Report of the Inter Ministerial Group on ICDS Restructuring

Chaired by
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Table of Contents

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Foreword

India is home to the largest number of young children in the world - nearly every fifth young child in the world lives in India. These early years are the most crucial years – because their impact lasts a lifetime. This is the time when there are the greatest risks to survival, healthy growth, development and vulnerability to a vicious cycle of malnutrition and disease /infections. But these years are also a time of rapid growth and development – an opportunity, in which even small investments can bring cumulative lifelong benefits, across the life cycle, especially for the most deprived children and community groups, which include diverse socio religious communities such as Scheduled Castes, Scheduled Tribes and religious minorities, among others. These are the years when the foundation is laid for physical, cognitive, emotional, social and linguistic development – for cumulative lifelong learning and human development. Early childhood interventions emerge as the natural entry point for more inclusive growth of nations and as an effective way of breaking an intergenerational cycle of multiple deprivations - of undernutrition, poverty, exclusion and gender discrimination.

Reaching out to about 8 crore young children under 6 years of age and 1.8 crore pregnant and breastfeeding mothers through a network of 12.96 lakh operational anganwadi centres across our country, Integrated Child Development Services (ICDS) is today the world's largest community based outreach programme for early child development. Enhancing the impact of this programme on child related outcomes is a major challenge.The restructuring of ICDS, recognised as a key priority in the Eleventh Plan, was recommended in the Multistakeholder Nutrition Retreat anchored by the Planning Commission in August 2010 and decided upon in the first meeting of the PM's National Council on India's Nutrition Challenges, chaired by the Prime Minister on 24 November 2010. An Inter Ministerial Group on ICDS Restructuring was mandated subsequently in June 2011to draft a comprehensive ICDS Restructuring proposal, while also considering the recommendations of the National Advisory Council regarding ICDS Reforms and Strengthening.

The deliberations of the Inter Ministerial Group provided valuable insights and enriched the multisectoral perspective of ICDS Restructuring. This also enabled harmonisation of the contours of policy reform, as emerging from various initiatives anchored in the emerging Twelfth Plan strategy, such as the draft National Food Security Bill, the High Level Expert Group on Universal Health Coverage and the B.K. Chaturvedi Committee on Restructuring Centrally Sponsored Schemes. Based on the deliberations of the Inter Ministerial Group on ICDS Restructuring and its Drafting Group, the Final Report of the Inter Ministerial Group was submitted to the Prime Minister's Office in September 2011. The ICDS Restructuring submission of the Ministry of Women and Child Development was then formulated, suitably incorporating these recommendations. Currently this submission is under consideration.

Recognising that there are both programme design and programme implementation gaps in ICDS- the Report of the Inter Ministerial Group on ICDS Restructuring creates new paradigms both for "What" would be different and "How " could things be done differently. Adopting a life cycle approach to early childhood care and development, Anganwadis would be transformed as vibrant, child friendly ECD centres which will ultimately be owned by women in the community. The strategic shift in "What" is the focus of a restructured ICDS on

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the critical age group - pregnant and breastfeeding mothers and children under three years, for enhanced early child development and nutrition outcomes, in a life cycle continuum. Preventive approaches will ensure significant and accelerated reduction in maternal and child undernutrition levels on a large scale, linked to improved health care, safe drinking water, sanitation and hygiene practices.

Undernutrition compromises children's development potential and preventing it in young children is an integral part of promoting their development and active learning capacity. More than 80 % of brain development is already complete by the first three years of life and the quality of nurturing impacts upon this significantly. The achievement of early development and learning outcomes therefore requires a holistic approach which addresses children under three years with care for development and developmentally appropriate early learning approaches for three to six year olds. This includes school readiness interventions for children five to six years old, linked to Sarva Shiksha Abhiyan.

The important difference in how things will be done differently is decentralisation, with flexibility in implementation, for ICDS to respond effectively to the needs of local communities- especially women and young children. Decentralisation centres on the leadership of Panchayati Raj Institutions and Urban Local Bodies, with effective devolution of powers. Women panchayat members have strong potential to be prime movers of social change for young children. Panchayats are also the natural platform for ensuring convergence with other flagship programmes such as the National Rural Health Mission, Sarva Shiksha Abhiyan, Total Sanitation Campaign, National Rural Drinking Water Programme and the Mahatma Gandhi National Rural Employment Guarantee Scheme. Increased mobilisation, ownership and support of women's groups, mothers' committees, volunteers and communities are integral to this paradigm shift in the implementation framework. Strengthened partnerships with civil society and voluntary agencies have also been envisaged.

The formulation of this Report has been an enriching process which brought together many voices from the field and diverse perspectives from across a wide spectrum of stakeholders. I extend my appreciation to all of those who have shared insights and contributed to this Report- especially all the members of the Inter Ministerial Group on ICDS Restructuring. The valuable contribution of the members of the Drafting Group is especially recognised - the former Secretary MWCD Mr. D.K.Sikri, Joint Secretary MWCD Dr. Shreeranjan, Joint Secretary PMO Mr.L.K.Atheeq and from Planning Commission Senior Adviser WCD Ms. Vandana K. Jena and Officer on Special Duty (WCD and Nutrition) Ms. Deepika Shrivastava.

The vision for ICDS Restructuring that has emerged is rights based – one that reaffirms the indivisibility of children's rights to survival, development, protection and participation. It acknowledges that integrated interventions for health, nutrition, cognitive and psychosocial development have proven to be more effective than stand alone interventions. The Report reminds us that it is our collective responsibility to ensure that children's rights to survival and to achieve full development potential, free from discrimination, in nurturing and protective environments- are fulfilled urgently – now.

For, to take from Gabriela Mistral –
Children cannot Wait. To Children, we cannot say Tomorrow- Their Name is Today.

Syeda Hameed

(SYEDA HAMEED)
26th April, 2012

Report of the Inter-Ministerial Group on ICDS Restructuring
(Under the Chairpersonship of Member, Planning Commission In-Charge of WCD)

I. BACKGROUND

More Inclusive Growth Begins With Young Children

There is consensus that the early years are the most vulnerable period - when there are the greatest risks to survival, healthy growth, development and vulnerability to a vicious cycle of malnutrition and disease/infections. The prenatal first three years are critical for preventing undernutrition, especially in India where levels of undernutrition remain persistently high, 40 % of children under 3 years are undernourished and 79 % are anaemic - undermining their survival, development potential and active learning capacity.

These early years are also the most crucial years – because their impact lasts a lifetime. More than 80 % of brain development is already complete by the first three years of life and the quality of nurturing impacts upon this significantly. These years are a time of rapid growth and development – an opportunity, in which even small investments can bring cumulative lifelong benefits, across the life cycle, especially for the most deprived. These are the years when the foundation is laid for physical, cognitive, emotional, social and linguistic development – for cumulative lifelong learning and human development. Early childhood interventions emerge as the natural entry point for more inclusive growth and as an effective way of breaking an intergenerational cycle of multiple deprivations -of undernutrition, poverty, exclusion and gender discrimination.

Integrated Child Development Services (ICDS) in India

ICDS is today the world's largest community based outreach programme for early child development, reaching out to over 7.5 crore young children below 6 years of age (around half of the total of 15.88 crore), around 1.67 crore pregnant and breastfeeding mothers through 6722 projects and a network of 12.6 lakh operational anganwadi centres across the country. Over 25 lakh Anganwadi Workers and Anganwadi Helpers (community based local women child care workers/helpers) constitute the core of these services and have the potential to be prime movers for social change –along with ASHAs, ANMs, teachers and women members of panchayati raj institutions. ICDS is the critical link between children and women and with the primary health care and elementary education systems. It also provides a protective environment for young children- including care and protection of the young and adolescent girl child.

