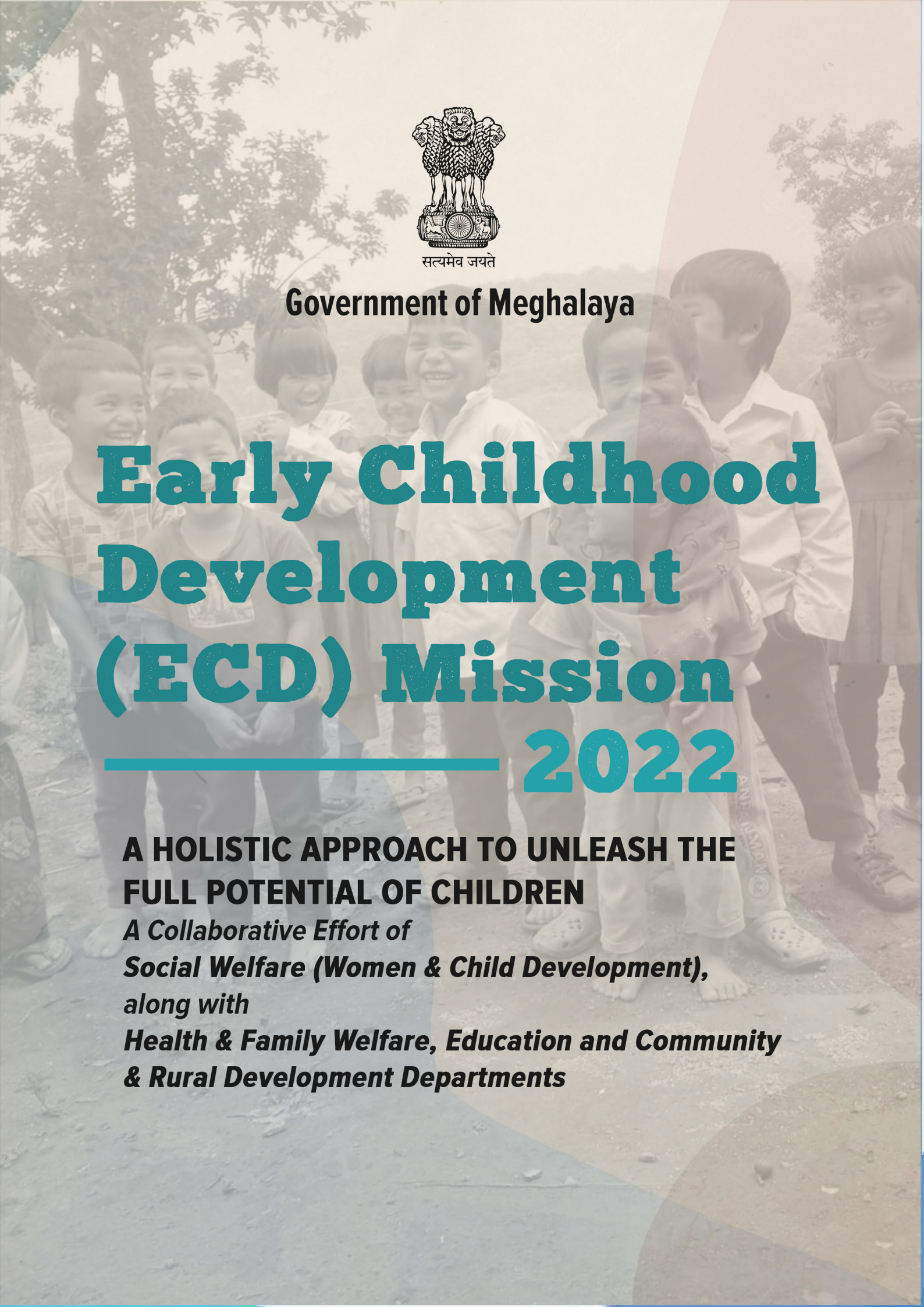

सत्यमेव जयते

Government of Meghalaya

Early Childhood Development (ECD) Mission

2022

A HOLISTIC APPROACH TO UNLEASH THE FULL POTENTIAL OF CHILDREN

A Collaborative Effort of
Social Welfare (Women & Child Development),
along with
Health & Family Welfare, Education and Community & Rural Development Departments

Conrad K. Sangma
Chief Minister
Meghalaya

FOREWORD

Meghalaya has launched a formidable project called the Early Childhood Development Mission. This Mission is part of Meghalaya's long-term strategy to bring about actual impactful changes in the State - in the strength of our economy, the health of our society, and the prosperity and well-being of each and every individual. The Mission is aimed at the overall welfare of children from conception until 8 years of age. This is a critical and often neglected period in which the most important brain development of an individual occurs, affecting their intelligence, physical fitness, and socioemotional capacities, in ways that impact their well-being and achievements for the rest of their lives. In this sense, early childhood is one of the most important periods for ensuring a vibrant and productive society, free from crime and disease.

The ECD Mission is a unique intervention for Meghalaya, and for all of India. The Mission has undertaken to bring a state-of-the-art approach to early childhood - using science-based methods to strengthen cognitive development, such as positive parenting and joyful learning, combined with improved nutrition, and mental stimulation. As such, it caters not only to the physical needs of children but their emotional and mental well-being as well. It is envisioned that the Mission will address socio-economic problems faced by all children in both rural and urban areas, and any inequities in child health and development will be addressed. This will eventually bring about a level playing field where all individuals can lead well-rounded, happy and productive lives. It is also a pioneering initiative because for the first time, these approaches are being scaled up across an entire state, working through our existing institutions and departments. As such, this initiative is also enhancing our capability as a state to serve the development needs of our people in a holistic and comprehensive manner.

The ECD Mission is also unique in the approach used to develop and roll out the mission. Here, we see meaningful convergence taking place, with close collaboration between the departments of Health, Education, Social Welfare, and Community & Rural Development, as well as other key government and non-government agencies. We are also mobilizing community involvement through active involvement and substantial training support to members of women's self-help groups. Finally, Meghalaya's own ***state capability enhancement*** approach has been applied to the Mission design and development, including problem-driven iterative adaptation (PDIA), to ensure different stakeholders' voices and perspectives are incorporated and to mobilize action across multiple levels of society simultaneously. It is a truly one-of-a-kind initiative.

Though Meghalaya has sometimes fared poorly at the national level in terms of its health and education indicators, I have confidence that the ECD Mission will be a beacon of hope and inspiration for Meghalayans and for the world, transforming the lived experience of our citizens, and showing a path for other states and countries to follow.

(Conrad K. Sangma)

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PREFACE

The COVID-19 pandemic put the limelight on the importance of public health and the need for a holistic approach to improve Meghalaya's crucial developmental indicators including health, education and several other socio-economic indices. It was at the peak of the pandemic that the State received its own health policy for achieving Measurable Outcomes in Transforming Health sector through a holistic approach with focus on women's Empowerment. Also known as MOTHER, it was launched in March 2021 and with this, Meghalaya became the first State to have brought up a State Health Policy during the COVID-19 pandemic period.

Meghalaya's Early Childhood Development (ECD) Mission is one of the important interventions envisioned in MOTHER policy. It is a first of its kind initiative that offers a holistic and sustainable approach to not only build cognitive human capital, and ensure a healthy population with an increased life expectancy, but one that will entail higher economic returns for the State and reduce poverty. The Mission is aimed at enabling Meghalaya's children to achieve their full long-term potential by ensuring good health care, nutrition and cognitive development support during the critical years of early childhood (0-8 years) and for pregnant and lactating women.

