

**Recommendations for a reformed and strengthened Integrated Child
Development Services (ICDS)
By National Advisory Council
June, 2011**

Background

- 1. There is urgent need to reform and strengthen the delivery of ICDS.** Despite the considerable expansion and additional investments made after 2005 (and following the Supreme Court Orders for ensuring ICDS universalization with quality), progress has been slow and uneven. At the first meeting of the Prime Minister's National Council on India's Nutrition Challenges held in November 2010, the Prime Minister noted that "the levels of under-nutrition continue to remain unacceptably high and the rates of reduction in under nutrition over time disappointingly low; this is simply unacceptable. The focus of ICDS on children under 3, pregnant and breastfeeding mothers is relatively weak and there is therefore a need to take a hard look at the ICDS to improve the programme."¹
- 2. The NAC recommendations take note of several important policy pronouncements.** The NAC recommendations take note of Government of India's efforts at universalization of ICDS with quality and incorporate the recommendations of the Prime Minister's National Nutrition Council where the following features for strengthening and restructuring ICDS were underscored: (i) ensure strong institutional convergence of Ministry of Women and Child Development (MCWD) with National Rural Health Mission and Total Sanitation Campaign; (ii) ensure flexibility for local action through empowerment of mothers and communities by giving them a stake in ICDS; (iii) pilot ICDS reforms in 200 high-burden districts by supporting alternate modalities of service delivery; (iv) launch a nationwide information, education and communication campaign against malnutrition; and (v) constitute a National Nutrition Mission Authority with appropriate powers and resources to implement ICDS. The NAC recommendations also take full cognizance of the Supreme Court that mandates the universalization of ICDS – namely "extending all ICDS services (supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of six years, all pregnant women and lactating mothers and all adolescent girls." Finally, the NAC recommendations are complementary to and consistent with the proposed National Food Security Bill which has at its core the "life-cycle approach to food and nutrition security" and calls for ICDS to be extended to all children under six, pregnant and lactating women, and adolescent girls.

¹ Record of Discussions at the First Meeting of Prime Minister's National Council on India's Nutrition Challenges held on 24.11.2010

3. Several deficiencies in the implementation of ICDS have been identified.

Designed in 1975, both the original objectives² of ICDS as well as the comprehensive package of six services offering care to the young child remain extremely relevant.³ However, evaluations in the past have thrown up a number of gaps in the delivery of ICDS. In many states, the ICDS has got reduced to a feeding programme operated through an overburdened and underpaid anganwadi worker (AWW); linkages with the public health system have been weak; the pre-school component is missing; early childhood care has never got the attention it deserves; anganwadi centres (AWCs) have not had the physical space to operate efficiently and effectively; community engagement and participation are virtually non-existent. Falsification of data, poor management information systems (MIS), and delays in release of funds and payments to AWWs are also reported from different states. Little attention has been paid to the needs of working women for whom access to a crèche is an urgent priority.

4. An invigorated and well-funded ICDS programme can, within a short period of five years, yield substantial nutritional and other benefits to children.

Many of the conditions needed for the 'success' of ICDS, not present some 35 years ago, exist today. Reducing child malnutrition requires simultaneous interventions along multiple fronts. Large synergies can be expected from the effective implementation of the ICDS today thanks to the launch of the NRHM, the boost to the universalization of total sanitation, the big push given to self-help groups (SHGs), the improvements in basic schooling infrastructure under Sarva Shiksha Abhiyan (SSA), and the emphasis on decentralized district planning with funds under the Backward Regions Grant Fund. Provision of crèche facilities under Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) - not necessarily at the work site but wherever convenient to working women - as well as the various provisions under the proposed Food Security Bill are expected to complement ICDS in significant ways. The development packages drawn up for extremism-affected districts also assign high priority to ICDS. In many states, panchayats are better situated today than before to play an active role in implementation of service delivery programmes such as ICDS.

Against this background, the NAC has identified a set of **core strategies** and **recommendations** for strengthening ICDS - drawing on a series of consultations with relevant ministries and departments of the Central and State governments as well as experts, activists, NGOs and other stakeholders

² The objectives of the ICDS are to (i) improve the nutritional and health status of children in the age-group 0-6 years; (ii) lay the foundation for proper psychological, physical and social development of the child; (iii) reduce the incidence of mortality, morbidity, malnutrition and school dropout; (iv) achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and (v) enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

³ The six services offered under ICDS are: (1) Immunization; (2) Health check-up; (3) Referral services; (4) Supplementary nutrition; (5) Non-formal pre-school education; and (6) Nutrition and health education.

