

# ICDS-IV PROJECT

## *Project Concept Note* [Revised]

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## ICDS-IV PROJECT: PROJECT CONCEPT NOTE

### 1. INTRODUCTION

Launched on 2<sup>nd</sup> October 1975, today, the Integrated Child Development Services (ICDS) Scheme represents one of the world's largest and most unique programmes for early childhood development. ICDS is the foremost symbol of India's commitment to her children – India's response to the challenge of providing pre-school education to children on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other.

ICDS is a centrally sponsored scheme implemented through the State Governments with 100 per cent financial assistance from the Central Government for all inputs other than supplementary food, which the States provide from their own resources. Since 2005-06, grant-in-aid pattern has been modified and the Government of India now provides central assistance to States for supplementary nutrition to the extent of 50% of the cost norms or 50% of the actual expenditure incurred by States, whichever is less.

The objectives of the Scheme are multifold:

- *to improve the nutritional and health status of pre-school children in the age-group of 0-6 years;*
- *to lay the foundation of proper psychological development of the child;*
- *to reduce the incidence of mortality, morbidity, malnutrition and school drop-out;*
- *to achieve effective coordination of policy and implementation amongst the various departments to promote child development; and*
- *to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.*

The above objectives are sought to be achieved by providing a package of six services comprising of (i) supplementary nutrition (ii) immunization, (iii) health check-up, (iv) referral services, (v) pre-school non-formal education and (vi) nutrition and health education. The services are provided concurrently so that synergetic and holistic development of children takes place. As the programme has developed, it has expanded its range of interventions to include components focused on adolescent girls' nutrition, health, awareness, and skills development, as well as income-generation schemes for women. The Scheme covers rural and tribal areas and slum population in urban areas.

With strong government commitment and political will, the ICDS program has emerged from small beginnings in 1975 to become India's flagship nutrition programme. ICDS is potentially well poised to address some of the *underlying* causes of undernutrition amongst children in India. The program adopts a multi-sectoral approach to child well being, incorporating health, education and nutrition interventions, and is implemented through a network of *anganwadi* centers (AWCs) at the community level.

The ICDS Scheme has undergone massive expansion ever since it was launched. Till the end of the 9<sup>th</sup> Five Year Plan (1997-2002), the scheme was gradually expanded to 5652 projects (blocks) across the country. The Government of India has now embarked upon a programme of universalisation of the scheme with emphasis on quality. During the 10<sup>th</sup> Five Year Plan (2002-2007), the ICDS Scheme was approved for implementation within the existing sanctioned 5652 Projects with no expansion activities due to resource constraints. However, with the mandate of the present Government as enunciated in the National Common Minimum Programme (NCMP) and as also decreed by the Supreme Court, through its various rulings, the ICDS Scheme has been expanded twice (in 2005-06 & 2006-07) during the 10<sup>th</sup> Five Year Plan, increasing the number of

ICDS projects from 5652 in 2004-05 to 6284 projects (blocks) and that of Anganwadi Centres (AWC) from 7.44 lakh to 10.53 lakh by the end of 2006-07. It is expected that a total of 6291 projects (blocks) will be operational in the country by the end of second year of the 11<sup>th</sup> Five Year Plan (2007-2012).

As on 31 March 2007, 5829 projects (blocks) and 8.45 lakh AWCs have been made operational. Currently, services under the scheme are being provided to about 705.43 lakh beneficiaries, comprising of about 581.85 lakh children (0-6 years) and about 123.58 lakh pregnant and lactating mothers. It is significant to note that during the 10<sup>th</sup> Plan period i.e. from 1.4.2002 to 31.03.2007, the number of beneficiaries under the supplementary nutrition programme (SNP) in ICDS have increased to the tune of 88% from 375.10 lakh in 2002 to 705.43 lakh in 2007. Similarly, the number of children (3-6 Years) attending pre-school education at AWC has increased from 166.56 lakh to 300.81 lakh during the same period (81% increase) (Table 1).

**Table 1: Progress in ICDS during the 10<sup>th</sup> Five Year Plan**

Year ending	No. of operational projects (blocks)	No. of operational AWCs	No. of Supplementary nutrition beneficiaries (both children 6 months – 6 years and pregnant & lactating mothers)	No. of pre-school education beneficiaries (3-6 years)
31.03.2002	4608	545,714	375.10 lakh	166.56 lakh
31.03.2003	4903	600,391	387.84 lakh	188.02 lakh
31.03.2004	5267	649,307	415.08 lakh	204.38 lakh
31.03.2005	5422	706,872	484.42 lakh	218.41 lakh
31.03.2006	5659	748,229	562.18 lakh	244.92 lakh
31.03.2007	5829	844,743	705.43 lakh	300.81 lakh

10 lakh = 1 million

## 2. THE CURRENT CHALLENGE

The ICDS Scheme would remain in the forefront of the efforts of the Government of India and the State Governments to achieve the child nutrition related Millennium Development Goal (MDG1)<sup>1</sup>. The Government of India has committed to achieve the nutrition MDG of halving underweight rates from 54% to 27% between 1990 and 2015, and to achieving the education MDG of universal primary education (MDG2) and the Education For All goal of expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. GOI is also committed to reducing infant and child mortality and improving maternal health outcomes (MDGs 4 and 5). Since malnutrition is closely linked to all of these MDGs, the strategies under the proposed ICDS-IV Project are expected to contribute towards achievement of each of these longer-term goals.

