per the NFHS survey, nearly half of all Indian children were underweight in 1998-9 and 2005-6 in both years. Even the decline of stunting in that period is about one percentage point per year. If the incidence of stunting continues to decline at this rate, it will take another twenty-five years or so to reach levels similar to those of China today. ("NFHS-3") The general pace of change in child health is much slower than countries like Bangladesh. And despite its sophisticated medical system and vast army of health personnel, India has not been able to achieve higher rates of child survival than any of its neighbours except Pakistan". It is not only the NGO and individuals like Prof. Sen who are convinced about the inadequacy of the ICDS program in improving the child health but even our Prime minister is also aware and showing concern Dr. Singh told. "There is strong evidence that the programme has not led to any substantial improvement in the nutritional status of children under six. Our prevalent rate of under-nutrition in this age group remains one of the highest in the world. Immunization status under ICDS continues to be poor." (13)

Analysis of the delivery of ICDS Red Herrings in effective implementation:

Any program for improving the quality of life including healthy growth & development of children is based on the premise that for achieving it we have to ensure a family; food security, social including economic security, environmental security and health security. India is committed to provide all the security to its citizen as enshrined in the Constitution. Accordingly there are many programs aimed to improve the nutrition, safeguard their health (promote, protect, prevent, cure & rehabilitate) and provide a healthy environment (water & sanitation), and empower them by providing proper education and avenues for income for sustenance. The state is committed to uplift the quality of life of all but mostly those who are in need like socially disadvantaged group and specially Women and child. The state is committed and there are programs which are being implemented successfully for decades but the impact is far from satisfactory. If we examine the governance /implementation of all the programs addressing the basic needs by different ministries/department; we shall observe that the programs are implemented in a fragmented and sectored way which does not fulfil the criteria of convergence of related services for effective results.eg. Nutrition supplementation without growth monitoring, health services, provision of safe water and sanitation services. The program designs are straight jacket type over centralized and do not address the contextual diversities in different communities, inadequacy of implementation due to faulty supply logistic, finances, material resources, and lack of skill improving mechanism like training as well as monitoring and effective supervision. ICDS and following ICDS other health schemes including NRHM were conceived to address the deficiency. It is high time that we should understand why ICDS failed in delivering the service packages as expected? A system analysis based on the paradigm of Health system and triangulating the results of different evaluation reports was carried out. The paradigm of “health system” includes: Concepts (e.g. Health & disease); Ideas: (equity, coverage, effectiveness, efficiency, impact) Objects: (e.g. hospitals, health centres, health programs) and persons ;(e.g. Providers and consumers).(7) The results of the assessment along with the recommendations are given below:

- Concepts:** Childs Health & Development should be viewed from two dimensions. One is the life cycle dimension and the other is the health determinants dimension. In the life cycle dimension it should be seen in terms health & nutritional status of the mother starting from her adolescence and continuing through her later life, pregnancy, delivery and its cumulative effect on the child’s health & nutritional status during the natal, perinatal, post natal and childhood period. Each of the preceding stages of life cycle in the mother and child tends to set the readiness level for the next sub stage. The other dimension is that of synergistic relationship of the different health determinants (health, education, nutrition, environmental sanitation, empowerment and income generation capacity) and its impact on health development at various stages of the life cycle which is also different in different stages and is specific in nature. So any program to improve the child health has to provide a different package of service for different period of the life cycle. The package mix must not only contain services related to health or nutrition but it should also contain the other related social determinants without which the health/nutritional package will not have a sustainable impact. The packages are stage specific and have to be provided in continuum to the enrolled beneficiary. Success of any such program depends on “beneficiary holding” for the entire period of life cycle. Family level convergence in the delivery of different health & other determinant related services is essential to get the maximum benefit.
- Ideas:** “Ideas” in a health system cover Equity, Coverage, Effectiveness and efficiency, impact. The ICDS coverage & equity is far from satisfactory. The study conducted by “Most of the children attending AWC are 3-6 years (rather than the 0-3 year olds who are most in need), or even older (we saw many 7 or 8 year old children at the feeding centres in our field visit). not reaching enough children, not reaching children in the poorest families, not reaching remote areas, and not reaching enough children in the critical under 3 years age group). In the implementation of the ICDS scheme it is seen that the priority is given for supplementary nutrition and pre-school education in the form of formal but not non formal education which it was suppose

