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# Strengthening ICDS for Reduction of Child Malnutrition

## Report of the National Consultation on Child Undernutrition and ICDS in India

New Delhi, May 2006

Ministry of Women and Child Development
Government of India and the World Bank

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ACKNOWLEDGEMENTS
This report summarizes the presentations and discussions at a national consultation organised by the World Bank and the Ministry of Women and Child Development, Government of India on May 11, 2006. The presenters at the consultation were P A Berman (WB), J F Schweitzer (WB), M Gragnolati (WB), S Adhikari (MWCD), V Kaul (WB) and AK Gopal (NIPCCD). Nira Singh made the consultation arrangements.



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# Contents

# Foreword

India has one of the highest rates of malnutrition in the world. Nearly one in every two of India's 120 million children is underweight, almost double the prevalence in Sub-Saharan Africa. An undernourished child will fail to reach her human potential in her adult years – in terms of educational attainment, health and productivity – perpetuating a vicious cycle of poverty and malnutrition.

Halving the prevalence of underweight children by 2015 is a key indicator of progress towards the Millennium Development Goal (MDG) of eradicating extreme poverty and hunger. Achieving the target will require difficult choices. It cannot be met by economic growth alone, however impressive that may be at the present time.

In India, until recently, food insecurity has been viewed as the primary or even sole cause of child malnutrition. By contrast, research indicates that high levels of exposure to infection and inappropriate child feeding and caring practices, especially during the first two to three years of life, are salient. This misperception has resulted in resources being skewed towards ineffective food-based interventions.

India's main early child development intervention, the Integrated Child Development Services (ICDS), has been operating for about 30 years. While it has certainly had some successes, it does not appear to have made a significant dent in child malnutrition. There are two main reasons. First, it has prioritized food supplementation over nutrition and health education interventions. Second, it has focused on children above the age of three, by which time the irreversible effects of malnutrition have already set in.

The National Consultation on Child Undernutrition and ICDS in India was organized by the Ministry of Women and Child Development of the Government of India and the World Bank to sustain the effort to improve the effectiveness and targeting of ICDS in collaboration with the other Development Partners supporting the reduction of malnutrition in India, such as CARE, the Micronutrients Initiative, UNICEF and the World Food Program.

This report summarizes the main findings of several reviews of the characteristics and impact of ICDS and presents the recommendations of technical working groups on how to introduce substantial changes in the program's design and implementation in order to transform it into an intervention that effectively addresses the principal causes of malnutrition, which, in turn, will yield huge human and economic benefits for India.

**Julian Schweitzer**
**Sector Director**
**Human Development Department**
**South Asia Region**

# List of Acronyms

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| AWC | Anganwadi Centre |
| AWW | Anganwadi Worker |
| BLS | Baseline Survey |
| DFS | Double Fortified Salt |
| DPED | District Primary Education Programme |
| ECCE | Early Childhood Care and Education |
| ECE | Early Childhood Education |
| ELS | Endline Survey |
| GoI | Government of India |
| ICDS | Integrated Child Development Services |
| IEC | Information, Education and Communication |
| IFA | Iron Folic Acid |
| MDG | Millennium Development Goal |
| MI | Micronutrient Initiative |
| MWCD | Ministry of Women and Child Development |
| NIPCCD | National Institute of Public Cooperation and Child Development |
| OBC | Other Backward Classes |
| PEM | Protein Energy Malnutrition |
| PRI | Panchayati Raj Institution |
| RCH | Reproductive and Child Health |
| RTE | Ready to Eat |
| SC | Scheduled Caste |
| SHG | Self Help Group |
| SNP | Supplementary Nutrition Program |
| ST | Scheduled Tribe |
| VAD | Vitamin A Deficiency |
| WFP | World Food Programme |


Chapter 1

# Objectives of the National Consultation:

## Evaluation and Consensus-Building on the Need for Strengthening ICDS

Welcoming participants and introducing the objectives of the consultation, Mr. Chaman Kumar, Joint Secretary, Ministry of Women and Child Development, Government of India, noted that the Integrated Child Development Services (ICDS) Scheme is the cornerstone of India's strategy for reducing malnutrition. Since consultations for the Eleventh Five-Year Plan have begun, this is the right time to assess gains and shortcomings of ICDS based on the experiences of the last few years and explore the possibility of adopting such best practices, which have been adopted by the partner organizations and have been proved beneficial and cost effective in ICDS Scheme.

Mr. Kumar presented the purpose of the Consultation emphasizing the two main agenda items (i) dissemination of the findings of the study conducted by the World Bank – "*India's Undernourished Children: A Call for Reform and Action,*" and (ii) a presentation by the CPMU on the endline evaluation of ICDS III, and a presentation by the National Institute of Public Cooperation and Child Development (NIPCCD) on the evaluation of the ICDS program. He also briefly described the four types of change strategies that would be taken up by the working groups in the afternoon session. The key objectives of the consultation were presented as follows:

- ICDS strengthening and reform: consensus on need, broad scope, and key principles and content
- Scope out specific elements of improvement strategies as basis for further work
- Launch process of partnership for future program development

Ms. Reva Nayyar, Secretary, Ministry of Women and Child Development (MWCD), noted the need to evaluate the collaboration of GoI with the World Bank with respect to ICDS. Realizing the strategic importance of ICDS, all


concerned must work together to utilise the full potential of the program. ICDS – a very powerful tool for development of women and children – has achieved synergy between stakeholders and government, different government departments as well as the government and developmental partners. The Indian government is keen to learn from the special expertise each partner brings to the program, and take these learnings to other project areas as well.

Professor Peter Berman, Lead Economist, Health, Nutrition and Population, World Bank, noted that ICDS is remarkable in its scale, scope and coverage. He described the objectives of the present consultation as evaluation and consensus building on steps required for strengthening and redesigning ICDS. Participants would examine ICDS in wider perspective, recent evaluations, and suggest strategy changes relating to options for service delivery mechanisms, supplementary food as an entry point for better household caring and feeding behavior, micronutrient interventions, and decentralization. Based on these discussions, specific elements of improved strategy would emerge. These would launch the process of partnership for future program development.

Mr. Rachid Benmessaoud, Operations Advisor, World Bank, India, emphasized the importance of partnership for furthering the joint goal of reduction of malnutrition in India.

Mr. Julian Schweitzer, Sector Director, South Asia Human Development, World Bank, reiterated the critical nature of the task at hand. He described the dimensions of malnutrition in India in some detail, by summarizing

the arguments of two recent World Bank Reports: *Repositioning Nutrition as Central to Development (Global Report) and Child Undernutrition in India*. The continuing high prevalence of child undernutrition in India suggests the need for qualitative improvements in ICDS, with a focus on processes as well as outcomes.

In her keynote address, Smt. Renuka Chowdhury, Honorable Minister of State for Women and Child Development, noted that her Ministry faces enormous challenges, as it deals with 72 percent of India's population. Nutrition of women and children is one of the most significant challenges. Her Ministry has declared the coming decade as the Decade of the Girl Child, and is preparing a vision document as well as road-map for tackling multiple problems. These include declining sex ratio, gender discrimination, high rates of disease, lack of food and water security, as well as perceptions and attitudes towards girls and women. Mega-areas that need to be addressed include – precise understanding of what is basic malnutrition, links with disease control, hygiene and sanitation, deworming and other preventive measures, IEC, strengthening of service delivery systems, and women's rights. Sound and cost-effective traditional food security practices should be preserved and reinforced, since knowledge of nutritional and healing properties of food has been widespread in India – in fact the kitchen has been a veritable pharmacy. All this needs to be integrated into ICDS functioning. Commenting, "I am very optimistic we can evolve qualitatively improved ICDS", the Minister was emphatic about the need for this, saying, "I cannot accept that India has a high economic growth performance but our poor are starving. I cannot accept this!"

The Minister was optimistic about achieving the MDG targets. She emphasized the need for sustained information campaigns throughout the country, which her Ministry is committed to. An award called the Rani Rudramma Award is also being instituted for women who single-handedly combat malnutrition.