Though successful in many ways, the ICDS Scheme has failed to make a significant dent in reducing the proportion of underweight children, which continues to be one of the highest in the world (46% in 2005-06 in 0-3 years age group). While the Infant Mortality Rate (IMR) did register a significant decline from 146 per 1,000 live births in 1951 to 58 per 1,000 in 2004 (SRS 2006), no such impact was visible during the last decade. Wide regional disparities continue to exist within States, Districts and even Community groups – for example Kerala has an IMR of 12 while Madhya Pradesh has an IMR of 79 per 1000 live births in 2004 [SRS 2006].

<sup>1</sup> MDG1: *Eradicate extreme poverty and Hunger*. Target 2: *Halving the proportion of people who suffer from hunger*. Indicator 4: *Prevalence of underweight children under 5 years of age*.

Undernutrition continues to be a major public health problem in India, the most vulnerable groups being women of reproductive age group and young children. The NFHS fact sheets reveal the following trends:-

- In 1992-93 (NFHS-1), the prevalence of underweight children (weight-for-age) below three years was 52%. There had been limited progress in improving the prevalence of child malnutrition of less than one percentage point per year between 1992-93 (NFHS-1) and 1998-99 (NFHS-2: 47%). According to NFHS-3, in 2005-06, 45.9% of children below three years are found to be underweight i.e. only 0.2 percentage point progress per year since 1998-99.
- Dis-aggregation of underweight statistics (NFHS-2) by socio-economic and demographic groups reveals that weight-for-age underweight prevalence is higher in rural areas (50 percent) than in urban areas (38 percent); higher among girls (48.9 percent) than among boys (45.5 percent); higher among Scheduled Castes (53.2 percent) and Scheduled Tribes (56.2 percent) than among other Castes (44.1 percent).
- There is also large inter-State variation in patterns and trends in underweight. In six States, at least one in two children are still underweight, namely Maharashtra, Orissa, Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan. The four latter states account for more than 43 percent of all underweight children in India (NFHS-2).
- Nearly 23% of all children born in the country have low birth weight (NFHS-2).
- Proportion of children (6-35 months) who are anaemic has increased from 74.2% to 79.2% and that of pregnant women from 49.7% to 57.9% between 1998-99 and 2005-06.

Currently India is witnessing a high economic growth as measured in terms of booming and vibrant market and GDP growth; yet, there is no substantial evidence to prove that the economic prosperity has been translated into improvement in quality of life. There is virtually no significant improvement in undernourished children over the last 10-12 years reinforcing the argument that economic growth is a necessary, but may not be a sufficient condition for improvements in young child survival, nutrition and development.

It has been felt that mere physical expansion of the ICDS programme is not, however, enough to combat the complex problem of malnutrition. The programme has reached a stage where it has become essential to harmonize the expansion of the programme and its content enrichment in order to accelerate the implementation in achieving the core objectives, especially to reduce the child malnutrition and help reduction in mortality rates. Addressing issues like prevention and management of malnutrition, poor maternal and adolescent nutrition, gender discrimination, lack of nutrition and health education, inadequate community participation in the programme etc. continue to be a major challenges during the 11<sup>th</sup> Five Year Plan.

### 3. THE CONTEXT

After more than 30 years of rich experience in the programmatic perspective, a paradigm shift is required in the ICDS Programme with a framework restructured to suit the current needs which would not only hasten universalisation of ICDS with quality to reach out to all under six children, but also intensify decrease in malnutrition, IMR and early child development. But this requires multi-sectoral interventions and changes in key family care behaviors. Reduction in underweight children below three years, enhancing early development and learning outcomes in all children (0-6) years and reduction in IMR in a normative time frame clearly needs a 'Mission Mode' of implementation of the ICDS Scheme as against the present 'Programmatic Mode'.

**3.1 Guiding Principles:** With the above perspectives, the Ministry of Women & Child Development has initiated a consultative process to develop a revised implementation framework for ICDS with the following guiding principles:

- *Accelerating action in mission mode to reduce under-nutrition and assure children the best possible start to life;*
- *Fostering decentralization, flexibility and community based locally responsive child care approaches;*
- *Strengthening partnerships with Panchayati Raj Institutions, NGOs/CBOs, Public and Private Sector;*
- *Ensuring equity-inclusive approaches to reach the most vulnerable & disadvantaged;*
- *Strengthening local capacity development;*
- *Empowering ICDS functionaries; and*
- *Promoting convergence to address nutrition, health and development needs of young children, girls and women.*

### **3.2 Vision of the Revised Framework**

- To provide early childhood care and education to all children up to the age of 6 years (to fulfill Constitutional obligation) through ‘Universalisation of ICDS with Quality’;
- To raise the level of nutrition of children below six years and pregnant and lactating mothers, with an inclusive approach to reach the most vulnerable, particularly SC/ST and Minorities;
- To undertake architectural corrections and promote policies to strengthen child development management with effective and transparent service delivery; and
- Lever, through decentralized management, integration of nutrition determinants viz. health services, sanitation and hygiene, safe drinking water, gender and social concerns and child care behaviors.