to be. The scheme is conceived to provide services as per the need of the beneficiaries. The main activities at the AWW level are to register all beneficiaries identify their needs by assessing the health and nutritional status through weighing and plotting in the growth chart. This is the principal activity to categorize the service needs other than those who are obviously ill for providing them services like Supplementary nutrition, Health check up, therapeutic nutrition, immunization referral if any and the related health and nutrition education to the mother. This is the activity by which the AWW who are in constant touch with the child can hand over the needy beneficiaries to the Female Health worker or other health service providers. Similarly the registered pregnant & lactating mother may be referred to the Health workers who provides her services and intimates back the AWW for putting her in a loop for other services. In the ICDS program several standalone service packages like Growth monitoring, Supplementary nutrition, health check up, treatment of ailments & referral, immunization, non formal preschool education, health & nutrition education to the mother and adolescent girl of reproductive age group, water & sanitation, other non formal adult education are available. These services are to be provided at three levels; individual, family and community. The service delivery strategy is “linkage” of the services as per the individual and the families need and deliver it through a “single window” approach for equity and compliance. To improve the efficiency all the field level workers for different departments delivering related services are to be linked through a community based training so that the final convergence in delivery can take place. The field level workers are supposed to provide all the necessary inputs and the supervisors are supposed to help in chalking out the work plan. The block level workers are to make it administratively possible for linkage and convergence and encourage the different group of development workers as a composite team. The impact should be assessed as per mortality, morbidity, nutritional status.

- **Objects:** These are the service delivery infrastructure and the programs: For child health development currently we have different service delivery infrastructure as per specific programs under different departments. The services are stand alone and are to be provided under similar and or different criteria to the same community. The beneficiary selection criterion is subjective as it is mostly based on social/economic category. Objective criterion like morbidity, mortality, nutritional status etc is not included in defining the beneficiaries. This method of arbitrary selection of beneficiaries’ is one of the reasons for our failure to lower the malnutrition and excess morbidity & mortality as most of the time we miss those who are in need. For example if we can identify, a BPL family who is a land less labourer with a number of malnourished children and with an adult member suffering from TB, under any of the existing program viz. Health, ICDS, Income Generation and can provide all the available service packages under different schemes to this individual family through a “single Window” approach; we can expect remarkable results. For the child health & development we should not only limit our self to only ICDS program. Rather the first step should be to listing out all the programs in different departments related to child health. A detailed functional linkage in the delivery of the services through the available infrastructural net work is to be worked out at various levels eg; District, Block, Panchyat, village and family level to address the common goal of improving the health and nutritional status. The process is to be contributed by each participating department. This should be the objective of the common program. Once the program is developed the details of service delivery can be worked out..
- **Persons:** This includes Providers and consumers. Providers are all the employees of each selected department. Here the need is to improve their capacity not only on their own area but must be exposed to child health & development, & nutrition and what role they can play and how to work as a team to discharge each individuals duties effectively and efficiently. They are to be trained how to work with other departmental employees and achieve a common goal. Regarding the consumers each of the consumers should know what services are available and also information like what are the services provided, who is going to provide where it is provided, how it is provided, when it is provided and how to get it, the consumer also should know about the existing reappraisal and redressal mechanism.

Suggested Recommendation:

1. Coverage:

- The directives of the Hon'ble "Supreme Court" are to be followed in letter and spirit. The goal of the government should be beyond the recommendation of the "Supreme Court" Verdict. It should aim to cover as per the actual requirements of our population and not restrict to the old census data.
- All the beneficiaries in each AWC are to be registered and to be updated every year. This should form the basic document verified by the Panchyat and other local registration authorities. Registration of each family in the AWC should be made mandatory. Family information of the ICDS should be the basic registration instrument for providing all welfare services which should include health, subsidized food, work guarantee, housing etc under all state & central government scheme.

2. Service Package:

- The package mix should not only confine to personal care packages to the beneficiaries viz. Supplementary feeding, Health check up, non formal education and health education. But a package mix for such needy family be constituted from among the prevailing government welfare and income generating program and delivered as a family package. Effective linkage between the personal care package and family package and timely and successful delivery of the same to the family in need will help them to get out of the "Disease & poverty Cycle". Success of any such program depends on "beneficiary holding" for the entire period of life cycle from the time of registration.

3. Service Delivery Strategy:

- To get the maximum effect of the program the service delivery approach should be "Single Window Approach". The single window should be at the level of Anganwadi Centre. Besides providing personal services like growth monitoring, nutritional supplementation, immunization, health check-up, etc, to the registered beneficiaries, family level convergence in the delivery of other services complimentary in nature like income generation, poverty elevation, water sanitation etc, will have an sustainable impact on the family too.
- Department of health has a very crucial to play. The community level worker "ASHA" and the AWW worker should work together in tandem for providing health care package to the registered beneficiaries under the direct supervision of Female Multipurpose worker. Their work should be complimentary to each other rather than competitive. Preventive and promotive programs are to be arranged jointly but to be delivered through AW centre. If the AWC can also be the service delivery unit of the health department at the village level, it will improve the accessibility of the health services at the village level. Periodic preventive & promotive services should be delivered routinely through this outlet. In emergency also the same infrastructure can be utilized. Medical care and referral is another area which can be made more functional. Referral should be two way. One the AWC sending sick children to the health facilities and the other way is that if a child is admitted due to some acute condition after hospitalization the nutritional rehabilitation must be done at the AWC where the child belongs to.
- As a feeding program it has become successful even in the remote areas popularly known as "Khichidi Scool". But it can only have a health impact if the nutritional program is managed under three heads, therapeutic, supplementary and rehabilitative. And the yard stick should be

growth monitoring which is routinely done by the AWW & the health condition of the child. And for this the linkage between the AWW and ASHA with a well trained MPW (F) is essential. To effectively deliver such case specific package needs constant supervision and on the job training.

