CHAPTER 3 – HOW TO ENHANCE THE IMPACT OF ICDS?

Urgent changes are needed to bridge the gap between the policy intentions of ICDS and its actual implementation. This is probably the single biggest challenge in international nutrition, with large fiscal and institutional implications and a huge potential long-term impact on human development and economic growth.

ICDS was designed to address the multidimensional causes of undernutrition. As the program expands to reach more and more villages, it has tremendous potential to impact positively on the nutritional and health status and well-being of the millions of women and children who are eligible for participation. The key constraint on its effectiveness is that its actual implementation deviates from the original design. There has been an increasing emphasis on the provision of supplementary feeding and preschool education to children four to six years old, at the expense of other components that are crucial for combating persistent undernutrition. Because of this, most children under three—the group that suffers most from malnutrition—are not reached, and most of their parents do not receive counseling on better feeding and child care practices. Realizing ICDS' potential, therefore, will require substantial commitment and resources in order to realign its implementation with its original objectives and design:

- The first immediate step should be to resolve the current ambiguity about the priority of different program objectives and interventions;
- To reduce malnutrition, ICDS activities need to be refocused on the most important determinants of malnutrition. Programmatically, this means emphasizing disease control and prevention activities, education to improve domestic child-care and feeding practices, and micronutrient supplementation. Greater convergence with the health sector, and in particular the Reproductive and Child Health (RCH) program, would help tremendously in this regard;
- Activities need to be better targeted towards the most vulnerable age groups (children under three and pregnant women), while funds and new projects need to be redirected towards the states and districts with the highest prevalence of malnutrition;
- Supplementary feeding activities need to be better targeted towards those who need it most, and growth-monitoring activities need to be performed with greater regularity, with an emphasis on using this process to help parents understand how to improve their children's health and nutrition;
- Involving communities in the implementation and monitoring of ICDS should be used to bring in additional resources into the *anganwadi* centers, improve quality of service delivery and increase accountability in the system;
- Monitoring and evaluation activities need strengthening through the collection of timely, relevant, accessible, high-quality information, — and this information needs to be used to improve program functioning by shifting the focus from inputs to results, informing decisions and creating accountability for performance.

3.1. STRENGTHS AND WEAKNESSES OF ICDS

Studies of the ICDS program, including this one, have repeatedly raised concerns about its design and implementation. Three major mismatches in the implementation of ICDS can be identified. These relate to the type of services that ICDS actually delivers; the characteristics of the beneficiaries that ICDS reaches; and the geographic areas that ICDS targets. These mismatches undermine ICDS potential to address child undernutrition effectively, efficiently and equitably.

Mismatch I: Although the design of ICDS recognizes the multidimensional determinants of undernutrition, too much emphasis is currently given to providing food security through the supplementary nutrition program. Not enough attention is given to the most effective interventions for child nutritional outcomes, e.g. improving child-care behaviors and educating parents how to improve nutrition using the family food budget.

Mismatch II: Service delivery is not sufficiently focused on the youngest children (under three), who can potentially benefit most from ICDS interventions. In addition, children from wealthier households participate much more than poorer ones and ICDS is only partially succeeding in preferentially targeting girls and lower castes.

Mismatch III: Although the increase in program coverage was greater in underserved than well-served areas during the 1990s, the poorest states and those with the highest levels of undernutrition still have much lower levels of program funding and coverage.

Table 13 summarizes the main strengths and weaknesses of ICDS and suggests a menu of options to increase its impact on the nutritional status of priority groups.

Table 13 Summary of strengths and weaknesses of ICDS

POSITIVE FEATURES	AREAS NEEDING IMPROVEMENT	HOW TO DO IT
Overall program		
Designed to address the multiple determinants undernutrition, i.e. food security, health services and caring and feeding behavior Designed to address the intergenerational cycle of undernutrition, i.e. pregnant women and young children – although the initial design focus was on children 3-6 years, over the last decade the design focus has shifted towards children 0-3 years. Designed to target poor	**Mismatch I** ▪ Wide gap between original intention/design and actual implementation – food supplementation dominates and linkages with health sector and counseling of parents are neglected	▪ Rationalize design and improve implementation ✓ Define priority objectives ✓ Identify cost-effective interventions to achieve those objectives ✓ Implement activities to deliver those interventions ✓ Monitor execution and evaluate impact
	Mismatch II ▪ Service delivery remains focused on older children (3-6 years) ▪ Some of the poorest and most vulnerable groups are not reached	▪ Improve targeting of children under three and pregnant women ✓ Strengthen nutrition and health education activities ✓ Increase home visits ▪ Improve targeting of poorest and most vulnerable households ✓ Introduce mini-AWCs (*poriawadis*) ✓ Increase outreach activities
	Mismatch III ▪ Per child spending is higher in richer states	▪ Address regressive distribution of financing across states by targeting future expansions to districts and blocks with highest prevalence of malnutrition