Emerging Issues: Design, Implementation and Resource Gaps

ICDS has witnessed unparalleled expansion over the last three decades, with the larger part of expansion (more than 50%) having taken place post 2005. The programme has evolved and been enriched by innovations in different areas and components and is poised for universal coverage reaching 14 lakh habitations during the Twelfth Plan. However while the ICDS Scheme has been well conceived, there is need for comprehensive programmatic, management and institutional reforms. These relate to enhancing nutritional impact, reaching the child under three years in the family and community, changing caring and feeding behaviours in the family, reaching the most deprived community groups, responding flexibly to local needs for child care, responding to community demand for early learning, increasing ownership of Panchayati Raj Institutions and achieving an optimal balance between universalisation and quality. A major challenge lies in implementation gaps that arises out of inadequate resource investment, inadequate funding, lack of convergence, lack of accountability of those managing and implementing the programme, especially, at the level of anganwadi centres and supervisory level, lack of community ownership and the general perception about ICDS being a "feeding" programme and not an Early Childhood Development programme.

Implementation experience and evidence from innovative models indicates that if the above issues and inadequacies are addressed appropriately, ICDS has the potential to ensure satisfactory nutritional and child development outcomes. The proposed strengthening and restructuring of the ICDS Scheme

has been designed to address these concerns. The restructuring shall have to be concomitant with and should also undertake transformation of ICDS into the Mission Mode, with flexibility in implementation along the lines of Sarva Shiksha Abhiyan (SSA) and the National Rural Health Mission (NRHM), building on lessons learnt from their implementation experience.

The Mandate: Restructuring Integrated Child Development Services

Strengthening and restructuring of Integrated Child Development Services (ICDS) scheme to accelerate improvement in nutrition and child development outcomes is a long-felt and well recognized need, also reflected in the Mid Term Appraisal of the Eleventh Plan. The Prime Minister's National Council on India's Nutrition Challenges which met on November 24, 2010 decided to strengthen and restructure ICDS, with special focus on pregnant and lactating mothers and children under three years, with strong institutional convergence and to provide flexibility for local action and empower mothers in particular and the community in general to have a stake in the programme. The National Advisory Council (NAC) also made recommendations for a reformed and strengthened ICDS, adopting a genuinely integrated life cycle approach to early childhood care and development and transforming AWCs into vibrant, child friendly ECD centres, to be ultimately owned by women in the community.

Taking the above and various other consultations into consideration, the Ministry of Women and Child Development evolved a comprehensive proposal on ICDS Strengthening and Restructuring. This was informed by the discussions during two meetings of the Inter Ministerial Group on ICDS Restructuring, held on 12th July 2011 and 28th July 2011. **(Minutes of these meetings are at Annex-I).** An updated version of the comprehensive proposal incorporating broad agreements reached was shared with Planning Commission on 2nd August 2011 **(Copy at Annex – II).** This report is the essence of the same.

II. ICDS STRENGTHENING AND RESTRUCTURING

Monitorable Outcomes of ICDS Restructuring

ICDS Restructuring aims to achieve three monitorable outcomes:

By the end of the Twelfth Five Year Plan (2017)-

- Prevent and reduce young child undernutrition (% underweight children 0-3 years) by 10 percentage points.
- Enhance early development and learning outcomes in all children 0-6 years of age.
- Improve care and nutrition of girls and women, and reduce anaemia prevalence in young children, girls and women by one fifth.

Together with the implementation of other decisions of the PM's National Council (Multisectoral Maternal and Child Nutrition programme in 200 high burden districts, nutrition focus in sectoral programmes and Nationwide IEC campaign), ICDS Restructuring will contribute to achieving the Twelfth Plan Monitorable Targets.

These outcomes would also contribute to reduction in IMR and MMR, incidence of low birth weight in convergence with health and improved care and nutrition of adolescent girls in convergence with the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls and the National Rural Health Mission. The second outcome will also contribute to increased enrolment, retention and learning outcomes in elementary education, in convergence with SSA. Together this will contribute to more inclusive growth. Some of the key indicators are given in **Annex 1D**.

In order to achieve the above monitorable outcomes the following reforms will be undertaken mainly as new initiatives to transform and energise the ICDS system-

(i) Programmatic reforms

The major features include-

- **Repositioning the AWC as a vibrant, child friendly ECD centre (Baal Vikas Kendra) which will ultimately be owned by women in the community.** This will have expanded /redesigned services, extended duration (6 hours), with an additional AWW initially in 200 high burden

districts and with piloting of crèche services in 5 % of AWCs. (Greater ownership of women and communities would also come with institutional reforms that include Anganwadi Management Committees, which include mothers /mahila mandals /parents as members, empowered with untied funds for local action). AWCs would function as the first village outpost for health, nutrition, early learning and other women and child related services. This would include provision of adequate infrastructure (4 lakh AWC buildings), facilities such as safe drinking water, toilets, hygienic SNP arrangements, wall painting, play space & a joyful learning environment including provision for activity corners, and anchoring of other services for maternal, child and care for out of school adolescent girls through the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls. Evidence that the improvement of ICDS infrastructure and facilities would improve the functioning of AWCs and child related outcomes is provided by the NCAER Evaluation of ICDS (May 2010), supported by the Planning Commission. This revealed that ICDS has the potential of contributing to a reduction in mortality, improved child nutrition status (increased weight for age in children) and a favourable impact on reducing malnourishment. Coverage could be enhanced by strengthening the quality of spending, infrastructure, human resources and convergence of services in ICDS. The study report stated that one of the most important pre-conditions for success of the ICDS programme is the adequacy of infrastructure of the AWC and that "this deficiency has adversely affected the quality of delivery of services and hence impact of ICDS".

- **Re-designing & reinforcing of the package of ICDS services, including a new component of Child Care and Nutrition Counselling for mothers of children under three years**. (Details at Annex - IA). This will focus on regular and prioritised home visiting at critical contact points, improving Maternal Care and Nutrition, Infant and Young Child Caring and Feeding Practices, especially optimal breastfeeding, preventing growth faltering and the early onset of malnutrition and promoting care for development. (The roles of AWW/ASHA/ANM are being redefined jointly to reflect this accordingly). Skilled interpersonal counselling will be complemented by the development and implementation of National/State Communication strategies for improved Maternal and Child Care and Nutrition. Communication for Behaviour Change strategies will support improvements in key family care behaviours- Infant and Young Child Feeding, health, hygiene, psychosocial care and care of girls and women.
- **Enhancing Nutritional Impact** with revised nutrition and feeding norms; cost indexation of Supplementary Nutrition (SNP); ensuring provision for Nutritious freshly cooked, culturally appropriate meal, (morning) snack and THR as per norms, guidelines and legislation, and greater involvement of women's SHGs. Piloting of community kitchens and joint kitchens with Mid Day Meals will also be undertaken. A focus on early preventive action in a public health perspective will be promoted by reaching pregnant and breastfeeding mothers and children under three years more effectively in the family and community. A continuum of care will be promoted across the life cycle, extending from care in the family, in anganwadis and communities to health sub centres and health facilities. An innovative new component is SNEHA SHIVIRS for promoting community based prevention and care of severely undernourished children, backed by stronger referral linkages with health. This includes 12 day Nutrition Care and Counselling Sessions at AWCs for mothers of undernourished children, using positive role model mothers/peers whose children are growing well, for demonstrating and promoting optimal caring and feeding behaviours (Learning By Doing) (Details at Annex 1 A).
- **Strengthening Early Childhood Care and Education (ECCE)** by redefining ICDS non formal pre school education to ECCD, with additional and trained human resources, introduction of a developmentally appropriate curriculum framework with joyful learning methodologies. This will be supported by the use of local culturally relevant play/activity materials, AWC activity corners and local toy banks in child friendly AWC environments. Joyful early learning approaches will be promoted - for children 3-6 years of age, including school readiness interventions for children 5 plus years of age, either in AWCs or in schools (depending upon the state context). Colocation of ICDS AWCs with schools where locally decided, will enable resource sharing, mentoring of AWWs and better school readiness and transition. This component will be based on a new ECCE policy, training and curriculum framework, which is evolving through a Core Committee including both MWCD and MHRD,which will improve the quality of early learning and its

continuum across families, anganwadi centres and schools. In 200 high focus states/districts, ECCE activities will also benefit from additional AWWs.