Meghalaya's ECD mission is a result of careful evaluations and thoughtful deliberations, based on scientific research and evidences. For instance, the Perry School Study conducted in the US reveals that children aged 3-4 years who received early childhood care and education, and who were followed up until the age of 40, showed drastic improvement in IQ level, improved percentage of graduation, had better income among others. Similarly, the Ekjut study in Jharkhand and Odisha also gives enough evidence that extended work hours of daycare centers with special focus on nutrition, parents counseling and provision of a stimulating environment, reduces stunting, underweight and wasting. Duly backed by scientific research, Meghalaya's ECD Mission has three key components as part of its holistic approach- Healthy nutrition, mental stimulation and parent coaching.

The Mission will follow a lifecycle approach, right from the time of pre-conception, up until the age of 18 years. A unique State Capability Framework is being used to materialize the vision of ECD by- identifying and addressing systemic gaps, leveraging existing resources and developing strong and coherent institutional structures and systems at all levels. As part of the mission, a unique intervention is being undertaken across the State, whereby all those villages that remain uncovered under the ICDS Supplementary Nutrition Programme (SNP) scheme, which amount to more than 1500 in number, are being provided ICDS services through women-led Self-Help Groups (SHGs) formed under National Rural Livelihood Mission (NRLM). This is happening for the first time in India. Likewise, leveraging on the strong traditional community institution of the State, Village Health Councils (VHCs) are being set up in each village, to lead community action on health and nutrition.

Following the preparation of the first draft of the ECD document in August 2020, the document has gone through several rounds of iterations, using the Problem Driven Iterative Adaptation (PDIA) Approach of problem diagnosis and strategizing solutions for challenge and objective in focus. Groundwork is already underway to further the ECD Mission with the constitution of an independent society- the State Early Childhood Development (ECD) Committee in June 2020, the members of which have played crucial roles in conceptualizing the ECD document, as the domain experts. ECD is a multidisciplinary issue and, as such, inter-department collaboration at block, district and state level is at its crux. To further this end, the Human Development Council, headed by the Hon'ble Chief Minister of Meghalaya has been established to authorize and effectuate convergence and collaboration at all levels.

Through this approach, visible progress is already being seen in terms of improving outcomes such as maternal mortality, immunization and addressing malnutrition of SAM/MAM children. I have faith that investment in early childhood development will bring significant returns on investment to the overall society and economy for generations to come. Furthermore, since Meghalaya envisions becoming a middle-income state by 2030, the cognitive children nurtured under the ECD mission now, would contribute significantly when they become adults, and help build the State Capability as a whole, with positive effects passed on to future generations. A bright future will certainly be ensured through Meghalaya's ECD Mission, not only for the State, but for the Nation as a whole.

Sampath Kumar, IAS
Principal Secretary & Development Commissioner
Government of Meghalaya

MEGHALAYA'S EARLY CHILDHOOD DEVELOPMENT (ECD) MISSION

1. Introduction

1.1. Early childhood refers to the earliest years of a child's life beginning from conception through pregnancy and birth all the way up to the child's entry into primary school. It refers to the biological and psychological changes that occur in children between conception and the age of six. Neuroscience explains that more than 90% of brain growth occurs in this period and it influences every aspect of a child's future. Globally, early childhood is now being considered up to 8 years of age to cover the period of transition to school.

1.2. India has the second largest population in the world (1.3 billion) which is rapidly growing. The country has a standing of having a high percentage of children born with low birth weight. India also has severe problems of malnutrition, especially high levels of stunting among children below 5 years of age and anaemia across age-groups. This, coupled with rising incidence of overweight and obesity, predisposes children to non-communicable diseases (NCDs) during adulthood. These factors all together hamper the overall cognitive development of children which limits their capacity to achieve their full human potential. As mentioned in the constitution of India and India's National Children's Policy resolution, as well as the UN convention on Rights of the Child, it is the responsibility of policy makers to ensure that all critical parameters are addressed and no child should be deprived of achieving their full potential. It is also in India's - and all countries' - best interests to ensure that children reach their full potential to achieve the broader social and economic goals of a healthy and vibrant society.

1.3. As per the Centre's National Education Policy, 2020, there is to be an increased focus on Early Childhood Care and Education. Early childhood services are to begin at least from the age of 3. This is an important step as this period is globally recognized as a crucial stage for development of mental faculties. As per the revised policy, every child should start his/her education either at pre-schools or Anganwadi centres and should receive quality education up till the age of 18 years.

1.4. Holistic development of an individual begins in infancy and early childhood, ie. 0 to 8 years. What happens in these years affects all of the stages of life that follow, and can have a multigenerational impact by affecting the kinds of parents that our children grow up to become. It is thus critical to take a "Life Cycle" approach to human development, considering each period of life, including preparation for parenthood, pregnancy, safe-delivery, care during the susceptible first years of a child's life, childhood, and adolescence..

State Profile

1.5. Meghalaya has a population of about three million (Census 2011), of which approximately 20 percent belongs to 0-6 years of age. Of these, a large number (4,67,979) are enrolled under the Integrated Child Development Services (ICDS) programme and Mid-Day Meal Program (MDM) (3,83,186 in 2018-19). Ninety percent receive immunization from the health department in addition to other essential health services. Thus, government safety net programs provide an opportunity to nurture children to help them unleash their full potential.

1.6. Nevertheless, many of these programs fall short of the needs of the population. ICDS has limited services for children under 3 years of age; many Anganwadi Centres are in disrepair or lack appropriate facilities; many Anganwadi Workers provide only nutrition services rather than developmental programming; and many parents and families do not avail themselves of services at Anganwadi Centres. In addition, over 1500 villages in Meghalaya are not covered under ICDS.

1.7. The National Health Survey (NFHS-5 2019-21) estimates that in Meghalaya, 46.5% of the children below five years of age are stunted (low height for weight) and 26.6% are underweight (low weight for age). Further, the prevalence of Severe Acute Malnourishment (SAM) and Moderately Acute Malnourishment (MAM) in under-five groups is 4.7% and 12.1% respectively. While the prevalence of SAM and MAM in Meghalaya is lower than the national prevalence (7.7% and 19.3%), stunting in the state is much higher than the national prevalence (35.5%). Access to health department services likewise falls short. Only 63.8% of children aged 12-23 months are fully immunized, 61% of children aged 9-35 months receive Vitamin A supplements and only 58.1% of pregnant women (82.7% urban and 54.3% rural) have institutional births.

