

**WORKING GROUP ON THE CHILD DEVELOPMENT
FOR
THE ELEVENTH FIVE YEAR PLAN (2007-2012)**

Final Report of the Sub-Group on “ICDS & Nutrition”



**MINISTRY OF WOMEN & CHILD DEVELOPMENT
GOVERNMENT OF INDIA
SHASTRI BHAWAN, NEW DELHI**

AUGUST 24, 2006

CONTENTS

		<i>Page</i>
Chapter One:	Background	1-4
	Terms of Reference of the Sub-Group on “ICDS & Nutrition”	
	The Context	
	Supportive Policies Legislations and Commitments	
	Supreme Court Judgment	
	Child Development Programmes and Strategies in the Five Year Plans	
Chapter Two:	Review of ICDS in Tenth Five-Year Plan	5-6
	Expansion of the ICDS	
	National Common Minimum Programme (NCMP)	
	Linkages with Other Programmes	
	Mid Term Appraisal of the Tenth Five Year Plan	
Chapter Three:	Situational Analysis of Children - Major Trends	7-8
Chapter Four:	ICDS in Eleventh Five Year Plan	9-19
	Strengthening ICDS for Reduction of Child Malnutrition	
	Emerging Issues	
	Strategic Recommendations for ICDS & Nutrition	
ANNEX	Members of the Sub-Group on ICDS & Nutrition	20-21

BACKGROUND

TERMS OF REFERENCE OF THE SUB-GROUP ON “ICDS & NUTRITION”

In the context of the formulation of Eleventh Five Year Plan (2007-2012), the Government of India has decided to set up a Working Group on “Development of Children”. The Working Group has been set up under the Chairpersonship of Secretary, Ministry of Women & Child Development. In order to carry out the job assigned to the aforesaid Working Group on Development of Children, four Thematic Sub Groups on (i) ICDS & Nutrition, (ii) Early Childhood Education, (iii) Child Protection, and (iv) Girl Child, have been set up by the Ministry of Women & Child Development.

The Terms of Reference of the Sub-Group on ‘ICDS & Nutrition’ under the Chairmanship of Joint Secretary (CD), MWCD, are as follows:

- *Early Childhood Care*
- *Nutrition and food security*
- *Registration of births*
- *Breast feeding*
- *Universalisation of ICDS*
- *Linkages with health, learning and early childhood development*
- *All matters relating to early childhood care and nutrition*

THE CONTEXT

Child Development – The Foundation of Human Development

Children are the first call on agenda of development – not only because young children are the most vulnerable, but because the foundation for life long learning and human development is laid in the crucial early years. It is now globally acknowledged that investment in human resources development is a per-requisite for economic development of any nation. Early childhood (the first six years) constitutes the most crucial period in life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative life long learning. By the end of the second year of life – most of the growth of the human brain is already complete and critical brain structures are in place. The young child under 3 years is more vulnerable to the vicious cycle of malnutrition, disease/infections and resultant disability, all of which constitute risks, development opportunities determine both the present of every child and family as well as the future human resource development of the nation.

Child Development and ICDS

Child health, nutrition and development have to be looked at as a holistic approach, and one cannot be achieved without the other. Child Development can be incorporated in any programme for children and not entirely dependent on this component of ICDS. Development is a much wider holistic concept and not limited in the way it is generally understood. There have to be balanced linkages between education and nutrition for proper development of a child. For achieving optimum results, the first three years are crucial. For proper development of the child, we need inputs from every development programme that deals with women and children, starting from home, where mother is the most important caregiver and provides constant stimulus, which helps the child grow and develop. Contribution of the rest of the family too plays an important role. A child who is cared for and fed adequately is automatically getting the advantage of childcare and development. The crucial period is birth to two years when maximum growth and development of brain takes place. Any deprivation at this age, both nutritional and care related in

development is difficult to remedy later. Programmes like ICDS can help a great deal in this regard. However, one has to remember that malnutrition is not the result of a single cause but of multi faceted problems acting singly or in combination with other complex factors like poverty, purchasing power, health care, and ignorance on nutrition and health education. Female illiteracy has been identified as the foremost cause of child malnutrition by various studies.

SUPPORTIVE POLICIES LEGISLATIONS AND COMMITMENTS

Constitutional Provisions

Article 45 of the Constitution states that “The State shall endeavour to provide early childhood care and education for all children, until they complete the age of 6 years’. Article 47 embodies the commitment that ‘The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among the primary duties.....”.

Legislative and policy framework

Various policy provisions for the development of children have been in existence in the country. Some of the relevant policies include -

- ❑ ***National Policy For Children 1974***, which provides the conceptual basis for an integrated approach to addressing the whole child- which commits the State to provide adequate services to children, both before and after birth and through the period of growth- to ensure their full physical, mental and social development.
- ❑ ***National Policy on Education 1986, and its National Plan of Action***, which has a full section on Early Childhood Care and Education. It clearly recognizes the holistic nature of child development, and that ECCE is the crucial foundation for human resource development and cumulative lifelong learning. It is viewed as a feeder and support programme for universal elementary education- especially for first generation learners, and an important support service for working mothers and girls.
- ❑ ***National Health Policy 2002*** accords primacy to preventive and first line curative care at the primary health level, and emphasizes convergence, and strategies to change care behaviors in families and communities.
- ❑ ***Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) 1992 and its Amendment Act 2003***. This is a globally well-recognized instrument to promote, protect and support breastfeeding and to ensure optimal Infant and Young Child Feeding practices, harmonized with recent WHO/UNICEF guidelines.
- ❑ ***National Plan of Action For Children 2005*** which is a comprehensive multi sectoral plans to ensure child survival, development, protection and participation to achieve child related national and Millennium Development Goals, and fulfill national and global commitments to children.