Dr. Michele Gragnolati, Senior Economist, South Asia Human Development, World Bank, presented a vote of thanks to the Minister and other participants, and stressed the significance of the present consultation for building consensus on practical steps for delivering improved services through ICDS.

Chapter 2

# Child Malnutrition: Dimensions of the Problem in India

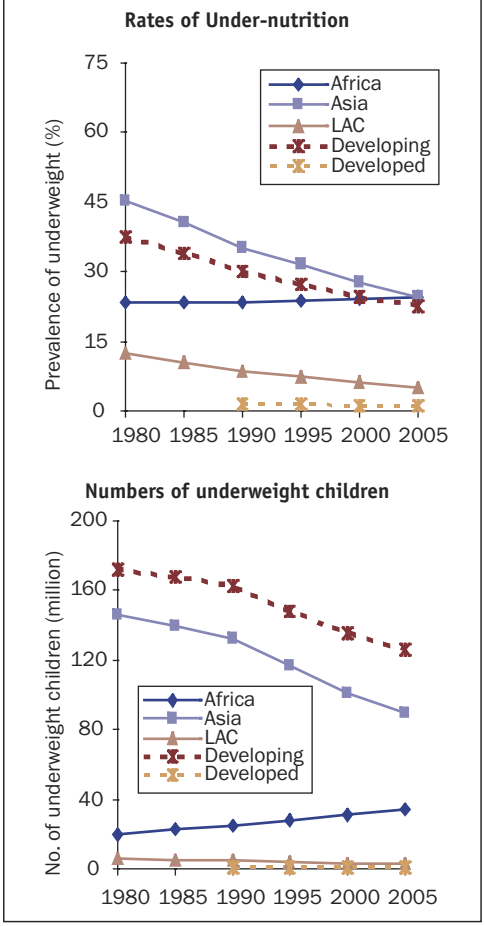
India has a serious problem of child undernutrition. Reduction of child undernutrition is imperative, since it has enormous consequences for child and adult morbidity mortality, as well as productivity. Undernutrition directly affects many aspects of children's development, retarding physical and cognitive growth and increasing susceptibility to disease. Improved policy and programs are needed if India is to reach the nutrition MDG target of halving the figures for malnutrition by the year 2015 (from in 1990 to in 2015).

The prevalence of underweight among children has been higher for Asia than for Africa. However, the situation has been improving in Asia as a whole, unlike the African situation, so that by 2005 the rates for Asia and Africa were at par. However, in terms of numbers, Asia has by far the greater number of underweight children. Disaggregating the Asian situation, we find marked differences between countries. Bangladesh and India, in fact, lag far behind China.

India has a higher level of protein-energy malnutrition (PEM) than most parts of the world, including sub-Saharan Africa.

Micronutrient deficiencies in India are among the highest in the world. Over 75 percent of

Global trends in underweight (Children 0-4 Years)




*Data Source: de Onis et al (2004)*

## PEM in India is worse than most parts of the world, including Sub-Saharan Africa

| Region | % of under-fives (2000) suffering from | | |
|---|---|---|---|
| | Underweight | Stunting | Wasting |
| Latin America and Caribbean | 6 | 14 | 2 |
| Africa | 24 | 35 | 8 |
| Asia | 28 | 30 | 9 |
| India | 47 | 45 | 16 |
| Bangladesh | 48 | 45 | 10 |
| Bhutan | 19 | 40 | 3 |
| Maldives | 45 | 36 | 20 |
| Nepal | 48 | 51 | 10 |
| Pakistan | 40 | 36 | 14 |
| Sri Lanka | 33 | 20 | 13 |
| All developing countries | 22-27 | 28-32 | 7-9 |

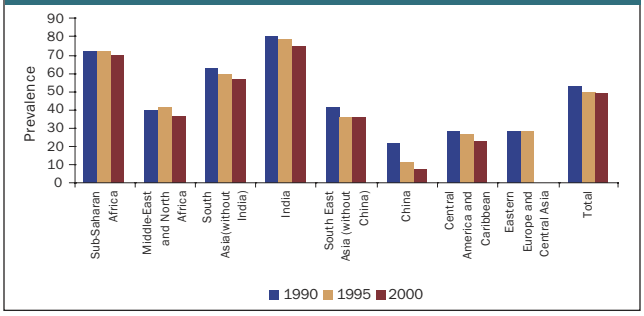
*Source ACC/SCN 2004*

Underweight prevalence is higher in rural areas (50%) than in urban areas (38%), higher among girls (49%) than among boys (46%), higher among scheduled castes (53%) and scheduled tribes (56%) than among other castes (44%), and is as high as 60 percent in the lowest wealth quintile. Inter-state variations are large, with six states (Bihar, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Uttar Pradesh) having at least 50 percent children underweight. The prevalence of underweight is falling more slowly in high-prevalence states. Overall, the inequalities in undernutrition between demographic, socioeconomic and geographic groups widened during the 1990s.

Undernutrition in India has been estimated to be associated with about half of all child deaths. Most growth retardation occurs by the age preschool children suffer from iron deficiency anemia, and 57 percent have subclinical Vitamin A deficiency (VAD). Iodine deficiency is endemic. The prevalence of different micronutrient deficiencies varies widely across states. Progress in reducing the prevalence of micronutrient deficiencies has been modest.

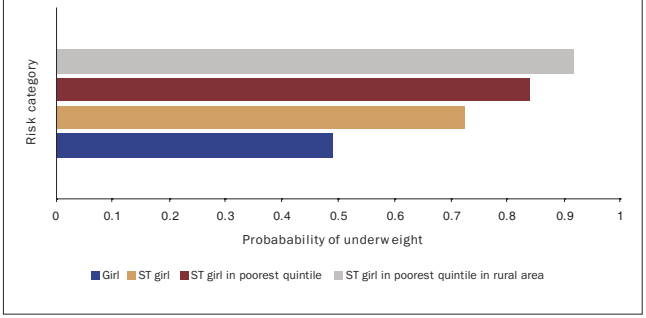
There are marked inequalities in urban-rural, inter-caste, male-female and inter-quintile nutritional status.

## Micronutrient deficiencies: Iron deficiency anemia (IDA)

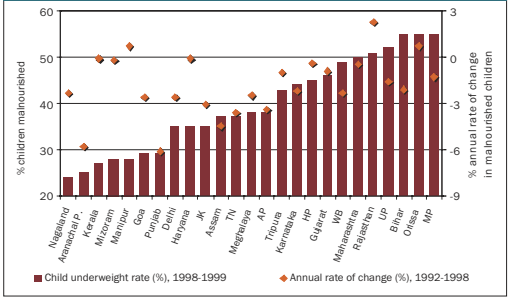



*Source: Calculated from NFHS I and NFHS II data*

## Now the probability of underweight increases for girls in increasingly vulnerable positions

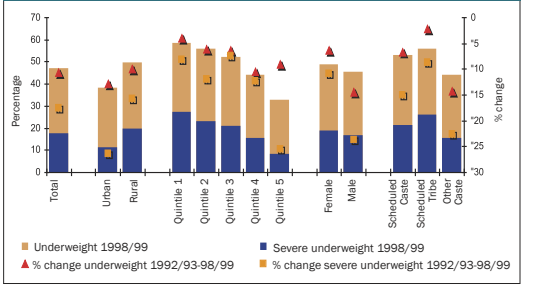


## Variations across states in underweight levels




*Source calculated from NFHS I and NFHS II data*

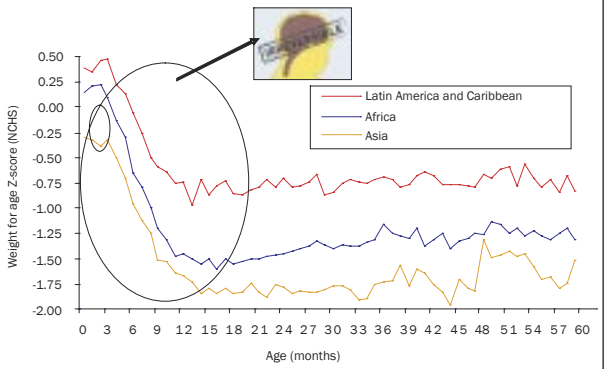
## Inequalities in nutritional status across socioeconomic groups




*Source calculated from NFHS I and NFHS II data*

of 2 – in part because about 30 percent of Indian children are born with low birth weight – and it is largely irreversible. The "window of opportunity" for preventing undernutrition is thus very small – pre-pregnancy until 18-24 months of age.

