Malnutrition and ICDS

Pronouncements about the ICDS scheme have to be juxtaposed against the grim reality of malnutrition.

In his Union Budget 2009-10 speech soon after the Congress-led United Progressive Alliance-II (UPA-II) government took office, Union Finance Minister Pranab Kumar Mukherjee stated that "Government is committed to *universalisation* (our emphasis) of the Integrated Child Development Services (ICDS) scheme in the country. By March 2012, all services under ICDS would be extended, *with quality* (our emphasis), to every child under the age of six." We are now a year away from March 2012, but with two-fifths of children under five years of age suffering from moderate to severe malnutrition, one-third not getting a full course of diphtheria, tetanus and pertussis (DTP) immunisation, and two-thirds deprived of the opportunity of preschool learning, surely the actual outcome next year is going to fall far short of the pronouncement made two years back. Yet, the Union Budget for 2011-12 has stepped up the allocation for the ICDS from Rs 8,430.21 crore in 2010-11 (revised estimate) to just Rs 9,294.19 crore in 2011-12 (budget estimate), which will be an increase of no more than 10.2% and that too in nominal terms.

Perhaps the finance minister knew even when he made the pronouncement in 2009 that the ICDS scheme could not deliver the outcome he promised. And he presumed that the pronouncement itself would have been forgotten. But the reality of malnutrition in India is grave. Even if our "India shining" elite have declared India as an economic superpower, the grim reality reflected in the infant, under-five child and maternal mortality rates, and the high incidence of malnutrition, puts the nation in the category of the least developed countries.

Certainly though, the increase in honorariums (still grossly inadequate) of the *anganwadi* (childcare) worker and helper is for the better. In each anganwadi a single worker and her helper are expected to deliver many services as part of the ICDS scheme – deliver supplementary nutrition to children under six and to pregnant and nursing mothers, be a link to immunisation and health check-ups, give health and nutrition tips, offer referral services, and provides non-formal, preschool education. The ones that actually do all they can to accomplish their job to the best of their ability would be working harder than most government employees. Surely, they deserve to be absorbed at least as grade III (the anganwadi worker) and grade IV (the anganwadi helper) employees of the government. By depriving these workers of their due, successive governments have been practising gender and class discrimination of a high order, and are yet to be pulled up by the courts.

Thirty-six years have passed since the ICDS was launched in 1975. What impact has it had on people's nutritional standing? Of course, one cannot single out a single government scheme for what is a systemic problem. Exploitation is written large on the faces and bodies of the poor in India. You do not have to be a scientist with the right specialisation to discern this; the body mass index (BMI) – the ratio of weight in kilograms to height in metres – is a reliable indicator of chronic hunger. In the 1970s, about half the Indian population had a BMI of less than 18.5 (which is the lower end of "normal" nutritional status), this number has come down only to around 40% in 2005-06. The mean weight of babies born to poor women is far below that of those born to rich women. Is the dispensing of vitamins and nutritional supplements, sold by the pharmaceutical companies in bulk to the government, going to change that fact? No, poor women (and their men) have to struggle for decent wages and social security so that they gain "normal" BMIs, and their babies are born with a weight at birth of around 3.2 kg.

The fact is that the parents of those babies and the anganwadi workers and helpers who provide childcare services to them suffer grave deprivations in their lives. They need to be uplifted so that they can give their babies a better start in life. The mothers need the requisite BMI in order to breastfeed their children over the first six months (currently only one in three infants are exclusively breastfed in the first six months). They then need to give the appropriate foods to the infants. But the poor women do not have the requisite BMIs and their families cannot afford such foods. Not surprisingly, the proportion of underweight children rises dramatically between six months and two years of age. And then when diarrhoea, fever, and influenza strike, the impact of child malnutrition assumes more serious proportions, and with it, under-five child mortality. What else can one expect when the mothers have to work long hours away from home without any support system, and are unable to afford healthcare? Is it surprising then that India is still one of the four countries with the highest prevalence of under-five children who are underweight.