SUPREME COURT JUDGMENT

- ❑ In a landmark order dated 28 November 2001, the Supreme Court, in a PIL by the People’s Union of Civil Liberties, directed the central and state governments to:

“Implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under:

- *Each child up to 6 years of age to get 300 calories and 8-10 grams of protein;*
- *Each adolescent girl to get 500 calories and 20-25 grams of protein;*
- *Each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein;*
- *Each malnourished child to get 600 calories and 16-20 grams of protein;*
- *Have a disbursement centre in every settlement.”*

- The Supreme Court, *vide* its subsequent order dated 29.4.2004, issued the following directions to the GOI in relation to the implementation of the ICDS Scheme:
 - *We direct the Government of India to file within 3 months an affidavit stating the period within which it proposes to increase the number of AWCs so as to cover 14 lakh habitation;*
 - *We notice that norm for supply of nutritious food worth Re. 1 for every child was fixed in the year 1991. The Government of India should consider the revision of the norm of Re. 1 and incorporate their suggestion in the affidavit.*
- Supreme Court in its further order-dated 7.10.2004, has, *inter-alia*, directed that BPL shall not be used as an eligibility criteria for providing supplementary nutrition under the ICDS Scheme.

CHILD DEVELOPMENT PROGRAMMES AND STRATEGIES IN THE FIVE YEAR PLANS

Approximately 15.76% of India's population (2001 Census) consists of children of six years and below. With a young population of this size, plans for child development have been within the mainframe of India's planning process from the First Plan itself. In the initial years, the main responsibility of developing childcare services had primarily rested with voluntary organizations. The Central Social Welfare Board played the lead role in planning and assisting voluntary efforts.

Over the years, the planning of strategies for children in the country has evolved from welfare to development to rights approach. Considering that the opportunities for early childhood development determine both the present and the future human resource development of the nation, child development received attention from the very First Five Year Plan.

In the Second, Third, and the Fourth Plan the same approach for the welfare of children continued. The Fourth Plan focused on accelerating the basic minimum services for the children culminating finally in the adoption of a National Policy for Children in 1974.

The **Fifth Plan** saw a shift in focus from child welfare to child development and an emphasis on integration and convergence of sectoral social inputs for the well being of infants, children and pregnant and lactating women, which finally took place by the launching of Integrated Child Development Services (ICDS) in 1975, which aimed to enhance the holistic development of the child through the involvement of a community based voluntary worker called Anganwadi worker.

The **Sixth Five Year Plan** reiterated the approach and strategy outlined in the Fifth Plan, and promoted consolidation and expansion of the programmes started earlier. It witnessed expansion of ICDS Projects and an accelerated implementation of Universalisation of Elementary Education (UEE).

The **Seventh Five Year Plan** continued the strategy of promoting early childhood survival and development through programmes in different sectors, important among these being ICDS, universal immunization, maternal and child care services, nutrition, preschool education, protected drinking water, environmental sanitation and hygiene, and family planning. Greater emphasis was also given to human development through advocacy and community empowerment.

The main focus of the **Eighth Five Year Plan** was human development with policies and programmes for child survival and development receiving high priority. Children were viewed as the nation's future human resource and investment in child development services as an investment in the country's future. The government declared its commitment to the development of 'every child', which was manifested in the two National Plans of Action adopted in 1992, one for children and the other exclusively for the girl child. The National Nutrition Policy 1993 and National Plan of Action 1995 were also adopted.

The **Ninth Five Year Plan** placed the young child at the top of the Country's Developmental Agenda with a special focus on the girl child and re-affirmed its priority for the development of early childhood services as an investment in Country's Human Resource Development. It continued to lay a special thrust on the three major areas of child development viz., health, nutrition and education and universalisation of the Nutrition Supplementary Feeding Programmes.

The **Tenth Five Year Plan** advocates a convergent *Rights based Approach* to ensure the survival, development, protection and participation of children- with priority to the young child and the girl child. ICDS was recognized as the mainstay of the plan for child development, and convergence of three nationwide programmes- RCH, ICDS and SSA was strongly recommended. The Plan reaffirmed its belief in integrated approach for meeting the survival, growth and developmental needs of young children, adolescents and women across the life cycle- through family and community based interventions. Integrated community based early childcare approaches, focusing on reaching children under three years of age were emphasized. The Plan acknowledged the need to make special efforts to reach the un-reached, disadvantaged community groups, for a more inclusive society- and specifically identified urban poor groups as having been left out of the ambit of ICDS. It also called for expanding the support services of crèche/day care services, thus reducing the burden of working/ailing mothers and of the girl child who is expected to bear the burden of sibling care.

REVIEW OF ICDS IN TENTH FIVE YEAR PLAN

EXPANSION OF THE ICDS

The ICDS Scheme was approved for implementation in the X Plan within the existing sanctioned 5652 Projects with no expansion activities due to resource constraints. It may be noted that only 4200 ICDS Projects were operationalized by the end of VIII Plan (31.3.1997) while 1452 more Projects were sanctioned in the VIII Plan, these were permitted to be operationalized in a phased manner, during the IX Five Year Plan. As a result, only 408 additional projects could actually become operational by the end of IX Plan. Remaining 1044 ICDS Projects, which were non-operational at the beginning of X Plan became operational by 31.3.2006 only.

To comply with directions of the Supreme Court and to implement the National Common Minimum Programme (NCMP) of the Government, the scheme has been expanded to cover 466 additional Projects and 1,88,168 additional Anganwadi Centres during the FY 2005-06. As on 31.12.2005, 5653 Projects and 745,943 AWCs have become operational.

As a result of operationalization of Projects, permitted for operationalization in IX Plan, the total number of beneficiaries has recorded a significant rise during the X Plan. The total number of beneficiaries as on 31.3.2006 was about 568.40 lakh comprising of about 474.52 lakh children (0-6 years) and about 93.88 lakh pregnant and lactating mothers through a network of about 7.48 lakh Anganwadi Centres; whereas the same stood at 375.09 lakh (315.03 lakh children and 60.06 lakh women) as on 31.03.2002.