Core Strategies

Reforms of the ICDS should be marked by significant programmatic shifts that incorporate the following set of core strategies.

- 1. A genuinely integrated approach:** It is critical to adopt a life-cycle approach to early childhood care and development, emphasizing the child's physical, cognitive, emotional and social development until the age of six. In terms of programmatic thrust areas, there is urgent need to focus on:
 - the 1000-day window of opportunity from pregnancy through age two by giving priority attention to children under two, mothers during pregnancy and lactation and adolescent girls;
 - child survival and growth through assured health care and nutrition;
 - balanced and nutritious diets
 - early childhood education and care including mechanisms for early detection of delayed developmental milestones and early intervention for children with special needs;
 - day-long child care centres that are safe and child-friendly to reduce the burden of working women; and
 - pre-primary school education
- 2. Crèches:** Integral to the ICDS package should be an explicit recognition of the need for crèches for several reasons.⁴ Many women, especially those who work in the informal sector, are income insecure and therefore need to earn a living in order to feed their families. They may also not be able to take their young children with them to work where they can breastfeed them. Poor women may simply not be able to stay at home and care full-time for their infants. Moreover, sufficient maternity benefits that enable women to stay at home are not yet available. Even if they were available, women should have the choice to work and appropriately feed their infants.
- 3. Decentralized management and flexible architecture:** A new architecture for ICDS should recognize the wide diversity in local conditions at the community level. The new architecture should provide for flexibility in program design, in budget norms, administrative and programme structures, human resource provisions, fund flow mechanisms, planning and decision-making processes, reporting, accountability and implementation modalities.
- 4. Home-based nutrition counselling and related services:** Offering counselling on essential nutrition practices, breast feeding and child-health related services to parents and family members of households where young children live should become the backbone of ICDS. This requires harnessing of appropriate technical competencies, in particular, at the community level.

⁴ Only a few states have converted AWCs into crèche-cum-AWCs.

- 5. Training and capacity building:** Massive efforts towards training are required for all aspects of the programme. There is a need for improving the overall training curriculum for ASHAs and AWWs in nutrition counselling, early childhood care and education, as well as other services. Joint training and continuous learning for frontline workers, as well as supervisors is essential. All teaching facilities at the disposal of state government departments including rural development, health and education should be utilized for joint, as well as independent, training programmes.
- 6. Community ownership:** New, innovative and effective mechanisms are needed to mobilize and engage the community, especially parents, in ensuring care and protection to the young child. This calls for a shift in the role of the Central government from being a provider of ICDS to an agency that creates the necessary conditions for local communities and local governments to take ownership of and manage AWCs. State governments should be allowed the flexibility to decide on the most effective modalities for ICDS implementation. Wherever possible, panchayats should assume responsibility for the operations and management of AWCs. Village Health, Nutrition and Sanitation Committees (VHSNCs) could be constituted as sub-committees of the panchayat that report to the panchayat. In other instances, like in Andhra Pradesh, community engagement could take the form of actively involving Self Help Groups (SHGs). Other possibilities could be to bring in cooperative societies, NGOs and local, community-based organizations to run the AWCs. Involvement of community volunteers can also play an important role. As part of volunteerism, wherever possible, local people should be encouraged to contribute in cash or in kind towards the operations of the AWC. Panchayats and municipalities who ensure that their village or urban area is malnutrition-free should be recognized and incentivized. Similarly, state governments should be specially incentivized for showing improvement in outcomes, especially reduction in malnutrition.
- 7. Public education on nutritional well-being:** Initiating a massive public education and advocacy initiative to tackle malnutrition should become an urgent priority. Such an initiative should address issues relating to the position of women in society, the care of pregnant mothers and children under two, breastfeeding, and the importance of balanced diets and nutrition, health, hygiene and sanitation. Nutrition counselling should be made an integral part of public education.
- 8. Convergence at all levels:** Effective mechanisms are needed for ensuring convergence at different levels (village, block, district, state and national) and across sectors.

Recommendations

Implementing the strategies for ICDS will require the following actions to be taken. Our recommendations are grouped under three categories: programmatic, managerial and institutional reforms

Programmatic reforms:

1. Expand operations of AWCs: The AWC should play a new and pivotal role in the implementation of the ICDS. Besides serving as a safe, child-friendly day-long childcare and early childhood education centre, the AWC should become an active centre for all women-and-child related activities. It is important that AWCs are seen as 'belonging' to women in the community, and not as Central government-run feeding programme centres. A few suggestions for extending and improving the functioning of AWCs are listed below:

a) Expanded activities: The AWC should expand its activities to regularly provide children and parents the following core services:

Crèche: The AWC should become a safe and child friendly centre for parents to leave children below the age of two. Arrangements should be made for such children to stay on in the AWC for the whole day, where they should receive special care and attention.