states and poor people within these states Strong grass-roots presence Wide coverage	**Other issues** ▪ Quality of services is poor	▪ Develop capacity to deliver all nutrition interventions ✓ Increase external participation in service delivery (e.g. mothers' groups) ✓ Increase synergy with other programs (e.g. RCH, primary education, etc.) ✓ Add a second AWW ✓ Contract private sector for specific activities
		▪ Optimize use of available resources ✓ Improve skills of AWWs and AWHs ✓ Introduce supportive supervision ✓ Improve supply of inputs ▪ Strengthen focus on results and accountability ✓ Decentralize responsibility and management of the program to state governments and PRIs through performance-based financing ✓ Reform the Management Information System (MIS) ✓ Reward performance at all levels of the administration ✓ Strengthen community ownership and enhance accountability to local communities ✓ Involve PRIs in monitoring service delivery
	▪ Design is standardized and does not reflect local needs	▪ Introduce flexibility through bottom-up planning
By determinant of malnutrition		
A. Food security		
Designed to fill the "food gap" in the intake of young undernourished children	▪ Food supplementation is universal and absorbs much of the financial and time resources in the AWC	▪ Ensure that mslnourished children are reached by SNP ▪ Improve the efficiency of procurement and distribution of SNP so that resources can be freed up to strengthen other nutrition interventions
	▪ Food availability is irregular; quality is often poor	▪ Improve procurement and distribution of food ✓ Decentralize procurement of food to community level ✓ Contract the private sector (e.g. for food distribution)
	▪ Leakage to non-priority groups	▪ Strengthen MIS ▪ Encourage community ownership and monitoring
B. Health		
Designed to link with health services for immunization, Vitamin A supplementation and referral of high-risk children and pregnant women	▪ Weak articulation with health system	▪ Strengthen convergence with RCH Program ✓ Introduce joint ICDS-RCH bottom-up planning process ✓ Provide better training of ANMs in nutrition issues and best practices
	▪ Poor focus on counseling and behavior change	▪ Reset priorities and redirect resources towards disease prevention/control
C. Care		
Designed to support effective nutrition counseling and growth promotion linked to regular growth monitoring	▪ AWW is overburdened with many other tasks that take priority over nutrition promotion ▪ AWW has received little training to develop skills needed for counseling parents	▪ Foster community support (e.g. mothers' groups) ▪ Increase manpower in AWCs ▪ Improve training
	▪ Poor quality of equipment for weighing/growth promotion	▪ Strengthen MIS and improve the supply system
	▪ Poor focus on counseling and behavior change	▪ Reset priorities and redirect resources towards promoting appropriate breastfeeding, home-based complementary feeding and caring behaviors ▪ Training
D. Micronutrients		
Center-based interventions are potentially useful for supplementation of Vitamin A and IFA.	▪ Inadequate articulation with RCH Program	▪ Strengthen convergence with RCH Program

3.2 ELEMENTS OF SUCCESS IN PUBLIC HEALTH: HOW CAN ICDS REACH ITS FULL POTENTIAL?

This section examines some key issues in ICDS that are central to achieving results. To do so we use the findings of "Millions Saved. Proven Successes in Global Health", a recent report that documents 17 cases in which large-scale national, regional and global efforts have succeeded in improving health status in developing countries[1]. In order to be labeled successful, these cases had to meet a set of rigorous selection criteria: be of large scale, have a duration of five years or more, employ a cost-effective intervention, and have an impact on an important health problem. Although no single recipe emerges from the review of the successful programs, a consistent set of ingredients contributes to success: (i) predictable, adequate funding from both international and local sources; (ii) political leadership and champions; (iii) technological innovation within an effective delivery system, at a sustainable price; (iv) technical consensus about the appropriate biomedical approach; (v) good management on the ground; and (vi) effective use of information. Moreover, in most cases, community participation was also a contributing factor.