NATIONAL COMMON MINIMUM PROGRAMME (NCMP)

Recognizing the criticality of improving young child survival, growth and development outcomes, the National Common Minimum Programme of the present Government clearly emphasizes the need to accord priority to children – especially the girl child. It stipulates a commitment to ‘Universalize the Integrated Child Development Services (ICDS) scheme to provide a functional Anganwadi in every settlement and ensure full coverage for all children’. The Common Minimum Programme also states that nutrition programmes, particularly for the girl child, will be expanded on a significant scale.

LINKAGES WITH OTHER PROGRAMMES

The second half of the Tenth Plan witnessed major landmarks in policy and resource commitments to child survival and development, targeting children directly -such as ICDS Universalisation, Universalisation of school mid day meals, Sarva Siksha Abhiyan (SSA), Kishori Shakti Yojana (KSY), and those addressing poor communities and impacting upon children -such as the National Rural Health Mission (NRHM), Total Sanitation Campaign (TSC), and the National Rural Employment Guarantee Scheme (NREG). These initiatives are synergistically linked – seeking to touch the lives of rural poor and marginalized communities and their children and women. They are now translating CMP commitments into action – within the families and communities in which children live grow and develop.

MID TERM APPRAISAL OF THE TENTH FIVE YEAR PLAN

Given the importance of ICDS in the survival and development of children and its centrality within the programmes of the Ministry of Women & Child Development, the Mid-term appraisal of the 10th Plan highlighted the following:

- *The existing crèche facilities need to be expanded exponentially.*
- *Universalisation of ICDS, one of the goals of NCMP, needs to be completed in five years time. Universalisation of cannot and should not be interpreted merely in terms of doubling the number of centres to 14 lakh. The nature of change and quality improvement is as important.*
- *Lack of food security and poor nutritional status affects the physical growth, intelligence, behaviour and learning abilities of children and adolescents, especially during the development of the brain in 0-3 years period. Since most States are unable to meet the supplementary nutrition component of ICDS because of financial constraints, Centre could consider sharing of the cost of the supplementary nutrition. Supplementary nutrition can be supervised by women's SHGs on behalf of the panchayats.*
- *For the ICDS to achieve its objectives, an effective synergy is required between the DWCD and the Ministry of Health & family Welfare, the Department of Education, the Department of Drinking Water Supply and other ministries/departments to meet the requirements of health, sanitation, drinking water, pre-school education, etc.*
- *Accountability should remain with the State departments of WCD, but with increasing attempts to involve the Panchayati Raj institutions (PRIs) as partners.*

SITUATIONAL ANALYSIS OF CHILDREN – MAJOR TRENDS

Despite a vibrant growth rate of around 8 per cent of country's economy, progress in improving the health and nutrition status of the women and children has been rather slow. While income poverty in India has been reduced to 26 per cent (1999-2000) - underweight prevalence in children under three years remains at 47 per cent in 1998-99 (NFHS-II). How this indicator (underweight children) has improved since 1998-99 would be known only after the results of NFHS-III, which is currently underway, are released some time by the year-end. However, the argument that economic growth is a necessary, but not sufficient condition for improvements in young child survival, nutrition and development still holds good. The country has achieved self-sufficiency in food grains at national level but food insecurity at household level continues to be a cause of concern.

HEALTH STATUS

- (i) The infant mortality rate (IMR) has shown a significant decline from 146 per 1,000 live births in 1951 to 58 per 1,000 in 2004 (SRS 2006). However, the decline has not been as significant over the last decade. Wide regional disparities exist within states, districts and even community groups –for example, Kerala has an IMR of 12, while Madhya Pradesh has an IMR of 79 in 2004 (SRS 2006).
- (ii) The under-5 mortality rate has also shown some improvement, but still remains high at 77 per thousand live births.

	2001	2002	2003	2004
IMR	66	63	60	58
Under-five Mortality Rate	85	81	77	NA

Source: SRS Bulletins, Sample Registration System, Registrar General of India

- (iii) The slow rate of decline in infant mortality rate during the last decade can be improved only if the problem of malnutrition is addressed through a multi-pronged strategy as malnutrition is an underlying cause of such deaths in 50% of the cases. According to a report of WHO, 55 per cent of infant mortality is reported to be contributed by malnutrition directly or indirectly.

NUTRITIONAL STATUS

Undernutrition continues to be a major public health problem in India, the most vulnerable groups being women of reproductive age group and young children.

- There has been limited progress in improving the prevalence of child malnutrition (i.e., Protein Energy Malnutrition –PEM) over time - a reduction of underweight prevalence of less than 1% per year between 1992-93 (NFHS-I) and 1998-99 (NFHS-II). According to NFHS-II in 1998-99, 47 per cent of children under three years are underweight. A similar percentage (45.5 per cent) are stunted.
- Dis-aggregation of underweight statistics (NFHS-II) by socioeconomic and demographic group reveals that weight-for-age underweight prevalence is higher in rural areas (50 per cent) than in urban areas (38 per cent); higher among girls (48.9 per cent) than among boys (45.5 per cent); higher among scheduled castes (53.2 per cent) and scheduled tribes (56.2 per cent) than among other castes (44.1 per cent).

