Community Participation in Integrated Child Development Programmes

The Kerala Experience

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This paper, attempts to enumerate the obstacles that stand in the way of community participation in Child Development Programmes, drawn from the experience of Kerala state in India. There is also an attempt to provide a conceptual and theoretical basis to the need for community participation in health programmes.

IN this article I shall attempt to discuss some of the issues related to community mobilisation for action in child development programmes. The first part of the paper shall delineate the conceptual or theoretical basis for the need for community participation in child development programmes; the second part shall be devoted to examining some of the experiences in the light of these.

The first major task in such an attempt is to define the nature of child development programmes. Child development programmes grew out of two ideas:

1. The realisation that the development process has to be seen not just in its economic perspective.

Rajni Kothari says: "I suggest that the unidimensional and almost exclusively economic basis of the development paradigm has undermined the prospects for not just development, but for the sheer survival of large strata of the world's people. Mere transfer of resources and technology does not necessarily bring us any closer to the realisation of a desired state". (Kothari, 1985).

Among these 'extra economic' goals of development, child survival should certainly demand high priority. "High rates of infant and child mortality are one of the heavier burdens borne by the populations of the less developed world". (Barnum and Barlow, 1984). Hence even from an economic point of view, investment in child services—for health, literacy, and in general better quality of life for children—have returns in terms of quality of personal in later years that justifiy the investment.

2. The second idea—closely related to the first—is that of an integrated package of services for children. Most of the services offered have nothing now in their content: be it immunisation, supplementary feeding, promotion of breast feeding, or informal education. What is new is the integrated approach in supplying these services. But it should be realised that ". . .true integration must mean something other than the simplistic invitation of everybody professionally concerned with a problem, to do what they are used to doing in their sector specialities, with the only difference that they do it simultaneously". (Kunttson, 1985). Thus integration itself is to be seen as a strategic move, a specific input into the defence against deprivation.

The Child Survival and Development Revolution (CSDR) as envisaged by the UNICEF could be described as the fomalisation of all these ideas. The CSDR is—or should be—the ultimate goal of the integrated child development services initiated by many of the developing countries including India. But it should be understood that it is difficult to separate the process and the goal in this: the CSDR is both the objective of the programmes as well as their organisational content. The CSDR be said to be characterised by three principles in its organisation, each of which underscores the importance of community participation for its success:

(1) The 'demand based approach' to child health

(2) Low cost interventions that can be afforded by the poorest of communities; and

(3) Approaches with minimum technological complexity, so as to encourage self reliance. I shall examine each of these in detail.

The Demand Approach to Child Health

The central idea behind the concept of the CSDR is to enable parents to protect their children from preventable death and disablement: and the thrust of the strategy is to convert 'latent demand into effective demand' for child health. (Vittachi, 1984). What is the concept of demand for health? For economists, the demand is the "ability and willingness to pay". (Fuchs, 1968). Paying may not be always in terms of money. In an under-developed community, even when services are supposedly free, mothers have to forego one day's work to avail of these services, because of so many reasons that I need not go into. The value these sometimes illiterate and mostly formally unemployed women place on their time, is the cost of the service. In terms of relative value to the family earnings, this should be certainly a high value. The demand approach to child services in underdeveloped communities should mean, if successful, that mothers, who are the key figures in caruing for the children, are prepared to incur this cost in order to avail this service. Thus we see successful demand oriented programmes have a built in element of community participation.

But it is often not realised that what is demanded is not what is needed. The health or development needs of a community are those defined by the expert as those required for them to reach a certain predetermined level of development. In an ideal situation, health demands coincide with health needs. But more often, health 'demands' are in excess of or totally different from, health needs. There are two types of problems arising out of demand: demand failure and inappropriate demand. Demand failure in the context of child survival strategies means that mothers do not come forward to seek the protection of available services like immunisation, oral rehydration, growth monitoring, and even curative services. This problem is common in developing com-

munities, and is in turn due to two reasons: the illiteracy and ignorance of mothers and their lack of self confidence in decision making roles about children, which are themselves related problems. The second demand problem, that of inappropriate demand, is more common in developing communities like Kerala, where under the influence of high pressure advertising, educated but poor mothers reject cheap but effective alternatives and go in for child health inputs like milk foods, weaning foods, and tonics which they can ill afford. Both these problems, insufficient demand as well as inappropriate demand, exclude community participation in child development programmes: the first because people do not come forward to take part in the programme, and the second because they seek solutions elsehwere.