Early childhood education: The AWC should offer a strong early childhood education programme for children in the age group 2-4 years. Children older than four should be encouraged to join the pre-primary class (being recommended). Measures to improve the quality of early childhood education at AWCs should include provision of an additional AWW to handle early childhood education component at AWCs, development of standardized pedagogy for early childhood education, development of teaching and learning material. Adoption of joyful learning methodologies should include local development of play materials, revival of traditional games, folktales, etc.

Nutrition and health counselling: Offering regular health and nutrition counselling should become an important activity of the AWC. At least one day per week should be dedicated in the AWC to group counselling and support for pregnant women and breastfeeding mothers. This should be in addition to home visits to mothers and households requiring specific support.

Balanced and nutritious diets: The AWC should continue to function as a feeding centre where children and women receive balanced and nutritious cooked foods under the ICDS. Take home rations for pregnant and lactating women and infants and young children should also be provided.

b) Reach, coverage and inclusion: The coverage of the AWCs will, as a consequence of the expanded activities, further extend to mothers with children below the age of two who can avail of regular child care services. Special efforts should be made to ensure fair inclusion and non-discrimination of children belonging to poor and disadvantaged communities such as children belonging to SC/ST and migrant families, children with disabilities, as well as slum and homeless street children.

c) Timings: Parents and the local community should determine the precise timings of the centre which ought to be open for at least 6-7 hours a day.

- d) Space: Appropriate physical space (based on specified norms) should be provided for AWCs. Depending upon the conditions, such spaces could be rented or built. At a minimum, AWCs should be clean, well-ventilated and sunny, and spacious enough for children to play. They should have adequate storage facilities, running water, toilets and a decent kitchen.
- e) Operations: Government of India should encourage decentralization and local ownership so that AWCs are run by the local community through the panchayats with the involvement of women's groups, SHGs, Community-Based Organisations (CBOs), Membership-Based Organisations (MBOs) and NGOs.

2. Human resources: The success of ICDS will depend largely on the motivation and competencies of AWWs and other functionaries associated with it. A number of human resource issues need to be addressed.

- a) Staffing: Flexibility should be given to state and local governments (in consultation with local communities) to decide on the exact arrangements for delivery of ICDS depending upon the numbers of children as well as specific conditions in each context. It is however clear that undertaking the expanded functions of the AWC would require more than one AWW and one helper. Options to consider would include the (i) appointment of an additional AWW; (ii) co-opting for a payment the local ASHA; (iii) recruitment of youth volunteers who could be paid a stipend; and (iv) any other possibility that might involve the engagement of the local community and NGOs. There ought to be flexibility vis-à-vis the educational qualification of the AWWs, with emphasis on motivation, commitment and acceptance by the parents.
- b) Appointment of AWWs: AWWs should be selected through a transparent procedure from amongst the eligible women from the panchayat where the AWC is located. Special efforts should be made to appoint women from disadvantaged communities as AWWs. Experience of several state governments suggests that involvement of elected representatives from outside the village and panchayat in the selection of AWWs should be dispensed with. Outcomes are best when AWWs are appointed by the local organization managing the AWC.
- c) Training: AWWs will need to be trained in the holistic care of young children by qualified trainers from government or non-government organizations. National and state agencies in partnership with NGOs should develop appropriate training modules to ensure standard quality training which can be further adapted to suit local conditions. Every AWW should receive a minimum of three month's induction training. She should also be enrolled in a programme of continuous learning.
- d) Hours of work: If the ICDS has to succeed, then the notion of an AWW being a part-time worker has to be dropped. To be effective and useful, AWWs will have to be present most of the day. This happens only in a few states like Tamil Nadu and Andhra Pradesh. Even in Tamil Nadu, however, AWWs are not considered as 'regular' government employees; and this is one reason why AWCs operate for seven and a half hours and not eight.
- e) Reducing the burden: Careful thought needs to go into the burden on the AWWs. Filling out several registers and forms is one aspect of the work load. If AWCs are to run as fully functional day-care and education centres for children, then