Below, we review how ICDS scores with respect to the elements of success outlined above and we present options that the Department of Women and Child Development could consider to realign the design and implementation of ICDS and improve the chance of maximizing its impact[a]. Particular attention is given to what can be done to fix the three mismatches identified in Table 13 above.

3.2.1 Predictable, adequate funding – further expansion or consolidation of impact?

Availability of funds has not been a major problem for ICDS, which has received extensive financing from both national and international sources. Over the years, absolute spending, as well as the spending per child on various ICDS components, has increased substantially[2]. For example, the GOI's contribution increased from Rs 329.8 crores in 1992/93 to Rs 1311.2 crores in 2001/02. The expenditure on supplementary nutrition, which is financed by the state governments, also increased by almost four times during the same period. However, it is not clear that the increased funding has had a measurable impact on children's nutritional status, and it might be more beneficial to allocate funds to improving service delivery within existing AWCs projects, rather than to expand coverage.

[a] In the case of ICDS, we do not consider the element of technological innovation since, unlike in other public health programs, the development of a technology like a drug, vaccine or pesticide, is unlikely to play a key role in nutrition interventions.

3.2.2 Political leadership and commitment – do malnutrition in India and ICDS really matter to the key decision-makers?

High-level political commitment to the cause is key to all successful public health programs. Although India has one of the highest proportions of underweight children in the world and the Government has often expressed its commitment to reducing malnutrition, this is not adequately reflected in current policy discussions. Several factors may explain the failure to implement an *effective* nutrition intervention, including lack of awareness of the most cost-effective interventions; a tendency to view malnutrition interventions as transfers to the poor and to under-estimate their economic impact for the country as a whole; the multiplicity of organizational stakeholders involved; and the relatively muted voice of the poor.

Building commitment and effectively mobilizing political leadership towards supporting changes in the existing array of nutrition programs in India will require engaging several public and private stakeholders in understanding the size and characteristics of the undernutrition problem in India, the devastating human, social and economic consequences of failing to address it and the large human, social and economic benefits associated with the correct implementation of available, affordable and cost-effective nutrition interventions.

3.2.3 Technical consensus about the right approach – can the mismatches in ICDS be fixed?

Agreement among technical experts about the right strategy to combat malnutrition is a central factor in the appropriate design of a program. In the case of the ICDS program, however, the program has not succeeded in implementing the most cost-effective nutrition interventions and in reaching the priority groups. Substantial changes in program implementation need to be introduced to fix the three most important mismatches in ICDS.

3.2.3.1 Fix mismatch I: bridge the gap between program design and implementation so that the most important causes of undernutrition in India are addressed

(i) Feeding and caring practices. Although exclusive breastfeeding in the first months of life is important to avoid infection, water and other supplements are frequently given in early infancy[3]. The Breastfeeding Promotion Network in India (BPNI)[4] conducted a study in 49 districts in 2003 that revealed that only 39.7% of infants were exclusively breastfed during the first six months. Studies also indicate that the quality of complementary foods can be poor, due to local customs and beliefs[5], and much needs to be done to reduce this source of nutritional deprivation during this crucial growth period. The situation regarding the introduction of semi-solid complementary foods is even worse. According to the NFHS II, only one-third of children in India were offered any semi-solid food between six and nine months and in Uttar Pradesh, Bihar, Madhya Pradesh this figure was approximately 40%. Even in prosperous Punjab and Haryana,

more needs to be done to encourage the feeding of children with modified family food. Along with infections, delayed introduction of semi-solid foods is an important trigger of malnutrition, which is worst between six months and one-and-a-half to two years. The AWW should devote much more attention to encouraging exclusive breastfeeding for the first six months and adding semi-solid complementary food three to four times a day in appropriate quantities thereafter[6].

Another key way to improve child growth is to show women how to use their own resources to feed their children more effectively. This approach has been used in many settings including the Republic of Korea, China and Vietnam[7]. An intervention in Haiti[8] taught mothers to use inexpensive local foods to prepare nutritious food for their children. This was highly successful in helping mothers rehabilitate their malnourished children: the children of mothers who received demonstration-education had mortality rates that were 68% of the mortality rates experienced by children of mothers who had received growth-monitoring and counseling services but no demonstration-education. In households in which the mother participated in demonstration-education, the younger siblings of malnourished children were also less likely to become malnourished and had significantly lower mortality rates than did the younger siblings of malnourished children whose mothers had not participated in demonstration-education. Similar positive effects of growth promotion on maternal knowledge and child caring practices have been found in Bangladesh[9]. The promotion of feeding and caring practices is an aspect of ICDS that very much needs to be strengthened.