The key principles and strategies to be adopted for translating this vision into reality, are:-

- Restructuring ICDS Institutional managements at National, State, District, Project and village level;
- Strengthening basic infrastructure facilities and service delivery in Anganwadi Centres;
- Decentralized planning and management to allow States to formulate context specific child care approaches;
- Targeting children below three years more effectively and promote Infant and Young Child Feeding (IYCF) practices;
- Strengthening the pre-school education component;
- Promoting convergence of inter related services viz. RCH-II/NRHM, Sarva Siksha Abhiyan (SSA), safe drinking water and sanitation etc.;
- Empowering ICDS functionaries, Anganwadi Workers and Helpers;
- Strengthening capacity building of ICDS functionaries;
- Promoting community participation;
- Strengthening M & E framework with emphasis on community based monitoring.

Following the above broad framework, a five-year project viz., ICDS-IV with IDA assistance from the World Bank is proposed with the objectives/rationale stated below.

#### 4. Project Development Objectives

The key objective of the project will be to reduce child malnutrition through expansion of utilization of nutrition services and awareness and adoption of appropriate feeding and caring behaviors by the households of 0-6 years of age; and improve early child development outcomes and school readiness among children 3 to 6 years of age; in selected high burden districts/States. Special focus would be given on girl child and children from disadvantage sections.

#### 5. Project Rationale

- To improve quality of service delivery to beneficiaries and increase outreach;
- To strengthen institutional framework for project implementation;
- To sustain capacity building efforts through decentralized and need based training of ICDS functionaries ;
- To replicate and upscale successful innovations and initiatives;
- To introduce new activities in line with latest paradigms of child development; and
- To ensure better involvement of community.

#### 6. Project Design – Five Key Principles

- **Better Targeting-** *More intensive efforts and resources will be targeted to the high burden areas.* Since its inception, the ICDS Scheme has been implemented all over the country with uniform norms and without any flexibility to accommodate the area-specific needs to combat child malnutrition. Previous analyses have shown that malnutrition in India is concentrated in certain districts and villages. Therefore, these will be targeted for intensive support since improvements in these districts will have an impact on the national indicators. Under the proposed project, there would be a mechanism to address the needs of those areas (states/districts/blocks) where prevalence of malnutrition amongst children is more pronounced and participation of 3-6 year olds in ECE is below average. This would enable to have a level-playing field for these nutritionally backward areas with the others within a State or between the States. These States/Districts/Blocks would be provided additional interventions to combat child malnutrition and thus to correct the intra and inter-State imbalances.
- **Flexibility** in terms of management and programme implementation is also sought to be built up in the project design. Simultaneously, all efforts will be made to maintain quality standards in services to all beneficiaries. The RCH and SSA models will be followed for decentralized planning, with a stronger role for PRIs and District/ Community-level planning and accountability. The revised implementation framework will build upon and learn from a series of “best practices” in ICDS, and will aim to scale-up those that are evidence based and amenable to scaling-up. Different “best practices” may be scaled up in different Districts/States. Similarly, the urban and rural districts may have different designs and different strategies.
- **A simplified, evidence and outcome-based program design:** The new project will include a simplified program definition with a clear focus on evidence and outcomes. Nutrition will be the key focus during pre-pregnancy to three years of age, and early education outcomes for older children (3-6 years). The project design also seeks to incorporate life

cycle approach by addressing nutrition, health and education needs of beneficiaries at different stages of life, viz., pregnancy, childhood, child bearing and rearing, and adolescence. There will be a much stronger focus on Nutrition and Health education and on enhancing community awareness at all levels. Private sector/Corporate participation in Nutrition and Health Education/IEC and the use of traditional and mass media will be strongly encouraged. For ECCE the IEC component will focus on advocacy for developmentally appropriate practices thereby regulating demand for both public and private provision of services.

- ❑ **Stronger convergence** at the operational level will be forged with health (RCH & NRHM) to maximize the potential for nutrition outcomes. Convergence opportunities may include joint training of Anganwadi Worker (AWWs), ASHA and ANMs, joint supervision visits, jointly observed Mother-Child Health/Nutrition Days, etc . For ECE, close convergence and linkages may be with primary schools for curricular continuity, and synchronization of timings/location of ECE centers, where feasible and appropriate.
- ❑ **Strong Monitoring & Evaluation:** The project will put in to place a strong M&E component to enable collection of timely, relevant, accessible, high-quality information and to use this information to improve programme functioning by shifting the focus from inputs to results, outlays to outcomes, and for creating accountability for performance. A stronger evaluation component will report on the progress towards the outcomes, and a stronger MIS to allow for better management of the program at decentralized levels. Options will also be explored on how best to link key project outputs to the expenditure at all levels.

The project would promote the following:

- **Decentralization:** Of programme support activities;
- **Partnership:** Between communities and ICDS functionaries to nurture a sense of community ownership;
- **Sustainability:** Of changes to positive nutrition, health and education seeking behavior as also mother and child development status;
- **Empowerment:** Of adolescent girls by increasing their awareness, capacities and capabilities.