Low Cost Intervention

The second point of stress in the CSDR, and also important in ensuring community participation, is that the interventions suggested are less costly, which can be afforded even by the poorest community. In fact, "voluntareeism or community contributions are a necessary element in the cost structure if the programme is to be maintained on a national scale". (Nyix, 1984). We should define what we mean by 'cost'. What is apparently 'low cost' in terms of rupees and paise may be high cost in terms of time spent to a rural mother in a developing community. Here again, it is important to understand that in such a situation, community participation is one thing that can make costs less.

Inputs of Low Technology Complexity

The third point of emphasis is that the suggested interventions have very little technical 'density', in the sense of needing trained personnel and sophisticated equipment, in spite of being the fruit of modern thought. In fact, among the four key strategies currently emphasised in the CSDR—growth monitoring, oral rehydration, breast feeding and immunisation—the only intervention with any technological sophistication is immunisation. The central idea is that instead of becoming complex tools in the hands of experts in respective fields, these techniques become effective weapons in the hands of the community to combat threats to betterment of children's conditions. Thus theoretically, this should also have a strong component of community participation.

There are two reasons why I have gone into some detail to show how the child survival and development revolution is built around concepts which essentially entail community participation, by their very nature. The first is to build a conceptual background against which I shall examine some experiences with child development programmes. The second and the more important reason, is to make the point that while the three aspects discussed: demand orientation, low cost, and limited technology, are necessary conditions for community participation, they are not sufficient. If community mobilisation is to be truly effective, there should be a really participatory role for the beneficiaries at every stage from planning to implementation. I shall come back to this point in the last part of this paper.

In this part there shall be an attempt at examining some of the bottlenecks to community participation from experience of child development programmes in Kerala. We have witnessed a series of programmes operating at various stages, fulfilling different needs in child survival and development norms. The two programmes which shall be discussed here are the (i) the Composite Programme for Women and Preschoolers, which was in operation through balwadis (children's centres) in Kerala. Here the development department of the government of Kerala in conjunction with the health department, provided an integrated package of services to preschoolers and pregnant and lactating mothers. (Government of Kerala); (ii) The Integrated Child Development Services Scheme of the government of India. It was launched in 33 community development blocks all over India in 1975, and consequently grew to 300 blocks by 1981. In 1982 the ICDS was included as the principle vehicle for meeting the needs of children and their mothers under the twenty point programme of the prime minister. (Sadka, 1984).

Demand need variation: One of the most important flaws cramping the execution of such programmes is the design which is decided centrally and is usually inflexible. It is not often remembered that child survival goals, and hence demand as well as need differ widely in India, among states as varied as Kerala with its low infant and toddler mortality to that of Uttar Pradesh, which would approximate to the all India picture in these indices. Unfortunately this factor is not given due consideration in the programme, and the goals and style of functioning are decided without taking into account the regional differences in child survival and development priorities. As a result, aspects of the programme which are very relevant to some areas are totally irrelevant in others, and consequently cannot attract people's participation. This is a price we have to pay for inflexibility. Kerala being a state where the demand for formal education is very high, the age of school entry is five years, and pre-primary education is very much in vogue, it is not surprising to find many rural areas where even poor mothers are reluctant to send their children to the ICDS after four years. But in a state with a poor level of formal schooling, the non-formal education imparted in the ICDS centre till six years may be an important input which cannot be ignored.