- 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.
- Nearly 23% of all children born in the country have low birth weight (NFHS-II).
- Micronutrient deficiencies (MND) of public health significance are vitamin 'A' deficiency (VAD), iron deficiency anaemia (IDA) and iodine deficiency disorders (IDD). One of the major causes of micronutrient deficiencies diseases in the country is dietary inadequacy of the specific nutrients. According to surveys carried out by National Nutrition Monitoring Bureau (NNMB) during 2000-01, in the rural areas of 9 States in the country, the average daily intake of almost all the micronutrients were grossly inadequate. The median daily intake of vitamin A was about 50-60 µg among 1-6 year children, as against the recommended level (RDA) of 400 µg/day. About 88% of the children were consuming vitamin 'A' in amounts less than 50% of RDA. Similarly, about 80% of the individuals were consuming iron in amounts less than 50% of RDA.
- According to the MND survey carried out by NNMB in 8 States, the overall prevalence vitamin A deficiency (VAD) was 0.8%, which is more than the WHO cut-off level of 0.5%, indicating public health significance of VAD. Iron deficiency anaemia (IDA) is widely prevalent among all the age and physiological groups. The prevalence of IDA as assessed ranged from 70 to 80% among preschool children (67%), adolescent girls (70%), Lactating mothers (78%) and pregnant women (75%). The survey also revealed that the coverage of target beneficiaries for supplementation of massive dose vitamin A to children (25-30%) and iron & Folic acid tablets to pregnant women (≥ 90 tablets) was very low (30%). only about 31% of the households in general were found consuming adequately iodized (iodine levels of ≥ 15 ppm) salt.
- The promotion of early and exclusive breastfeeding for the first six months and appropriate complementary feeding continue to be major challenges. Only 16 percent of children begin breastfeeding within one hour of birth. According to NFHS-II, only 55 percent of children under four months of age are exclusively breastfed and this percentage drops significantly when assessed for the 0-6 months age group. Only 35.9 percent of children in the 6-9 months age group are receiving any solid or mushy foods, in addition to breast milk.
- Almost three-fourths (74.3%) of India's children below 3 years were found to be anaemic (NFHS-II). About 52% of women were found to be anaemic with the rates being higher amongst younger women (56% among those aged 15-19 years) and women from SC (56%) and ST (65%) communities (NFHS-II). There was strong correlation between the maternal anaemia levels and status of anaemia amongst children. Higher anaemia were reported among children belonging to SC (78.3%) and ST (79.8%) communities, and those with literate mothers (78.2%).

ICDS IN THE ELEVENTH FIVE -YEAR PLAN

STRENGTHENING ICDS FOR REDUCTION OF CHILD MALNUTRITION

The ICDS 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 of the programme 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, and inadequate community participation in the programme, continues to be a major challenge during the Eleventh Plan.

After more than 30 years of rich experience in the programmatic perspective, a paradigm shift is required to reform the ICDS in respect of overall programme management for a faster and sustained achievement of child and women nutritional goals. During the Eleventh Plan, while we rededicate ourselves to promoting early childhood care for survival and development of the children, an attempt would be made to re-structure the ICDS programme implementation framework to suit the current nutritional needs of the women & children and to strengthen the existing service delivery mechanism. This would not only help accelerate ICDS universalisation with quality to reach out to all under three children, but also help accelerating reductions in IMR, malnutrition and promoting early development.

EMERGING ISSUES

During the Eleventh Plan, many of the above issues would require renewed focus by revisiting the primary mandates of ICDS. Accordingly, the thrust areas during the Eleventh Plan are identified as under:

- *Achieving ICDS Universalisation with Quality – Population norms/population density - Targeting both in terms of area and population groups*
- *Strengthening basic infrastructure and service delivery in AWCs*
- *Restructuring Programme Management/Revised ICDS Implementation Framework*
- *Strengthening HR management in ICDS*
- *Mobilizing Resources*
- *Addressing Nutritional Issues- Eradicating severe malnutrition*
- *Strengthening Nutrition & Health Education*
- *Advocacy, Communication and Social Mobilization*
- *Strengthening Training and Capacity development*
- *Strengthening Monitoring & Evaluation*
- *Fostering Public-Private and Community Partnership (PPCP)*
- *Strengthening partnerships with PRIs, NGOs and voluntary sector*

STRATEGIC RECOMMENDATIONS FOR ICDS & NUTRITION

The following recommendations are made for consideration in the 11th Plan to address the aforesaid emerging issues as identified by the Sub-Group on 'ICDS & Nutrition'.

1. Universalisation of ICDS with Quality

The ICDS Scheme was approved for implementation in the X Plan within the existing sanctioned 5652 Projects with no expansion activities due to resource constraints. Even the operationalization of 1044 ICDS Projects, which were non-operational at the beginning of 10th Plan, was to be phased over the entire X Plan period. To comply with directions of the Supreme Court and to implement the National Common Minimum Programme (NCMP) of the Government, the scheme has been expanded to cover 466 additional Projects and 1,88,168 additional Anganwadi Centres. Based on the revised population norms recommended by the Inter-Ministerial Task Force, the States have given requirement of 173 Projects, 107274 AWCs and 25961 mini-AWCs.

During the last five years (2002-2006), although the total number of children beneficiaries has increased to 51%, there still exists a significant gap in reaching out to all children under 6 years in the country. As per Census 2001, there are 15.79 crore children in the age group 0-6 years, of those, only 4.74 crore children are covered under the supplementary nutrition programme in ICDS (as on 31.3.2006), which is only 30% of all children in the country.

Recommendations

- ❑ The challenge in expanding the ICDS in uncovered areas may be not only to ensure inclusion of the most marginalized and poorest community groups including thinly scattered habitations in hilly/forest/desert areas, but also to ensure better inclusion of un-reached SC/ST/ Minority/ migrant population/children with disabilities, and urban poor groups.
- ❑ Strengthening and full coverage of ICDS services in SCSP/TSP areas shall be the special focus.
- ❑ In order to achieve the universalisation of ICDS by including marginalized and disadvantaged groups, there is a need for revision in the existing population norms. The following revised population norms may be considered in the 11th Plan:
 - *For Rural Projects, there can be one AWC for population of 500 to 1000, instead of existing 500 to 1500, followed by a second AWC for population of 1000 to 2000 and for every additional 1000 population.*
 - *For tribal projects, there can be one AWC for population of 150 to 500, followed by 1 mini-AWC for population of less than 150, Mobile AWCs providing take-home ration and other services, as needed, to cover thinly scattered habitations in hilly/forest/desert areas..*
 - *For Urban projects, there can be one AWC for population of 500 to 1000, followed by second AWC for 1000 to 2000 population and for less than 500 population one mini-AWC/Mobile.*
- ❑ Monthly weighing of all under-three children at the AWC and counselling their mothers to be taken as a key coverage as well as service quality indicator in ICDS. This indicator would help bridge the gap between the total child population/registered/participating.
- ❑ District Plans of Action for Child Development would be made following SSA framework to reach every habitation and to address coverage gaps between child population and those registered.
- ❑ Universal registration of births to be ensured, using mother and child protection card.
- ❑ ASHA worker of NRHM should be associated with Mini AWCs also.