(ii) Disease control and prevention. Recognizing that child growth and health can be enhanced by improving environmental hygiene and domestic health management practices, the ICDS program has components for de-worming, iron supplementation for children and home visits to improve childcare practices, but these policies need to be implemented much more rigorously given the high prevalence of worm infestations and gastro-enteric infections in India. Some of these interventions clearly lie within the scope of the AWWs' work, but AWWs need to be given more training and encouragement to implement these interventions and work with communities to improve their sanitary practices.

Collaboration between ICDS and the health delivery system has improved in recent years, one consequence of which has been better immunization coverage. However, the partnership between the AWW and the ANM has been less successful with respect to identifying high-risk pregnancies, providing prenatal and postnatal care, and conveying adequate health and nutritional messages to women. Increased collaboration will also help to ensure the provision of broader child and maternal health services. Strengthening convergence of ICDS and RCH should be a priority for the concerned departments.

(iii) Micronutrient supplementation. ICDS can also be used to facilitate children's access to national micronutrient supplementation programs for iron, Vitamin A and iodine. These interventions have been shown to be exceptionally cost-effective in a number of settings[10], and their benefits for child growth, health, and cognitive development are well-documented. So far, the micronutrient interventions in India, namely the distribution

of iodized salt, the administration of a semi-annual massive dose of vitamin A to young children, and the distribution of iron-folic acid tablets to vulnerable groups, appear to have had little effect[11]. These programs need to be strengthened.

(iv) Supplementary feeding. ICDS functionaries, at all administrative levels, as well as program beneficiaries, appear to consider the supplementary nutrition program (i.e. food distribution) to be synonymous with the full set of nutrition interventions of ICDS, often using the two concepts interchangeably. This is indicative of the pervasiveness of the food bias in the ICDS program. The food bias is also evident in the allocation of expenditure across ICDS components: the supplementary feeding program currently accounts for about two-thirds of the total cost of the ICDS program[12]. It is important to use supplementary feeding strategically – as an incentive for poor and malnourished children to attend the AWC where they, and their mothers, can receive health and nutrition education interventions. Rather than being used for supplementary feeding, resources could be redirected towards effecting improvements in the delivery of other ICDS services. It is absolutely crucial that ICDS implementation emphasizes the multi-dimensional nature of malnutrition and that food intake be understood as only one, and most often not the main, determinant of child nutritional status.

3.2.3.2 Fix mismatch II: increase impact by reaching the youngest children

Because of the type of services provided and the focus on center-based activities, ICDS tends to reach 3 to 6 year olds more easily, to the neglect of pregnant women and children under three. Young children need to be accompanied to the AWC and require more time and attention than the AWW has available. Thus, interventions often miss the most critical groups, and the prevalence of stunting and underweight remains very high. Failing to reach young children is of particular concern in light of the evidence that most growth faltering occurs during the first two years of life and that it negatively affects children's development throughout their lives. A more concerted effort needs to be made to recruit young children into the program, perhaps through reaching out to women effectively while they are still pregnant or at birth. Succeeding in this effort would produce a shift towards preventing malnutrition instead of just treating it, when it is often already too late to recover the growth trajectory. The advantage of some of the cost-effective measures described above is that they can effectively reach children under three because, unlike food supplementation, they are occasional interventions and so (1) do not require regular attendance at the AWC, and (2) can even be delivered to people's homes.

In this context, conditional cash-transfers have been very successful in increasing the demand for healthcare for young children, educating parents about adequate caring and feeding practices and, ultimately, improving child nutritional and health status quite rapidly in other countries, such as Mexico[13], Honduras[14] and Colombia[15]. The possibility of introducing such programs in India should be explored thoroughly.

The supplementary feeding program is not effectively targeted at children during the early childhood years, i.e. during the optimal window for influencing growth[16]. Instead, it

has attracted children aged four to six years, presumably largely because of the preschool activities that are offered concurrently[b].