## The "Window of Opportunity"




*Data Source: Shripton et al (2001)*

### Different yardsticks

Standards relating to malnutrition are expressed differently in different contexts. For instance studies such as the National Family Health Survey (NFHS), the baseline survey of ICDS III and the endline survey use the NCHS standards, while the growth monitoring records at the AWC level uses the Indian Association of Paediatrics (IAP) standards. This has created problems of understanding the results of the BLS at some of the state level dissemination workshops, particularly, by the stakeholders.

Chapter 3

# ICDS: Findings from Recent Evaluations

ICDS – India's primary policy response to child malnutrition – is well-conceived and, in many ways, well positioned to address the major causes of child undernutrition. It has emerged from small beginnings in 1975 to become the country's flagship nutrition program. ICDS offers a wide range of health, nutrition and education services to children, women and adolescent girls. It intends to target the needs of the poorest and most undernourished, including the age groups that present a "window of opportunity" for nutrition investments (children under three and pregnant and lactating mothers).

To maximize the impact as well as introduce evidence-based planning of ICDS, it is important to undertake periodic evaluations and make strategic changes based on the findings.

## Recent Findings on ICDS and its Performance

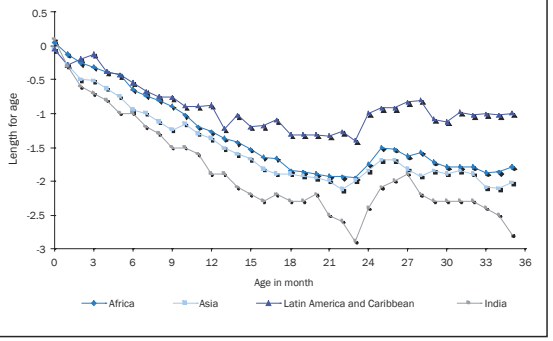
A presentation by Dr. Michele Gragnolati, World Bank

The ICDS program is well-designed to address the multiple determinants of malnutrition (food-health-care), the intergenerational cycle of malnutrition, and to target areas and households with highest prevalence of malnutrition. There are mismatches between intentions and implementation, which prevent ICDS from reaching its full potential.

### Mismatch I – Dominant emphasis on food

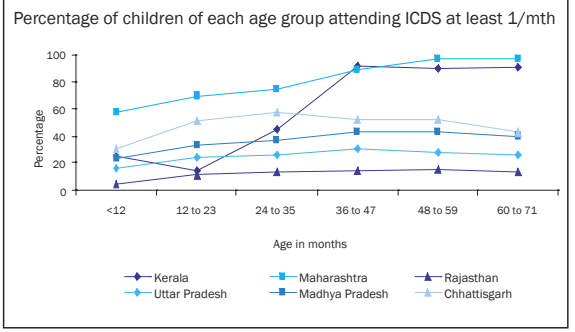
Although the design of ICDS recognizes the multiple determinants of undernutrition, too much emphasis is currently given to providing food security through the Supplementary Nutrition Program (SNP). Not enough attention is given to educating parents on how to improve nutrition within the family food budget, and improved child-care behavior – which would in fact be the most effective interventions for child nutritional outcomes.

## Most growth-faltering occurs by age two



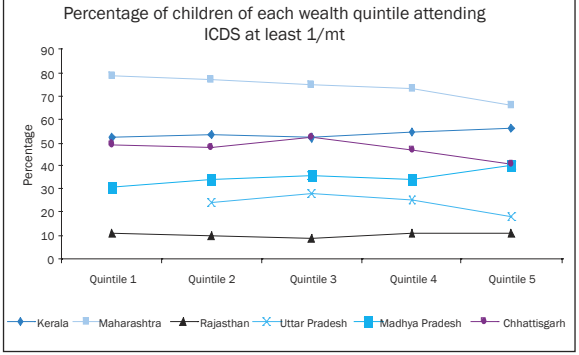

*Source: Regional estimates from Shrimpton et al 2001: India data from IIPS and ORC macro 2000*

## Low participation ratio: Under twos




*Source: ICDS III baseline/ICDS II endline survey 2000-2002*

## Insufficient targeting of the poor




*Source : ICDS III baseline/ICDS II endline survey 2002-2002*

Forty percent of the time of AWWs (Anganwadi Workers are the village based primary functionaries of the ICDS program) is spent in preparation and distribution of supplemental nutrition. Another 30 percent of the AWW's time is spent on preschool education. This is at the expense of the other ICDS activities that are crucial for promoting children's growth and better nutritional status, such as:

- Promoting good breastfeeding and complementary feeding practices;
- Promoting disease prevention and control; and
- Providing micronutrient supplementation.

**Mismatch II - Limited reach to the youngest and most vulnerable children**

Service delivery is not sufficiently focused on the 0-3 age-group children, who can potentially benefit most from ICDS interventions. Moreover, children from wealthier households participate much more than poorer ones, and ICDS is only partially succeeding in preferentially targeting girls and disadvantaged castes and tribes (Scheduled Castes and Scheduled Tribes).

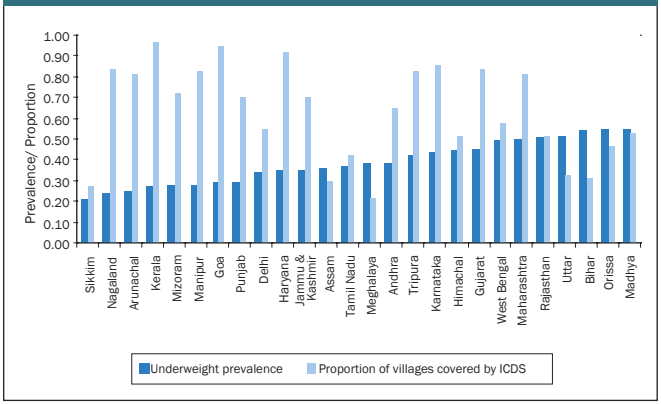
**Mismatch III – Uneven ICDS coverage**

The states with highest prevalence of malnutrition are among ones with the lowest ICDS coverage, and states with most malnutrition spend less on ICDS than other states. Based on the findings, it is important to ask whether significant reforms are needed in ICDS implementation. Although ICDS is a remarkable program, one key outcome, that is reduction in child undernutrition, is not improving rapidly enough. The following

key questions are therefore being put out, with the aim of enhancing effectiveness of ICDS:

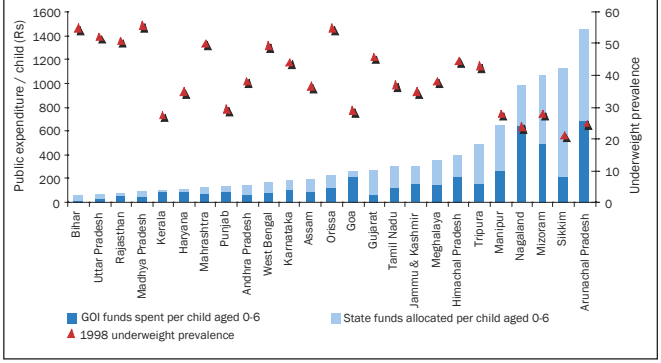
- Can a new service delivery model be introduced to separately address the developmental needs of both under-3s and 3-6 year olds? Is one AWW enough?
- Can SNP be delivered more efficiently and also more strategically to help improve home-based caring and feeding behavior for the under-3's?
- What are the most cost-effective options to deliver micronutrients to children, adolescent girls and pregnant women?
- Is decentralization of ICDS an option to improve its effectiveness?