- Upgradation of AWCs into AWCs-cum-crèches for meeting the pressing needs for child day care and due attention to younger children in the farm/non-farm areas will be taken up selectively on a pilot basis. These centres may be called as ‘Child Care Centres’ and will have its AWWs specially trained to support in breastfeeding, complementary feeding and lactation management and also to help lactating mothers with babies as small as below six months.

2. Strengthening Basic Infrastructure and Service Delivery in AWCs

The ICDS Scheme does not provide for construction of AWC buildings. 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 was revealed that only 21% AWCs were running from semi-pucca building, about 15% from *kutchha* 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. During the 11th Plan, there would be a major thrust on building the infrastructure at the AWC level. There is also a need to improve service delivery at the AWC by ensuring the availability of basic kits and equipments.

Recommendations:

- Thirty percent of the allocated fund for the ICDS Scheme shall be earmarked for infrastructure development, including construction of AWC buildings, Baby friendly toilets, provision of water supply and sanitation facilities in the pattern of ‘Sarva Siksha Abhiyan’.
- Whenever an Anganwadi centre is sanctioned, it would be sanctioned with a building. The Ministry of WCD and the states/UTs (excepting the special category States) may contribute towards construction of AWC buildings on a 50:50 basis. Ministry may indicate broad specifications of the building to ensure uniformity and the adequacy of space for various activities in AWC.
- Unit cost of both PSE and Medicine kits would be upwardly revised. Utensils may be replaced once in every 5 years. Three types of weighing scales viz. (i) Tubular Salter balance (10kg, 100 gm sensitive) to weigh the neonates and monitor growth during infancy, (ii) 20 kg Dial Salter or equivalent balance for weighing children between 1-5 years of age, and (iii) Adult weighing balance to weigh pregnant and lactating women, would be provided to AWCs with provision for periodic replacement. Display Board indicating the services being provided may be displayed in each AWC.
- 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).
- Flexi-funds may be provided at the AWC level for local innovations and community contact programmes.
- As far as possible, procurement, processing and distribution of supplementary food would be encouraged through community-based organizations/ SHGs/ Mahila Mandals/Mother’s Committees, to ensure greater participation of the community.
- Infant and young child feeding counseling as a ‘service’ in the ‘delivery’ list of both the MOHFW & WCD with clear objective to achieve high rates of exclusive breastfeeding would be mainstreamed.

3. Restructuring Programme Management/Revised ICDS National Framework

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.

Recommendations:

- ❑ During the 11th Plan, a national restructuring of ICDS implementation framework may be initiated replacing the existing structure of programme management and following the model of SSA/NRHM. The restructuring of ICDS framework would be based on the premises of a more responsive and flexible structure at the national, State and district levels. Such a model would help faster execution of the activities with greater flexibility in implementation of the programme and thus accelerate in achieving the programme goals/objectives.
- ❑ State ICDS Directorates and District cells will be appropriately strengthened by bringing in professional and technical expertise in the areas of IEC, Early childhood care, training, nutrition, health, community mobilization, procurement, monitoring & evaluation both at the district and State level for a better implementation of the programme.
- ❑ Management cost up to a certain per cent of the total programme cost to be kept for administrative costs including that for engaging experts at the district level. Management cost would be used to develop effective teams at State/District/Block/Cluster levels. Priority to hire experts in MIS, Nutrition, Community Mobilization, IEC etc depending on capacity available in a particular district would be given. There would be support at the State level from the aforesaid management cost as the funds for Research, Evaluation, Supervision and Monitoring at State level.
- ❑ Decentralized District based planning would be adopted in ICDS following SSA framework. 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.
- ❑ It is well known that no single Ministry/Department/Organization can achieve the objectives laid down in ICDS Programme. Integration and convergence of efforts and services of all related programmes such as NRHM, Rajiv Gandhi National Drinking Water Mission, SSA, NREG, etc need to be further strengthened.
- ❑ The Logical Framework Approach (LFA) which is an analytical, presentational and management tool, may be introduced in ICDS. LFA has become widely accepted as a useful and necessary tool for project planning. Necessary training of the programme managers both at the Central and State levels would be taken up to equip them with the LFA techniques of programme implementation.
- ❑ To strengthen supervision of the programme at the field level, mobility of Supervisors and CDPOs, who are mostly women, may be ensured.
- ❑ **Better Targeting:** 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. During the 11th Plan, there would be a mechanism to address the needs of those areas (states/districts/blocks) where prevalence of malnutrition amongst children is more pronounced. 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.

4. Strengthening HR Management

ICDS aims to bring about the change in behaviors in caregivers of millions of malnourished women and children, therefore, a re-look into the whole system of hiring the right village worker, to providing her the enabling environment through training, supervision, and building

accountability through responsibility and incentives at the state levels would be a priority during the 11th plan. In order to prepare her for the catalyst role of a ‘change agent’ she should possess and learn attributes apart from the requisite educational qualification. Also, there is an urgent need to shift the focus of the programme towards the under-three children – from the centre to the family.

Recommendations:

- ❑ In view of the expansion of the ICDS scheme and inclusion of multifarious activities in the ambit of the scheme, it has become necessary to prescribe a proper educational qualification for the post of Anganwadi Worker. However, varying qualifications may be prescribed in urban/rural/tribal areas depending upon the availability of the personnel in the area.
- ❑ It is also proposed to suitably enhance honorarium to Anganwadi Workers and Helpers periodically. In addition, there would be a mechanism to ensure additional remuneration to the AWWs based on their performance.
- ❑ Effective supervision mechanism may be ensured with an appropriate Supervisor to AWW ratio that are commensurate with level of effort needed to achieve programme goals. Role of Supervisors in ICDS needs to be looked into and re-defined according to the emerging needs.
- ❑ A performance appraisal system for AWWs may be introduced. There shall be a reward and disincentive mechanism for effective delivery of services.
- ❑ An accreditation system, to grade AWCs, with defined quality standards may 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.