- there has to be a ban on AWWs being drawn in to perform miscellaneous tasks for other departments.
- f) Conditions of work: Ensuring that AWWs are satisfied with their working conditions is fundamental to the success of ICDS. The compensation paid to AWWs varies across states. In many states, before the announcement by Government of India in this year's budget to double the compensation paid to AWWs, their monthly salaries would average between Rs. 2,500-3,000. In Tamil Nadu, which has established one of the most successful ICDS programmes, the state government has been topping up the monthly compensation of Rs. 1,500 paid by Government of India. Today, AWWs in Tamil Nadu earn around Rs. 6,000 a month. In addition, AWWs are entitled by the state government to a range of other benefits including old-age pension, monthly medical reimbursements of Rs. 100, the state-run medical insurance scheme and bonuses during Pongal and other festivals. There is scope for greatly enhancing the remuneration of AWWs through innovative measures combining performance-linked incentives with a fixed stipend.

3. Early childhood care and development: Broad national guidelines and norms should be developed to ensure effective provision of crèche and other ICDS services. These guidelines will need to take into consideration several factors including (i) the number of children per centre (preferably no more than 10 children per centre); (ii) appropriate physical space and room sizes which could be provided by the panchayat, primary school, primary health centre, etc. (iii) number of AWWs required at each centre depending on the total number of children; and (iv) foods needed to take care of children's requirements as per their age. State and local governments, however, should have the flexibility to adapt and innovate to match the requirements of the local context and people's needs.

4. Balanced and nutritious foods: Addressing the many gaps in the existing food supplementation component of ICDS will require incorporating the following suggestions:

- a) Proper foods: The concept of 'supplementary' nutrition measured in terms of calories will no longer be valid if children spend most of the day in the AWC. Hence, all children in the AWC should be offered a 'balanced and nutritious' diet depending upon how old they are. The Tamil Nadu practice of providing weaning foods for children in the age group of 6 months to 2 years and hot cooked food for children in the age group of 2-6 years should be adopted across the country. Food norms may need to be reviewed and revised. In addition, provision should be made for providing top-feed to infants below the age of six months when their mothers are unable (for a variety of reasons) to exclusively breastfeed them.
- b) Freshly cooked meals: All children coming to the AWC should get snacks as well as freshly cooked culturally appropriate hot meals. Such meals should be preferably cooked at the AWC by the anganwadi helper or by local women (and their SHGs or cooperative societies) using locally available vegetables and foodgrains. Systems should be in place for monitoring and reviewing the hygiene and quality of the prepared foods. A different menu for every day should be planned.

- 5. Growth monitoring:** Regular and proper monitoring of the growth of children is critical for prevention and ensuring early detection of child malnutrition. The weight of children should be recorded every month and height every year. This information along with other developmental milestones should be shared at monthly meetings with parents. Wherever active, panchayats and other local community-based organizations should be involved and associated with the monitoring of children's progress. For growth monitoring to be useful, it is important that every AWC has a functioning weighing scale, that these machines are regularly serviced and that AWCs are properly trained to weigh and measure young children.
- 6. Children with special needs:** Early screening and detection of children with special needs to identify those requiring special attention for disabilities must be regularly undertaken. AWWs and their parents should be provided information on recognition of early symptoms and the need for early action. Systems should be set up for the AWW, with the help of the ASHA, to refer such children for further care to the Primary Health Centre (PHC), Community Health Centre (CHC) or any other tertiary care facility.
- 7. Care of severely malnourished children:** Special and immediate action should be taken for the care of severely malnourished children - by identifying and referring them without delay to Nutrition Rehabilitation Centres (NRCs) set up under the National Rural Health Mission (NRHM). AWWs should ensure that ASHAs and link workers (in urban areas) counsel the parents and provide extra nutrition to the child.
- 8. Education and counselling:** AWWs should provide basic counselling and education to parents at monthly meetings at the AWCs. This education and counselling will include the importance of breastfeeding including immediate feeding at birth, the need for complementary foods after six months, immunization, Oral Rehydration Therapy, and Acute Respiratory Infections, among other childhood conditions. Home visits should also be used to provide in-depth counselling and repeated health and nutrition education.
- 9. Information, Education and Communication (IEC):** Having in place an effective national system of information, education and communication on care practices is essential for the effective functioning of ICDS. Different channels of communications must be utilized to ensure that parents, panchayat members, community leaders, ASHAs and others have easy access to the necessary information. The services available, as well as the norms, should be publicly displayed in the panchayat office, schools and health centres. Generating greater public awareness about the widespread prevalence of and solutions to malnutrition will be a prerequisite for initiating public action.

