Universalisation of ICDS and Community Health Worker Programmes

Lessons from Chhattisgarh

Lack of political will and inability to address the basic rights of children like pre-school education, créche facilities, food security and health have made the ICDS programme a failure. This article critically examines the ongoing ICDS programme in Chhattisgarh where the child malnutrition rate is around 60 per cent.

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Universalisation of ICDS is an idea long overdue. The delay in doing so stems from a lack of political will. This weak political will seeks "justification" in the poor functioning of current ICDS programmes in most parts of the country. Data are repeatedly presented to show that malnutrition does not differ between areas that do and do not have ICDS programmes. The international donor community's largely negative assessment of food supplementation programmes as having very limited impact (as per the disability adjusted life years (DALYs) saved), and the pressures to shift funds into micronutrient management, have also played a major role in the lack of political and administrative will towards the universalisation of ICDS.

However, if we start the discussion with different foundations – from the perspective of children's rights – we arrive at different conclusions. With reference to the pre-school child, there are four basic rights that society has to guarantee to every person, whether it is through ICDS or through other government programmes. These four rights are: (a) the right of children to pre-school education; (b) the right of working mothers to créche facilites; (c) the right of children to food security; (d) the right of children to health.

Today ICDS is not addressing all these goals – even in terms of state policy. For instance, anganwadi centres do not see themselves as having to deliver pre-school education. There have been some efforts with this but often it is dismissed as not possible for the over-worked anganwadi worker (AWW).

The crèche facilites relate primarily to small children in the age group of six months to two years – but the ICDS programme requires such children to stay at home and be given "take-home rations" only. The function of a crèche is not a part of the ICDS mandate, and indeed, it is not part of any major scheme of service provision.

In child health, the auxiliary nurse midwife (ANM) is seen as playing the key role, with the anganwadi worker assisting. Thus, the ANM does the immunisation and the AWW provides the site and helps to bring the children. In some states, anti-worm medication and Vitamin A are stocked and administered by the anganwadi worker. For the rest it is through growth monitoring, food supplementation and related health education that the anganwadi is expected to make its contribution to child health.

In practice, therefore, ICDS is largely perceived only as a measure for the management of child malnutrition.

Child Malnutrition and the South Asian Enigma

Child malnutrition, indeed malnutrition at any age, is no doubt the central health problem in India, and the largest human development gap that the nation faces. The most puzzling aspect of this endemic child malnutrition is that its prevalence is much higher than what would be expected on the basis of India's GDP or various measures of poverty. This phenomenon has been called the "south Asian enigma" (V Ramalingaswami; Progress of Nations; 1993 UNICEF publication). Ranked on an index that adjusts child malnutrition level to GDP, India had the second highest level of malnutrition – worse than all of Africa, second only to Bangladesh, and closely followed by Nepal and Pakistan (Sri Lanka, though south Asian, does not conform to this pattern).

The truth of this characterisation is evident even on a cursory examination of the statistics. Whereas poverty figures are always cited as anywhere between 26 and 40 per cent, malnutrition figures always hover at 46 to 70 per cent. Almost twice as many children are malnourished as are poor. Anecdotally, village visits show repeatedly that even in relatively well-off households within a rural community, child malnutrition (even of severe grades) is common.

This is not to deny that there is a close relationship between poverty, hunger and child malnutrition. That much is obvious. Less obvious are the non-hunger related factors that influence child malnutrition. The two major influences that have been discussed in relation to the south Asian enigma are gender discrimination and poor access to healthcare. The gender differences in child malnutrition rates are not significant, but the weaker position of the woman in hierarchical family relationships influences the perception of food needs of different members and the intra-family allocation of food, especially as regards non-cereal food elements. Gender discrimination also tends to increase child malnutrition through determinants like low age of the mother, inadequate spacing interval between children, and lack of male support for childcare. Similarly, poor access to healthcare has a disproportionate impact on children due to the vulnerability of the child, especially of the malnourished child, to recurrent infections.