1.8. State data shows that Meghalaya is facing several challenges in terms of Health, Nutrition, Education, and Poverty amongst others and several indicators are higher than the national average. Meghalaya performs poorly on human development indicators which are some of the major concerns that need immediate attention. The data pertaining to Meghalaya in terms of various indicators with regard to ECD is given below:

HEALTH		NUTRITION		EDUCATION	
MMR	197 (SRS 2016-18) India:113	Children Stunted	46.5% India: 35.5%	Std V can read Std II level text	50.1% India: 50.3%
IMR	34 India: 32	Children Wasted	12.1% India: 19.3%	Tenth Pass Percentage	50.3% (MBOSE)
Life Expectancy	62.3 years India:68.5	Anaemia among Women	53. 8 % India: 57%	School Dropout at lower primary	7.05% (MSSE)
High Risk Pregnant Women	>6892 (HMIS Jun-Oct 2020)	SAM & MAM Children	4.7% & 12.1% India: 7.7% & 19.3%	School Dropout at upper prima-ry	8.05% (MSSE)
NMR	>633 (HMIS June-Oct 2020)	Disabled Children	>6000 (between 0-6 years, ICDS)	School Dropout at secondary level	22.4% (MSSE)
Teenage Pregnancy	>975 (HMIS Aug-Oct 2020)	Lactating mothers	85,000 (PW and LM of ICDS)	Poverty	34% (SECC)

OTHERS

Persons below poverty line 4,21,503 HH covering 21,45,145 members

OTHERS	
Persons below poverty line	4,21,503 HH covering 21,45,145 members (NFSA, 2019-20)
High Risk Pregnant Women	>6892 (HMIS June-Oct 2020; >12 % as identified by FLWs). However, it is more than 40 % if we take the age and order of the pregnancy into consideration.

1.9. Micronutrient deficiency is a major contributor to childhood morbidity and mortality. Vitamin A is an essential nutrient for the immune system. Severe vitamin A deficiency (VAD) can cause eye damage and a higher risk of dying from measles and diarrhoeal disease and the Government of India recommends that children under five years of age receive Vitamin A supplements every six months, starting at age 9 months. A study conducted by Nongrum & Kharkongor (2015) in Pynursla Block of East Khasi Hills District, Meghalaya reveals that Vitamin A Deficiency (VAD) is a public health problem among children between 0-15 years. In order to effectively address this problem, it is essential to enhance the knowledge of nutrition and appropriate diets and to encourage the consumption of traditional foods especially locally available vitamin A-rich foods.

1.10. Iron deficiency is a primary cause of anaemia. Eating foods rich in iron and taking iron supplements can help prevent anemia. A community based cross-sectional study was carried out in West Khasi Hills D+9istrict of Meghalaya which revealed that the prevalence of anaemia among children between the age of 1 to 5 years old was 68 per cent, and Vitamin A deficiency 59%. Among women, these figures were 83% and 48%, respectively (Chyne et al, 2018).

2. ECD - A Comprehensive Approach

2.1. To address the low performing indicators related to ECD and ensure that every child can reach his or her potential, the State has come up with a comprehensive approach to initiate and roll out a first-of-its-kind Early Childhood Development (ECD) Mission that will cater towards the holistic development of children and young adults. The Mission will enable young children **(0-8 years)** to develop a sound foundation to be able to achieve their full potential during their early years to contribute positively towards themselves, the society and the development of the State. The Mission will also target young adolescent boys and girls **(9-18 years)** in order to provide a conducive supportive environment to help unleash their full potential. Brain science shows that to unleash the full potential of the brain there are two windows that need to be nurtured i.e. 1) during early childhood and 2) during the adolescent period (Kumar S.,et al, Harvard University, 2013). Through the Mission, the State aims to introduce a science-based approach to childhood development, strengthen the state's capacity to deliver services and address missed opportunities, and effectively engage citizens and communities in improving early childhood development.

2.2. Vision of the Mission: Meghalaya's ECD Missions vision is to enable Meghalaya's children to achieve their full long-term potential by ensuring good health care, nutrition and cognitive development support during the critical years of early childhood (0-8 years)

and for pregnant, lactating women by creating a comprehensive structure for community participation.

2.3. Addressing poverty & inequality: The Mission has been designed to also address inter-generational poverty of disadvantaged groups in India by blending the science of early childhood with the concept of women's Self-Help Groups. The Mission will be an all-inclusive programme where children with any kind of disability will also be identified at an early stage to detect developmental delays so that effective measures are taken for addressing their issues more effectively.

3. Components of ECD Mission

3.1. Since a child's development is not one-dimensional but holistic in nature, ECD interventions are required to adopt an integrated approach to address children's basic needs right from conception till the child attains the age of 8 years. The integrated approach requires all interventions for this stage of development to be designed in ways that ensure inclusion of five essential elements ***i.e. responsive caregiving, good health, adequate nutrition, opportunities for early learning, safety and security.***

The Mission will have the following components as key areas for intervention:

3.1.1 Component- 1: "Building Human Resources for Positive Parenting" by leveraging and training grassroots institutions such as Self-Help Groups, Village Health Council and Village Organisations. These institutions will provide local leadership in identifying health challenges and mobilize community action and health-seeking behavior change, e.g., on birth spacing, teenage pregnancy, Kangaroo Mother Care, Positive Parenting, proper nutrition, etc. These institutions will implement local-level initiatives such as tracking pregnancies and generating awareness on the importance of diet diversity or starting Nutri-gardens. This component will also try to leverage the existing state resources more purposefully and train Anganwadi Workers (AWWs), teachers, Community Health and Gender activists and Cluster Coordinators on ECD concepts such as improved preschool curriculum, positive parenting, active Learning, learning Through Play and responsive caregiving. By leveraging the existing resources and identifying systemic gaps, the mission will use its existing resources to expand ECD activities in areas deprived of ECD services.

- This component of the mission through its activities will provide socio-emotional support to low-income groups for the reduction of poverty. The component will address stress brought on by poverty, multiple children, and lack of care and attention.
- **Engaging Graduate ECD Educators**
  A new set of cadres will be introduced under the mission. The mission will engage ECD Graduate Educators as special educators from the strong network of SHGs trained to take leadership on health and nutrition issues. A cadre of ECD Educators among SHGs who can work with AWWs to provide ECD services will be onboarded at AWCs. As the qualification of most AWWs is below matriculation, ECD-educators would provide additional support to the AWCs who would be specifically trained in ECD concepts as well as adolescent training. They will be engaged to train and guide children from months to 6 years at AWCs. The AWWs would act as co-facilitators during these sessions. The Expression of Interest for ECD-GVs is attached at Annexure- IV
- The activities undertaken by ECD Educators and other frontline staff (eg. Anganwadi workers (AWW), Accredited Social Health Activists (ASHA), and Community Resource

Persons (CRPs) will include group and home-based counselling of parents/ caregivers as well as home visits.