Management reforms

Effective implementation of ICDS will require a number of changes in the way the delivery of services is currently organized. Some key recommendations for improving the managerial efficiency of the programme are listed below:

- 1. Convergence:** Implementation of ICDS must envisage a close working relationship between the AWWs, ASHAs and the ANMs with the AWC being the physical space where all these service providers and services converge. Within the ICDS as well, the presence of two workers and a helper will help make the AWC a meaningful place for young children. As a team they will be able to provide crèche and pre-school services. This is the first step for ensuring essential convergence and complementarities. Clear division of roles and responsibilities between AWWs and ASHAs will help establish better accountability as well.⁵ Two practices being currently adopted by state governments to address the issue of convergence at the field level are described below:

Convergence through Village-level Fixed Health and Nutrition Days (VFHND):

Village-level Fixed Health and Nutrition Days (VFHND), piloted in a number of states, have been instrumental in bringing about convergence between the community (particularly women SHGs), Health Departments, and Social Welfare or Women and Child Development Departments. . VFHNDs have emerged as platforms for community engagement to ensure continuum of nutrition services. They can be effectively used to increase the awareness of the community on growth monitoring, breastfeeding, complementary foods, vitamin A supplementation, de-worming and other matters of health and nutritional wellbeing.

Village-level strategies adopted during VFHNDS that have yielded positive results include the following:

- Identification and listing of high-risk pregnancies by the Maternal and Child Health (MCH) team and identification of moderately and severely malnourished children
- Tracking of referral cases (pregnant and lactating mothers, infants and all children below 5 years with malnutrition)
- Prioritizing of home contacts by MCH teams that offer nutrition and health education to promote behavioral changes at the household level
- Sensitization of family members, specially men, during home visits and VHFNDs
- Extending technical training to health staff for addressing malnutrition

Convergence through community-managed Health, Nutrition and Day-Care Centres (HNDCCs): Another example of convergence is provided by the SHG-

⁵ Annex 1 shows a possible division of roles and responsibilities between AWWs, ASHAs and ANMs.

managed HNDCCs that are providing health and nutrition services to pregnant women, lactating women and children 0-3 years. Pregnant and lactating women are provided balanced diet with breakfast, lunch and dinner at these centres. They also receive health and nutrition education. In addition, the centres function as daycare centres or crèches for children 0-3 years. HNDCCs are typically provided a one-time investment in the form of seed capital. They are easy to replicate when SHGs and their Federations are trained to manage the nutrition and day-care centres. These centres, particularly in Andhra Pradesh, have yielded impressive results including 100% institutional deliveries, zero instances of low birth weight babies, 100% adoption of breast-feeding practice and good health and nutrition levels among mothers and children.

Such partnerships and implementation arrangements that promote convergence should be encouraged.

- 2. Civil society participation:** National guidelines should be developed by Government of India for the engagement of NGOs and other community-based organizations in the delivery of ICDS. A proportion of funds must be earmarked for such engagement with NGOs and civil society organizations. Non-governmental organizations (NGOs), community-based organization (CBOs), research and academic institutions in India have considerable expertise and experience in operating crèches, offering counselling and early childhood care, conducting training, undertaking research, and running early childhood education centres. Developing formal mechanisms for their active engagement will be important especially when the focus is on design and piloting of new initiatives in these areas. Particularly impressive has been the initiative of the Government of Andhra Pradesh to involve SHGs in the promotion of health and nutrition. Engagement of such organizations is also important for ensuring community participation and establishing networks with governments.
- 3. Responsibilities for outcomes:** It is important to have clear-cut responsibilities for outcomes. In the absence of this, and given both the multi-sectoral nature of interventions needed to tackle malnutrition, as well as the overlap between the tasks to be performed by AWWs and ASHAs, no one is directly responsible for guaranteeing outcomes under ICDS. It is suggested that the Department of Health should be accountable for health and nutrition outcomes for children under 3, adolescent girls and pregnant and lactating mothers. This would imply that accountability for outcomes relating to four of the six services provided by ICDS should rest with the Ministry of Health and Family Welfare. These are (i) immunization; (2) health check-up; (3) referral services; and (4) nutrition and health education. At the same time, MCWD should be directly accountable for ensuring effective provision of the remaining two ICDS services, namely, balanced and nutritious foods; and early childhood care and education at the AWCs.
- 4. Record-keeping and IT tracking systems:** Developing national norms for collecting most relevant and real time data for decision-making should become integral to management reforms of ICDS. It is important to rationalize the data collected under ICDS for effective decision-making and also to reduce the record-

keeping burden of the AWW. Many states have been innovating with IT-based solutions (including use of laptops and mobile devices) that generate real time data for initiating immediate action, verifying achievements, tracking progress and assessing performance. At the same time, there should be a universal comprehensive mother and child health record with a unique identity number for the tracking of pregnant women and children by name until the child reaches the age of 5 years. Special strategies need to be devised for using the information system to reach out to the poorest of the poor.