5. Mobilizing Resources

Following the strategy adopted in Sarva Siksha Abhiyan (SSA), ICDS programme too calls for a long-term perspective on financial partnership between the Central and the State governments to make the scheme sustainable. During the 11th Plan, there would be an attempt to mobilize additional resources, which would be required to restructure the programme in accelerating reduction of child malnutrition in the country through ICDS.

Recommendations:

- ❑ It is proposed that the financial assistance under the programme will be on 85:15 sharing arrangement during the 11th plan, followed by 75:25 sharing during the 12th plan and 50:50 sharing thereafter between the Central Government and State Governments.
- ❑ To levy a cess called ‘Anganwadi Cess’ so that the cess amount collected is utilized to cover at least a good portion of the additional expenses incurred on account of enhanced honoraria of AWWs and AWHs.
- ❑ To create a public trust under the control and supervision of the Government by associating representatives of business, industry and trade, to seek donation for the trust to be solely intended to cover children under the scheme and providing tax relief for the amount so contributed to the said Trust. The cost of setting up of an Anganwadi and running it for a year can be calculated and the cooperation of business, industry and trade can be sought to bear the expenses of as many Anganwadis as possible to be set up in new areas.
- ❑ In addition to above, the corporate and private sector undertakings should be encouraged to support the ICDS programme in individual States/UTs, especially for constructing buildings, sponsoring children with malnutrition under Grade III & IV, and children with disabilities and for improving the service delivery of ICDS, by giving them 100% income tax exemption for contributions of Rs.10,000 and above to the Anganwadi centres.

6. Nutritional Issues – Eradicating Severe Malnutrition

The Tenth Plan has set specific nutrition goals to be achieved by 2007. One of the major goals is to intensify nutrition and health education to improve infant and child feeding and caring practices so as to bring down the prevalence of under-weight children under three years from the current level of 47 per cent to 40 per cent and to reduce prevalence of severe undernutrition in children in the 0-6 years age group by 50 per cent. There are several emerging nutritional issues, which could be addressed through ICDS. One of them is the micronutrient deficiencies (MND) in children, termed as ‘hidden hunger’, which have been attracting attention of both academicians and administrators. In India, the micronutrient deficiencies of public health significance are vitamin 'A' deficiency (VAD), iron deficiency anaemia (IDA) and iodine deficiency disorders (IDD). 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. There is also an urgent need to focus on eradicating severe malnutrition and reducing mild and moderate malnutrition in children through ICDS.

Recommendations:

- ❑ There would be a universal screening of all preschool children for undernutrition, monitoring growth in individual child’s card and identifying children with different grades of undernutrition. This would be included in the existing strategy of carrying out health check-ups in NRHM.
- ❑ To operationalize nutritional interventions for the management of undernutrition:
 - *For children with mild undernutrition – to teach the mothers on care of the children with home available foods;*
 - *For children with moderate undernutrition: give appropriate health and nutrition advice. If needed provide once a week take home food supplements (roasted cereal pulse oil seed mixed and powdered);*
 - *For children with severe undernutrition – to give appropriate nutrition & health care; take home food supplements will have to be given and close monitoring of these children;*
 - *To identify severely malnourished children who fail to improve under home management, those with infections and other complications and refer them to hospitals for care*
- ❑ 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).
- ❑ All lactating women will be identified and weighed in the first month after delivery. Those weighing less than 40 kg will be identified and provided 6 kg of food grams per month free of cost upto 12 months of lactation instead of the existing provision for 6 months.
- ❑ Allocation for supplementary nutrition may be suitably enhanced to ensure universal coverage of all children. There is a need to revisit the existing nutritional norms for the pregnant women and children. A mechanism to suitably devise SNP strategy for these sections shall be in place.
- ❑ 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 may be included in the monthly appraisal of AWW.

- ❑ 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 should be utilized to monitor undernutrition among children.
- ❑ The current efforts for addressing the issues of adolescent girls be stepped up substantially and also in an integrated manner. It necessary to merge the KSY and NPAG, enrich their content and expand their coverage. Merger of KSY and NPAG, and expansion of the coverage of SNP to the adolescent girls in all districts in the country may be the appropriate strategy for 11th Plan. An integrated approach taking care of life skills, nutrition, Health of Adolescents may pave way for a healthy society/ better quality human resources.
- ❑ Special drives will be conducted to weigh all adolescent girls in the age-group 11-19 who are out of schools and their growth will be monitored at AWCs in each quarter. 6 kg of food grains free of cost to be provided to all those girls with weight less than 35 kg.
- ❑ All malnourished girls would get Ready to Eat ration at the Anganwadi. The Anganwadi worker would distribute the requirement of 15 days at a time. If the girl crosses the malnourishment threshold then the supply of supplementary nutrition would stop after one month.
- ❑ Fortification of the supplementary food with micronutrients such as iron, iodine, calcium, vitamin A, thiamin, riboflavin, folic acid and B₁₂, at a level to meet 50% of the RDA through de-centralized and efficient models would be tried out.
- ❑ Universal supplementation of Vitamin-A dose for children and IFA tablets to pregnant women and adolescent girls would be ensured in convergence with RCH programme.
- ❑ A preventive/curative mechanism to treat all those severely malnourished children who may need urgent hospital based care would be established – through referral to PHC/District Hospitals. Pilot establishment of Nutrition Rehabilitation Centres (NRCs) in PHC/CHC in the nutritionally backward districts/blocks and tribal areas may be ensured for providing proper care and treatment of the severely malnourished (Grade III & IV) children. Necessary guidelines in this regard with the support of the health department may be issued. A separate fund for the purpose may be provided at the AWC level.

7. Strengthening Nutrition & Health Education (NHE)

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 is reiterated during the 11th Plan. Nutrition & Health Education 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.