- **Convergence with flagship programmes will be strengthened** through expanding coverage of Monthly Fixed Village Health and Nutrition Days (with NRHM) and introduction of Monthly Fixed Village ECCE Days (with SSA and TSC), strengthening local community participation and contribution of local play/activity material, toy banks, activity corners and ECCE demonstration. (Such innovative approaches have been experimented with in some projects in Tamil Nadu, Karnataka and Rajasthan).
- **Community Mobilisation and Monitoring** will be strengthened through village contact drives, involvement of women's groups, mothers' committees, women link volunteers and flexi/untied funds to empower local communities and panchayats for action. Community based monitoring will be done through the universal roll out of the ICDS NRHM Mother and Child Protection Card, which is kept by the family. Using the card, which incorporates new WHO child growth and development standards, the Mother –Child cohort (pregnancy- 3 years) will be tracked jointly by AWWs/ASHAs/ANMs. Monthly growth monitoring of all children under three years and quarterly growth monitoring of all 3-5 year olds will be done at Monthly Fixed Village Health and Nutrition Days, with the active participation of Village Health, Sanitation and Nutrition Committees, recognised as sub committees of panchayats. Through this process, families and communities can monitor the nutrition status of children under three years, key care practices, access to and utilisation of services. Community based validation processes are also envisaged.
- **Options for flexibility and additional services** such as intensive activities in high focus / high burden states/districts, crèches in 5 % AWCs will be provided based on State/ District Programme Implementation Plans. Convergence with MGNREGA will be strengthened for supportive child care provisions.

(ii) Management Reforms

- **Decentralised programme planning, management and monitoring systems, with a results framework and flexible architecture**: Programme design will now be more locally responsive; with the introduction of outcome oriented Annual Programme Implementation Plans (APIPs), within a flexible normative framework, at state level, progressively later at district levels, moving towards village habitation based planning. The use of simplified community level key indicators for community based monitoring and action and incentivisation for achieving results will be complemented with awards for states /districts and panchayats, like Nirmal Gram Puruskar.
- **Improved Human Resource Management for Women and Child Development**: Enhanced professional, technical and administrative support personnel will be provided at national /state /district /block levels and empowered for delegated actions. States will be encouraged to create a dedicated cadre for ICDS with a long term human resources policy. This will include strengthening motivation, recognition and pathways for development for AWWs, rationalising workload of AWW and redefining roles of AWWs/ ASHAs/ ANMs. Additional AWW / nutrition and child care counsellor / ECCE worker will be introduced initially in 200 high burden districts. Additionally other options of incentivised ASHA /youth/ women link community volunteers may be taken up in all states, based on the state context and requirements.
- **Training and Capacity Building** to ensure professional child development services and local level support for strengthening community organizations, PRIs, women's groups /mothers' committees, with flexibility to states. Systems and mechanisms for effective decentralised planning, management, quality improvement and monitoring of ICDS training will be introduced including National/State ICDS training Task Forces supported by thematic groups and technical support groups, with Voluntary Action Groups and NGOs mentoring support at field level.
- **Strengthening civil society partnerships for operating upto 10% of the ICDS projects** with these models contributing to innovation, component enrichment, quality improvement, extending reach to unreached areas and better responsiveness to local contexts. Flexibility will be provided to States to decide upon this, as reflected in State Annual Programme Implementation Plans.
- **Increased public accountability by strengthening the role of PRIs, urban local bodies** and village level functionaries in overseeing AWC functioning - Village Health Sanitation and

Nutrition Committees (VHSNCs) as Sub-committee of PRIs to be actively engaged in the management and supervision of the ICDS programme and Anganwadi Management Committees to be linked with the VHSNC; giving greater powers/ responsibilities and resources to Panchayats for addressing women, child care and nutrition.

- **Ensuring convergence with related sectors such as NRHM, TSC, NRDWP, SSA MGNREGA** through joint planning, inclusion of young child related concerns in State/District Annual Programme Implementation Plans (APIPs) of relevant sectors, joint monitoring of key results and indicators and defined roles and accountabilities. Institutional mechanisms for convergence, anchored in panchayati raj institutions such as Village Health Sanitation and Nutrition Committees at village level will be strengthened and forums such as Fixed Monthly Village Days at AWCs will take this forward. Resources of other programmes will also be mobilised for AWC construction and up gradation. Specifically with NRHM, roles of the frontline worker team, coterminous areas, dual reporting and shared cluster level networking and mentoring support for frontline worker teams will be jointly evolved. Colocation of schools and AWCs where locally feasible, will enhance the early learning continuum and school transition.
- **Strengthening of ICDS Management Information System (MIS):** This would be revamped to focus on real time data for assessment, analysis and action, closest to the level at which data is generated, using Information Communication Technology (ICT) and the reach of mobile telephones. The use of Mother Child Cards for growth monitoring, with transparent community validation at Village Health and Nutrition Days and community owned accreditation processes, with the active involvement of VHSNCs and women's /community groups will be a key feature.
- **Improved Financial Management Systems**, with linkages to outcomes and social audits will be introduced, allocating adequate financial resources and providing untied funds with empowerment for local action. Performance linked funding such as incentives to better performing districts through additional flexi fund (as specified) will also be evolved.

(iii) Institutional Reforms

Institutional Reforms aim at transforming ICDS into a "Mission Mode" decentralised programme with a flexible implementation framework with monitorable outcomes for improved effectiveness, efficiency and accountability. The emphasis is on reinforcing the AWC as a village habitation level institution owned by the community, with the leadership and support of panchayati raj institutions. ICDS Restructuring seeks to empower states /districts /blocks and villages to contextualise the programme and find innovative solutions, building on local capacities and resources, with concomitant support for capacity development, innovation, social mobilisation, communication and community based monitoring. This empowerment would come through State /District /sub district Plans, based on local needs, with structures and mechanisms that give a voice to the beneficiary group through Anganwadi Management Committees at habitation level, linked to Village Health, Sanitation and Nutrition Committees, which are sub committees of panchayats. The Mission Mode would include-

- **ICDS Missions at National, State and District levels with structure and systems,** enhanced human and financial resources, empowered for action with clearly laid down systems for financial, human resource, logistics and procurement, programme and operations monitoring. The existing service delivery mechanisms will be strengthened through setting up of a National/State ICDS Mission Directorates, Technical thematic groups State & District Child Development Societies with coordination and monitoring committees at block, village and anganwadi levels.
- **National Mission Steering Group (headed by Minister I/C WCD) and Empowered Committee** with delegated authority. Adequate human and financial resources will be provided with decentralized powers for decision making. An overview of the proposed institutional arrangements under the ICDS Mission is given at **Annex – IC.** The same arrangement would function for Nutrition coordination as well and report to the PM's National Council on India's Nutrition Challenges. A Policy Coordination Support Unit in Planning Commission will provide multisectoral policy coordination support to the same.
- **Memorandums of Understanding between Central/ State governments, and APIPs** with agreed state specific monitorable outcomes for preventing under nutrition, promoting early child

development; milestones of achievement and shared policy, programme and resource commitments.