## 7. Thrust Areas

- Addressing health and nutritional needs of under-3 children
- Addressing early childhood development outcomes and school readiness in 3-6 year olds
- Implementation of Communications for behavior change (CBC): *Promotion of home based care for infants, appropriate feeding and caring practices etc.*
- Capacity building of ICDS functionaries and community
- Addressing needs of Adolescent Girls
- Strengthening Community participation/ownership in ICDS
- Strengthening convergence between ICDS and RHC-II/NRHM and SSA

## 8. Special Targeting Strategies

### (a) Targeting under 3s for health and nutrition

- Need assessment for under-3 children based on local customs, socio-economic status of the households and geographical region.
- Ensuring appropriate infant feeding practices through campaign and awareness generation
- Introduction of multiple feedings with a mix of on-the-spot and take-home ration approaches
- Universal growth monitoring and growth counseling through nutrition and health days/home visits



- Ensuring timely immunization
  - Providing necessary micronutrients
- (b) **Targeting 3-6 year olds for ECE**
- Need assessment for 3-6 year old children based on local customs, socio-economic status, language of the households and geographical region.
- (c) **Targeting Adolescent Girls**
- Special focus on iron folate supplementation
  - Formation of adolescent girls club
  - Training on family life and health education
- (d) **Targeting SC/ST/Minorities**
- Development of focused IEC strategies for targeting tribals keeping in view variations in languages, customs, mores, symbols and nuances.
  - Preference to construction of AWCs in SC/ST/minority areas
  - Establishment of min-AWCs in project States
  - Development of special tribal strategies in project States for improved maternal and child health and nutrition

## 9. PROJECT COMPONENTS & INTERVENTIONS

The project will have two major components: i) Nutrition and ii) ECE. The nutrition component will primarily focus on the “window of opportunity” between pre-pregnancy through 3 years of age, and the ECE component will focus on preschool education for children 3-6 years of age.

### 9.1 NUTRITION COMPONENT

Under the nutrition component, a two-pronged strategy is proposed wherein there would be:

- (i) specific measures to improve the quality of services in the entire country on one side and
- (ii) additional measures to improve the coverage and effectiveness of ICDS in the high-burden States/Districts where prevalence of malnutrition is more.

**High burden States/Districts:** Based on the findings of a study titled “*Mapping and Profile of Target Districts*” carried out by the World Bank, eight States viz., Uttar Pradesh, Madhya Pradesh, Maharashtra, Rajasthan, Bihar, Chhattisgarh Jharkhand and Andhra Pradesh have been selected for intensive support under the project. While the first seven States have been selected due to highest concentration of child malnutrition, Andhra Pradesh has been selected in view of State’s best practice experiences in the activities of Mother’s Committees/Self Help Groups and community participation in development activities, which can serve as a model for other States to follow. About 160 districts from these States have been identified for intensive support under the project.

The **nationwide component** of the project will have two major activities viz., (i) training/capacity building; and (ii) IEC.

#### 9.1.1 Training/Capacity Building

The importance of training and continuous capacity building of the ICDS functionaries for improving the quality of service delivery in ICDS has been recognized as vital for success of the programme in earlier five-year plans. The National Training Component of WCD/ICDS-III Project, christened as ‘*Udisha*’, has been implemented during 1999-2006 with a focus on eliminating the heavy backlogs in job and refresher training of all functionaries all over the country and also introducing ‘innovative (other)’ training. After the closure of the project on 31 March 2006, the training programme has been continued with domestic resources during FY 2006-07, following the pattern of Project Udisha. During the Eleventh Five Year Plan (2007-

2012), training and capacity building of ICDS functionaries would continue to be on the forefront of the agenda in ICDS.

The Training component will have three major sub-components:

**(a) Capacity Building of the ICDS Field Functionaries:** This would basically follow the pattern of the erstwhile Project Udisha. Already a substantial network of institutions both Governmental and Non Governmental has been set up throughout the country, which would be used to impart training to the ICDS functionaries. The following would be strategy under this component:

- ❑ Training functions would be planned, implemented and monitored at the state levels by a competent technical body (State level Resource Centre - SRC); this body would provide dynamic guidelines for determining training content from time to time, which should be fully aligned to carefully determined program priorities.
- ❑ There would be a continuous assessment of the skills and capacity of the AWWs workers, and the training programmes would be dovetailed accordingly.
- ❑ The entire training programme would be monitored with the help of a district/State level computerized database of the AWWs and AWHs. A common core joint training module for ICDS and RCH would be worked out – including new IYCF guidelines.
- ❑ For effective convergence with health, joint-training programmes would be organized for the Anganwadi workers with the health functionaries on a regular basis.
- ❑ There would be renewed emphasis on ‘Other Training’ component whereby the States are given flexibility to identify State specific problems that need more focused or innovative training and to take up such training programmes.

**(b) Capacity Building of the family members and the community, especially the mothers:** In some states, the Mother’s committees/Mahila Mandals have played an important role in the implementation of the ICDS programme. In order to replicate this success, capacity building programme would be organized for the mothers. Some of the best practices evolved for involving the community in the past, would also be up-scaled through regular orientation and training.

**(c) Capacity Building of the Key Project Management Staff:** There would be provisions for periodic programmes to enhance capacity of the key management staff under the project from CPMU/SPMUs/Districts through regular orientation trainings/workshops/seminars in reputed Institutes/Organizations and best practices exposure visits both in India and abroad. These training programmes will generally cover relevant subjects including project management & planning, procurement, financial management, performance monitoring and evaluation, IEC etc.