Recommendations:

- ❑ The NHE component under ICDS should be redesigned with a particular emphasis on Mahila Mandals to a more comprehensive parenting support initiative. This should 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) in place of Nutrition & Health Day (NHED) 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 may 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.
- ❑ Nutrition and health education would also focus on improving over all dietary intakes and promoting consumption of iron and folate-rich foodstuffs to meet RDA for all macro and micronutrients would.
- ❑ Community Food and Nutrition Extension Units (CFNEUs) of FNB located in 29 States/UTs would serve as resource centres for nutrition education materials.

8. Advocacy, Communication and Social Mobilization

The IEC involves various approaches, build linkages, strengthen capacities, and enhance capabilities and skills besides building the environments for statewide people's movement of participation in the ICDS Programme. It is envisaged that IEC shall evolve successful processes which would result in AWCs 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.

Recommendations:

- ❑ State specific IEC strategy would be developed and interventions would be made after assessing the communication needs for a particular community /region.
- ❑ Behaviour Change Communication (BCC) needs to go beyond the traditional printed materials and should involve identification of local communications needs, use of multiple channels including folk media and mass media in addition to inter-personal communication (IPC) through AWWs and community level volunteers. In this regard, celebration of traditional occasions, like 'annaprashan' (for children completing 6 months), birthday (for all children), "godhbharai" (for pregnant women) etc would be observed at the AWC 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 appropriate infant feeding practices including early and exclusive breastfeeding, complementary feeding at six months of age along with continued breastfeeding (upto two years or beyond) alongwith the new born care would be taken up.
- ❑ A separate budget line under IEC component would be created keeping in view the aforesaid aspects. Existing financial norms for IEC should be upwardly revised to enable the States to develop and implement State specific IEC/BCC Strategy, separately for the State/District/Block/AWC level.

9. Strengthening Training and 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. During the 10th five-year plan, the National Training

Component of WCD/ICDS-III Project, christened as ‘UDISHA’, has been implemented with a focus on eliminating the heavy backlogs in job and refresher training of all functionaries all over the country. During the 11th plan, the issues of the training and capacity building of the ICDS functionaries would continue to be on the forefront.

Recommendations:

- ❑ Training functions should be planned, implemented and monitored at state levels by a competent technical body (State level Resource Centre - SRC); this body must provide dynamic guidelines for determining training content from time to time, which should be fully aligned to carefully determined program priorities.
- ❑ Existing infrastructure of the State Institutes of Health & Family Welfare, Education Department (SCERTs) etc may be used for strengthening of the ongoing training and capacity building of the ICDS functionaries.
- ❑ Efforts may be made to make all ongoing capacity building initiatives, the direct responsibility of program managers and implementers, and they should also be closely involved in induction training.
- ❑ A continuous Training Need Assessment (TNA) of ICDS functionaries, based on their educational level, length of service and understanding of the issues would be carried out in order to devise State specific training strategy.
- ❑ States would be encouraged to share cost of the training appropriately for implementation and monitoring of the training programmes.
- ❑ There would be renewed emphasis on ‘Other Training’ component which is other than the regular training and whereby the states are given the flexibility to identify state specific problems that need more focused or innovative training and to take up such training schemes.
- ❑ To ensure quality of training and better participation in the programme, existing financial norms at all levels of training at AWTCs, MLTCs and NIPCCD would be upwardly revised with a provision of increment in the honoraria of the trainers periodically, food expenses of the trainees and other recurring costs.
- ❑ NIPCCD will play a pivotal role in formulating the training strategy during the 11th plan.
- ❑ Food & Nutrition Board (FNB) under the Ministry of WCD will plan and integrate their training strategy on nutrition issues with the regular training programme of ICDS in consultation with the State Governments, NIPCCD.
- ❑ Various training methodologies, including decentralized training model and mobile training teams may be scaled up to ensure job/orientation training of all ICDS functionaries.
- ❑ A common core joint training module for ICDS and RCH would be worked out – including new IYCF guidelines, and a common core counseling kit – including mother child card, guidebook, cohort tracking mechanism, for nation wide use.

10. Strengthening Monitoring & Evaluation

Monitoring & Evaluation component of ICDS needs continuous strengthening through the 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. During the 11th Plan, emphasis would be to develop a Nutrition Information System in ICDS to gauge the progress in respect of all nutrition related outcome and process indicators.

Recommendations:

- ❑ To strengthen the existing MIS in ICDS, it is proposed to establish a Technical Support Group (TSG) both at the national and state levels with a clear mandate of guiding the programme to achieve the stated goals at the State and national levels.
- ❑ A nutrition monitoring, mapping and surveillance system would be piloted, in order to have an effective monitoring of the outcomes of ICDS interventions. Community based monitoring mechanism would be encouraged to bring in accountability in delivery of services by the AWWs.
- ❑ A system of concurrent evaluation of ICDS (of outcomes, nutritional status of the children) at the national level through external research agencies/professional bodies and also in each individual state/UT at the end of every three to five years would be established. Evaluation of NGO run ICDS projects *vis-à-vis* those run by the State Governments would be taken up periodically.
- ❑ Issue/area specific operational research studies and periodic social assessments would be introduced to make mid-course corrective actions. Periodic district level nutrition surveys would also be taken up.
- ❑ Home visit planner to help AWW to prioritize and plan home visits to households at critical periods of life cycle would be introduced. The critical periods when the home visits are most required, are the last trimester of pregnancy, first day (to ensure initiation of breastfeeding) of birth, first week, 6-8 months, 9-11 months 12 to 18 months including contacts during and after sickness.
- ❑ 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.
- ❑ An appropriate revamping of MIS System would be taken up at the central/state levels, with capacity building. The existing large number of reports/registers/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

11. Public-Private and Community Partnership (PPCP)

As mentioned earlier under Section 5, efforts would be made to involve corporate/private sectors for mobilizing resources by way of getting their support to ICDS programme in the construction of AWC buildings and also helping improvement in service delivery. The partnership would be encouraged with a clear direction to respect nation's legislations and without any 'conflict of interest'. Locally relevant effective PPCP initiatives can be piloted for better project outcomes.