Rigid structure: The second and very important aspect which precludes community participation is the rigid nature of the programme implementation. The beneficiaries have no role in deciding the site, or number of functionaries at the local level. Here it is interesting to contrast with the CPWP programme which is now being eclipsed by the ICDS. The design of the CPWP was such that in each area, the people had to form and register a mahilasamajom (women's club) which had to provide the building, premises and local level functionaries for supplementary feeding and other child development programmes. There was also an attempt to provide the local type of food and grow some of the vegetables in the premises, coupled with many employment generating activities for women, like goat rearing etc. This character of participation has been lost in the design of the ICDS. This

is also a particular example of the point raised earlier, i e, whereas in other states of India one should not expect women to take the initiative to run their own community development programmes, and hence a government administered programme might perhaps act as a focus for initiation of such activity, the opposite is the case in Kerala. In Kerala women do have the confidence and initiative to run these programmes, perhaps borne of their better literacy and exposure to media, and as such the programmes should be sufficiently flexible to allow their participation. This would be expected of a demand-based approach, and would simultaneously ensure community participation.

Goals for beneficieries and goals for functionaries: The point is again related to the first two. When a programme becomes centrally administered with a fixed pattern and permanent staff, it is inevitable in the long run that the executives of the programmes, on the whole, put their own personal goals first. This is a folly to which it is particularly susceptible in Kerala with its large number of educated unemployed. While it should not be grudged that such programmes have provided jobs for a number of youth it should not also be forgotten that furthering their career opportunities is not the primary aim of the programme. This point has been at the back of many recent incidents in Kerala. This is an area of conflict, which, unless resolved, effectively blocks people's participation in the programme.

Not identifying priority needs: Sometimes a community may be badly in need of a service, like protected water supply, or irrigation facilities, which, while not directly linked to child health needs, can act as a rallying point from which child development services can reach the people. Unfortunately, this aspect of community development has not been given its true importance in the programme. This is another obstacle on the way to better community participation.

Emphasis on technical aspects: There is a tendency on the part of the experts concerned with planning and implementation of the programme, especially medical personnel, to see it as exclusively a technical programme. Doctors connected with the programme should be disabused of the idea that it is a medical programme. On the other hand it should be seen as a non-medical programme with health returns. From the side of beneficiaries, there is a tendency, at least in Kerala, to view the ICDS as a formal preschool education. This is to be expected in a state where mothers put such a high value on formal education even at the pre-primary level. Here again, it is an instance of demand conflicting with need, and unless people are properly appraised of the objectives of the programme, there is a danger that they shall be disillusioned and this will effectively block their participation.

Using the programme for political leverage: It is inevitable in a highly politically-conscious state like Kerala, with political fortunes see-sawing, that programmes like the ICDS are used for political advantage. If this should happen, it alienates a large section of the community and this works contrary to the spirit of community participation.

In summing up, I should point out that child development programmes indeed have a large potential for community participation in their design and execution. In our experience, a large part of this potential is fulfilled. In fact, it would not be wrong to state that the ICDS is one programme in in the state with a large element of community participation even as it stands now. I have only tried to point out areas of conflict, the resolution of which is a must if we are to go further.

Coming back to conceptual basics, community participation in child development programmes fails if community participation itself is not seen as a primary objective. Participation should not be a means to facilitate reaching other goals. On the other hand, maximising community participation should be the primary objective, subject to the constraints. If this approach is adopted, reaching the other goals will be much faster and automatic.

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nuclear mind-set of those who are in a position to take crucial decisions concerning nuclear war and the arms races.

While local and regional peace movements can play a vital role in promoting the *process of disarmament and sustaining its momentum, a world completely* and *permanently* safe from the fear of nuclear weapons cannot be created by movements against nuclear weapons alone. Such a world requires transcending nationalism and national elites in the name of the universal interests of human kind. In short the struggle to create a truly and permanently nuclear free world is an intrinsic part of the struggle for socialism. Without a nuclear free world there will be no socialism. Without socialism there will be no nuclear free world!