- There will be extensive counselling and training which will be focused on health and nutrition, sanitation, education as well as socio-economic development. This will also act as an opportunity to interlink activities of the Health Department which will sensitize on ANC, institutional deliveries, Infant and Young Child Feeding (IYCF), Screening for Obesity, Non-Communicable Diseases (NCD), Cancer, TB, etc.
- The role of VHCs, SHGs and existing community institutions will be crucial as ECD training will be given to women of Self-Help Groups for generating wider scale awareness.
- Grassroots healthcare workers including ASHAs and AWWs as well as SHG members will be imparted training in the field of education, health and nutrition. They will in turn impart training to key community members.
- The existing sub- committees of Village Organisations (Vos/cluster of SHGs) such as poverty reduction committee, social audit and action committee, health, nutrition & gender committees will further be strengthened and trained on ECD concepts for awareness generation.
- Milestones will be defined for children between 0-8 years of age in a simple checklist which can be easily marked by parents and caregivers to monitor progress of child development (a sample of the checklist is attached as **Annexure I and Annexure II**). Also, a checklist on locally available healthy diet can be provided to all households. Monitoring timely immunization for pregnant mothers, children and adolescents is given in Annexure III

3.1.2 Component 2: Centre Based Interventions for "Improving Infrastructure, Materials and Quality Care"- This will include strengthening the supply chain for early childhood development services, especially through outreach mechanisms of various programs including Poshan Abhiyan, NRHM, Health and Education. Below are the pilot models for delivering of services:

At AWC

- The component will strengthen the existing AWCs as early learning centres by building capacity of Anganwadi workers in ECD concepts such as emotional support, early initiation, training on executive functioning skills. Convergence with C&RD and Social Welfare Department will be sought for this activity.
- The Mission will expand the scope of AWCs to become early childhood care and learning centres; undertake innovative pilots by leveraging different platforms and bringing convergence with different government departments and grassroots collaborations, where health, nutrition (maternal and child nutrition), early learning, socio-emotional support through positive parenting will be its key elements.
- The policy will ensure that with the conversion of AWCs into learning centres/creches, proper training will be imparted in order to improve spatial and cognitive abilities. The policy will also ensure that community ties are optimized whereby safe environments are created for children not only at home by parents and caregivers but also put importance on the role community and church in moulding children. Sensitization and awareness programmes will be given during this crucial time at the grassroots level with focus on issues such as stunting, malnutrition, special needs and cognitive development.
- **There will be infrastructural development of AWCs where** newly built AWCs will provide favourable environments for early learning & caring and supplementary feeding. AWCs will provide a joyful and conducive learning environment and system with creative methods for unleashing children's cognitive skills.
- Extension of centre-based care for children between 1.5 – 3 years of age and transforming AWC into a day-care centre. This can be taken up as an innovation under the mission

to reduce women's time poverty. The services of AWCs will also be extended to 8 hours per day catering to children between the age group 1.5 years to 6 years as AWCs will not only perform as AWCs but also as day-care centres/ creches, wherein three meals to meet the nutritional requirements of the children will be borne by the state.

- Construction of new Anganwadi Centres in uncovered villages. Creation of dedicated play spaces for promoting physical and barrier-free activities among children. Provision of books, toys and other materials for play and cognitive development. Materials and space for kitchen garden and building and equipment for onsite kitchen. Ensure clean and functioning toilet.
- Renovate all Anganwadi Centres to be Early Childhood Education Centres and ensure provision of the same quality of rooms, materials, equipment and spaces as described for the new Centres. Repair of any degraded equipment and buildings
- The proposal for construction and up-gradation of new AWCs will be sent by ICDS Officers to their respective districts (DCs at district level and BDOs at block level) so they can include the same in their annual perspective plans.

At Primary-schools

- This component will leverage primary-schools to deliver ECD services in AWCs in a partnership mode.
- Further, the Mission recognizes that apart from government primary schools (3540) there exists a private ecosystem wherein there are over 3000 primary and upper primary schools in the state (http://megeducation.gov.in/dsel/lp_up_schools.html) offering Early Childhood Education (ECE) to young children. Therefore, the Mission will strive to have an overarching ECD policy for the State and quality parameters which will be applicable to both the government and private ecosystem.
- All pre-primary schools in the State (Govt & Non- Govt) will be identified and trained on ECD concepts. A standardized curriculum or framework will be developed for all private and public Nursery or Montessori schools by experts under the Mission along with DERT.

Accreditation of Private Primary School Teachers

- A system of accreditation will be put in place under the Mission to provide a standardised learning environment across the State. A standardised curriculum will be developed by the SRO. This will be done in collaboration with the State Education Department/DERT.

3.1.3 Component 3: "Enhancing State Capability and Building a State Resource Centre for Developing Child"- The mission will apply the principles of the State Capability Enhancement Project principles to transform how state institutions (line departments and community) collaborate to provide ECD services. A continuous process/system of cross-department check-ins at block, district and state level will be put in place to develop key action plans, review implementation challenges and learnings and follow an adaptive approach to implementation.

This component will also be designed along the lines of Harvard Centre for Developing Child whereby the Centre is envisaged as a knowledge and resource centre which will develop, curate and disseminate a wide range of information (especially scientific information which will be easily accessible to the public.)

- The key institutions such as the newly formed **Meghalaya Human Development Council** headed by the Chief Minister, along with concerned Cabinet Ministers will promote the state's vision and coordinate efforts for human development. The council will be housed under the Planning Department and actively facilitated by the Office of Development

Commissioner. The council will convene leadership of different departments for the state-level strategic planning process for human development issues such as health, nutrition, education, and women and youth empowerment. It will work closely with leadership of different state departments to design and implement projects that achieve high priority outcomes, while strengthening departmental capacity. It will be involved in developing partnerships with aid agencies to conceive and implement externally-aided projects (EAPs) that are aimed at building the state's human development capacity. It will also develop partnerships with researchers, think tanks and academic institutions to identify, evaluate and scale innovations and ideas pertinent to Meghalaya.

- **State Resource Centre for Developing Child** aims to be a one stop centre for all information related to the Mission with information from the State, District and Block level easily available. It will comprise a facilitation team to strengthen cross-dept collaboration & program implementation, a design team for technical inputs & content creation and training and coaching team along with a project management documentation and evaluation team.
- SRCDC will analyse and evaluate said data and come up with comprehensive articles which can be a valuable resource library for the entire country. The Centre will be responsible for designing knowledge materials with the help of relevant experts and will also be given the license to provide accreditation to workers/volunteers who are part of the ECD Mission. The Centre will track the progress of the Mission and document and show the intergenerational poverty impact by 2030. This may also include studying and documenting brain architecture and measuring cognitive development as per existing tools.
- A state ECD convergence committee with representatives from key departments such as Health, Social Welfare, Education, C&RD and Urban Affairs will work together for achieving ECD objectives. Work across departments and with communities will be actively facilitated by the SRCDC facilitation team. The Facilitation team will mentor programme staff and will work with line departments to support community mobilization.
- This component will strive to make high-quality ECD learning and teaching material available in the State. Appropriate partnerships with private research agencies (national and international) will be forged for developing these materials. These materials will cover the following (but not limited):
    1. Age-appropriate preschool kits and teaching material will be available at the AWCs
       and other institutions.
    2. Identifying the physical and learning disabilities at the early stage.
- This component of the Mission should prepare the children for school readiness. Special emphasis will be laid on training of teachers, with special focus on SSA teachers to ensure 'school readiness'.
- The ECD Educators will also be specifically trained to promote healthy development in adolescents, to prevent and respond to health problems challenging this population group. Young adults will be sensitised at schools on a wide range of topics including mental health, HIV in Adolescence, ill effects of Drug usage, Adolescent Development, Brain Development, Adolescent Pregnancy, sex education and other modules.
- Training and capacity building for SHG members/ community development staff/ on ECD implementation as well as economic mobility concepts in which women will be coached or counselled through SHG Promoting Institutions / Agencies like MSRLS.
- VHC platforms will be leveraged for increasing awareness on science of early childhood. VOs of NRLM will be also mobilised under the mission for active participation and discussion on the importance of ECD. PHCs, Health & wellness Centres and frontline workers to be trained on the ECD concepts

- Training will also be imparted to teachers of government primary schools in consultation with DERT at DIET. Private School Teachers will also be trained on concepts of ECD and the importance of providing a safe learning environment essential for long term benefits. However, a system of accreditation will be followed for the same.