- **Capacity Development** will include setting up of National /State ICDS Mission Resource Centres, professionalisation of technical and management support at different levels, linking service delivery and training resources through the mission, interstate and inter district sharing of innovative models /best practices and learning. Further high performing districts will be treated as "Living Universities" – for learning by other districts; with an enriched and extended network of training resources and inter sectoral teams. Civil society partnership is envisaged for content and process enrichment and mentoring support at field level for decentralised planning.

WHY ICDS IN MISSION MODE- LIKE NRHM&SSA

- Time bound goals and outcomes
- Results based monitoring of indicators at different levels
- Decentralised planning -State, district, block, and village habitation levels
- States' ownership and local solutions
- Leadership and centrality of PRIs
- Bringing together different sectors
- Induction of professionals, voluntary action
- Normative approach and addressing gaps as per standards- entitlements
- Empowerment for local action
- Greater participation of women's SHGs, mothers' committees
- Partnerships with community based organisations and voluntary agencies

- **Powers will be devolved to Panchayati Raj Institutions and Urban Local Bodies.** Training, capacity development of PRIs, especially women members and members of VHSNCs will be supported, with need based catalytic support from NGOs at field level. Flexible innovative child care service delivery options will be promoted with upto 10% of the projects earmarked for civil society participation- within a normative framework.
- **Community ownership of ICDS** will be ensured through the common Village Health, Sanitation and Nutrition Committees and the AWC Management Committees. Involvement of women SHGs, Mothers' Committees/ women link volunteers will also be promoted in order to deepen community ownership of ICDS. Initiatives for extending and deepening the involvement of women's SHGs in ICDS, including in the Supplementary Nutrition component, will be promoted, in convergence with Rural Development.
- **Community owned ICDS accreditation system** to ensure quality standards in child care service delivery at all levels, with grading of AWCs, sectors, block/projects, districts, based on child related outcomes, using a checklist based on service standards. This would be reinforced by community based recognition and awards for child friendly Anganwadi Centres, Panchayats, blocks and districts.
- **High Focus/ High Burden States /Districts** will receive focused attention, addressing the higher burden of the challenges and development deficits, with intensified activities. Progressively, District ICDS Programme Implementation Plans would be a major instrument for decentralized and convergent planning, implementation and monitoring, supported by strong community empowerment processes. Gap filling needs at local levels using flexi/untied funds will be considered against defined service norms or entitlements.
- **Public Accountability, Reviews and Evaluation**, including real time data dissemination and use for action, regular mission reviews with participation of civil society /voluntary action groups, public information using service standards, citizen's charters- social audits, public hearings, with greater transparency and accountability. Operations Research, base line assessments, mid term, concurrent and end line evaluation will be undertaken.

IV. FINANCIAL RESOURCES

Enhancing Financial Resources: ICDS is an ongoing Centrally-sponsored programme being implemented through the State Governments / UT administrations based on a cost sharing basis

between the Central Government and the State Government. The proposed financial allocations under the ICDS Mission would be as under:

I. ***Operational Cost:*** The operational cost of ICDS implementation in Mission Mode at National, State, District, Block / Project and Village levels works out to be Rs. 1,65,315 crore for five years with the cost for 2012-13 being Rs. 37,824 crore. Besides the staff salary and honorarium, it will include recurring expenses, such as rent, travel allowances, administrative expenses, and funds for advocacy and public education, training, research, contingencies for AWW, preschool material, information education material and medical kit.

II. **Proposed Budget:** An average annual GoI share of about Rs. 35,000 crore and total requirement for the 12th Five Year Plan, i.e., Rs. 1,83,778 crore would be required for effectively implementing ICDS in Mission Mode to achieve the above mentioned goals and objectives. A detailed summary sheet with cost break up of non-recurring and recurring expenditure is given below.

ICDS Mission - Average Annual Requirement (Rs in Cr)				
S.No.	Major Heads	GOI Liability	State Liability	Total
1	Recurring	30,776	12,641	43,417
2	Non recurring	3,641	1,227	4,868
	Total	34,417	13,868	48,285
SI. No.	Recurring Budget Heads	Annual GOI Liability	Annual States Liability	% of Total Recurring budget (GOI Liability)
1	Honoraria	9,411	1,046	30.58
2	SNP (GOI share)	10,151	10,151	32.98
3	Salary	5,997	666	19.49
4	ECCE	926	103	3.01
5	Others*	508	75	1.65
6	Rent	818	91	2.66
7	PSE & Medicine kits	745	83	2.42
8	Flexi Fund + Uniform	301	33	0.98
9	Untied fund including Creches	755	265	2.45
10	Monitoring	326	36	1.06
11	Training (including IYCF training cost of Rs 358 Cr & ECCE trg cost of Rs 151 Cr for 5 years)	325	36	1.06
12	Purchase, Hiring, POL & Maintenance	200	22	0.65
13	IEC & Advocacy (Including IYCF activities @Rs 32 Cr per annum at project level)	219	24	0.71
14	Sneha Shivirs	94	10	0.31
	Total	30,776	12,641	100
* Others include TA, Insurance(RSBY), Grading & Accreditation, Other social securities, Administrative expenses and Contingencies				

As may be seen in the above table, major components of the above (as indicated by % Total Recurring Budget- GOI liability) are Supplementary Nutrition GOI share (33%) and Honoraria (30.58%). Salary constitutes 19.49%.

A SYNTHESIS OF THE REPORT

PROGRAMME DESIGN - " WHAT"		
Theme	**Existing ICDS**	**What is Different?**

1. Reaching children under 3 years and pregnant, lactating Mothers	• 6 services	• Redesigned package of services with-
		  • New components
		  ▪ Child Care and Nutrition counselling
		  ▪ Early stimulation and detection of developmental delays
		  ▪ Community based care for undernourished children
		  • Redefinition of existing services - preschool education: growth monitoring: IEC and community mobilization

	• Limited Outreach to children under 3 years	• New Child Care and Nutrition Counselling service for pregnant and breastfeeding mothers, children under 3s with prioritised home visiting at critical contact points • AWC duration of 6 hours – nearly day long child care • Creches piloted in 5 % AWCs
	• Inadequate infrastructure and facilities for child care	• Increased investment in infrastructure and facilities, including buildings, safe drinking water, child friendly toilets, hygienic cooking arrangements and play space • Usage of AWC for other women and child related activities eg for adolescent girls under RGSEAG
2. Enhancing Nutritional Impact	• State experiments	• Additional AWW/ nutrition counsellor/ECCE worker initially in 200 high burden districts • Incentivised ASHAs /volunteers, based on state choices • Examples such as ASHA Sahyoginis in Rajasthan, 2 AWWs earlier in TINP in TN, local women volunteers in Bihar, Jharkhand
	• Revised in 2009	• Revised Nutrition and Feeding Norms
		• Cost indexation of the Supplementary Nutrition component
	• State initiatives	• SNEHA SHIVIRs for community based care of moderately and severely undernourished children. • Learning By Doing - 12 day Nutrition Care and Counselling Sessions at AWCs using positive role model mothers/peers whose children are growing well for demonstrating cooking and optimal feeding behaviours
		• Piloting of community kitchens and pilots linking ICDS with Mid Day Meals
	• Sporadic IEC	• National /State specific Communication strategies
3. Improved Growth monitoring, with participation of communities and NRHM	• Not conducted regularly • Growth registers kept at AWCs • Joint ICDS NRHM card now being rolled out	• Mother Child cohort tracking using an ICDS NRHM joint card (with new WHO child growth standards), given to mothers. • This is in addition to growth records held at AWCs, so that families are empowered to track their own children's nutritional status, improve family care behaviours, demand and utilise ICDS and health services. • Child nutrition and development outcomes would be made visible to families and communities (through the card and display of community charts), and discussed at home visits, Monthly Fixed Village Health and Nutrition Days for action