Other than through hunger, poverty acts in various ways to create malnutrition. Adding to this is the complex relationship between traditional knowledge of feeding practices and the changing context in which such knowledge has to be applied. Thus, there may be enough cereals (carbohydrate) for the child, but the iron-rich foods are lost as variety in the diet is lost. In tribal areas, the decrease in meat availability due to the decline of game and change of lifestyles is not compensated by increases in other sources like leafy vegetables or lentils, or in other meats like pork or beef – due to a combination of cultural and monetary constraints. Again the availability of rice and wheat in the public distribution system, instead of coarse grains such as millet which are richer in iron and calcium, leads to a change of dietary patterns and a loss of variety, which in turn lead to iron deficiency, anorexia and malnutrition. Traditional knowledge, which was adequate in the context whence it was created, cannot cope with the rapid changes in dietary patterns that are taking place due to the depletion of the natural resource base, the action of the state and the influence of markets.

Poverty also acts to create child malnutrition through insanitary conditions and thereby recurrent infections. Poverty acts as a barrier to accessing health services. Above all poverty deprives the child of his or her mother's time. So much is the burden of work (especially food, fuel and fodder collection) that time is lacking to feed the young child and play with him or her. Without the stimulation provided by play and the warmth of parental care, growth lags.

Elimination of Child Malnutrition and ICDS

Given the complexity of determinants of child malnutrition, it is welcome that the ICDS programme has a focus on it. But there are serious contradictions due to such a limited focus – as compared to a more comprehensive approach based on the rights of the child.

At the local level, the ICDS system is repeatedly denying the existence of malnutrition. This is difficult to do given its ubiquity – but nevertheless managed by a variety of mechanisms. The most common form of denial is to equate malnutrition with grades III and IV malnutrition, and thereby declare that it does not exist in that locality, or exists only as an exception. This denial is necessary to show that the anganwadi centre is functional and achieving its goals. At the policy level, however, the enormity of the malnutrition is always emphasised (whether it is by the government, or by the anganwadi workers' associations, or by civil society) to argue for extending the scheme, paying its workers more and continuing with this programme and goal in perpetuity.

We shall return to the reasons why the ICDS schemes have shown such poor results in tackling child malnutrition. For now, the point being made is that there is a curious tension between these poor results claimed nationally and the good results claimed locally. Both have synergistically become necessary conditions for the continuation and universalisation of ICDS in its current form. This is not a good development for attaining the goals of tackling malnutrition.

The government needs to reconceive the child malnutrition agenda as an immediate campaign agenda, pegged around ICDS but not confined to it, and culminating in at least halving child malnutrition every five years. Thus, ICDS should aim at freeing itself gradually from this malnutrition commitment (by virtue of having achieved its goals), and then moving on to its main role in early childhood care, as the malnutrition problem reduces. This gradual shift from child malnutrition as the immediate agenda to aspects like pre-school education as the long-term agenda would help to give urgency to the task of tackling malnutrition without threatening the livelihoods of lakhs of anganwadi workers. It would also revive their role as teachers and health workers – an identity they aspire to. Further, this shift would help ensure that child malnutrition is an intersectoral agenda and not just an agenda relegated to the ICDS department. It is worth exploring the possibility of making the elimination of child malnutrition the main priority of the panchayati raj institutions, and providing them with the resources and support needed for this. Central to this is the realisation that even within current socio-economic constraints, the reduction of child malnutrition is indeed possible, as shown by the experience of other countries with equivalent GDP and inequities. And, if this is not being achieved today, the very belief that nothing much can be done to the problem by government schemes and local action is contributing to poor accountability of the ICDS programme and the resulting

persistence of such high levels of child malnutrition.

Universalisation of ICDS in Chhattisgarh

Chhattisgarh has a persistent child malnutrition rate of around 60 per cent. It also has a universal ICDS programme – in the limited sense that every block is under the ICDS scheme. There are 146 rural blocks and six urban projects.[1]

However, the situation in terms of outreach and impact is not very different from elsewhere across the country. There are four major reasons for the poor coverage. First, there is a shortage of anganwadi centres. The official number of hamlets in Chhattisgarh is 54,000, though unofficial estimates that include sub-hamlets are higher (over 73,000). As against this, there are only 20,100 sanctioned anganwadi centres in the state. The result is that a single anganwadi centre is expected to cover many hamlets. The main hamlet where it is situated gets covered but surrounding hamlets are left out.

Second, economically or socially disadvantaged families tend to get left out. This may be due to their living in outlying hamlets, or to their inability to send the children to the anganwadi centre, or (in larger villages) to the fact that there is an informal limit on the number of children per centre and no affirmative action to ensure that disadvantaged families get priority.