Develop an overarching ECD policy framework for the State

- A comprehensive policy framework with clear roles and responsibilities of various departments and other stakeholders will be put in place.
- Define and develop quality metrics and parameters for ECD at par with global standards – teaching and learning materials; training materials for various workers, ECD- Educators, VHC and SHG members (face-to-face and virtual); and monitoring systems.

Awareness generation around ECD and the promotion of adopting appropriate ECD practices by communities. The key activities will include:

- Designing comprehensive social behavioural change strategies and dissemination through various platforms i.e. health, education, social welfare, rural development. Interpersonal and mass media communication is also important for creating an enabling and supportive environment for ECD within the community.

- **Project Management, Monitoring& Evaluation and Documentation-** The Mission will establish a Mission Management Units (MMU) at the State, District and Block level. The State MMU will include units for project management and technical support, as well as housing the Monitoring, Evaluation and Documentation component. Project management will build on existing systems at the state and district levels and strengthen the capacity in an incremental manner.
- Monitoring systems will be put in place. This can be done through the existing Social Audit platforms which can help in auditing and assessing training and implementation at the ground level.
- The project management component will ensure that all training is provided in a timely manner and that all the other components such as health, nutrition, training, awareness, collaborations and convergence are implemented in a time bound manner.
- A comprehensive management information system (MIS) will be put in place. All Data related to the target villages under the mission will be handled on a regular basis. The M&E system will generate management information and provide the government with evidence of results and impact against indicators. This will involve activity/output, process, outcome and impact monitoring.
- Collaboration with agencies for independent impact and process evaluations including baseline survey as well as annual rapid assessments on program coverage and behaviour change will be considered. Piloting this comprehensive model in selected districts and undertaking impact evaluation will be a major task of the M&E component.
- The Documentation component will also develop comprehensive communication strategies for dissemination through various platforms (IEC, videos, training materials, online platforms etc.) The component in consultation with state experts will support the other components with information on health, nutrition, early education, schemes and other interlinked benefits to overall support the mission implementation. Dissemination and communications to spread information on ECD Mission to external stakeholders and a wider audience will also be integral for further collaboration and up-scale of the mission.

4. The Science of Early Childhood Development

4.1. It is important to note that the period of ECD (prenatal to age 8 as recognised by WHO) determines physical, socio-emotional, motor and cognitive development in a child. It is imperative that a child be provided with proper nutrition and care; the environment of the child is also equally important where it should be considering the child's emotional needs. Stress is a routine part of life but constant adversity can have disruptive effects on the brain especially with regards to ECD. Poverty, maltreatment, violence can result in poor outcomes, increase the likelihood for problems in school, problems with behaviour, problems with later economic productivity, lifelong problems in physical and mental health. Healthy brain architecture is formed in safe and secure environments. It has been found that maltreatment of children in the early years precipitated physiological changes in the body that continues into adult life. It is not necessary to have a conscious memory of the maltreatment; however, the body biologically remembers the maltreatment.

There are 3 different types of stress response:

- **Positive stress** which is the activation of the stress system in everyday situations and the ability to respond.
- **Tolerable stress** which is accompanied by more serious challenges eg. death of family members, natural disasters etc. To ensure that the stress does not overwhelm the child, the response of the adults is crucial as this can give them a sense of safety and security; both emotionally and psychologically.
- **Toxic stress** which is accompanied by acute threatening circumstances- maltreatment, poverty, violence etc. This wears and tears the body down. Toxic stress can disrupt circuits needed for learning, paying attention and development; this is the underlying explanation of many lifelong health problems. Constant threats and burden activate the stress system excessively which can bring about mental health problems and difficulty in learning.

  In all stressful situations, the behaviour and response of the adults is crucial on how the child deals with stress. Adults can buffer children from the sources of stress and build their capacity for dealing with stress. Children can develop coping skills- shaped by experience and adults can help model and shape these skills.

4.2. Building Resilience: Resilience is not about willpower and is not an innate trait; it is a capacity that is built over time and produces positive outcomes in spite of risk factors. Early childhood years are critical to build resilience.

High level executive functioning and self-regulation skills such as focus and attention are taught and begin very early but mature around age 25 to 30. For overall growth and development of these skills, the period with optimal plasticity should be utilized. For adults with a history of maltreatment, this can be taught by active coaching and practice later on in life; however, this is a very difficult and expensive process, hence it is imperative to address this during the early childhood period.

4.3. Research has shown that children who received high quality treatment starting from birth had significantly better life outcomes than those who did not receive centre-based care or those who received lower quality care. Access to high-quality ECE can break the cycle of poverty across generations. Children who receive high-quality early childhood supports have significantly better life outcomes and pass the positive effects on to their children. Early investments in high-quality programs for disadvantaged kids pay for themselves over time and produce gains across multiple generations. Home environment matters

more than neighbourhood for adult outcomes. There are significant gains in employment for participants in high-quality ECE programs and their children. There is significant reduction in crime by participants in high-quality ECE programmes (Heckman et al 2013).

4.4. Research has also shown that the first 1000 days of a child's life must be given the utmost importance and attention to avoid issues pertaining to neonatal and child deaths (Cusick and Georgieff, 2016). Stunting can happen in the first 1000 days of life and is caused mainly by severe under-malnutrition which is most common in middle- or low-income countries and harms children's physical and cognitive development. Prenatal nutrition is of importance along with proper nutrition for the mother. It can be noted that there should be due importance given on a mother's touch. The concept of Kangaroo Mother Care (KMC) which emphasizes skin to skin care and touch is to be encouraged for a baby. Exclusively breastfeeding in the first six months is also a key aspect of development as this leads to stronger immunity, lower diarrheal and other infections, greater growth in weight and height, a lower likelihood of transmission of HIV to the child; all these are in turn linked to higher cognitive skills.

4.5. With regards to motor skill development, there are two aspects: fine skills which involve small muscles which are linked to functions such as grasping and gross skills linked to functions such as crawling. The timing of when children reach these motor milestones measures their development which will be addressed by the ECD Mission.

Focus on Brain Architecture Development

4.6. Science has proven that adult-child relationships, other early experiences, and environmental exposures influence the well-being of a child. Meghalaya's ECD Mission focuses on an integrated approach by combining health, nutrition and education in a single policy and will adopt the following 3 approaches:

i. **Support responsive relationships:** This will involve a simple five-step guide for parents and caregivers to learn how to "do" serve and return with children. This is necessary for building sturdy brain architecture, buffering children from excessive stress, and strengthening the building blocks of resilience, all of which support healthy development.
ii. **Reduce sources of stress:** Children make for the next adult population in the society. When a baby is not attended, or when there is a break in the serve and response flow, this activates the stress systems. Basic needs must be met.
iii. **Strengthen core skills:** This implies building core capabilities in children-flexibility, self-control, awareness and focus. This involves two basic approaches: Environmental Approach and Individual approach.

4.7. Environmental approach involves building systems at home/schools/institutions that create a less stress inducing environment, while providing positive opportunities to develop and practice acquired skills. Individual approach implies focusing on real-life daily situations, where adult caregivers and their children work together to plan and execute consistent routines. Consistent routines allow children to know what comes next, plan, act, reflect on their behaviour and compare it to their plans, and resist temptations and distractions (NSCDC, 2020).