3.2.3.3 Fix Mismatch III: improve targeting by increasing coverage in poorer states and districts

Another source of poor targeting lies in the regressive distribution of the ICDS program across states. The poorest states tend to receive the lowest government budgetary allocations per malnourished child. Thus, the states with the highest prevalence of stunting and underweight tend to have the poorest program coverage. However, there are some encouraging signs. First, the poorest states have shown the highest rate of *growth* of program coverage during the 1990s. Second, the program is more evenly distributed within states than across states – about 60 percent of the poorest villages in every state are covered by ICDS programs compared with 70 percent of wealthiest villages. Controlling for other village characteristics, we find that program placement is progressive within a given state.

The ICDS program will continue to expand the extent of its coverage and the Government of India has an action plan to construct another 188,000 *anganwadi* centers over the next few years. Given the high degree of concentration of child malnutrition observed in India, any future investment in ICDS should be driven by careful targeting of high-prevalence districts, villages and habitations across the countries[c]. Unfortunately, currently available data cannot yet shed light on which villages should be chosen because the available sample surveys are not large or representative enough at the village level. However, promising new methodologies, based on the merging of household survey and census data, can help identify villages that are likely to have the highest prevalence of malnutrition. Targeting resources at villages based on their need is desirable not only for equity reasons; it will also be the most effective strategy to reduce the prevalence of malnutrition[17].

3.2.4 Good management on the ground – can service delivery be improved?

Good and effective service delivery requires that trained and motivated workers are in place and have the supplies, equipment, transportation and supervision to do their job well. This requires both adequate funding and good management – and in some instances strong management can partially compensate for budgetary restrictions.

A large number of studies have shown that ICDS experiences many difficulties with its implementation[18]. As mentioned earlier, this is in part due to the rapid expansion of the program, which has been faster than the institutional capacity necessary to manage it[19]. Under these circumstances, for example, it has not been possible to provide adequate

[b] Many of these problems were addressed in Tamil Nadu's modification of the ICDS program (TINP), which halved the prevalence of severe malnutrition in the villages in which it was implemented by targeting the food to the needy and requiring them to eat it on the premises instead of taking it home to share with others (Heaver 2002; Greiner and Pyle 2000).

[c] For example, a mere 10% of districts and villages account for 27-28% of the overall number of malnourished children. See World Bank 2004a for more details and caveats.

AWW training, so many workers have been sent to their workplace with little or no prior training, and have had to learn on the job itself. Refresher training is also scarce. Nor is there the degree of supervision that might help AWWs to acquire the skills to perform their duties. ICDS support services at state level are also inadequately staffed. As a result, the AWW has very little technical or other support in providing ICDS services – a job that requires not inconsiderable understanding of nutrition, preschool education, and maternal and child health issues. Moreover, the AWW is charged with a multiplicity of tasks, not all of them related to the central ICDS objectives, and which may force her to divert some of her energies from the most important interventions. It is imperative that the AWW is perceived and treated as the core input for ICDS service delivery and given the right tools and support to perform her tasks effectively.

The supply of food in ICDS is erratic: the national evaluation in 1992[20] found that the average AWC was without food for 20% of the time, and more than a quarter of AWCs experienced shortages that lasted longer than 3 months. Leakages in the distribution of ICDS food are substantial at many levels, notably in the procurement of food supplies[21]. In the absence of localized food insecurity (such as drought or crop failure), local procurement may be a more effective means of supplying food: the supply would be more regular since it is easier to hold local providers accountable for delivery and local inhabitants would have a vested interest in the well-being of the children in their community. Moreover, local procurement provides a source of income to local inhabitants and promotes community involvement in and awareness of ICDS activities.

Clearly, the lack of growth-monitoring equipment needs to be addressed. Many AWCs do not have weighing scales that are in working condition, many lack growth charts, others have insufficient numbers of growth cards and the current monitoring and evaluation system fails to remedy shortfalls in supply. What is more crucial, though, is that growth-monitoring activities are used as communication tools to educate and encourage mothers to adopt behaviors that promote the growth of their children. It is in this area that the ICDS program is found to be most lacking. The training of AWWs needs to pay urgent attention to ensuring that AWWs are competent and effective in growth-monitoring and growth promotion activities.