The five states with most malnutrition are among the ones with lowest ICDS coverage




*Source : Underweight prevalence calculated from NFHS II; villages Covered calculated from NFHS Ii data ini Das Gupta et al. 2005*

States with the most malnutrition spend less on ICDS than other states



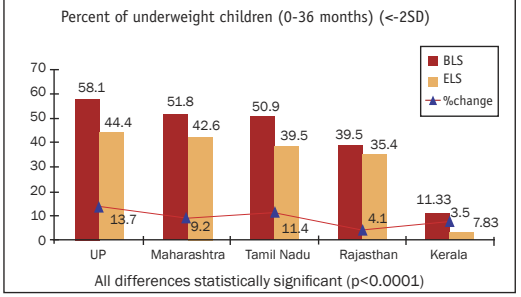

*Source : Underweight prevalence calculated from NFHS II data; expenditure data from DWCD; 1998/99*

## End-line survey and impact evaluation of the World Bank assisted ICDS-III/WCD project (1999-2006)

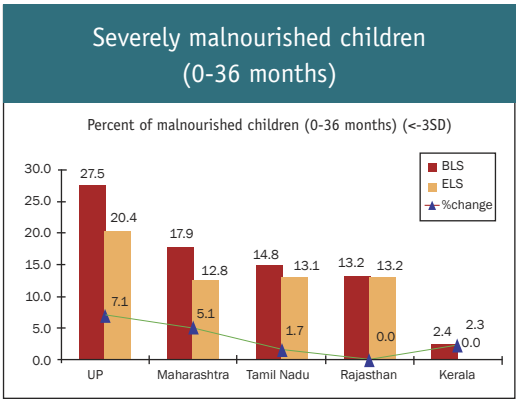
A presentation by Dr. Saroj K. Adhikari, MWCD, GOI

An endline survey (ELS) was conducted in five states, i.e. Rajasthan, Maharashtra, UP, Kerala and Tamil Nadu, which were originally covered under the World Bank, assisted ICDS-III (WCD) Project since October 1999. The sample sizes in ELS were 44,000 households, 40,000 mothers of children aged 0-6, 1,900 pregnant women, 8,000 adolescent girls and 720 AWWs. The ELS was conducted in 2005, while the base line survey (BLS) was in 2000. The preliminary results are summarized below. Detailed analysis on impact issues are still being carried out. The study found a significant decline in underweight children aged 0-3 years in the project blocks. As compared to the project objective of reduction of underweight children aged 0-3 years by 10 percent, a reduction

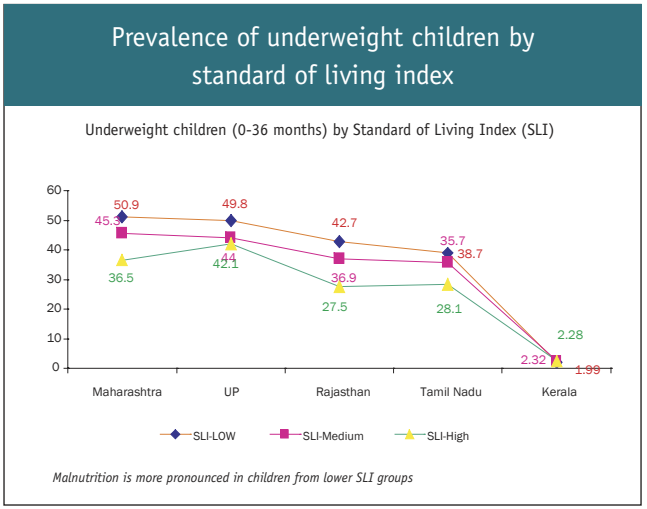
## State-wise prevalence of underweight children




## Severely malnourished children (0-36 months)




## Prevalence of underweight children by standard of living index




*Malnutrition is more pronounced in children from lower SLI groups*

of 8.5 percent was actually achieved. While all five states contributed to this decline, UP, Maharashtra and Tamil Nadu achieved the 10 percent target. There was also a marginal decline in percentage of severely malnourished children (from 14.8% to 13.4%).

The state-wise prevalence of underweight children shows maximum decline in UP. The same is true for decline in severely malnourished children.

As for the gender differential, the finding is surprising – the percentage of underweight boys is greater than percentage of underweight girls (except in UP). As regards caste, no significant difference between Scheduled Caste (SC), Scheduled Tribe (ST), Other Backward Classes (OBC) and others was found, except in Maharashtra where ST children were found to be more malnourished than others. However, as expected, malnutrition is more prevalent among children of lower socioeconomic groups.

The findings indicate positive changes in the infant feeding practices during the period of ICDS-III:

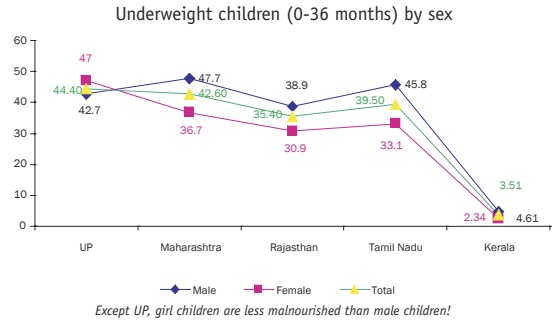
- Early (within 2 hours of birth) initiation of breastfeeding (36.4 percent in BLS to 52.6% in ELS)
- Complementary feeding for children aged 6-9 months (59% to 63.8%)
- Consumption of Vitamin-A rich food by children aged 6-36 months (51.7% to 70.9%)
- Receipt of Vitamin-A dose for children aged 12-36 months (55.5% to 70.5%)

However, exclusive breastfeeding up to six months remains to be a problem. Only 22.8 percent children up to six months were reported to have been exclusive breastfed (BLS: 28.3%). The study reveals that about 37 percent of the children up to six months were given plain water along with breast milk.

Significant progress is indicated in antenatal care, immunization, de-worming and treatment of diarrhoea.

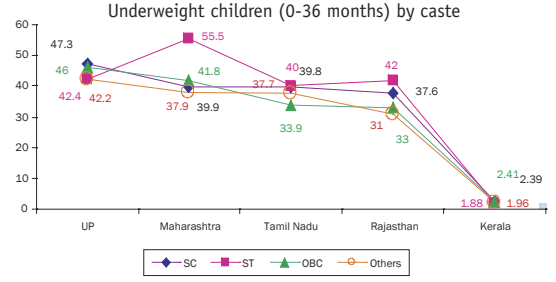
Growth monitoring of under-3 children improved overall (from 66.9 to 82.5%). The increase occurred in UP, Rajasthan, Maharashtra and Kerala, whereas Tamil Nadu already had 100 percent growth monitoring. Availability of weighing scales went up in UP, Rajasthan and Maharashtra, contributing to an overall increase from 73.5 to 81.7 percent. Practice of weighing at birth showed overall improvement from 40.0 percent to 46.2 percent. Incidence of low weight at birth declined from 15.4 percent to 13.0 percent.

## Prevalence of underweight children by sex




*Except UP, girl children are less malnourished than male children!*

## Prevalence of underweight children by caste (0-36 months)




*In Maharashtra, ST children are more malnourished than other. No significant difference in other States*

Impact of IEC and training is evident in increased awareness of infant breastfeeding practices among AWWs. But knowledge transfer from the AWW to adolescent girls and women remains a matter of concern. However, service delivery, according to about 50 percent of AWWs who were interviewed, improved due to training in the following key areas:

- Preschool activities
- Household survey
- Immunization
- Creating awareness on health and hygiene among mothers
- Nutrition education to adolescent girls

The study suggests the following areas for improvement:

1. Effective convergence of ICDS with health services to ensure complete antenatal care of all pregnant women;
2. Strategizing IEC interventions to remove cultural barriers in infant feeding practices, especially in exclusive breastfeeding;
3. Deworming of children;
4. IFA supplementation;
5. Awareness generation on health and nutrition issues among the target groups; and
6. Specific training of AWWs for effective service delivery.