4.8. All of the aspects of human development in the early years create a foundation for future academic achievement in school, economic productivity, responsible citizenship, lifelong health, strong communities, and even the ability to be a parent of the next generation. Hence ECD can build a strong foundation for well-defined sustainable societies.

4.9. Interaction with adults (parents, neighbours, teachers etc.) during early childhood is very important as this back-and-forth mutual interaction shapes circuitry of the brain. It is during this period that the brain architecture is developed. It is important to note that different functions of the brain cannot be separated and social, emotional, motor, cognitive, language development are all integrated.

4.10. The adaptability and flexibility of the circuitry of the brain as it develops is called plasticity. This plasticity is optimal during early childhood. It is important to note that providing the right environment at the earliest possible times in life when the brain is optimally plastic will produce the best outcomes, and as the brain matures, as the circuits of the brain get formed and get stabilized, it gets harder to change.

4.11. Brains are built over time from the bottom up - human brains during infancy and toddler years can make up to 700 connections per second. The time when these circuits are being made are called the sensitive or critical periods of development where the brain is most responsive to environmental influences.

4.12. The cognitive development of a child is also conditioned to the birthing process. Studies have shown that natural birthing triggers the production of a protein in the brains of new-borns which subsequently improves the brain development and function in adulthood (Karen N. Peart, 2014).

4.13. The American Academy of Paediatrics recommends that children between the ages of 2-3 years should not be given any gadgets especially smart phones. Children are better directed to play using educational toys and directed to activities that can develop language, cognitive, motor, and social skills. There must be a commitment between family members in providing time limits in using gadgets. (Sumarnia, Pertiwi TS., et al, 2019). The ECD Mission will also ensure that such importance is discussed with experts and delivered further to the communities.

5. ECD Pilot undertaken at Rongram Block by World Bank

5.1. A pilot was undertaken in Rongram block of West Garo Hills district in the State. The Meghalaya State Rural Livelihood Society (MSRLS) and the women's Self-Help Group structures were used as the implementation platform.

5.2. An exposure visit for selected MSRLS staff to Bihar provided valuable first-hand experience of leveraging community-based platforms to improve health and nutrition.

5.3. A total of 61 pregnant women (PW) and young mothers (YM), i.e., mothers of children below 3 years of age were the target beneficiaries and primary recipients of the ECD package who were selected out of a total of all 351 women from 37 SHGs in the target area. A total of 60 'other SHG women', i.e., those women who were neither pregnant nor mothers of children under three, and who regularly attended SHG meetings and community events were selected. The primary reason for selecting them was for the pivotal role they could play in spreading ECD messages across the community through the snow-ball effect. All resource team members of MSRLS, all 74 EC members and all nine AW were included in the sample. Village Organizations were also taken into the pilot.

5.4. A comprehensive ECD package integrating nutrition, health and nurturing care messages was developed to cover pregnancy, lactation and childhood age group of 0-3 years. The ECD package included information on the following three themes:

- Health, hygiene, nutrition, quality care giving, and early stimulation and learning for the age group of 0-3 years, based on the characteristics, developmental milestones and needs of the children in this age group;
- Prenatal development of children and care for the mother during pregnancy and the lactation period;
- The role of the entire family in supporting pregnant and lactating mothers and participating in childcare.
- Overall, the MSRLS platform was assessed as a feasible one to promote ECD at the community level through the three-pronged approach of the pilot.

6. INSTITUTIONAL SET-UP FOR THE ECD MISSION

6.1. Overarching Approach: Cross Department Collaboration

This is an integrated mission wherein departments including Health, Education, Women and Child Development, Rural Development, Social Welfare Department, as well as Urban Development, will work in a collaborative manner and collectively address issues related to intergenerational poverty, poor health, and nutrition, learning outcomes as well as violence and crime reduction by focusing on providing **socio-emotional, health, nutrition and early education support** as key areas for the successful implementation of the Mission. It is important to recognize that each department has a key role in ensuring the Mission proves impactful whereby roles and responsibilities are delegated to ensure that the physical, mental and emotional needs such as adequate diet, quality education, and timely vaccinations etc. of a child are met. This would require close inter-departmental workings which not only work in tandem by in sync with one another. With the gradual implementation of the mission, all line departments falling in the purview of ECD as well as for reducing poverty will work together for achieving the shared purpose of development.

6.2. Human Development Council

The Government of Meghalaya will establish a Meghalaya Human Development Council which will serve as an anchoring body for facilitating collaboration and implementing reforms in the human development space. Since there is currently no agency/agencies that are taking care of a holistic and systematic approach to human development, the council is headed by the Chief Minister as the chairperson with concerned Cabinet ministers, Chief Secretary, and all concerned departments as members of the council would take decisions on the critical gaps identified for effective convergence. The Human Development Council will be initiated with Meghalaya's Early Childhood Development Mission which will be expanded to all other areas of development in the future. The human development agenda will be a top priority of the state which will eventually also align with the national priorities and Sustainable Development Goals (SDGs).

6.3. Governing Council

7.2. The Mission will be implemented through the Meghalaya Early Childhood Development Mission which will be a registered society of the Social Welfare Department. The Society will be led by a Governing Council from which a more functional Consultative Executive Committee will be formed for taking all policy-level decisions and advising the functionaries on the management of the Society. The Chief Secretary will be the Chairperson of the Governing Council and the Development Commissioner, Planning Department will be the Vice-Chairperson with Director,

Social Welfare as Member Secretary. The Governing Council shall comprise of representatives from related departments such as (i) Finance Department (ii) Health and Family Welfare, (iii) Education, (iv) Community & Rural Development, (v) Planning Department, (vi) Meghalaya State Rural Livelihood Society, (vii) National Health Mission viii) State Rural Livelihood Society ix) Indian Institute of Public Health

6.4. Consultative Executive Committee

The Mission will have a consultative Executive Committee to take all policy-level decisions and advise the functionaries on the management of the Society. The committee will comprise of experts from the State Early Childhood Development Committee and representatives of implementing agencies to go through the evidence that has been generated about the science of early childhood and its potential for promoting the holistic growth of children. The Executive Committee shall be chaired by the Principal Secretary/Commissioner Secretary, Social Welfare and the Director of Social Welfare will be the Convenor. The Committee shall comprise of representatives from (i) Planning Department ii) H&FW Department iii) Finance Department iv) Education Department v) Community & Rural Development (vi) CEO, Meghalaya State Rural Livelihood Society, (vii) Director of Social Welfare (viii) Specialists on Health, Nutrition, Early Childhood Education and Development, (ix) Mission Director, National Health Mission, (x) Mission Director, SRES and other stakeholders.

6.5. State Mission Management Unit (SMMU)

The Principal Secretary / Commissioner & Secretary, Social Welfare Department will function as the CEO of the State ECD Mission. The Director Social Welfare will function as Deputy CEO. The COO along with other specialists/functionaries will be full time dedicated functionaries to oversee and manage the daily functions of the Society.

6.6. Domain Experts for ECD Mission

The Meghalaya Early Childhood Development Mission will be a registered society which will function and act as a State Resource Organisation for developing child where domain experts from various fields (both government and private) will be hired on a full time or part time basis (example: - a cognitive skills expert for developing a curriculum for training of Supervisors/ AWWs/ASHAs/identified field functionaries).