Third, there is a problem of social distance between service providers and the population served, e g, in terms of caste. This adds to the other two problems mentioned above, which act as a local justification for the exclusion of disadvantaged sections. Finally, urban areas (especially slums) have very little coverage and what is there is poorly adapted to the complexities of the urban slum and its vulnerable sections.

The other problem with ICDS in Chhattisgarh is the poor functioning of anganwadi centres. A large number of activities are slated to happen there, but few actually take place. There are large gaps in growth monitoring, and an almost complete absence of appropriate counselling to prevent and manage malnutrition. It is not uncommon to find that even where malnutrition has been found in a child, this information is not conveyed to the family.

As far healthcare is concerned, immunisation occurs with greatest frequency and the anganwadi is the preferred site where ANM and child meet, but there is virtually no other health activity. Other health activities that are supposed to take place under ICDS include deworming, Vitamin A supplementation, paediatric anaemia correction, diarrhoea management and acute respiratory infection (ARI) response. Of this, only Vitamin A supplementation is occurring in some places. The oral rehydration salts (ORS) packets are stocked at anganwadis but since stocks can never be enough to manage all cases of diarrhoea, its use is sporadic.

The anganwadi, we already noted, is no longer seen as a pre-school education institution. The coverage of adolescent girls and pregnant women is also very poor – almost non-existent.

Therefore, the only activity that actually happens is food supplementation – when usually the 'dalia' is either distributed as dry rations or served out cooked to the children who come. Often less than half the children of the village are utilising this on a daily basis and usually it is the weakest children who get left out.

Even when nutrition counselling takes place, there is a tendency to convert health and nutrition education into a form of victim blaming. "Ignorance" of poor parents, and an irrational reluctance to change, are perceived as the main barriers to changes in feeding practice. The messages tend to be didactic and stereotyped, and are seldom individualised. Nutrition counselling is often confined to mothers coming with children to the anganwadis and home visits seldom happen – thereby leaving out the key decision-makers in the family from any exposure to these messages.

While there is considerable scope to improve the functioning of anganwadis, the need was felt in Chhattisgarh for fresh ways of addressing the problem of child malnutrition and mortality in a campaign mode, bearing in mind its various interrelated determinants. One of the strategies that have been experimenting with is the Mitanin programme – a statewide community health volunteer programme.

The Mitanin Programme

In Chhattisgarh's tradition a 'Mitanin' (a health volunteer) is a girl bonded ceremoniously in her childhood to another girl, as a lifelong friend. "In happiness, every one; but in sorrow, your Mitanin" goes the village saying.

The objectives of the Mitanin programme are: Improving awareness of health and health education; improving the utilisation of health services (with an emphasis on the ICDS-provided services); providing a measure of immediate relief to health problems; organising the community, especially women and the weaker sections, on healthcare issues; sensitising panchayats and building capabilities.

In operational terms, the objectives of the Mitanin programme have been defined as follows:

Select a Mitanin in each of the state's 54,000 hamlets (with selection by the community, approved by the panchayat); Train the Mitanin over 18 months (18 days of camp-based training and 30 days of on-the-job training in the village); Provide support to her in her work and closely coordinate with the ANM and AWW for maximum effectiveness.

The need for a community health volunteer, as perceived by the government, arises from the large gap between the number of health sub-centres (4,600) and anganwadi centres (20,100) on the one hand, and the number of villages (20,000) and hamlets (54,000 officially, but actually more than 73,000) on the other. It is well recognised that if infant mortality is to fall rapidly in the state, from the current high level of 73 per 1,000 live births, then every birth and every case of diarrhoea, ARI or fever among infants must be attended to on the very first day. This essential goal is physically impossible to achieve for the existing functionaries (the ANM and the anganwadi worker) without substantial community support including a massive force of volunteers.

Further, health education that leads to a change in practices requires an effective communicator. Such a health education communicator is preferably someone from within the community who knows the local idiom and perceptions. Finally, the community health volunteer (CHV) is also seen as a catalyst for promoting community level collective action and for local governments taking up health issues as their responsibility.