### 9.1.2 Information, Education and Communication (IEC)

Experiences in the erstwhile ICDS-III/WCD Project showed that there had been substantial impact of IEC on behavior changes of the households in respect of infant and young child feeding practices, awareness on health and nutrition needs of pregnant and lactating women, and adolescent girls, as was evident from the endline evaluation. This had been possible due to sustained interventions, which were tailored for the specific needs of the communities following development of State-specific IEC strategies.

IEC in ICDS will involve various approaches, build linkages, strengthen capacities, and enhance capabilities and skills besides building the environments for nation wide people’s movement of participation in the programme. It is envisaged that IEC shall evolve successful processes which would result in AWCs being managed by village/slum women, responsibility for the food supplementation being taken over by the village community and effective targeting of all ICDS

services to reach out to the most needy as decided collectively by the village/slum dwellers themselves.

The communication strategy would also bring to the forefront on how to change behaviors of the community for the correct health and nutrition practices, by removing cultural barriers/ age-old practices/ superstitions. The advocacy programme in ICDS would enable widespread and sustained community participation as result of a better understanding and appreciation amongst the communities of the ICDS programme as well as health and nutrition issue. The following interventions are proposed:

- ❑ State specific IEC strategy would be developed and interventions would be made after assessing the communication needs for a particular community/region. The strategy would, inter-alia, involve use of multiple channels including folk media and mass media in addition to inter-personal communication (IPC) through AWWs and community level volunteers.
- ❑ Celebration of traditional occasions, like ‘*annaprashan*’ (for children completing 6 months), birthday (for all children), “*godhbharai*” (for pregnant women) etc. would be encouraged to be observed at AWCs by involving local leaders and community members to convey the messages of timely and appropriate complementary feeding and also ANC and new born care.
- ❑ A periodic and concerted campaign on early and exclusive breastfeeding for the first six months, new born care, timely immunization, appropriate complementary feeding at six months of age along with continued breastfeeding (upto two years or beyond) would be taken up through both electronic and print media, apart from involving folk media.
- ❑ Technical expertise in planning, implementing and evaluating context-specific behavior change communication (BCC) at state and district levels would be brought in. Each district or a cluster of districts would be allocated to a professional agency for carrying out the social marketing task. This would reduce the workload on the existing Anganwadi functionaries on one hand and bring in professionalism on the other.
- ❑ There would be a concurrent evaluation mechanism through external agencies to assess the outcome of all types of IEC activities under the project.

In the high burden districts/States, the following interventions are proposed:

### **9.1.3 Nutrition & Health Education**

The importance of nutrition and health education for improving the nutritional and health status of children and mothers, for adopting optimal infant and young child feeding practices, promoting consumption of micronutrient rich foods and also to increase compliance under vitamin A and IFA supplementation programmes and use of Iodized salt cannot be overstated. Nutrition & Health Education (NHE) is not merely a process of transferring facts or information about nutritive value of foods, the role of food in preventing nutritional deficiency diseases or methods of food preparation. The fundamental objective of Education in Nutrition is to help individual to establish food habits & practices that are consistent with nutritional needs of the body and adopted to the cultural pattern and food resources of the area in which they live.

Keeping in view the above, the NHE component under the project would be redesigned with a particular emphasis on Mahila Mandals to a more comprehensive parenting support initiative. This would cover both mothers and fathers and not mothers alone, for improved health and nutrition of children.

While the Nutrition & Health Education will remain to be a continuous activity at the AWC, a fixed day in a month to be called as ‘Mother & Child Day’ (MCD) will be mandatory to observe

by each AWC. The Supervisor and ANM would monitor the session on health and nutrition issues both for the mother and children. Participation of parents, local PRI members, NGOs and Mahila Mandals during MCDs may be encouraged. A token budget provision would be made to observe MCDs in all AWCs. During MCDs, universal early registration of pregnancy, antenatal care (ANC) of the pregnant women, immunization of women and children, IFA supplementation and more specifically one to one counseling for behavior change on infant feeding practices and improved care would be ensured.

Implementation of IYCF guidelines in letter and spirit with clear goals to make all stakeholders aware of the correct feeding practices will be ensured. Indicators on IYCF, such as initiation within one hour, exclusive breastfeeding upto 6 months, and appropriate complementary feeding at six months would be included in the monthly appraisal of AWW.

#### **9.1.4 Micronutrient Interventions**

One of the emerging nutritional issues, which would be addressed through the proposed project, is the micronutrient deficiencies (MND) in children, termed as 'hidden hunger'. The micronutrient deficiencies of public health significance are vitamin 'A' deficiency (VAD), iron deficiency anaemia (IDA) and iodine deficiency disorders (IDD). Findings have shown that one of the major causes of micronutrient deficiencies diseases in the country is dietary inadequacy of the specific nutrients. The GoI, in its National Plan of Action on Nutrition, under National Nutrition Policy, has recommended fortifying foods with micronutrients as one of the medium to long-term strategies to tackle the problem of MND in the community.

Under the project, States are expected to address micronutrient malnutrition *via* food fortification and micronutrient supplementation. While much of the micronutrient supplements are provided-for through the RCH program, the support through ICDS in the identified States can consider demand generation and uptake of micronutrient supplements, and on filling-in the supply gaps where needed (such as iron-folate supplements for adolescent girls; and related strategies such as de-worming for young children). Micronutrient sprinkles for complementary foods for infants (*Micronutrient Sprinkles sachets*) or local multiple-micronutrient fortification of locally prepared complementary foods (*fortificants, other relevant supplies for fortification at decentralized levels.*) would be tried out on pilot basis, after obtaining technical/expert opinions/suggestions.