## District Primary Education Program (DPEP) evaluations – Findings on ECE and ICDS

A presentation by Dr. Venita Kaul, Senior Educational Specialist, South Asia region, World Bank

The DPEP (District Primary Education Program) aims at qualitative improvements in primary schooling, and expanded access, especially for socially disadvantaged groups. Two concerns for DPEP were that girls often stay out of school to care for younger siblings; and children from disadvantaged homes often come to primary school without experiential or cognitive readiness. Objectives of ECCE (Early Childhood Care and Education) in DPEP were – facilitating participation of older out-of-school girls through provision of surrogate sibling care; and provision of a foundation to children aged 3-6 years to help them develop school readiness.

A convergence model was designed under DPEP, the major feature being relocation of ICDS centers (AWCs) to primary schools. AWC centre timings were synchronized with schools to facilitate girls' education. Additional honorarium, ECCE training and training materials were provided to AWWs and helpers, and planned learning activities for children to ensure school readiness.

Evaluation of the convergence model was conducted in four states – Uttaranchal, Bihar, UP and AP – and indicated qualitative improvement in AWCs, better learning and play environment, enhanced achievement and confidence levels, better hygiene, and better participation of girls due to sibling care facility and security in school due to presence of female workers.

However, negative aspects of the convergence model included neglect of under-3 components in AWWs' schedules, requirement of double nutrition and space for sleeping, and overcrowding due to more than one AWC being relocated to one primary school. Convergence was found to be weak at district and block levels. ICDS ownership of DPEP model was weak, and sometimes the school head would hand over grades I and II to the AWW.

The main conclusions from this study were that the convergence model has better potential for ECCE for 3-6 year olds compared to the habitation-based model, provided there is a separate dedicated worker or para-teacher, separate room and space for play, school location at walkable distance from habitation, a well-planned schedule for additional hours with corresponding outcome monitoring, induction and refresher training for ECCE workers, joint orientation for heads, supervisors and Child Development Project Officers (CDPOs) with clearer role definitions, and extension of mid-day meals and school health programs to cover children aged 3-6 years.

These findings raise a very important question – Can the revised ICDS framework address the priorities of both age groups by providing two separate service delivery points? One would be an AWC in habitations for children under 3 years with focus on behavior change through better nutrition and health care, early psychosocial stimulation and crèche facility. The other would be an ECCE centre fro 3-6 year olds, attached to the primary school, with nutrition and health components provided through mid-day meal and school health. All this has significant implications for ICDS program design.

## Three Decades of ICDS – An Appraisal

A presentation by Dr. AK Gopal, Director, NIPCCD

For the study, 150 ICDS projects were selected as a sample, out of 4,200 projects operational in 2000. Beneficiaries, functionaries and community leaders were interviewed – a total of over 41,000 respondents. The research indicated improvement in infrastructure, training status and educational qualifications of AWC staff.

The percentage of children aged 6 months to 3 years and 3-6 years, and of pregnant women and nursing mothers availing of Supplementary Nutrition services showed a marked increase between 1992 and 2006. The quality of supplementary nutrition has improved markedly.

The percentage of newborn children with weight less than 2500 grams declined from 41 percent in 1992 to 29 percent in 2006. Between ages 0-3 years, nutritional status improved, as shown by much less percentage of children in Grade IV, and much higher percentage in `normal' category.

Significantly more 0-3 year-old children (56.1%) are receiving health checkups in 2006, as compared to 1992 (45.9%). Percentage of children (6 months to 3 years) receiving IFA tablets has gone up from 30 percent to 59.6 percent. Percentage of children immunized (0-1 years) for BCG, measles and polio has increased.

The projects supported by World Bank have better levels of infrastructure, equipment and service delivery, as compared to regular and NGO-run ICDS centres – i.e. more functional toilets, availability of indoor and outdoor space, separate storage and cooking space, availability of weighing scale, regular health checkups, immunization services, and referral services for children.

Gaps exist for ICDS projects in terms of infrastructure, equipment and service indicators. Health checkups are not being done for 43.9 percent children aged 0-3 years, and 40.4 percent children aged 6 months-3 years do not receive IFA tablets, while 34.0 percent children are not fully immunized.

## Open Discussion

Several points were raised during the open discussion. A participant from UP raised the need for differential ICDS models across states which have wide variations in terms of size, achievement levels and specific needs. A participant from the World Food Program noted that a reinforced model, which would pay greater attention to SC and ST children, is required – since these children have higher malnutrition levels. He also emphasized the need for communities to play a greater role, for instance in actual cooking of SN items. The AWW should be the manager, and communities should be empowered to take more responsibilities.

A participant from the Synergos Institute asked the pertinent question – how do we ensure that all voices are represented at the planning stage? From Tripura, came the idea that ICDS be taken up in mission mode and implementation decentralized quickly through primary program stakeholders such as the Panchayati Raj Institutions (PRIs) and women's self-help groups (SHGs).

Chapter 4

# Redesigning ICDS: Discussions and Recommendations

The reports presented in the morning session clearly identified the need to address certain issues in ICDS:

- **Strategic choices**
  - Focus on preventing malnutrition, as early as possible, across the life cycle.
  - Greater emphasis needed on key determinants such as improving family care and health-related behaviors – infant and young child feeding practices, improving health services and hygiene.
- **Targeting**
  - Reaching poorest and most marginalized households.
  - Reaching the more crucial and vulnerable children under 3 years of age during the `Window of Opportunity', in a life cycle approach.
  - Prioritizing worst off communities/blocks/districts/states.
- **Decentralization**
  - Locally relevant flexible child care responses.

These key issues formed the basis for discussions in the afternoon session. These four themes were discussed thoroughly, and recommendations drawn up. Four working groups were formed, each of which focused on one of the following themes:

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|---|---|
| Group I - Theme 1: | New Service Delivery Options for under-3s and for 3-6 years-olds |
| Group II - Theme 2: | Supplemental Nutrition Program |
| Group III - Theme 3: | Micro-nutrient Interventions |
| Group IV - Theme 4: | Decentralization of ICDS |

## Theme 1: New service delivery options for under-3s and 3-6 year-olds

The session was chaired by Ms Alka Kala, Principal Secretary, WCD, Government of Rajasthan.

The theme covered new service delivery options in the revised national ICDS framework. The following points were addressed -

1. Need for redesigning the National ICDS Framework in the XIth Plan.
2. New service delivery options for improved child survival, growth and development outcomes, addressing separately, at village level – i) children under 3 years ii) children 3-6 years (a two-worker model, preschool centers for 3-6 year olds linked to primary schools, local women as community link volunteers, etc.)
3. How would the new options ensure covering of all under-3s for improved health and nutrition services?
   (family counseling, prioritized home visits for improved care behavior, etc)
4. How can the reduced population norms in ICDS be used for rooting ICDS more firmly in the community, reaching the poorest and most marginalized groups, through more locally responsive approaches?
5. What is different in the new package of services that will improve the quality of ICDS/ AWC – leading to better survival, nutrition, development and learning outcomes for each of the two age groups?
6. What systemic changes and mechanisms are needed in ICDS to initiate and sustain service quality improvement at different levels?
7. What changes are needed in ICDS training and capacity development for the new service delivery options to be effective?
8. Are improvements needed in management and monitoring systems for ensuring better child related outcomes?
   (e.g. an ICDS accreditation system using key child related indicators for assessment, analysis and action.)
9. What changes are envisaged in resource flows, to support decentralized quality improvement processes?

The chairperson began the discussion stating that ICDS is an extremely well designed scheme that integrates various services and that apart from WCD, no other government department takes care of women and children at the village level. Ms. Kala also mentioned the Supreme Court's revision of norms as per which every habitation is to have one AWC. In the tribal belt, there is to be one AWC for every 300 persons.