The Mitanin is perceived as effecting an increased utilisation of healthcare services through four key strategies: providing information on existing healthcare services; creating awareness on access to key healthcare and the ICDS services as an entitlement; facilitating the delivery of healthcare services in coordination with the ANMs, anganwadis and primary health centre; and local advocacy to ensure proper functioning and access to these services. To be

effective in these four functions her perception of herself and her own role should be that of a leader of the local community seeking to secure the entitlements of the people and make the system accountable, rather than of an employee or assistant or helper to the government functionary, reporting to them as the last and least peg in a chain of command.

Two key features of the Mitanin programme are that the volunteer is a woman (and so are all her trainers) and that the selection is hamlet based. The selection is through a three-to six-month process where the community makes the choice but the community's choice and the interests of the weaker sections within the community are facilitated by a trained 'prerak'. Also, first contact curative care is an essential but supplementary component of the programme. It is not central to the programme.

The programme also includes training and support as well as processes of social mobilisation as continuing activities for the entire duration of the programme – not merely as an initial effort. Further, the programme design envisages a parallel strengthening of public health systems including ICDS. The Mitanin programme is not a substitute for strengthening public health systems and ICDS, but forms a context in which the public health system and ICDS may be reformed and become more accountable. To operationalise such an ambitious programme with its inherent contradictions (a programme run by the government but holding it accountable), the programme design envisages a partnership between state and civil society at all levels.

Mitanin and the ICDS Programme

The Mitanin, though operationalised through the health department, is inherently a convergence between the health sector and the ICDS programme – both in design and in functioning. The experience of such an extensive interaction between the Mitanin, ICDS and health department programmes is now available before us. There were conscious efforts to institutionalise this coordination in the form of a monthly meeting of these three workers (Mitanin, AWW and ANM) with women and children. This measure served to help declare the programme's intention to improve coordination between these programmes, though such monthly melas did not quite materialise. There was also a conscious effort in some blocks to choose anganwadi 'sevikas' (helpers who assist the anganwadi worker) as Mitanins so that there is a fusion of the programmes. But this was a step backward, because it limited community choice and ownership over the programme and could not act to improve anganwadi functioning or accountability. Moreover, the sevikas perceive themselves only as humble and obedient assistants to the already marginalised anganwadi workers, and were unable to play any effective role in social mobilisation, much less rise to leadership of the communities they worked with.

An interim internal evaluation of the programme (done by researchers drawn from an NGO external to the blocks sampled, visiting 240 villages and interviewing a sample of 1,200 Mitanins) found that there was a high level of coordination between the programmes. The survey showed that only 63 per cent of the hamlets where Mitanins were in place had an anganwadi. The remaining hamlets were, on paper, attached to a main village where the anganwadi was located, and were supposed to get services from there, but this was rarely happening in practice. This is not surprising considering the distance between hamlets and the fact that most villages are in scattered hamlets with a population well below the norm required for a separate anganwadi (750 in tribal areas and 1,000 elsewhere). There is also suboptimal location of the anganwadis in relation to the distribution of the hamlets. In the hamlet where the anganwadi was located, most ICDS services were in poor shape (as discussed earlier), but the outreach of food supplementation was much better. However, since the outlying hamlets were generally poorer and more malnourished, the overall effectiveness of food supplementation was very limited.

In most places Mitanins reported good coordination with anganwadi workers. When they were asked about the specific tasks they helped to perform, the responses were as follows: dalia distribution 57 per cent; promoting child attendance at the anganwadi 48 per cent; weighing children 45 per cent; malnutrition diagnosing and counselling at the anganwadi 36 per cent; immunisation 46 per cent; other categories of assistance 6 per cent (Mitanin Evaluation Report, State Health Resource Centre, July 2004). This assistance was most critical in the hamlets that did not have an anganwadi. Thus, most of those who reported that they were bringing children for immunisation were bringing children from other hamlets.

In food supplementation the help was in the form of dalia being taken as dry rations to the hamlet. There was an effort to encourage them to cook it and serve it – but without fuel and without organisational support this was seldom possible. One proposal was to mobilise the women self-help groups (SHGs) or women health committees associated with the Mitanin programme for this purpose – but this was not followed up. The very fact of having information and seeking their quota of rations also encouraged the anganwadi worker herself in many cases to send the rations over.