		• Monthly weighing of under 3s; quarterly for 3-5 yrs • Community based monitoring using the above.
4. Better Health Care	• Convergence efforts with NRHM ongoing; varied	• Ensuring a continuum of care from the family, to anganwadis and communities to health sub centres and health facilities • This also includes redefinition of responsibilities /accountabilities of AWWs//ASHAs//ANMs, joint training; strengthening Nutrition in ASHAs/ANMs/MOs roles; joint reporting mechanisms and joint monitoring through common Village Health Sanitation and Nutrition Committees &Anganwadi Management Committees • Monthly Fixed Village Health and Nutrition Days • Stronger referral linkages with health
5. Improving the quality of early learning	• Inadequate non formal preschool education • Curriculum framework inadequate	• Early stimulation for children under 3 years • New Joyful learning approaches for children 3-6 years old that are developmentally appropriate, with trained AWWs (ECCE Policy,Training and curriculum framework being developed by MWCD/MHRD core committee) • School readiness interventions for 5 plus year olds –in AWCs or in Schools, as per state context • Monthly Fixed Village ECCE days, local materials • Colocation of AWCs/school where locally decided for better quality and transition

PROGRAMME IMPLEMENTATION – "HOW"

Theme	Existing ICDS	How will it be implemented differently?
1. Transforming ICDS in "Mission Mode"	• One size fits all • Rigid programme structure • State PIPs only introduced recently • No District Planning	• Flexible implementation framework with monitorable outcomes, with flexibility of state /district specific approaches/models • Mission structures and systems like NRHM, SSA • MOUs between Central / State governments, and State Annual Implementation Plans • State/District Implementation Plans • States/districts/blocks and villages empowered to contextualise the programme and find solutions • Normative approach and addressing gaps as per standards-entitlements • Build on local capacities and resources • Performance linked funding • Untied fund for replication of best practices / innovations, voluntary action, AWC cum crèche, pilots based on APIP
2. Paradigm shift towards decentralisation –with leadership of panchayats	• Village user group committees sporadic • Varied PRI engagement	• Constitution of Anganwadi Management committees, with members including mothers and ASHAs, with defined roles and linked to common VHSNCs • Common Village Health Sanitation and Nutrition Committees notified. Recognised as sub committee of panchayats • Devolution of powers related to ICDS to PRIs and ULBs, depending on the state context. This could include supervision of AWCs, selection of AWWs/AWHs, location/construction /maintenance of AWCs supervision of SNP and monitoring of honoraria payment among others. The Chairperson of Anganwadi Management Committee will be Gram Panchayat/ Ward member (preferably woman member)

3. Increased ownership of Women / Communities	• Depends on state initiatives • Flexi funds to AWCs initiated in 2009	• Deeper reach into communities through Anganwadi Management Committees, mothers'/ women groups, volunteers, village contact drives • Community participation and contribution through Monthly Fixed Village Health and Nutrition Days and Village ECCE Days • Examples of community contribution include local play materials, activity corners, wall painting, durries, chowki/ curtain for ANC check up, utensils, cooking facilities, seasonal vegetables /fruits, shramdaan /materials for AWC fencing / improvement, kitchen gardens etc. • Flexi Funds to AWCs (ALMCs) for local gap filling and quality improvement
4. Promoting Quality	• Service standards only for some	• Introduction of service standards /guarantees • Community owned ICDS accreditation system • Incentivisation of panchayats /blocks /districts- through awards like Nirmal Gram Puruskar
5. Increased NGO partnership	• Sporadic	• Upto 10% of the projects for civil society participation • New Voluntary Action Groups
6. Capacity Development	• Routine training • Capacity limited	• National/State ICDS Mission Resource Centres • Professionalisation of technical and management support at different levels , with specialists on Nutrition, ECCE, Training, Communication and Programme Management recruited as contractual staff • Linking service delivery and training
7. Strengthening Convergence	• Mechanisms needed	• Inclusion /linkages of PIPs- NRHM, ICDS, TSC, SSA • Joint training • Joint monitoring of key results and indicators eg, by the common Village Health Sanitation and Nutrition Committee that is empowered for this at village level • Defined roles and accountabilities
8. Monitoring and Evaluation	• Not outcome focused	• Using ICT and the reach of mobile telephones • Linked to GIS and community based monitoring
9. Public Accountability	• Sporadic	• Mission reviews with participation of civil society • Citizen's charter, based on service guarantees • Social audits, public hearings

ANNEX - IA

RE-DESIGNING & REINFORCING OF THE PACKAGE OF ICDS SERVICES

Sl. No	Components	Services	Core Interventions	Target Group	Service Provider
1.	Early Childhood Care Education & Development (ECCED)	Early Childhood Care and Education (ECCE) / Pre-school Non-formal Education	Home based guidance for parents Early stimulation Early screening and referral Optimal IYCF Practices Monthly Monitoring & Promotion of Child Growth & Developmental Milestones. Fixed Village ECCE Days	0-3 years Parents/caregivers	Second AWW cum Child Care & Nutrition Counsellor
			Non formal preschool education: activity based semi-structured play and learning method Quarterly Monitoring & Promotion of Child Growth & Developmental Milestones. Fixed Village ECCE Days	3-6 years Parents / caregivers	AWW
		Supplementary Nutrition	Morning snack, Hot Cooked Meal and THR as per norms	6 m – 3 yrs 3-6 years P&L Mothers	AWW / Second AWW/ AWH / SHGs / others
2.	Care & Nutrition Counselling	Infant & Young Child Feeding (IYCF) Promotion &Counselling	One to one counselling for optimal breastfeeding practices One to one counselling on Complementary feeding Counselling to ensure food intake Home visit and follow up	P&L mothers. Mothers of children under 3 yrs	Second AWW cum nutrition counsellor/ supervisors ASHA / ANM
		Maternal Care and Counselling	Early registration of pregnancy, 3 or more ANC, Institutional delivery and PNC Counseling on diet ,rest and IFA compliance during Home visit Monitoring weight gain Examination for pallor and oedema and any danger signs Home based counseling for essential newborn care Counseling and lactational support Counseling on spacing	P&L women	ASHA / ANM / MO/Second AWW cum nutrition counsellor
		Care, Nutrition, Health & Hygiene Education	Monthly health and nutrition education sessions Education on Improved caring practices-- feeding, health, hygiene and psychosocial care. Knowledge sharing for care during Pregnancy, lactation and adolescence	P&L Mother and other caregivers , community and families	AWW / Second AWW cum nutrition counsellor / supervisors