The group agreed that instead of redesigning the framework, it would be more appropriate to identify gaps and modify the existing framework based on evidence. Some concerns voiced by group members included the following:

a. The number of AWCs is not enough to meet the needs of the population;
b. Day-to-day time and activity management in ICDS is weak;
c. Service inputs in ICDS are not linked to measurable outcomes, and sometimes tasks exceed the mandate of the program objectives
d. Accountability, ownership, financial management and quality are issues of concern;
e. Space is an issue as the AWC is often cramped and an inappropriate environment for learning;
f. The nutrition element of ICDS has downgraded and the focus shifted from caring for the beneficiaries to simply distributing food; and
g. There is no mechanism through which to know about best practices in other states and learn from these.

The erstwhile two-worker model of Tamil Nadu – with selective feeding, regular growth monitoring and referral – was cited as a successful practice. Similarly, the system of decentralized training of Tamil Nadu was also referred to as a best practice (both efficient and cost-effective) worthy of study for possible replication elsewhere.

The case of Rajasthan where the Sahayogini and AWC are together managing 0-3 years-olds was also cited. A participant observed that while ICDS itself does not deliver services (health, education), it relies on coordination and convergence. Another cited the convergence model operational in Uttaranchal under DPEP, in which there is successful convergence of health, nutrition and primary school education. The use of the primary school as the location for the AWC was proving advantageous. The group agreed that the separation of nutrition and pre-school education components is a key issue to be addressed. To this extent, redesigning is required. The group also felt that ICDS is a flexible scheme in practice, though not on paper.

The following recommendations emerged from the group:

### Key conceptual issues

- A rethink of the original ICDS objective is required in the context of linking performance and outcome based budgeting, as announced by the Planning Commission.
- Accountability in terms of nutrition outcomes should be ensured.
- Child development should be dealt with in a holistic manner - health, education and nutrition; the overall integrated approach should be reflected in ICDS.
- ICDS should be reconceptualized based on manageable number of outcomes.
- Inter-linking training and implementation.
- Adolescent girls should be included among the beneficiary groups.

### Service package

- Emphasis should be laid on changing feeding behaviors – frequency, quantity and quality.
- Targeted feeding to undernourished and low growth children should be ensured.
- Emphasis should be laid on home contacts for pregnant women.
- Focus should be laid on IYCF, triple A approach and nutrition education to achieve MDG1.
- Service delivery for 0-3 years-old should focus on prevention of malnutrition.

### Convergence

- Convergence with Health departments should be enhanced in terms of immunization, ante-natal check-ups and care of low birth weight babies.
- AWC should serve as crèches for 0-3 years-old.
- Pre-school education should be provided at primary schools.
- AWC and school timings should coincide.

### Two-worker model

- Instead of one AWW, there should be two women workers – one to look after 0-3 years-old at the household level and the other for 3-6 years-old at the AWC.
- Separate premises/location should be provided to run AWCs.
- Pre-school education and nutrition should be handled by different workers.
- Service delivery points for 3-6 years-old should be kept close to primary schools.
- Financial aid to AWWs should be provided through incentives in various health programmes, such as RCH II.
- Construction of AWCs should be an integral part of central government budgeting.

### Capacity building

- Capacity and accountability of supervisors need to be strengthened.
- There is need for more formalization.
- IEC needs to be emphasized under the training component.

### Decentralization & flexibility

- Norm-based project designs should be avoided.
- State budgets for ICDS should support district operationalization and innovation.
- District models should continue to adopt the integrated framework.
- Flexibility while developing district-specific plans.

**Community**

- Systematic approach needs to be evolved to ensure community involvement in order to reach the poorest .
- For pre-school education, services of mothers and the community could be solicited.

**Monitoring & evaluation**

- Monitoring structures should involve the community.
- Outcomes need to be defined and mechanisms to capture the same developed.
- ICDS goals should be made measurable so that inputs can be linked to outputs.

**Livelihoods for behavior change**

- At grassroots level, ICDS is linked with employment issues — providing better services for workers and children.
- ICDS should create a link with livelihood opportunities that allow women to undertake breastfeeding and child rearing.

**Comments during discussion hour**

- Training for ICDS and Health should be sensitive to malnutrition as well as gender issues.
- On-the-spot training of AWWs has been tried and it is yielding good results.
- Rigorous evaluation and monitoring is required at district levels – currently it is only at central and state levels.

## Theme 2: A More Efficient and Strategic Supplementary Nutrition Program

Working Group II discussed this theme and focussed on strategies for improving home-based caring and feed behavior for under-3 children. The group was chaired by Mr. Vijoy Prakash, Commissioner and Secretary (Social Welfare), Government of Bihar.

The group discussed the following questions:

1. How to address exclusion of children, especially from ultra poor sections, who require ICDS services? What could be the new inclusion approaches?
2. What could be appropriate choice of food for under-3 and severely malnourished children? Is the current choice of SN under ICDS appropriate?
3. Can a well-chosen food bring about the desirable nutritional impact? What should be the minimum package, and how can it be achieved?
4. What changes are needed in the current SN strategy? What could be a more efficient strategy?
5. Can community groups, e.g. SHGs and PRIs, be actively engaged in ICDS? Can they help make AWW functionaries accountable? What kind

of capacity needs to be created for community action?

The group discussion began with the facilitator noting that the AWW already has too much work to do. She should be recognized as a manager, and more community inputs should be drawn in. Other participants agreed, and added that the AWW should focus on educating target groups, with an emphasis on nutritional education. If SN has to be cooked (in some areas it is pre-cooked) then the community should take over the cooking.

Components of nutrition and health education were discussed. It is important to provide education about SN for babies and for lactating mothers. Exclusive breastfeeding must be promoted for babies up to 6 months. IEC should be provided through home visits and counseling for the whole family. AWW should give essential messages about colostrum, first feed, and also complementary feeding (for children after 6 months age). Since under-3 children are not brought to the AWC regularly, home-based practices have to improve.

One participant felt that nutrition for under-3s is not a food availability issue, since families can provide the amount required from the family pot. The child, and feeding of the child, is the responsibility of the entire family, not only of the mother. Complementary feeding practices are deep-rooted, and difficult to change. Powders and packs provided under programs are usually not acceptable to communities, nor are they sustainable. Providing locally available foods as complementary feed should be encouraged – staple food of the area is the best.

SN should be different for lactating mothers, and children at different ages. Fortified foods and local foods should be provided. In Maharashtra cereal-based therapeutic food powder is given for malnourished babies, and excellent SN food recipes are coming from other states as well.

Another participant said that people need extra food packets due to lack of food security. People who are starving are unable to feed even young

children. Poor communities have limited options. AWWs should be trained to identify and provide support to such children.

Doctors too need to be sensitized and carefully trained in appropriate feeding practices for newborn and young children. Melas, camps, use of local media and advocacy methods should be used to maximise IEC outreach to the community. Mass media as well as extension education through face-to-face communication should be utilized to get relevant messages across.

There was consensus among participants on the role of the AWW as a change agent. She is "omnipresent, omniscient, superwoman and super person". AWWs also need training upgradation – refresher courses are very important and must be integrated into the system. At present AWWs are not fully trained and competent. ICDS budgets should be rebalanced to include education for home-based care. Quality of training, as well as monitoring and supervision, should be tightened.

The group made the following recommendations:

**Key Principles**

- Emphasis should be on knowledge building for improved home-based care.
- Tasks to be delegated to community – AWW to be a 'manager'.
- Two distinct cadres of functionally trained workers (for 0-3 and 3-6) should be developed.
- Food products should be different for different groups of children (0-3 and 3-6). Fortified foods and locally produced traditional foods should be used.
- Budget should be revised to include education component on home-based care.
- Double ration to be given to children in second degree malnutrition onwards.