Mitanin and Child Malnutrition

One of the most important tasks of the Mitanin programme was to tackle child malnutrition. There were two key strategies for achieving this. The first was to ensure wide awareness of child malnutrition as a major problem in the community. This included persuading both healthcare providers and panchayats to take grades I and II malnutrition seriously.

The second strategy was a particular form of family counselling. The Mitanin was trained to do what was called a "fourfold analysis" of the causes of malnutrition in a particular child, and to discuss a wide set of possible responses with the family. The Mitanin's fourfold analysis involved looking at: feeding practices; the history of recent illnesses the child had suffered; the family context of malnutrition (not only economic factors, but also the age of the mother, spacing intervals and time spent on childcare); and finally what the family members were already doing to cope as well as their access to health, childcare and food security services.

Mitanins were trained not to convey gratuitous messages when they were counselling families. For example, they were specifically warned against lines such as "give nutritious food", "keep the child neat and clean", "take proper care of the child", etc. They were asked to discuss the problems and solutions in the house in the presence of the family, especially the husband and the mother-in-law. And most importantly, they had to ensure through dialogue that any suggestion made was acceptable and pragmatic.

Thus, coordination of a wide variety of services and messages of the health department, women and child department and ICDS would occur as a singular seamless activity. Efforts were also to be made by the Mitanin to ensure that food security

provisions for the poor under various schemes are accessed.

However, under real programme conditions, given the problems involved in developing and applying such analytical skills, the actual results have been modest. And aside from the difficulties of developing these analytical and counselling skills, recognition of malnutrition remains a major stumbling block, which holds the key to change.

There are other problems in trying to energise the ICDS programme or the health sub-centre through community health volunteers. The system has been quite hardened by years of poor governance. In many places the weighing machines do not work, or the cooperation offered by the Mitanin is brusquely rejected.[2] Mitanins who have been selected by the ANM or AWW, and not through due process by the community, are sometimes quite tolerant of non-functioning ICDS centres. Nevertheless, the whole social mobilisation process that accompanied the programme set a new context in which measures within departments to strengthen these peripheral services were facilitated.

The impact of the programme on core indicators of child health is difficult to assess, since the programme is statewide. The only reliable source is the Sample Registration System (SRS) data released by the registrar general of India and this becomes available only after a two-year interval. However, trends are certainly encouraging. The rural infant mortality rate (IMR), which was a high 85 per 1,000 live births in the year 2002 when the programme began, dropped to 77 in the year 2003, and then as the programme peaked it further dropped, rather dramatically, to 61. Even after allowing for a substantial margin of statistical error, a 24-point drop coinciding with the two initial years of the programme needs to be taken seriously. This cannot be attributed only to the Mitanin – for her work is inseparable from that of the anganwadi worker and the ANM, and is indeed, ineffective without these functionaries being active. Moreover, as we saw earlier the Mitanin's directly measurable activity was limited. This impact on rural IMR is, however, more understandable if we see the Mitanin programme in its entirety: the entire process of social mobilisation, of awareness building, of conscientisation of the employees, and its effects on perceptions of health and health-seeking behaviours. However, we have to wait to see whether such a campaign-driven decline in IMR can be sustained. And we would need to study its impact on child malnutrition.

Community Level Interventions and Women's Empowerment

Recognising the importance of the Mitanin being more than an individual, the programme has put a lot of emphasis on developing women's organisations at the hamlet level, where women can articulate their needs and own these services. Collective action for improved ICDS and health services is also an opportunity to empower rural women. This process is led by the hamlet-level women's committee.

There have been two recommended approaches to the formation of the committee. Firstly, if a functional hamlet-level committee already exists, it can be used

to select the Mitanin and subsequently to work with her, by adding a health dimension to the committee. The most commonly available pre-existing committee is the women's SHG involved in savings and credit provision. But other than this, there may be other village committees, or development committees, or even health committees organised as part of NGO programmes or other government programmes.

In hamlets where there is no such pre-existing committee, a women's health committee is to be initiated. Subsequently, it should acquire the character of the women's SHG activity. Eventually all these hamlet-level women's committees should link up to the village committee and themselves become more of a development committee.

About 76 per cent of Mitanins reported that their hamlet had a women's committee linked to this programme. This includes 64 per cent who had a SHG in the hamlet, which functioned as the committee, or was there in addition to the health committee. Assessing the functionality of these committees, the finding was that in 55 per cent of hamlets there had been one to three meetings and only 24 per cent had held four to six meetings in a four-month period. As many as 25 per cent had held no meetings whatsoever in these four months (Mitanin Evaluation Report, State Health Resource Centre, July 2004).