- 5. Tracking progress:** Well-defined tangible and easy-to-measure performance indicators should be developed for the different components of ICDS. Such indicators have been proposed for some of the nutrition-related components of ICDS.⁶ Similar indicators and surveys need to be developed for other components of care provided by ICDS. There is also need to undertake periodic surveys that measure prevalence of child malnutrition and anemia as well as progress with respect to early childhood care and development. Disaggregated data gathered through such surveys should be used to track progress by gender, rural-urban habitats, socio-economic groups and other categories.
- 6. Research, monitoring and evaluation:** Governments ought to invest appropriately in systematic research to improve knowledge and understanding of factors affecting nutrition. Concurrent monitoring of ICDS should throw up signals for initiating corrective actions. Like with MGNREGA, social audits, independent monitoring and evaluations should be made integral to the functioning of ICDS.
- 7. Financing arrangements:** Existing administrative and financial arrangements governing ICDS should be reviewed and changes incorporated in order to make them more efficient. Some of the suggestions for consideration are listed below:
 - Government of India should index the cost of supplementary foods and other monetary items in order to protect the entitlements against inflation.
 - Good practices from the National Rural Health Mission (NRHM) should be adopted to increase focus and provision of resources, establish structures and systems for flow of resources from the central level to the state, block and village level, undertake effective planning and delivery, make for transfer of untied funds, strengthen information systems and increase community monitoring.
 - Flexible mechanisms for financing ICDS should be adopted. There is likely to be considerable experimentation with the revamped ICDS over the coming years. With this in mind, Government of India should encourage state governments to innovate and experiment with alternative ways of delivering ICDS services. Release of funds to state governments should be based on an approved plan where nutritional and other outcomes are clearly specified. This will necessarily imply that the Central Government will have to adopt vertical and horizontal differentials in financing.

⁶ See Annex 2 which provides an indicative list of indicators that can be used for tracking nutrition-related outcomes.

- Given how significantly costs of delivering ICDS will be affected by the enormous diversity of local conditions within the country, Government of India should consider developing per capita norms that make for experimenting with different modalities of service provisioning at the community level. This will enable experimentation with different cost-effective, innovative, community-based approaches to the provision especially of crèches and early childhood education centres.
- Government of India should shift away from announcing uniform national norms to differential financing so that different districts can have the benefit of receiving differential funding across states. This will also help to address the special problems relating especially to the availability of space for AWCs in large cities.
- A proportion of funds must be earmarked for research, concurrent monitoring and evaluation as well as for the engagement with NGOs and civil society organizations.

8. Financial requirements: Adequate funds should be made available for the expanded activities of the AWCs envisaged under the ICDS. Precise requirements will have to be worked out by state governments in consultation with the Centre. Sharing of costs between central and state governments will need to be reviewed to take into account a variety of recurring and non-recurring costs.⁷ In deciding on allocations to state governments, Government of India should be open to reviewing the sharing of costs with the states. While ICDS offers a set of uniform entitlements to all children, the poor fiscal health of many states is likely to limit the resource allocations for ICDS. In other words, how can a state like Rajasthan start spending on ICDS as much as Tamil Nadu in order to provide the same level and quality of care to children? There is a strong case for specific purpose transfer schemes in order to ‘equalize’ the levels of spending by different states – as a way to offset the general disability of many states to mobilize resources and ensure that everyone gets the same level and quality of ICDS. Given the differential abilities of the states, it is important to ensure that state governments do not substitute central transfers for their own contribution to ICDS; and states continue to assign priority to ICDS even as they receive additional central funds.

⁷ Non-recurring items will include equipment like cradles, sheets, towels, mattresses, mats (durries), cooking utensils and equipment, feeding bowls and spoons, play materials, toys. Recurring items will include remuneration of AWWs, food, rentals, electricity, cleaning equipment and some play materials, transport of AWWs for meetings, trainings etc (if required) and for referral of children for further health care and nutrition.