**Children 0-3: Nutritional education and counseling**

- Nutritional counseling should lead to correct breastfeeding and complementary feeding practices.
- Mother and other family members should be provided counseling on breastfeeding and complementary feeding.
- Nutrition and breastfeeding component should be included in formative and refresher training for AWWs.
- Convergence with other departments/ programs is necessary (e.g. ensure breastfeeding and nutrition component is integrated in training curricula for doctors, ANMs (Auxiliary Nurse-Midwives), dais (traditional midwives), and for adolescent girls.
- Community role in SNP is essential (food handling & monitoring).
- AWW should only be manager. This will free up AWW to provide more education for home based care.

- The food should be a fortified food product. Specific home-based, complementary foods for 6-12 months should be identified.
- Foods should be locally acceptable, available and locally produced.
- Locally available foods should be utilized to prepare supplementary foods at the center.

**Comments during discussion hour**

- Home is the first school and families must take responsibility for young children's nutrition, but AWWs need to support families.
- Education for girls will help them take better decisions as mothers.

## Theme 3: Cost-effective Micro-Nutrient Interventions for Women, Children and Adolescent Girls in ICDS

The objective of this group was to highlight and brainstorm on solutions to eliminate micronutrient deficiencies. The group discussion was chaired by Mr. S.K. Panda, Principal Secretary, Department of Social Welfare and Social Education, Tripura.

Deficiencies in iodine, iron, vitamin A, folic acid and zinc are widely prevalent in India, and associated with a range of (often irreversible) effects. Vitamin A deficiency leads to over 330,000 child deaths every year. More than 6 million children every year are born without adequate protection from iodine deficiency disorders and may not be able to reach their true intellectual potential. About 75 percent of children under-5 and 51 percent women in the reproductive age are anemic.

The group discussion ranged over the following questions and issues: What are the successful ways to prevent micronutrient deficiencies? How best can ICDS be used to provide access to micronutrients for the at-risk groups? Are any changes needed in the strategy of providing cost-effective supplementation and fortification programs associated with the supplementary food component of ICDS? What solutions are available, tested, easily scalable and affordable?

Some efforts by developmental partners like UNICEF, WFP, CARE

and Micronutrients Initiative (MI), with state governments and ICDS, have demonstrated positive results. These include promotion of exclusive breastfeeding until 6 months of age, timely introduction of adequate complementary food, and promotion of good community-level care and feeding practices as in the Dular project, Bihar. Other successful programs include Vitamin A supplementation (with AWWs assisting ANMs in administering the Vitamin A supplements); iodized salt and double fortified salt; fortification of supplementary food such as `khichri'; fortified candies; distribution of `anuka' – a multiple micronutrient sprinkle; and use of fortified wheat flour.

The group made the following recommendations:

### Objectives

To tackle micronutrient deficiencies in the life cycle approach, the ICDS strategies should include supplementation for pregnant and lactating women, children 0-6 years of age, and adolescent girls.

### Approach

To address the issue of micronutrient malnutrition, it is important to implement interventions that offer a basket of services including:

- Supplementation
- Fortification and
- Dietary diversification

### Cross-cutting issues

- Promotion of Exclusive Breast Feeding (EBF) upto 6 months
- Adequate and timely complementary feeding (CF)

### Strategies

**A. Supplementation**

- Vitamin A (twice a year, 6 months apart for all children between 9-60 months)
- Iron and Folic Acid (daily for pregnant women, weekly for adolescent girls and children in the age group 1-3 years)

**B. Fortification**

- Iodized salt, Double Fortified Salt (DFS) and fortified wheat flour (where available) should be made mandatory in ICDS
- Mandatory fortification of supplementary food provided in ICDS:
  - Multiple Micronutrient Fortification
  - Fortified wheat flour
  - Home based fortification (e.g. fortified Anuka — MI experience with 6-24 month–olds; WFP experience in Uttaranchal)
  - ICDS fortified wheat and soya blended food (WFP experience)

- Fortified Ready to Eat (RTE): community based fortification such as Khichri, multi-candies and Mamri (MI experience in West Bengal and Gujarat)

**C. Dietary Diversification and Nutrition Education:**

Though this is already a component of the ICDS programme, there is a need to focus on locally available, affordable and accessible micronutrient-rich foods. For this the group suggested social marketing of the fortified food items.

**D. Advocacy and Awareness**

- Policy makers
- Program managers
- Local elected representatives (local self government)

**E. Special thrust on:**

a. States with poor indicators,
b. Where no programme has been taken up so far; and
c. Sharing of best practices

**F. Monitoring:**

- In addition to existing weight/growth monitoring parameters, monitoring should involve laboratory assessment of micronutrient intake.
- Mechanisms that integrate micronutrient interventions with health departments should be set up.
- Monitoring in respect of micronutrients is quite difficult. Therefore, it is important to look at what is feasible within the ambit of the ICDS.

**G. Issues of Concern**

- Convergence of ICDS with health
- Supply logistics of materials at the field level
- Provision of 'Total' funds

**H. Comments during discussion hour**

- Value of iodine component in iodized salt differs before and after cooking.
- Infants should be included in the supplementation plan. For example, syrups could be introduced in addition to breastfeeding.

## Theme 4: Is ICDS too Centralized?

Working Group IV discussed the need for strengthening decentralization of ICDS. The group was chaired by Ms. Ranjini Srikumar, Principal Secretary, Department of Women and Child Development, Government of Karnataka.

The following questions were discussed:

- What are the services that would benefit from decentralization? What are the constraints faced today?
- What level of decentralization is advisable – at state, district, block or village levels?

- Is there a decentralization model that can be replicated?
- What would be the desired linkage between the Department of Panchayat and Rural Development and ICDS?
- Is there a role for private sector or NGOs? If yes, to what extent could decentralization help effective monitoring of the NGO/private sector?
- How could decentralization lead to effective convergence between Education, RCH and ICDS programmes? Is there an opportunity to achieve economies of scale and synergy in utilizing human and other resources present at district and sub-district levels for multiple sectors/ projects?

The group discussion indicated consensus on the need for strengthening the role of states vis-à-vis the Centre, to bring in more flexibility, decentralized management and better implementation. Given the heterogeneity of malnutrition patterns observed in India, state governments should be encouraged to tailor the basic ICDS delivery model to local needs. A budget line specific to the financing of ICDS should be introduced in state budgets. States could finance innovations based on local need and micro-level planning. Decentralized management would strengthen the role of PRIs and communities, encouraging a sense of community ownership.

Given that extensive decentralization has been underway in India over the past decade, there is considerable scope for involving local elected village committees much more actively in implementing the ICDS program.

Participants from Karnataka and UP noted that among the list of discussed centralized procurement processes that lead to problems in supplying items like weighing scales, medicine kits and fortified foods. Despite a notification issued by the Karnataka government in 2001 transferring all activities to the block taluk, it has not been implemented. Karnataka is planning to enable e-tendering, so as to eliminate middlemen and allow greater transparency.

Another problem is of data management. AWWs are overburdened with maintenance of records and registers. The private sector should be drawn in for managing data at the AWC level. The AWW would then be able to use her time more effectively. This would also improve data flow and ICDS monitoring. Nutrition surveillance data could be analyzed at district and state levels.

The group agreed that recruitment of human resources is a concern for decentralization. To some extent this is already the case, as in selection of AWWs by Panchayats, on the basis of guidelines. But a participant from NIPCCD said that the NIPCCD survey found that though the guidelines are in place, they are not used in practice. A number of AWs are not residents of the village, instead they come from distances of 5 kms or more. Appointment of supervisors also needs to be rethought, as they are a weak link. They should be appointed at sub-centre level, and should be from the same area.

Mr. Negi from WCD shared that decentralization is inherent in the programme design and policies of ICDS. It is a joint enterprise involving the central government, state government, communities, and voluntary organizations/NGOs. The 73rd Constitutional Amendment on devolution of powers to the Panchayats necessitates involvement of PRIs. PRIs could supervise procurement of supplementary nutrition. Self Help Groups, mahila mandals and other village level groups could also be involved in the procurement and supply of SN.