These experts will train and support the full-time field functionaries on different ECD activities. There is a need to identify and hire the right people (consultants and field functionaries) who understand the concept of ECD and its connection in developing brain architecture, reducing infant, neonatal and maternal deaths. Hiring process can take place in a phased and systematic manner.

Experts will include health and nutrition experts (paediatricians), child psychologist, child nutritionist, and experts from education, health, community development, social welfare sector and other sectors as and when required.

6.7. District Mission Management Unit (DMMU)

At the District Level, the ECD Mission will have a District Human Development Committee headed by the Deputy Commissioner who will oversee the implementation of the mission at the District Level. The District Programme Officer of ICDS will work in close coordination with the District Mission Managers of MSRLS, District Mission Coordinator of SSA and District Maternal & Child Health Officer (MCH) for implementing the mission with support of the District Programme Manager and District Level ECD experts.

6.8. Block Mission Management Unit (BMMU)

The BMMU will also have a Block Human Development Committee headed by SDO Civil/BDO.

The SDO Civil/BDO will review the implementation of the ECD Mission at the block level. The Child Development Project Officer of ICDS will work in close coordination with the Medical Officer in charge of PHC/CHC, Block Mission Coordinator of the Education Department and Block Programme Managers of MSRLs for implementing the mission with the support of the Block Programme Manager, lady supervisors, ANMs, SHG federations, primary school teachers and other grassroots level functionaries. A dedicated staff may also be appointed for overseeing daily activities and reporting to the project Management Unit.

7. Expected Outcomes of the ECD Mission

7.1. Although the Mission will have four major components which will address to health, nutrition, early education and poverty reduction by targeting the period of conception to 8 years and above, the outcome of the Mission will have varied end results. The expected outcomes envisaged are as follows: -

i. Active participation of women in developmental programmes.
ii. Generation of a more informed community cadre.
iii. Reduction in MMR, IMR and NMR in mission implemented villages.
iv. Improved access to micro nutrients.
v. Improvement in school readiness of children and better performance in schools.
vi. Development of strong brain architectures and increase in cognitive skills
vii. Reduction in toxic stress and creation of a safe learning environment.
viii. Develop love for life-long learning- likelihood of children to take-up higher education.
ix. Young children and adults are less likely to get involved in crime and drugs in the long run.
x. More likely to be employed thereby reducing poverty.
xi. Will have better social skills and will be socio-emotionally balanced.
xii. Will have reduced health care cost.
xiii. Less likely for young girls to become pregnant during their teenage years.
xiv. Complete elimination of stunting by 2030.
xv. Intergenerational poverty reduction by 2030.
xvi. Reduction of number of anaemic mothers

8. The Mission will follow a lifecycle approach with a focus on different stages of early childhood. The table below highlights the key roles and responsibilities of various implementing bodies.

Stages	Conception to first 1000+ days (0-3 years)	Age 3 to 8 years	Age 8 to 14 years	Age 14 to 18 years
(Age Group)	- Antenatal care - Nutrition - Birth spacing - Safe delivery - HBNC - Immunization - Breastfeeding	Assessment of: - Defects at birth - Disability - Developmental delays - Deficiency - Provision of SNP	- School Health Education - School Screening programmes - Midday meal scheme	- Skill training - Mental health counseling
Implementing Agencies	- Health Department (specifically RMNCHA domain of the NHM) - ICDS - RBSK (NHM) - NRLM/NULM(Self-help groups or SHGs)	- ICDS (AW Services) - Pre Schools - RBSK (NHM) - NRLM/NULM (SHGs)	- Education Department (Primary and Secondary School Education Covered Under RTE) - ICDS - RBSK (NHM) - NRLM/NULM (SHGs)	- Education Department (Vocational/Skilled Based Schooling) - RBSK (NHM) - NRLM/NULM (SHGs)

Collaboration among Health & FW, ICDS (Social Welfare), Education and NRLM (C&RD) Departments is critical to carrying out interventions

Identified critical gaps that needs bridging	Trainings to address gaps and streamline services
1. Counselling session for all eligible couples (Family planning and use of contraceptives) 2. Iron Folic Acid Supplementation for women planning pregnancy (to avoid spinal cord deformities) 3. First 1000 days Exclusive Care (early ANC registration at VHND, Counselling on 4. Birth Spacing during the first ANC, consumption of IFA tablets, Importance of	- Antenatal and postnatal IEC training for community health workers (ANMs, ASHAs, AWWs including SHGs) - Training on Home Based Newborn Care (HBNC) for ASHAs to provide quality services. - Proper supply of iron/calcium/ nutrition-dense supplements

3. KMC for reducing cases of pneumonia. 4. Exclusive breastfeeding (importance of mothers' first colostrum, complementary feeding after 6 months). 5. Nutrition reach (for the health of mother and child- Include nutritious meal daily for extra calories, fat, iron, and calcium. (From 1st to 3rd trimester). Advice on dietary intake for pregnant women and lactating mothers. Promotion of Kitchen Garden. 6. Screening tests for pregnant women and new-borns for early detection of danger signs and deformities. 7. Promotion of Institutional Deliveries (training of SBAs, up-gradation of skills of ANMs and Nurses posted in District Hospitals and PHCs) 8. New-born Stabilization Units (NBSUs) and New-born Care Corners (NBCCs) to be made functional in all districts. 9. Immunization for mothers and children (timely immunization) 10. Addressing Disability and measurement of low birth weight, anaemia for reduction of MMR and IMR, and correction of SAM and MAM children. 11. Emotional and mental wellbeing of children at AWCs. 12. Improve Learning outcomes- upgrading AWCs as early learning centers, engaging pre-primary school teachers to AWCs and Graduate Volunteers 13. Community participation (social issues related to early pregnancy, early intimation of PW, the importance of birth spacing, diet diversity, etc.) 14. Personal Safety and reproductive health education for children from 6-18 years. 15. Effects of social media/ drugs/ substance abuse especially with adolescents 16. Addressing Teenage Pregnancy, sexual health, promotion of screening for cervical cancer and vaccination among adolescents. 17. Promotion of screening for cervical cancer and vaccination among adolescents.	- Measurement of positive health and cognitive skills from infancy to adulthood - Adolescent personal safety education - Physical games/ playgrounds - Encouraging girls to play physical sports and activities - Peer education programme