- To deliver such package under strict supervision we need a cadre of mid level public health manager which is at the moment lacking. Except for Health Assistant Female we don't have any other personnel to supervise the works of the peripheral worker. Moreover the existing Health Assistant female are inadequately trained and also least efficient. But they also need a continued on the job training by a trained cadre with sufficient knowledge of Public Health. A new cadre of supervisors with a basic public health training at the block level will go a long way in proper supervision and training.

4. Monitoring & Supervision (2)

- One of the important features of the monitoring and supervision in the earlier years was the mechanism of "Central Technical Cell (CTC)" and the involvement of the honorary consultant from the medical colleges. Till the CTC was there two sets of information Monthly progress report and Monthly monitoring report (ICDS) was generated by the AWW and MPW(F) and through CDPO & MO of the PHC used to reach the state and central level via District level. The consultants use to have on site verification and the discrepancy is to be reported in different block, district, and state forums for future rectification. The routine interdepartmental monitoring platform at Sub Block, Block, District was attended by all the stakeholders including the consultant and was one of the successful mechanism to address the deficiencies observed. The periodic continued education of both the health and welfare functionaries by the consultant at the block, district and institution level was one of the success stories of linking educational institution to the national building activities of the government. This component of the program was unceremoniously terminated for reasons known to the erstwhile decision makers. During that period only 125 odd medical colleges were functional. Now we have about 400 odd medical college spread out all throughout our country. As per the MCI norm each of the medical colleges must have three primary health centres as their field practice area. The private medical colleges which are considerable in number are hoodwinking the authority by adopting few villages as a practice area without exposing their students the health services and program prevailing in the country.
- The earlier program should be revived and each medical college should be asked to look after at least three of the ICDS block to look after the areas of monitoring supervision and continuing education. Their performance may be monitored and it should be reflected in the accreditation by the MCI. Here the earlier incentives and provision given to the medical colleges are to be revived and given to the medical colleges. But the government should not spend any special fund for additional infrastructure for implementing this,
- The other area to consider is to develop a band of workers who are trained to provide public health services at the Block level under the leadership of the Medical & Health Officer of the PHC. The details are as under. The course aims to produce a band of basic public health professional who can organize basic public health services at the community level and be able supervise and monitor the activities of the Multipurpose worker/basic public health workers working under him and are engaged in implementation of different National Health Program and other community/ work place based public health activity effectively. After the training they will be eligible to work in government health services as Block Public Health Extension officer/Block Extension Educator; in the Primary Health Centre and in the private as Junior & Senior Public Health officer to look after the public health needs of the employees in colonies/township and environmental sanitation in work places under the supervision and leadership of Medical officer of Health.

These are some of the suggestion for functional linkages of the two flagship program of the government of India ICDS & NRHM. The linkages are essential. For the benefit of the public we should redefine the straight jacket approach of the different service departments and make it community friendly for better compliance and effect.

References:

1. Bhore Committee Report. Government of India (1946) Report of Health Survey & Development Committee, Government of India Press, Simla.
2. Community Development Program in "Text Book of Community Medicine" 1st. Edition (2007) Sunderlal, Adarsh, Pankaj, CBS Publisher& Distributors, New Delhi & Bangalore.
3. Integrated Child Development Services, Nov 1983, Central Technical Committee on Health & Nutrition, All India Institute Of Medical Sciences, New Delhi.
4. ICDS, Deptt, of Social Welfare Ministry of Education & Social Welfare, Govt. of India, New Delhi-1976
5. A coordinated approach to children's health in India: progress report after five years (1975-1980). BN Tandon : Lancet. 1983 Jan 15;1(8316):109-11.
6. Nutritional interventions through primary health care: impact of the ICDS projects in India. Bull World Health organ. 1989; 67(1):77-80.
7. Preventive & Social Medicine by JE Park 19th. Edition feb 2007
8. Gostin LO (2006) In Oxford Handbook of Public Health Pr
9. actices. Ed. By David Pencheon, Charles Guest, David Melzer & JA Muir Gray Ox ford University Press.

Web sites:

10. www.hinduonnet.com/thehindu/nic/icds.htm>>wcd.nic.in/affidivticds.htm>pmindia.nic.in/nac/communication/icds1.pdf
11. wcd.nic.in/childdet.htm
12. wcd.nic.in/icds.htm
13. . "Focus on children under six" Abridged Report, December 2006 Citizens' Initiative for the Rights of Children Under Six, New Delhi Website: www.righttofoodindia.org.pp. 31-42
14. *Special Correspondent, Fewer low birth weight children in ICDS areas, THE HINDU, Online edition, Saturday, Aug 05, 2006, URL: <http://www.hindu.com/2006/08/05/stories/2006080501970900.htm>, Date of access: 26-01-07*