			Promotion of local foods and family feeding. Appropriate food demonstration Celebration of nutrition week, Breastfeeding week , ICDS day etc		
		Community based Prevention & Management of underweight children	100% weighing of all eligible children and Identification of underweight children Referral to NRCs/MTCs for children requiring medical attention 12 day Nutritional counseling and care sessions for moderate and severe underweight children (SNEHA SHIVIRs) 18 day home care and follow up during home visit Monitoring of weight gain after 12 days and 18 days	Moderately and Severely under-weight children & their mothers/caregiver	AWWs/ AWH/ supervisors/ Mothers' Group/PRIs. / SHGs /MO / Doctor on Call ASHA and ANM as facilitator
3.	Health Services	Immunization and micronutrient supplementation	Regular Fixed Monthly VHNDs Primary Immunization Boosters TT for Pregnant women Vitamin A supplementation IFA supplementation Deworming Counselling	0-3 years 3-6 years P&L Mothers	ANM / MO / ASHA/ AWWs as facilitator
		Health Check Up	• ANC / PNC / JSY • Support for IMNCI / JSSK • Identification of severe underweight children requiring medical attention • Support to Community based management of underweight children	0-3 years 3-6 years P&L Mothers	ANM / MO / Doctor on call ASHA /AWWs as facilitator
		Referral Services	• Referral of severely underweight to health facilities/ NRCs • Referral for complications during pregnancy • Referral of sick newborns • Referral of sick children	0-3 years 3-6 years P&L Mothers	ANM / MO / Doctor on Call/ ASHA/ AWWs
4.	Community Mobilization , Awareness, Advocacy & IEC		Information dissemination & awareness generation on entitlements , programmes behaviours and practices Sharing of nutritional status of children at gram sabha meetings Linkage with VHSNC Voluntary Action Groups Village contact drives	Families & Community	AWW / Second AWW/ supervisors / FNB / Dist. & Block Resource Centres / ICDS Management

ANNEX - IB

COMPREHENSIVE REFORMS –MOVING FORWARD PROGRESSIVELY

Complete ICDS Universalization & Third Phase of Expansion → **ICDS Strengthening& Preparation to Mission Mode&ICDS Restructuring** → **Continued ICDS strengthening &Restructuring in Mission Mode** → **Transformed ICDS**

Current Status : (2011 – 2012)

Coverage:

- Approved for Universalization (7076 projects) - 6722 Operational (March 2011)
- Approved for Universalization (14 lakh habitations) - 12.60 lakh AWCs Operational (March 2011)
- Cost of Supplementary nutrition:
- Rs.1 (1991 to 2004); Rs. 2 – 2.70 (2004 – 2009); Rs. 4 – 6 (2009 – 10)
    - Supplementary nutrition: as gap filling; 9 crorebenf.
    - No provision for construction of AWC buildings
    - Programmatic gaps:
- Inadequate Infrastructure and facilities
- Constraints of Quality & no. of human resource
- Poor focus on under 3s and ECE
- Perceived as feeding center
- Low investment on child development
- Poor convergence of programmes / services- only flagship programme not in Mission Mode
- Largely left to States for implementation - no cost sharing on SNP prior to 2005 -06
    - Operational Gaps:
- Emphasis primarily on SNP: Challenges of delivery -Issues in management of SNP & no cost indexation
- Envisaged as community driven: evolved as State run programme; regularity of AWC functioning
- Slow pace of universalization due to limitations of States/UTs
- Concurrent monitoring a weak point
- Single AWW at each AWC & ICDS functionaries burdened with non- ICDS functions

Stabilization & Transformation to Mission mode (2011 – 2013)

- APIP in at least 10 States, rest to follow
- ISSNIP (soft element in 160 districts) in eight selected States
    - Universalization with quality:
- Coverage:- 7076 projects operational, 14 lakh AWCs
- Harmonization of jurisdiction- district cells, project & AWCs
- Cluster approach – on a cluster of 25 AWCs, a Cluster Office in a selected AWC to be set up by placing one Supervisor
- Focus on under 3s – Growth monitoring & IYCF
- Training & capacity building at all levels
- MIS, Monitoring and ICT
- Health & Nutrition Education and caring practices
- ECE preliminary actions
- Grading and accreditation of AWCs
    - ICDS as vibrant ECD centre(AWC- Baal Vikas Kendra):
- In principle approval of ICDS in Mission Mode
- Repackaged Services with focus on <3 and ECCE
- SNP Cost indexation, fuel & transport
- Additional nutrition counselor in 200 districts or options
- Scale up common aspects of past best practices & innovations
- Additional financial allocation Untied fund for developing & implementing pilots of flexi & innovative models
- AWC construction & facilities (starting 200 districts)
- Replacement of :
    - Weighing scales (20% each year)
    - Utensils & furniture (20% each year)
- Rent enhancement
- IYCF activities and focused action
- Fixed ECCE day & quarterly parent community meet
- Additional human resource to States for switching over to APIP mode
- Technical support - intensive in 200 districts
- Community Mobilization, Advocacy & IEC

Review of progress 2015

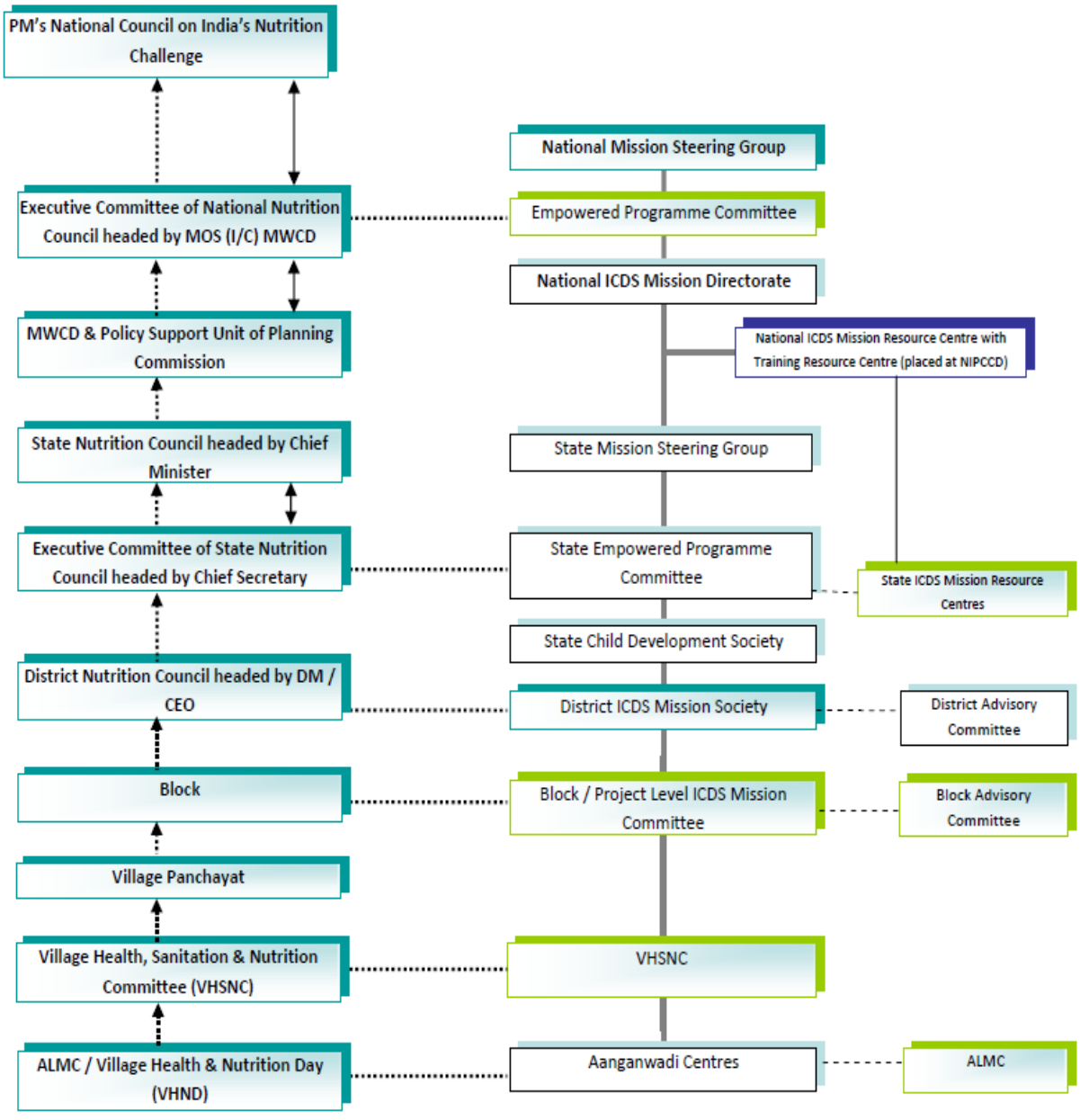
ICDS in Mission Mode (2013 – 2017)