Aside from helping women to own the programme, and from acting as a site of health education, these SHGs and committees also acted as a vehicle for reaching the outlying hamlets more effectively. Mitanins played an important bridge role in this respect. For instance, the SHGs, catalysed by the Mitanins, helped to ensure that outlying hamlets receive their food rations, and in some places they also cooked and served the food.

Mitanins and Social Services

A similar emphasis was placed by the Mitanin programme on the improvement of access to health services. The programme increased access to and utilisation of services such as immunisation, antenatal care, birth assistance (and where possible institutional delivery), and access to referral services. It also secured community participation in all the major disease control programmes. As with ICDS, the improvement of service delivery is difficult to achieve, but active social mobilisation facilitates and complements the health sector reform programmes that addresses supply-side issues.

At the next stage, the focus is on intervening at the hamlet level in the field of primary education. Food security is another area where hamlet-level intervention has been attempted through the Mitanin and the SHGs.

The social services in rural areas are weak not only because of weak capacities or weak design, but also due to resilient problems of governance. Social sector workers are demoralised because of serious, unresolved workforce issues: absence of a fair transfer policy, lack of timely promotions, lack of accountability of senior managers, leakages in procurement and distribution of supplies, and above all, a chain of corruption that ruins the soul of the system.

These problems are common to both health and education, as well as to ICDS services. Insofar as it increases local accountability, the Mitanin programme creates a context in which these basic governance problems become more amenable to reform. However, the programme does not address these governance issues directly. This requires political reform. Unless these governance issues are addressed politically, many administrative schemes and community initiatives are likely to go that far and no further.

Summing Up

Certain general points emerge from our experience in Chhattisgarh and may be used as a conclusion to this note:

(1) Strong community ownership and participation make a major difference to the functionality and outreach of the ICDS programme.

(2) Community ownership requires community mobilisation and a planned grassroot level programme where women are organised, systematic capability building is undertaken, and a support system is put in place. These three activities are an integral part of community health volunteer programmes. There is, therefore, a case for integrating ICDS programme interventions with community health volunteers (CHV) programmes like ASHA, taking care not to make the ASHA an assistant of the anganwadi worker, but training and supporting her to play a leadership and activist role for the community.

(3) The problem of outreach of the current anganwadi programme to all hamlets also requires community support along with changes in the ICDS design. For instance, changing the way food is procured, stored and used, and how costs of such local mechanisms are borne by the state, is critical to reaching weaker sections.

(4) The central problem of preventing and managing malnutrition, especially in young children, is its recognition – at the societal, community and family levels.

(5) The management of child malnutrition requires food supplementation, but this is only a small part of the effort required. The main input needed is to look at the complex of feeding practices, illnesses and familial factors that cause malnutrition, and to assist the family in its efforts to address the problem.

(6) There is a long way to go from the current anganwadi centres to an ideal "early childhood care and pre-school education" programme. Strong community institutions looking in an integrated way at health, nutrition, small savings, livelihood and pre-primary education interventions at the local level are likely to be more effective in reaching this goal than dispersed top-down actions on the part of many administrative departments. Universalisation of ICDS must go beyond increasing the number of anganwadis, and move from mere provision of food supplementation to comprehensive early childhood care.

(7) Issues of governance, especially in areas such as workforce management, supervision policies and procurement of supplies, have a major impact on the outreach and functionality of social sector programmes. Further, they cannot be countered adequately by strengthening grassroot institutions alone. They need legal action, advocacy by civil society and political action to counter or at least curtail the ravages of political and administrative misgovernance. EPW

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Notes

1 Of these, 96 blocks are under the INHP programme and the rest under ICDS alone. The former is monitored by CARE (funded by World Bank) and children get some edible oil in addition to the supplementary food.

2 In response to this, the Mitanin programme arranged for 10 weighing machines in every block, i e, one machine for about 20 anganwadi centres. This was calculated to be enough for occasional cross-checks and to persuade the weighing to begin where it had not been done, but not enough to enable Mitanins to substitute for anganwadi workers (the concern was that paid work should not be displaced by volunteers).