#### **9.1.5 Growth Monitoring & Promotion**

Regular growth monitoring is a tool for preventing malnutrition and for early detection of growth faltering. It provides clues for the causes of growth faltering and therefore, helps in timely interventions, *i.e.*, treating the causes of growth faltering.

- ❑ Monthly growth monitoring of all under-3 children to achieve 100% weighing efficiency and counseling families for improved child care behaviors would be ensured. Growth monitoring and promotion under ICDS would be utilized to monitor undernutrition among children.
- ❑ Keeping in view the fact that even with regular weighing, growth monitoring is effective only if accompanied by communication for behavior change that results in improved growth of the malnourished child, special emphasis will be given on counseling to mothers whose children are malnourished.
- ❑ Growth monitoring of the children especially of 0-3 years will be strengthened with the support of at least two Adolescent girls in the AWC catchments area who will work as volunteers. They will be provided 3-4 days training on Anganwadi activities, with special focus on malnutrition in children and ante/post natal care of mothers.
- ❑ All AWCs will be provided with a baby weighing scale and growth charts. In addition, for monitoring of the weight gained by the women during their pregnancy, adult-weighing scales will also be provided.

### 9.1.6 Strengthening Service Delivery

There is a continuing need of strengthening service delivery at the AWCs to ensure overall quality and impact of the services. Various measures are proposed under the project:

- ❑ Supplementary nutrition will be utilized strategically to prevent malnutrition in children. Provision of Ready-to-eat (RTE) energy food would be scaled up for the under-three children through Take-Home-Ration (THR).
- ❑ Provision of basic kits (medicine & pre-school kits), equipments (baby and adult weighing scales) and other materials (growth charts, display boards, utensils, outdoor-indoor play materials, furniture etc) would be made at AWC level. Blocks and districts will also be provided basic equipments including computers, furniture, vehicles etc.
- ❑ In addition to above, Mother and Child Protection Card would be introduced in every AWC. There is also a need for Nutrition & Health Education Kits (Flip chart) for each AWW for their ready reference on issues of health and nutrition of women and children during their home visits and observation of Mother & Child days (MCDs).
- ❑ A performance appraisal system for AWWs would be introduced. There shall be a reward and disincentive mechanism for effective delivery of services to infuse enthusiasm and motivation among the AWWs. An accreditation system, to grade AWCs, with defined quality standards would also be introduced.
- ❑ Provision for inter and intra-State study tour by the ICDS functionaries (AWWs, Supervisors and CDPOs/DPOs) would be made to encourage learning/sharing from/of each other's experience/exposure to best practices.

### 9.1.7 Infrastructure Development

The ICDS Scheme does not provide for construction of AWC buildings, except in North-Eastern States, where construction of AWCs has been sanctioned as a special provision. In the previous World Bank assisted ICDS Projects, civil works had been one of the key priority interventions. Various evaluation studies and long experience of the Ministry indicate that the services under ICDS Scheme have delivered better quality results in those AWCs, which are located in their own premises. In a recent survey by NCAER (*Rapid Facility Survey*), it has been found that only 21% AWCs are running from semi-pucca building, about 15% from kuchha building, 9% in open space and about 6% from other places. 46% of AWCs do not have any toilet facility and 27% AWCs do not have drinking water facility.

In order to provide safe and hygienic environment for ICDS service delivery, AWCs must have their own buildings. In the proposed project, construction of AWC buildings and CDPO offices, supply of safe drinking water, provision of toilet facility, and electricity connection to AWCs will be taken up. The improved infrastructure would be attracting more beneficiaries within the fold of the Anganwadi system.

### 9.1.8 Empowering Adolescent Girls

Following the life cycle approach, adolescent girls scheme will be implemented in all blocks covering all adolescent girls in the AWC catchment area. The spectrum of interventions would range from empowering adolescents with life skills education to provision of safe spaces and health services appropriate to the special needs of adolescents. Through intensive and focused training, adolescent girls will be mobilized to support AWC activities, especially in growth monitoring, growth promotion and counseling alongwith the AWWs. They would also participate in the Mother & Child days for nutrition and health education to mothers, thus equipping themselves with the knowledge on ante/post natal care, appropriate infant feeding practices etc.

### 9.1.9 Motivating the Anganwadi workers

To motivate the Anganwadi workers towards discharging their day-to-day functions satisfactorily, the existing scheme of giving monetary awards and incentives at national and state levels has been found quite effective. While the scheme will continue as per its approved norms, under the project, both number of awards and their monetary value would be increased appropriately. Besides, inter/intra state study-tours for the Anganwadi works within the project period would be made. More so, efforts will be made to enhance the workers own and family's health and socio-economic status and her self-esteem by providing her a seat in decision making within the system. Other non-monetary incentives such as recognition, enriching her job content would be used.

#### 9.1.10 Flexi funds at the Anganwadi centres

In order to provide flexibility in implementing the scheme, certain minimum amount would be provided per month at the disposal of each of the AWCs. This amount could be used for purposes of improving nutrition status of the undernourished children. The mothers' committee would be involved to operate this fund.