3.2.5 Effective use of information – can information be used for action?

Information is important in three ways. First, information about the extent of a problem raises awareness and focuses political and technical attention on finding solutions. Second, research on health behaviors and on the effectiveness of different service delivery approaches can help shape the design of a program and increase its prospects for success. Third, information creates accountability and motivates.

It is generally recognized that the monitoring and evaluation activities related to ICDS need strengthening, and a concerted effort is currently being made to do so. To this end, the DWCD might consider applying the monitoring and evaluation framework that they use for World Bank-funded ICDS projects to the general ICDS projects. What is crucial is an emphasis on collecting high quality information that is relevant, in the sense that the

data that is collected clearly reveals something about the functioning of important aspects of the program, and is of a manageable quantity, since large volumes of information are unlikely to be utilized to inform decisions.

In this regard, it may be helpful to revisit the guidelines and instructions issued for the monitoring and evaluation of ICDS in the past, and streamline and fine-tune them. This would cut down on the volume of superfluous information, and person-hours needed to process it. The number of registers currently collected by AWWs, for example, far exceeds the existing capacity to use this information for program management. Simultaneous with an effort that streamlines and standardizes the indicators that are collected across states, the development of a standard template with which to display information would make ICDS data more immediately accessible – at more levels and to more people in the project management system. Standardization would also facilitate comparisons to be made across states, highlighting the states from which lessons can be learned in key areas of implementation. It would also promote the analysis of trends within states and the aggregation of data at the national level.

Computerization and electronic processing of information would greatly facilitate monitoring and evaluation. The challenge is to find a way of processing the data into a form that is usable, so that a program manager or other interested party can find out what the status of activities (e.g. percentage of target group receiving benefits, percentage of AWCs with weighing scales, whether food was received by AWCs in the previous month) is at any point in time, present or past. Ideally, he or she should have easy access not only to aggregate indicators, but also to block and district level information. It is only then that data collected at the AWC level and aggregated further up the chain of implementation becomes potentially usable information that can be utilized to identify problem areas and take ameliorating action.

In general, more human resources need to be devoted to M&E. One way to do this is to increase the awareness of the importance of monitoring at all levels of implementation so that in the portions of their tasks that are allocated to M&E-related activities, functionaries give M&E the attention it deserves. This is challenging and requires a substantial mind-shift for functionaries - towards outcomes, results and performance, rather than inputs. In addition, some strengthening of community monitoring is desirable, either through existing community institutions or more informally, e.g. through encouraging community members to be alert to AWC opening hours and attendance and demand improvements where needed. Periodically, quality control checks on monitoring data should be undertaken to uncover any systematic errors in reporting, and the sources of any discrepancies resolved.

3.2.6 Community participation and decentralization – can they introduce flexibility, attract more resources and create accountability?

With few exceptions, ICDS remains a highly standardized intervention that follows rules and regulations set centrally. Given the heterogeneity of malnutrition patterns observed in

India, state governments should be encouraged to tailor the basic model to local needs and assume responsibility for the management of the overall program rather than focus almost exclusively on the procurement and distribution of supplementary food, i.e. the only activity in the program that they finance directly. A budget line that is specific to the financing of ICDS should be introduced in the state budgets so that the planning and monitoring of investments in ICDS becomes an explicit activity of State governments.

The program is also run in a very top-down fashion, with all the logistical and implementation inefficiencies and rigidities that such an approach entails. A program to provide daily services to young children and pregnant women requires strong participation and supervision by the community. There does appear to be some empirical association between the strength of community support for ICDS, in the form of financial contributions from the *panchayat* and the performance of AWCs[22]. However, country-wide, only about 25% of states receive support from *panchayat* leaders, and this support has mainly been in the form of the provision of space for the AWC and the recruitment of beneficiaries[23].

Despite statements of intent to involve communities in the process, there is little sense of community ownership[24]. This impression is reinforced by the fact that, in most places, the AWW is hired and paid by the government, and is not made accountable to the community in which she works. Also, equipment, food and other supplies are provided directly by the government. As discussed above, because of her daily presence in the village, the AWW is asked to take on many additional duties to support the field outreach staff of other government agencies (education, health and rural development in particular), but they are not encouraged to work as closely with community organizations such as the *Gram Panchayat* or *Mahila Mandal*. Given the extensive decentralization that has been underway in India over the past decade, there is considerable scope for involving locally-elected village committees much more actively in implementing the ICDS program. The experience of the mothers' committees in Andhra Pradesh could be replicated in other states.