- ICDS in Mission in Mode with flexible mode of implementation:
- Appropriate institutional mechanisms at Central, State, District & Block levels
- Adequate human and financial resources
- APIP linked to: Programme components;Performance;Financial
- ISSNIP (3 – 7 years) Assessment for Scaling up (if needed)
- Quality enhancement and statndards:
- AWCs as village WCD centres with adequate infrastructure & facilities- first village health, nutrition & early learning outpost
- AWC construction & facilities
- Replacement of weighing scales, utensils & furniture (all 14 lakh AWCs covered)
- Decentralized planning & management
- Supportive community actions & participation of women
- Regular training & skill building for ensuring adequate skilled human resource at all levels
- Improved MIS & M&E systems
- Focused Early Child Care & Learning Environment:
- ECE Policy, curriculum and activity
- ECD (ICD) beyond AWCs in private / organizations
- Institutionalization:
- NGO run/ facilitated projects/AWCs about 10-20%
- Improved norms and quality standards
- Grading and assessment
- Child Development Resource Centres (National / State / Dist.)
- Technical support
- Voluntary Action Group
- Parent / community meetings
- Community Mobilization, Advocacy & IEC
- Scale up learnings from pilot best practices & innovations

Review of progress 20717

ANNEX – IC

OVERVIEW OF THE PROPOSED INSTITUTIONAL ARRANGEMENTS UNDER THE ICDS MISSION (along with linkage with Nutrition Councils at different levels)



LIST OF RESULTS INDICATORS WITH TARGETS ANNEX – ID

	Indicators	***Current Status***	***Target*** *(End 12th Plan)*
i.	Reduction in percentage of underweight children below 3 and 5 years *(separately)*	42.5 % (NFHS-3) for below 5 yrs 40.4 % (NFHS-3) for below 3 yrs	10 percentage points ie by 25 %
ii.	Reduction in prevalence of anaemia in under-5 children	78.9 % (NFHS-3)	20 %
iii.	Reduction in prevalence of anaemia in pregnant women	57.9 % (NFHS-3)	20%
iv.	Percentage of 5-6 yrs children at the AWCs who are school-ready	NA	60%
	B. Outcome Level		
	ICDS Core:		
i.	Percentage of children initiated breastfeeding within one hour of birth	40.5% (DLHS-3)	75%
ii.	Percentage of children exclusively breastfed till 6 months of age	46% (NFHS-3)	75%
iii.	Percentage of children 9-23 months who have been given complementary feeding after 6 months in addition to breastfeeding	57.1% (DLHS-3)	90%
iv.	Percentage of mothers of 0-3 yrs children who are using MCP card and are aware of early stimulation practices	NA	70%
v.	Percentage of children 3-6 years achieved age appropriate developmental milestone tracked through child progress card	NA	50% of those attending ICDS PSE
	Common with Health:		
i.	Percentage of children 12-23 months received full immunization	20 % (NFHS-3)	(85 %)
ii.	Percentage of children who received Vitamin A dose in last 6 months	24.9% (NFHS-3)	(75%)
iii.	Percentage of children below 3 years with diarrhoea treated with ORS	34.2 (DLHS-3)	(70%)
iv.	Percentage of pregnant women receiving at least 3 or more ANC checkups	50.7 (NFHS-3)	(80%)
v.	Percentage pregnant women who consumed at least 100 IFA tablets	46.6 (DLHS-3)	(80%)
	Process level		
	i. Percentage of registered children who received supplementary nutrition		100%
	ii. Percentage of registered pregnant and lactating women receiving supplementary nutrition		100%
	iii Percentage of eligible children below 3 yrs who are weighed every month		100%
	iv Percentage of AWCs organized VHNDs every month		80%
	v Percentage of AWWs who have conducted *SnehaShivirs*		50%
	vi Percentage of AWC organized ECCE day		50%

ANNEX – IE

SERVICE STANDARDS UNDER ICDS MISSION

1. Early Childhood Care Education and Development (ECCED):

- A functional child friendly AWC based on population norms with a trained AWW, which is open for 6 hours daily (including 4 hours of ECCED, SNP and 2 hours for home visits and other AWC related services) and provides all ICDS services – through respective service providers/programmes
- A safe, protective & joyful early learning environment with necessary building, infrastructure and facilities (including clean environment, safe drinking water, child friendly toilet, play space and local play/learning activity support material)
- SNP for P&L mothers (as per norms)
- Need based services for Crèches and day care as locally determined
- Supplementary nutrition as per norms for children 6 months – 6 years (THR, Morning snack, food supplement, differential provisions for moderately & severely underweight, as per norms) for at least 300 days in a year
- Developmentally appropriate early joyful learning activities (ECCE) for 3-6 year olds for 4 hours a day for at least 21 days in a month
- School readiness interventions/package for 5 plus & linkages with school (pre-primary / primary)
- Platform for out of school adolescent girls (where applicable)
- Regular Monthly fixed ECCE Day (Anganwadi/ Balbodh Divas)

2. Child Development, Care and Nutrition Counselling

- Skilled counselling support for Infant and Young Child Caring and Feeding practices for under 3s (including EEBF for 0-6 months)
- Availability of support materials (weighing scales, cards, charts, PSE kit, local play / learning materials, medicine kits, mats, cooking facilities, utensils, records and registers etc.)
- Home visits at critical contact points including at least newborn postnatal and neonatal care (Days 1, 4,7, 14, 21 and 28) by respective service providers
- Monthly monitoring and promotion of young child growth and development of children under 3 years -using new WHO child growth standards and MCP Card package and quarterly for 3-5 year olds.
- NHED for mothers and women (at least 1 sessions/month)
- SNEHA SHIVIRs for locally appropriate feeding and care, nutrition care and counselling sessions with feeding demonstrations for prevention of nutritional deterioration and referral support for severely undernourished children in high burden pockets
- Parenting support for families through prioritized home visits and counselling
- Regular Quarterly parents meet (for under 3 and 3-6 on both nutrition & development indicators using joint MCP card, community charts and ECCE card) (applicable when rolled out)
- Maternity benefits for pregnant mothers as may be applicable