#### 9.1.11 Stronger Convergence with RCH-II/NRHM

Stronger convergence at the operational level will be forged with health (RCH & NRHM) to maximize the potential for nutrition outcomes. It would include joint training of *Anganwadi Worker* (AWWs), ASHA and ANMs, joint supervision visits, jointly observed Mother-Child Health/Nutrition Days, etc. Convergence with the activities of other departments, especially, Health and Family Welfare Department would be achieved by setting up of institutional mechanisms, joint training of functionaries, development and implementation of joint monitoring systems, and incentives for functionaries for achieving convergence.

#### 9.1.12 Monitoring & Evaluation

The project will put in to place a strong M&E component to enable collection of timely, relevant, accessible, high-quality information and to use this information to improve programme functioning by shifting the focus from inputs to results, outlays to outcomes, and for creating accountability for performance. A stronger evaluation component will report on the progress towards the outcomes, and a stronger MIS to allow for better management of the program at decentralized levels.

- The project would support the ongoing efforts of revamping the existing MIS. The existing large number of reports/register/proformas, which the Anganwadi Worker has to fill up, will be reduced to ease her burden. A more user- friendly and simple reporting system/MIS would be developed to ensure 100% capturing of data regarding the beneficiaries (especially growth monitoring).
- There would be a strong evaluation strategy under the project. Baseline surveys will be conducted in the project areas at the beginning of the project to collect the information on key performance monitoring indicators, which in turn would enable fixing the targets for the project. An in-depth endline survey/impact evaluation would be taken up during the final year of the project to gauge the achievements in respect of the project development objectives.
- In addition to input and process indicators, the project would focus on more output indicators (e.g. proportion of mothers who changed their child caring behaviors), so that the input and process indicators can be more persuasively linked to project outcome indicators. The collected monitoring and evaluation indicators would be analyzed and disseminated for policy-making and supervision. Inclusion of control groups for comparison in both baseline and endline evaluation would enhance the evaluation effectiveness.

- ❑ Issue-specific operational research studies and periodic social assessments to make mid-course corrective actions would also be taken up.
- ❑ Supervisors' role in monitoring of the key service delivery would be strengthened. Home visit planner to help AWW to prioritize and plan home visits to households at critical periods of life cycle would be introduced.
- ❑ MIS systems in selected states/districts would be strengthened for moving from a *Monitoring Information System* to a *Management Information System*. MIS would attempt to increased accountability to communities/beneficiaries through innovative mechanisms such as social audits, community report cards, etc.
- ❑ Through regular training and workshops, data handling and analysis capacity at block, district and state levels to allow timely analysis of the information would be enhanced.

## 9.2 ECE COMPONENT

The ECE component of the Project will have the following objectives:

- To contribute to expanded access, reduction in equity gaps and improvement in quality and utilization of ECE services for 3-6 year old children through a variety of context specific models. Some models already on the ground include a NGO implemented ECE centre, school based centre and the ICDS centre viz., habitation based AWC.
- To strengthen linkages with primary education for the poor, particularly in terms of ensuring school readiness at school entry and facilitating girls' participation in primary schooling through provision of surrogate care for younger siblings.
- To expand childcare arrangements and enhancing community awareness regarding developmentally appropriate psycho- social caring practices for children under 3 years and for 3 to 5 year olds and strengthening parental support.

Pre-school education is a key factor in early childhood development, and enhances the enrollment for and impact of primary education. Under the project, there would be specific interventions to strengthen the ECE component. Given the fact that the early childhood years, that is, the first 6 years in the life of a child are critical, since growth and development is very rapid during this period, there is a need of an environment which is both supportive as well as stimulating.

The ECE Component under the proposed project will have two sub-components:

### 9.2.1 Policy and Programmatic Support at national/state levels, which will have the following activities:

- (a) ***Setting of quality standards through a consultative process for***
  - ECE services including teacher-child ratio, supervisor- teacher ratio, salaries/honorarium, developmentally appropriate curricula, parent and community involvement, progress monitoring, convergence with primary school etc. and
  - ECE training for teachers and teacher educators, including frequency, scope, content, methodology etc.
- (b) ***Mechanisms for quality assurance and accreditation*** - based on above
- (c) ***Training and Resource Support***
  - Review and mapping of training facilities/provisions in all states and districts including curricula.
  - Identification of good training institutions within and outside the sector , NGOs, resource persons and establishment of a directory and network for training and on site resource support.

- Preparation of a broad training strategy including policy provisions required to ensure trained teachers; need assessment and matching training requirements/needs with provision through a phased plan, support for development of need based training curricula and materials.

**(d) Monitoring and Evaluation:**

- Identification of basic indicators for monitoring children's progress
- Establishment of a baseline for system monitoring and impact evaluation
- Conducting periodic research studies to see impact of various interventions and /or enhance understanding of factors influencing quality and outcomes.

**(e) Advocacy and information sharing:**

Development of a communication strategy including (a) identification of main messages *vis-à-vis* target groups for both early stimulation for under 3's and ECE for 3-6 year olds for promoting behaviour change and regulating demand for quality ECE (b) related modes of advocacy including identifying areas of convergence (c) development of content /scripts for the messages (d) monitoring impact.