Finally, one important way to enhance the responsiveness of the ICDS program and cultivate a sense of local ownership is to always select the AWW from the community that she is intended to serve. Although identified as a recommended policy in DWCD guidelines, this does not always occur in practice – appointments are sometimes political, or compassionate (made to women in difficult circumstances) and sometimes even for sale. Also, in many cases, the AWW is from a forward caste which may affect the access of scheduled caste and schedule tribe children since, by their own admission, some AWWs from forward castes only make infrequent home visits to scheduled caste hamlets[25].

3.3 NEXT STEPS: RATIONALIZE DESIGN AND IMPROVE IMPLEMENTATION

That ICDS has great potential to improve the nutritional status of India's children is undeniable, but it needs to overcome some challenges if this potential is to be realized. One challenge is the large and ever-increasing range of duties that AWWs are expected to fulfill. Since, unlike most government workers, their workplace is located right at the grassroots, they are asked to help implement a multiplicity of government programs in addition to ICDS. However, this diverts attention away from their core duties, which are already too onerous and rarely can be performed satisfactorily. Moreover, the changing scope of the ICDS program has resulted in considerable ambiguity among higher-level officials as to ICDS objectives, and the capacity of both the central and state units to manage and deliver the program is being stretched. Finally, three major mismatches between what an effective nutrition intervention should do and what ICDS is currently doing are preventing the program from achieving better results. Consequently, despite its national infrastructure, ICDS is not making the expected contribution to reducing the prevalence of malnutrition. It may be time to reconsider the approach that should be taken by ICDS.

Some alternatives include:

- Retain the present structure whereby a preschool function for older children (4 to 6 years), on the one hand, and maternal and child health and nutrition interventions with special emphasis on younger children (0 to 3 years), on the other hand, are offered within the same program. If this option is pursued, then the difficulties in simultaneously carrying out these disparate tasks need to be resolved. At the moment, this dual objective tends to result in AWWs devoting most of their day to preschool education and older children, to whom educational activities are directed, squeezing out the attendance of younger children. Since AWHs devote most of their day to food preparation, human resources are skewed even further away from health interventions and counseling parents about feeding and caring practices. If the present structure is maintained, introducing a system of two workers – one charged with health and nutrition functions and one charged with the preschool function – may be a good option. The National Health Mission that is planned for fiscal year 2005-2006 is considering introducing an additional village health worker (ASHA) to focus on maternal and neonatal health issues. If this option is pursued, such a worker can be assigned the needs of 0 to 3 year old children, including nutrition. The AWW would focus on preschool education of older children and the AWH would continue supporting the preparation of food. Coordination with the work of the Auxiliary Nurse Midwife of the RCH program also needs to be carefully studied, articulated and monitored.

- A more radical alternative would be to separate services provided to 4 to 6 year old children from those provided to 0 to 3 year olds and pregnant and lactating women.

The demand for preschool education, and for feeding the older children, could be met by devolving these responsibilities to the Department of Education or to local authorities. The District Primary Education Program (DPEP) already delivers preschool education services in some districts, and the feeding of 4 to 6 year olds could become part of the National Mid-day Meals Program[26]. In this manner, more of the AWW's time could be freed up for nutrition and health education and growth promotion, increasing the prospect of achieving better nutrition outcomes. In this case as well, the coordination between the AWW, the ANM and the ASHA (in the event that the proposal by the National Health Mission is implemented) will be crucial for the success of the programs.

To conclude, greater clarity and focus is needed if ICDS program is to make a substantial dent in the problem of persistent undernutrition in India. In particular, the three mismatches identified earlier need to be resolved so that a nutrition intervention is implemented that (i) provides the most effective services to address the most important determinants of malnutrition; (ii) reaches the younger children and the most vulnerable segments of the population; and (iii) is well targeted to areas where the prevalence of undernutrition is highest.

Moreover, leadership and commitment are necessary to address some of the structural inefficiencies of ICDS and many other public programs in India, including a weak information system, limited orientation towards results and lack of accountability for performance at all levels, which are hindering the success of the program.

Bridging the gap between the policy intentions of ICDS and its actual implementation is probably the single biggest challenge in international nutrition, with large fiscal and institutional implications and a huge potential long-term impact on human development and economic growth.