3. Health Services

- Linkages with ASHA, ANM & others under JSY & JSSK for early registration of pregnancy and at least 3 ANCs, IFA supplementation and institutional delivery.
- Linkages with health for timely and complete immunisation, Vitamin A supplementation, IFA supplementation (as per norm). [Deworming as per national guidelines]
- Linkages with health for management of common neonatal and childhood illnesses such as diarrhoea with ORS and zinc supplements and ARI
- Regular Health check-ups for all infants and children – by health functionaries / systems
- Priority care at health centres when referred for sick and / or severely undernourished children
- Regular Monthly fixed VHND

4. Community Mobilization, Advocacy and IEC

- Quarterly AWC management committee meetings (M&E circular)
- Quarterly VHSNCs meeting (as collective action)

**Above standards would imply involvement of PRI and local community and appropriate social commitments and agreements*

No. PC/SW/1-2(7)2011-WCD
Government of India
Planning Commission
(WCD Division)
***

Yojana Bhavan, Sansad Marg,
New Delhi – 110 001,
30 June, 2011

Subject: Setting up of an Inter Ministerial Group on ICDS Restructuring

The first meeting of the PM's National Council on India's Nutrition Challenges chaired by the Hon'ble Prime Minister on 24th November 2010 directed that the ICDS requires strengthening and restructuring, with special focus on pregnant and lactating mothers and children under three years. The meeting highlighted that the ICDS also needs to forge strong institutional convergence with National Rural Health Mission and Total Sanitation Campaign particularly at the district and village levels. It needs to provide flexibility for local action and empower mothers in particular and the community in general to have a stake in the programme. The Ministry of Women and Child Development has initiated steps in this regard, in consultation with Planning Commission and other relevant Ministries. A copy of the Record Of Discussions of this meeting is enclosed (Annexure I). Recommendations had also emerged from various consultations in this context, including the Multistakeholder Retreat on Addressing India's Nutrition Challenges, organised by the Planning Commission, which were placed for the consideration of the PM's National Council on India's Nutrition Challenges.

Further to the above, a review meeting on the follow up action of the decisions of the PM's National Council on India's Nutrition Challenges was chaired by Principal Secretary to the Prime Minister on 20 May 2011. As indicated in the Record of Discussions, a Group on ICDS Restructuring is to be constituted, under the chairpersonship of Dr. (Ms). Syeda Hameed, Member, Planning Commission, including the Ministries of Women and Child Development, Health and Family Welfare, Drinking Water and Sanitation, Panchayati Raj, representatives of state governments and PMO. A copy of the Record Of Discussions is enclosed (Annexure II).

Subsequently, the National Advisory Council finalised and shared Recommendations with the Hon'ble Prime Minister on 6 June 2011, for a Reformed and Strengthened Integrated Child Development Services, suggesting core strategies, programmatic, management and institutional reforms. As communicated vide PMO letter dated 21 June 2011, the Hon'ble Prime Minister has desired that the recommendations of the National Advisory Council regarding ICDS Reforms and Strengthening be considered by the Inter Ministerial Group under Member, Planning Commission in charge of Women and Child Development.A copy of the PMO communication is enclosed (Annexure III).

In the above context, an Inter Ministerial Group on ICDS Restructuring is hereby constituted, under the chairpersonship of Dr. (Ms). Syeda Hameed, Member, Planning Commission.

i. The Inter Ministerial Group is expected to draft a comprehensive ICDS Restructuring proposal, keeping in view the various points raised during discussions on ICDS Restructuring, during the meeting chaired by Principal Secretary to PM, on 20 May 2011.

ii. The Inter Ministerial Group will also consider the recommendations of the National Advisory Council regarding ICDS Reforms and Strengthening.

iii. The Report of the Inter Ministerial Group on ICDS Restructuring will be submitted to the Planning Commission by 31 July 2011.The Report will then be made into a proposal and posed for the consideration of the Expenditure Finance Committee.

iv. The composition of the Inter Ministerial Group on ICDS Restructuring is as follows:-

1. **Member (SH)** — **Chairperson**
   In-charge of WCD and HFW
   Planning Commission
   New Delhi

2. **Secretary** — **Member**
   Ministry of Women & Child Development
   Shastri Bhavan
   New Delhi

3. **Secretary** — **Member**
   Ministry of Health & Family Welfare
   Nirman Bhavan
   New Delhi

4. **Secretary** — **Member**
   Department of Drinking Water Supply and Sanitation
   Ministry of Rural Development
   Krishi Bhawan
   New Delhi

5. **Secretary** — **Member**
   Ministry of Panchayati Raj
   New Delhi

6. **Secretary** — **Member**
   Department of School Education and Literacy
   Ministry of Human Resource Development
   New Delhi

7. **Joint Secretary** — **Member**
   PMO, South Block
   New Delhi

8. **Joint Secretary (CD / ICDS)** — **Member**
   Ministry of Women & Child Development
   Shastri Bhavan
   New Delhi

9. **OSD (WCD and Nutrition)** — **Member**
   Planning Commission
   New Delhi

10. **Principal Secretary** — **Member**
    Health and Family Welfare
    Govt.of Bihar
    Old Secretariat, Patna, Bihar

11. **Principal Secretary** — **Member**
    Social Welfare & Nutritious Meal Programme
    Govt.of Tamil Nadu
    Secretariat, Chennai-600009

12. **Secretary** — **Member**
    Women and Child Development
    Govt.of Rajasthan
    Jaipur

13. Principal Secretary — **Member**
Health and Family Welfare
Govt.of Maharashtra

14. Senior Adviser — **Member Convenor**
Women & Child Development
Planning Commission
New Delhi

(Vandana Kumari Jena)
Senior Adviser WCD & VAC

To
Chairperson and All Members of the Inter Ministerial Group on ICDS Restructuring

Copy to:

1. PSs to DCH/ MOS (Plg.) / Members / Member-Secretary, Planning Commission
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3. Cabinet Secretariat, Rashtrapati Bhavan, New Delhi.
4. All Principal Advisers/ Advisers/ JS (SP & Admn.), Planning Commission.
5. Plan Coordination Division, Planning Commission
6. Secretaries, Concerned Ministries/ Departments of the Govt. of India
7. Chief Secretaries, State Governments/ UT Administrations
8. Information Officer, Planning Commission.

No. PC/SW/1-2(7)2011-WCD
Government of India
Planning Commission
(WCD Division)
***

Yojana Bhavan, Sansad Marg,
New Delhi – 110 001,
13 October, 2011

Subject: Final Report of the Inter Ministerial Group on ICDS Restructuring, Chaired by Member Planning Commission, Dr. (Ms.) Syeda Hameed

Further to meetings of the Inter Ministerial Group on ICDS Restructuring, Chaired by Member Planning Commission, Dr. (Ms.) Syeda Hameed and deliberations of the Drafting Group, the Report of the Inter Ministerial Group was finalised in mid September, 2011. This was shared with the Principal Secretary to the Prime Minister. Subsequently the Ministry of Women and Child Development is in the process of bringing the ICDS Restructuring proposal before the EFC, suitably incorporating the recommendations of the Inter Ministerial Group on ICDS Restructuring.

A copy of the Final Report of the Inter Ministerial Group on ICDS Restructuring, Chaired by Member Planning Commission, Dr. (Ms.) Syeda Hameed is attached for your reference.

Your participation and valuable contribution to this consultative process is appreciated, which enabled the Inter Ministerial Group to finalise its Report, under the guidance of the Chairperson Member Planning Commission, Dr. (Ms.) Syeda Hameed.

Deepika Shrivastava

(Deepika Shrivastava)
Officer On Special Duty (WCD & N)

o/c

Distribution to:

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