### 9.2.2 Targeted Service Delivery in high-burden districts

- Identification of high-burden States/districts with low girls' enrolment in primary schools.
- Development of a baseline of agreed indicators on census/sample basis and carry out of resource mapping of resource institutions /persons available, identification of good practices, convergence possibilities/experiences with primary school etc.
- Identification /selection of state and district program officials and district resource teams for ECE
- Delineation of a process of planning, budgeting and implementing the ECCE program
- Orientation and capacity development of state/district coordinators and planning teams in ECE including exposure to good practices and different models, need assessment and preparation of district plans and budgets through micro-planning; possibilities for partnership with NGOs and private sector etc.

Specific interventions that would be made under the project in special focus districts will be as follows:

- Provision of learning materials alongwith PSE kits would be made available to help impart quality pre-school education.
- Stronger linkages with SSA/primary school and linkages with programmes such as adult literacy would be forged to facilitate older girls' participation in schooling and to enable a broader understanding among parents of the significance and criticality of ECE for a child's growth and development.<sup>2</sup>
- Specific training strategy for ECE to develop qualities of sensitivity, empathy, and child centered pedagogy would be made following the positive experiences of Udisha Project<sup>3</sup>.
- There would be a system of continuous and comprehensive assessment of children's learning and development. Innovative methods of supervision, mentoring/training and on-site resource support would be piloted.
- Strengthening of program monitoring and having an effective social audit would be taken up. Participation of parents and community in this process would be ensured. Suitable and

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<sup>2</sup> Recommendations of the National Consultation on Early Childhood Education, June 6, 2006, New Delhi, MWCD and UNICEF

<sup>3</sup> Ibid



appropriate mechanism such as ICDS accreditation system would be evolved to enable community involvement in monitoring and social audit of ICDS & ECE component.<sup>4</sup>

- Media would be utilized proactively along the lines of Ministry of Health to propagate and advocate the cause of children and the importance of ICDS in general and ECE in particular<sup>5</sup>. In order to sensitize the public on various aspects of ECE – pedagogical and mother tongue language concerns, warns against the danger of neglect, significance and true meaning of ECE etc – mass public awareness and advocacy programmes would be undertaken involving different forms of print, electronic and folk media. Discipline experts and experienced practitioners would be engaged in this task<sup>6</sup>.

## 10. PROJECT MANAGEMENT

It has been felt that one of the main reasons for inadequate focus and sharpness in ICDS efforts is inadequate technical and managerial expertise at various levels of management to determine the content, guard it from external influences and guide the implementation with state-of-the-art technology. Keeping in view the emerging needs in ICDS, a paradigm shift is required in respect of the programme management *vis-à-vis* the ICDS programme implementation framework.

Under the proposed project, the following management structure would be adhered to:

- An Empowered Committee at the central level under the chairpersonship of the Joint Secretary, MWCD would be constituted under the Project to give policy directions to the project and also accord sanctions to the annual action plans. Apart from this, a three tier-management structure at the Central, State and district level would be set up in order to have effective planning, management, supervision and monitoring of the project (Annex).
- A Central Project Management Unit (CPMU) at the central level under the Ministry of WCD, State Project Management Units (SPMUs) under the Directorate of ICDS at the State levels, and District Cells in the selected districts (if not existing) would be set up. Both CPMU and SPMUs would consist of professionals and technical persons having expertise in the areas of nutrition, IEC, Finance & Procurement, PSE, Training, M & E/MIS, and Community Mobilization etc., alongwith key governments officials. Setting up of the PMUs at the State level would be a pre-requisite before starting off the project in the States.
- Project Directors in both CPMU and SPMUs will be delegated with certain administrative and financial powers for day-to-day implementation of the project including clearances of the proposals to make them more functionally effective.
- Decentralized District based planning would be adopted in the project. District level Health Surveys (DLHS) data will be used for assessing the impact of interventions through ICDS. Inter-sectoral district/block/village level micro planning for children - with clear synergistic health, nutrition and development outcomes, with decentralized locally responsive childcare approaches would be developed.
- Block Level Coordination Committee (BLCC) would be set up consisting of the members from the community, panchayat, NGO to monitor and coordinate the implementation of the programme.
- For the smooth fund flow from the centre to the implementation agency, Society model would be tried out, similar to that of Sarva Siksha Abhiyan/NRHM.

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<sup>4</sup> *Ibid*

<sup>5</sup> *Ibid*

<sup>6</sup> *Draft Recommendations of the Sub-Group on Pre-school education for the XI Plan*

## **11. PROJECT PERIOD**

It is expected that the project would be made effective during July-August 2008. Duration of the project will be for a period of five years.

## **12. PROJECT COST**

The exact project cost will be determined through the development of Project Implementation Plans (PIPs). The Ministry of WCD has, however, initially worked out budgetary requirements for the 11<sup>th</sup> Five Year Plan as Rs.41764.80 crore, which has been further revised tentatively to Rs.72877.52 crore (equivalent to US\$ 18 billion). The budgetary allocation (BE) for ICDS during FY 2007-08 has been made as Rs. 5293.00 crore (US\$1.3 billion). It is expected that the IDA assistance to the proposed project will be to the tune of US\$ 450 million with US\$ 250 million for the Nutrition component and US\$ 200 million for the ECE Component for five years.

Exhibit

**(PROPOSED) PROJECT MANAGEMENT STRUCTURE**