12. Strengthening partnerships with PRIs, NGOs and Voluntary Sector

The 73rd and 74th Constitutional amendments have created vibrant new partnerships – to reach the most disadvantaged and under-served – and the most vulnerable – the young child. In many States devolution of powers to Panchayati Raj Institutions has also involved transfer of some functions for managing and monitoring ICDS to District Zilla Parishads, Block Panchayat Samities and Gram Panchayats. This constitutes a major opportunity for rooting developing programmes, more firmly in the community, with active participation of women. The Gram Panchayat will help create a supportive environment for child care, by enlisting a better teamwork from frontline workers (ANMs, AWWs, ASHA) to ensure convergence of services.

Recommendations:

- ❑ Involvement of local self-governments/Panchayati Raj Institutions (PRIs) in ICDS in the areas of selection of AWWs/AWHs, supervision of distribution of supplementary nutrition to

beneficiaries, providing land and building, Nutrition & Health Education, Mother & Child Days is desirable.

- Contribution of community resources to AWCs for improvement in service delivery could be mobilized which may include:
 - *Local material for making toys and conducting play way activities*
 - *Local nutritious foods and developing kitchen gardens around the AWC*
 - *Transporting pregnant women to hospitals who require urgent medical care*
 - *Transporting sick children for timely referral*
 - *Promoting consumption of only iodized salt*
 - *Community based monitoring, using a sample checklist and community charts for nutritional status of the children*
- Voluntary sector/NGOs will be encouraged to support the ICDS with their greater involvement in the programme. Guidelines for entrustment of ICDS projects to NGOs/Corporate Sectors and an appropriate mechanism would be developed in active consultation with the State Governments.
- To bring in transparency and accountability in the delivery of the services at the AWCs, participation of the mothers' committees/PRI members would be ensured.

ANNEX: MEMBERS OF THE SUB-GROUP ON ICDS & NUTRITION

SHRI CHAMAN KUMAR JOINT SECRETARY MINISTRY OF WOMEN & CHILD DEVELOPMENT ROOM NO. 615, 'A' WING, SHASTRI BHAVAN NEW DELHI.	Chairman
SHRI PANKAJ JAIN JOINT SECRETARY MINISTRY OF URBAN, EMPLOYMENT & POVERTY ALLEVIATION ROOM NO. 112 'C' WING, NIRMAN BHAVAN NEW DELHI.	Member
SMT. LALITHA KUMAR JOINT SECRETARY & DIRECTOR MISSION RAJIV GANDHI NATIONAL DRINKING WATER MISSION (DEPTT. OF DRINKING WATER SUPPLY) MINISTRY OF RURAL DEVELOPMENT PARYAVARAN BHAVAN,CGO COMPLEX NEW DELHI	Member
SHRI A.K. AGRAWAL JOINT SECRETARY MINISTRY OF AGRICULTURE & COOPERATION ROOM NO. 237, KRISHI BHAVAN, NEW DELHI	Member
MS RITA TEAOTIA JOINT SECRETARY MINISTRY OF HEALTH & FAMILY WELFARE NIRMAN BHAWAN, NEW DELHI 110 001	Member
DR B. SESIKERAN DIRECTOR NATIONAL INSTITUTE OF NUTRITION JAMIA OSMANIA POST OFFICE HYDERABAD-500007.	Member
SHRI PRASHANT MEHTA PRINCIPAL SECRETARY WOMEN & CHILD DEVELOPMENT DEPTT. GOVT. OF MADHYA PRADESH SECRETARIAT VALLABH BHAVAN, BHOPAL-462 001	Member
SHRI BALVINDER KUMAR SECRETARY DEPTT. OF WOMEN & CHILD DEVELOPMENT GOVT. OF UTTAR PRADESH ROOM NO.121, BAPU BHAVAN, LUCKNOW-226 001	Member
MS LIDA JACOB SECRETARY SOCIAL WELFARE DEPARTMENT GOVT. OF KERALA	Member

THIRUVANANTHAPURAM-695033

DR (MRS) PREMA RAMACHANDRAN
DIRECTOR
NUTRITION FOUNDATION OF INDIA
C-13, QUTAB INSTITUTIONAL AREA
NEW DELHI-1100016
Member

DR. ARUN GUPTA
NATIONAL COORDINATOR
BREASTFEEDING PROMOTION NETWORK OF INDIA
B-33, PITAMPURA, DELHI-110088
Member

DR A.C. SHUKLA
EXECUTIVE DIRECTOR
U.P. VOLUNTARY HEALTH ASSOCIATION
5/459, VIRAMKHAND
GOMTI NAGAR, LUCKNOW
Member

MS DEEPIKA SHRIVASTAVA
PROJECT OFFICER
UNIFEF, INDIA COUNTRY OFFICE
73, LODI ESTATE, NEW DELHI-110003.
Member

SHRI M.S. NEGI
DEPUTY SECRETARY
INCHARGE OF ICDS
MINISTRY OF WOMEN & CHILD DEVELOPMENT
SHASTRI BHAVAN, NEW DELHI
Member

SHRI B.P. SHARMA
JOINT SECRETARY
INCHARGE OF NRHM
MINISTRY OF HEALTH & FAMILY WELFARE
ROOM NO. 145, 'A' WING, NIRMAN BHAVAN
NEW DELHI
Member

SMT. SHASHI PRABHA GUPTA
TECHNICAL ADVISER
FOOD & NUTRITION BOARD
MINISTRY OF WCD
NEW DELHI
Member

SHRI DEVENDER KUMAR SIKRI
REGISTRAR GENERAL & CENSUS COMMISSIONER OF INDIA
2A, MAN SINGH ROAD
NEW DELHI-110011
Member

SHRI K.RAJESWARA RAO
DIRECTOR
MINISTRY OF WOMEN & CHILD DEVELOPMENT
SHASTRI BHAWAN, NEW DELHI 110 001
Convener