Institutional reforms

1. Nutrition Mission of India

There is an urgent need to set up a Nutrition Mission of India with the following objectives:

- accelerate improvements in the nutritional and health status of children
- ensure effective early childhood education and development
- ensure effective delivery of ICDS services
- ensure convergence and collaboration between ministries and stakeholders
- undertake proper surveillance of nutritional status and outcomes
- provide technical support for addressing delivery of ICDS
- ensure effective community mobilization and engagement in implementation

The NMI should be headed by a Chairperson (with the rank of Cabinet Minister) and have officials from relevant ministries who have a stake in reducing malnutrition as its members. It should be staffed by experts and consultants in different fields, and be empowered with appropriate structures and resources to ensure reach of technical support at the community level.

The existing Prime Minister's National Council on India's Nutrition Challenges should be reconstituted and renamed as the Nutrition Council of India (NCI). The Prime Minister should continue to chair the Council. However, its membership would need to be modified to bring in appropriate representatives and experts from state governments, as well as from civil society. The Chairperson of the NMI shall be the member secretary of the NCI. The Nutrition Mission of India (NMI) shall report to the Nutrition Council of India. The Nutrition Mission of India (NMI) should develop a time-bound plan of action to reduce child malnutrition across the country.

2. A pre-primary class in all primary schools

Pre-school education is a critical part of the comprehensive child development package proposed by NAC. Children denied any pre-school education are severely disadvantaged when they enter Class 1 at the age of 6. In the absence of a comprehensive national policy and regulatory framework on pre-school education, children between 3-6 years remain neglected. Absence of accurate data on the provision of pre-school services, a proper assessment of needs, lack of clarity on the appropriate number of years of pre-schooling as well as the absence of a regulatory framework, policy guidelines, and designated pre-school services has led to confusion about the appropriate age of entry into Class 1, which in some states has dropped to 5 instead of 6 as envisaged by the RTE.

Introduction of pre-primary sections in government schools is being contemplated by many states. They already exist in Puducherry. Government of Punjab plans to introduce pre-nursery classes in government primary schools from the coming academic session. Government of Kerala is also contemplating a similar move to

remove the disadvantage that government schools face of not having nursery classes. Such a decision paves the way for admission of four-year old children in the pre-primary class. Such a move would imply that AWCs would address the early childhood education needs of children aged 2 to 4.

It is recommended that the MCWD and Ministry for Human Resource Development (MHRD) should jointly develop a comprehensive national policy for early childhood and pre-school education. The policy must identify and propose appropriate curricular modules, promote age-appropriate joyful learning pedagogy, and develop pre-school teacher-training modules and mechanisms. Norms and guidelines should be specified for all pre-school centres (including 'nursery' schools, play centres, etc.) in both the public and private sectors.

Following the growing support for and lead taken by some states, the NAC recommends the addition of a pre-primary section in all primary schools. Such a move to prepare children for Class 1 will also ensure better school performance, and stimulate greater interest among children. This would also pave the way for examining, over time, the feasibility of bringing pre-school learning under the purview of the Right to Education Act so as to prevent gaps and ensure continuity in the child's education.

Moving Ahead

- 1. Comprehensive reforms:** While there is need for urgency, outcomes are likely to be guaranteed only if a comprehensive view of the reforms and restructuring of ICDS is accepted. A transfusion of additional funds at this stage for limited components of ICDS such as constructing buildings or appointing additional AWWs is unlikely to yield the desired results. Similarly, streamlining administrative and financial arrangements for speedy transfer of funds, while important, will contribute little to revamping the delivery of ICDS. Detailed planning along the lines suggested in this note needs to go into the revamping of ICDS.
- 2. Mission Document:** It is necessary to get a firm commitment to the setting of the Nutrition Mission of India. Like with NRHM, this would pave the way for a series of in-depth and broad-based consultations with different stakeholders for developing a Mission Document where the vision, goals, strategies and detailed time-bound plans of action are developed over the next six months. Special attention will have to be paid to the delivery of ICDS in cities. The Mission Document should also make an assessment of the financial resources. Details of phasing options would need to be worked out including the proposed piloting in 200 districts and roll-out of the revamped ICDS across the country.