Convergence has already been integrated into ICDS – particularly convergence with health at all levels. District Planning Committees are in place and are the mechanisms for ensuring convergence. At the village level, Bal Vikas Samities and Nutrition and Health Committees are supposed to oversee the functioning of AWCs. A participant shared CARE's experiences in convergence, citing the example of monthly Nutrition and Health Days celebrated in all CARE-supported AWCs.

As regards public private partnership, a participant shared that there was a need to involve corporates in ICDS. She proposed that private companies like Reliance be given some projects to operate within the same budget and guidelines. Learnings from their management practices may help the government in improving overall systems.

There is also scope to involve NGOs in community mobilization, and increase the participation of communities in the operation and monitoring of ICDS.

The current government model has several constraints in terms of fund flows, monitoring, training etc. It is usually a low priority department for the state government.

One participant suggested the mission mode approach such as used by SSA, NRHM etc, be used for ICDS. There would be a national mission with state and district missions. It would mean faster transfer of funds, greater accountability, and better procurement.

The following recommendations emerged from the group:

**Key Strategies**

- Customized local planning
- Public private partnerships for improved mobilization, management practices and accountability
- Increased role of community committees in planning and monitoring

**Scope of Decentralization**

- Procurement to be decentralized
- Data Management to be decentralized
- Human Resources appointment and reporting/accountability to be locally managed

**Approach**

- Convergence between different departments at ground level
- Understand existing policy and use it at its best
- Mission mode

**Comments during discussion hour**

- Community involvement in crucial for improvement of ICDS services. This could focus on involving mothers, SHGs, parents, or PRIs – the approach should be flexible
- PRIs might not always be sensitive but it is worthwhile involving them. There are many women in PRIs, they could be involved
- AWWs are the fulcrum of ICDS. Plans are afoot to enhance their honorarium so that remuneration for their work is more honorable and fair.
- Habit of thinking and acting should be encouraged at the local level, this will result in marked improvements.

Chapter 5

# The Way Forward


A broad consensus on key issues emerged during the day-long consultation. The consultation brought together the collective wisdom of the Indian central and state governments and key developmental partners, for assessing and redesigning ICDS. The discussions were based on concrete experiences, and assorted research findings.

Strong consensus emerged about the potential of ICDS, as well as need for focused changes. Decentralization and greater flexibility call for urgent attention in the wake of the second phase expansion and demands of the expanded program. Innovations need to be shared across states so as to facilitate wide replication. Service delivery must be realigned to meet the nutritional needs of the most vulnerable groups. Micronutrient deficiencies need to be urgently addressed through scaling up already existing models. Supplementary nutrition programs should have a dynamic IEC focus so as to impact home-based feeding patterns and effect appropriate behavior changes. Capacity building needs to be undertaken with a focus on supporting AWWs to learn and transmit nutrition-related messages to target groups. Overall, more attention has to be paid to high-malnutrition districts and socioeconomic groups.

Ms. Reva Nayyar noted that the accent of ICDS should be on locally devised programs, rather than central control. Most decisions should be left with local authorities and stakeholders. Enhanced community ownership will come about when responsibilities and resources are shared with communities. Home-based care has to be improved through counseling and education interventions. She noted that while the recommendations being made for changes in ICDS are indeed ambitious, at the same time they are certainly desirable.

Mr. Chaman Kumar noted that some recommendations are already in place, but need to be activated. District level monitoring and identification of high-

malnutrition blocks need to be systematically undertaken. So also monthly sector meetings with AWWs and supervisors, for review and planning.

According to Dr. Peter Berman, a number of cross-cutting points were raised by the four thematic groups, reflecting common understanding that can be taken further. This meeting has taken stock of the current situation, discussed common interests and questions, and indicated that it is possible to find the answers.

The consultation brought together many points of view from different partners and stakeholders. Many rich ideas emerged. Fresh approaches and new ways of thinking were very much in evidence. The next step will be to draw out these ideas out and integrate them into a new framework for action – a revised ICDS program.

**Key Issues**

**Strategic choices**

- Preventing malnutrition as early as possible, in the life cycle
- Improving family care and health-related behavior

**Targeting**

- Poorest and most marginalized households
- Most vulnerable under-3 children
- Worst off communities/ blocks/ districts/ states.

**Decentralization**

- Local relevance and flexibility

**Key recommendations**

- Focus ICDS service delivery for under-3s on prevention of undernutrition
- Ensure accountability in terms of nutrition outcomes
- Develop two distinct cadres of functionally trained workers (for 0-3 and 3-6)
- Enhance convergence with health department for care of underweight babies, etc
- Encourage community involvement to reach most vulnerable children groups
- Offer a basket of services to address micronutrient malnutrition, including supplementation, fortification, dietary diversification and nutrition education
- Promote optimal home-based care, breastfeeding and complementary feeding practices through nutrition education and counseling of mothers and families
- Build a special thrust on states/blocks with poor indicators
- Encourage customized local planning and management
- Introduce decentralization in procurement, data management, human resource appointment, reporting and monitoring
- Enhance role of community committees in planning and monitoring

## Annexe 1: Consultation Agenda

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|---|---|
| **12.00 am - 01.30 pm** | **Session I - Findings from recent evaluations** |
| Session chaired by | Mr. Julian Schweitzer, Sector Director, South Asia Human Development Sector, World Bank |
| | India Report Highlights by Dr. Michele Gragnolati, Sr. Economist, South Asia Human Development Sector, World Bank |
| | WCD/ICDS III Baseline and Endline Evaluations by Ms. Saroj Adhikari, Asst. Director, Ministry of Women and Child Development, Government of India |
| | DPEP Evaluations - findings on ECE and ICDS by Ms. Venita Kaul, Sr. Education Specialist, South Asia Human Development Sector, World Bank |
| | NIPCCD/ICDS Evaluation 2006 by Dr. A.K. Gopal, Director, NIPCCD |
| | Open discussion |
| | Planning for group work by Dr. Michele Gragnolati, World Bank |
| 2:15 - 2:45 pm | Break for lunch |
| **3:00 pm** | **Session II - Group Work** |
| ***Group I:*** | ***Need for a revised National ICDS Framework - new service delivery options (address 0-3 year old and 3-6 year old separately at the village level)*** |
| Chaired by | Ms. Alka Kala<br>Principal Secretary<br>Department of Women and Child Development, Rajasthan |
| **Group II:** | ***A more efficient and strategic supplemental nutrition program that improves home base caring and feeding behaviors for under threes*** |
| Chaired by | Mr. Vijoy Prakash<br>Secretary<br>Social Welfare Department<br>Government of Bihar |

| | |
|---|---|
| **Group III:** *Cost effective micro-nutrient interventions program* | |
| Chaired by | Mr. S. K. Panda, Principal Secretary<br>Department of Social Welfare<br>Government of Tripura |
| **Group IV:** *Is ICDS too centralized?* | |
| Chaired by | Mrs. Ranjini Srikumar<br>Secretary<br>Department of Women and Child Development<br>Government of Karnataka |
| | Presentation of recommendations by the groups |
| 3:45 - 4:00 pm | Tea/coffee break |
| **4:00 - 5:45 pm** | **Session III - Way forward** |
| Session chaired by | Ms. Reva Nayyar<br>Secretary<br>Women and Child Development<br>Government of India |
| | Open discussions and consensus building on new directions for ICDS based on recent findings and group recommendations |
| | Summing up the key recommendations by TBD |
| Vote of thanks by | Mr. Peter Berman<br>Lead Economist, Health<br>Human Development Sector, World Bank |
| 5:45 - 6:00 | Break for tea/coffee |

## Annexe 2: List of Participants

Renuka Chowdhury
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(Independent Charge)
Ministry of Women and Child
Development
Government of India

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Ministry of Women and Child
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Chaman Kumar
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