Annex 1

Role of Anganwadi workers, ASHA and ANM (in relation to children under six, pregnant and lactating mothers)

(Note: Both AWWs need to be full time workers)

| Focus Group | AWW 1 | AWW 2 | ASHA | ANM |
|---------------|----------------------|---|--|---|
| | (pre-school teacher) | (focus on crèches under-3s) | Community based | Sub-Centre based with field visits |
| 0-6 months | | | <p>Supporting exclusive breastfeeding. Motivating for immunisation. Growth monitoring, , encouraging early initiation of breast feeding,</p> <p>Providing new born care, supporting management of low birth weight and sick babies. Weighing at birth and recording birth weight, Assist in beginning breastfeeding within one hour, and establishing exclusive breastfeeding as an accepted community norm, Establishing complete immunisation as a community norm.</p> | <p>Providing immunisation services and timely curative & referral services for sick new borns Assists in beginning breastfeeding within an hour (if she is conducting delivery)</p> <p>Management of severely undernourished children</p> |
| 6 – 36 months | | Crèche services for children in this age group at the anganwadi centre Providing | Positively influencing complementary feeding practices of families and at the | Providing timely curative and referral services. Management and referral of |

| Focus Group | AWW 1 | AWW 2 | ASHA | ANM |
|-------------------------|---|--|--|--|
| | | <p>supplementary nutrition in the form of THR and meals for children in crèches.</p> <p>For children in the crèches, along with ASHA providing growth monitoring, motivating for complete immunisation, Vitamin Supplementation. Nutrition rehabilitation of severely undernourished children and referral</p> | <p>community level, Encouraging adoption of hygienic practices regarding water and sanitation,</p> <p>Providing growth monitoring, motivating for complete immunisation, Vitamin Supplementation for all children in this age group</p> <p>Nutrition rehabilitation of severely undernourished children and referral Early detection and management of childhood illness especially management of diarrhoea. Counselling and follow up of families with severely undernourished children</p> | <p>severely undernourished children</p> |
| <p>3-6 years months</p> | <p>Pre-school education, Growth Monitoring, organising cooked mid-day meal, Nutrition rehabilitation of severely undernourished</p> <p>Day care</p> | | <p>Identification and referral of sick children. Counselling and follow up of families with severely undernourished children</p> | <p>Health Check ups and curative services, Management and referral of severely undernourished children</p> |

| Focus Group | AWW 1 | AWW 2 | ASHA | ANM |
|---|---|--|---|---|
| | services after pre-school hours | | | |
| Pregnant women | | Supplementary Nutrition Disbursing maternity entitlements | Working with women, families and the community to ensure adequate weight gain through appropriate nutrition, reduction in workload, rest and accessing timely health services especially supporting clean and institutional delivery Growth Monitoring | Ante Natal Care, Promoting delivery by Trained Birth Attendant, Promoting and Supporting Institutional Delivery |
| Nursing Mothers | | Supplementary Nutrition Disbursing maternity entitlements | Post Natal Care, Encouraging Early Initiation of Breast feeding Providing breastfeeding support | Post Natal Care, Immunisation |
| Anganwadi Helper (full time in case of AWW-cum-crèche) | <ul style="list-style-type: none"> • Cook and serves food in the crèche • Help children and AWWs in play activities | | | |

Annex 2

Illustrative indicators for tracking performance and progress on nutrition-related initiatives of ICDS

Improved breastfeeding practices in the first two years of life.

- Every newborn starts breastfeeding within one hour of birth and is fed colostrum in the first three days of life
- Every infant is exclusively breastfed for the first six months of life and is not given any fluids, milk or foods, not even water

Improved foods and feeding practices in the first two years of life.

- Every child starts receiving complementary foods by the beginning of the seventh month while breastfeeding continues until 24 months and beyond
- Every child 6-24 months is fed age-appropriate, energy and nutrient-dense complementary foods with increased quantity, density and frequency as the child grows

Improved protection against micronutrient deficiencies and disease:

- Every child is protected against micronutrient deficiencies with micronutrient-rich foods, bi-annual vitamin A supplementation and deworming, regular iron+ supplementation, and micronutrient fortified foods
- Every child is protected against disease with full immunization and hygienic feeding practices

Improve feeding for children who are sick and/or undernourished.

- Every child is fed frequently during and after illness, while breastfeeding continues. Children with diarrhea receive appropriate therapy and zinc supplementation
- Every child with severe acute malnutrition receives quality therapeutic feeding, preferably before the onset of medical complications

Improved nutrition for adolescent girls and adult mothers.

- Every adolescent girl is protected against anemia and undernutrition through dietary counselling, weekly iron+ supplementation, twice yearly deworming, and education and life-skills to avoid early marriage and pregnancy
- Every pregnant and lactating mother has access to sufficient food and nutrients, takes iron+ supplements daily and consumes iodized salt to prevent maternal anemia, fetal growth restriction, and low birth weight