Implementing agencies	**Health Department** (NHM, RBSK, RMNCH practices)	**ICDS (Social Welfare Department)** (Anganwadi services, AAAs)	**NRLM/NULM (C&RD)** (Village Health Councils, VOs, women self-help groups)	**Education Department** (School Management Committees, Primary & Secondary School teachers, counsellors, skill trainers) Graduate volunteers under ECD mission to take up actions in uncovered villages of ICDS
Full Responsibility	*Counselling on birth spacing, 1000 days, KMC, ANC and all aspects related to RMNCH practices. *Trainings on respective issues under each department for functionaries on ECD issues. * Iron Folic Acid Supplementation for women planning pregnancy (to avoid spinal cord deformities) * First 1000 days Exclusive Care (early ANC registration at VHND, Counselling on Birth Spacing during the first ANC, consumption of IFA tablets, Importance of KMC for reducing cases of pneumonia. * Exclusive breastfeeding (importance of mothers' first colostrum, complementary feeding after 6 months). * Screening tests for pregnant women and newborns for early detection of danger signs and deformities. * Promotion of Institutional Deliveries (training of SBAs, up- gradation of skills of ANMs and Nurses posted in District Hospitals and PHCs)	*Counselling on birth spacing, 1000 days, KMC, ANC and all aspects related to RMNCH practices. *Trainings on respective issues under each department for functionaries on ECD issues. * First 1000 days Exclusive Care (early ANC registration at VHND, Counselling on Birth Spacing during the first ANC, consumption of IFA tablets, Importance of KMC for reducing cases of pneumonia. *Exclusive breastfeeding (importance of mothers' first colostrum, complementary feeding after 6 months). * Nutrition reach (for the health of mother and child- Include nutritious meal daily for extra calories, fat, iron, and calcium. (From 1st to 3rd trimester). Advice on dietary intake for pregnant women and lactating mothers. Promotion of Kitchen Garden.	*Counselling on birth spacing, 1000 days, KMC, ANC and all aspects related to RMNCH practices. *Trainings on respective issues under each department for functionaries on ECD issues. *CHGA- family planning, diet diversity and importance of 1000 days. * First 1000 days Exclusive Care (early ANC registration at VHND, Counselling on Birth Spacing during the first ANC, consumption of IFA tablets, Importance of KMC for reducing cases of pneumonia. *Immunization for mothers and children (timely immunization) * Community participation (social issues related to early pregnancy, early intimation of PW, the importance of birth spacing, diet diversity, etc.) *Cover a total of 1554 ICDS uncovered villages deprived of AW services since inception.	* Counselling on birth spacing, 1000 days, KMC, ANC and all aspects related to RMNCH practices. * Trainings on respective issues under each department for functionaries on ECD issues. * Emotional and mental wellbeing of children at AWCs. * Improve Learning outcomes- upgrading AWCs as early learning centers, engaging pre-primary school teachers to AWCs and Graduate Volunteers * Personal Safety and reproductive health education for children from 6-18 years. * Effects of social media/ drugs/ substance abuse especially with adolescents.

	* Newborn Stabilization Units (NBSUs) and Newborn Care Corners (NBCCs) to be made functional in all districts. * Immunization for mothers and children (timely immunization) * Addressing Disability and measurement of low birth weight, anemia for reduction of MMR and IMR, and correction of SAM and MAM children. * Promotion of screening for cervical cancer and vaccination among adolescents.	* Promotion of Institutional Deliveries (training of SBAs, up- gradation of skills of ANMs and Nurses posted in District Hospitals and PHCs) * Immunization for mothers and children (timely immunization) * Addressing Disability and measurement of low birth weight, anemia for reduction of MMR and IMR, and correction of SAM and MAM children. * Emotional and mental wellbeing of children at AWCs. *Improve Learning outcomes- upgrading AWCs as early learning centers, engaging pre-primary school teachers to AWCs and Graduate Volunteers. *Promotion of screening for cervical cancer and vaccination among adolescents.		
Monitoring Agencies	Community Health Officer (CHO) Mid-Level Health Providers (MLHP)	Child Development Programme Officers (CDPOs)	Block Project Managers of NRLM	SSA/Government and Government-aided schools
Monitoring and Evaluation for impact assessment	• Frequent Social Audits in targeted villages through MSSAT • Audits through independent organizations for impact assessment			

9. Time Frame

9.1 The Mission is being implemented in a phased manner. During the first phase, 1574 villages deprived of the Integrated Child Development Scheme (ICDS) or Anganwadi services are now being covered under the ECD Mission. Gradual scale-up for the remaining villages will be done over a period of 6 years in phase wise- manner covering all 12 (twelve districts of Meghalaya)

9.2. Under Phase 1 of the Meghalaya ECD Mission, 10 villages from each Block covering all 12 districts of the State will be considered for coverage. The criteria for selecting villages will be based on the following and not limited:-

a) Villages with a high number of SAM and MAM children.
b) Villages with high stunting and anaemia rates.
c) Villages of aspirational districts.
d) Villages with extreme poverty
e) Villages where there are active ASHA/AWW/SHG and VHSNC members.

9.3. After completion of the first phase and based on learning, the mission will be implemented in 50 villages per block in Phase 2. Similarly, in Phase 3 the mission will be implemented in another 80 villages per block.

SHG ECD Educators, CDPOs of ICDS will be trained on the ECD mission and they can pilot the project. Alternatively, CDPOs can be tasked with taking care of the administration and programme implementation requirements while the project Management Unit will be responsible for ECD implementation. At the district level, master trainers of various line departments such as Education, MSRLS, Health and ICDS will be trained to equip Supervisors, AWWs, ANMs, ASHAs and SHG members. Centres with proper buildings and infrastructure will be identified for training.

ANNEXURE I

Stages	Period	Modalities for measuring physical development	Modalities for measuring cognitive development	Modalities for measuring language/ communication	Modalities for measuring social and emotional development	Measuring of disease/ Deformity/ factors to be reported to a doctor
Newborn	2 months	• Can hold head up and begins to push up when lying on tummy • Makes smoother movements with arms and legs	• Pays attention to faces • Begins to follow things with eyes and recognize people at a distance • Begins to act bored (cries, fussy) if activity doesn't change	• Coos, makes gurgling sounds video icon • Turns head toward sounds	• Begins to smile at people camera • Can briefly calm herself (may bring hands to mouth and suck on hand)camera • Tries to look at parent camera	• Doesn't respond to loud sounds • Doesn't watch things as they move • Doesn't smile at people • Doesn't bring hands to mouth • Can't hold head up when pushing up when on tummy
	4 months	• Holds head steady, unsupported • Pushes down on legs when feet are on a hard surface • May be able to roll over from tummy to back • Can hold a toy and shake it and swing at dangling toys • Brings hands to mouth	• Lets you know if he is happy or sad • Responds to affection • Reaches for toy with one hand • Uses hands and eyes together, such as seeing a toy and reaching for it • Follows moving things with eyes from side to	• Begins to babble • Babbles with expression and copies sounds he hears • Cries in different ways to show hunger, pain, or being tired	• Smiles spontaneously, especially at people • Likes to play with people and might cry when playing stops • Copies some movements and facial expressions, like smiling or frowning	• Doesn't watch things as they move • Doesn't smile at people • Can't hold head steady • Doesn't coo or make sounds • Doesn't bring things to mouth • Doesn't
			familiar people and things at a distance			on a hard surface • Has trouble moving one or both eyes in all directions

Stages	Period	Modalities for measuring physical development	Modalities for measuring cognitive development	Modalities for measuring language/ communication	Modalities for measuring social and emotional development	Measuring of disease/ Deformity/ factors to be reported to a doctor
	6 months	• Rolls over in both directions (front to back, back to front) • Begins to sit without support • When standing, supports weight on legs and might bounce • Rocks back and forth, sometimes crawling backward before moving forward	• Looks around at things nearby • Brings things to mouth • Shows curiosity about things and tries to get things that are out of reach • Begins to pass things from one hand to the other	• Responds to sounds by making sounds • Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds • Responds to own name • Makes sounds to show joy and displeasure • Begins to say consonant sounds (jabbering with "m," "b")	• Knows familiar faces and begins to know if someone is a stranger • Likes to play with others, especially parents • Responds to other people's emotions and often seems happy • Likes to look at self in a mirror	• Doesn't try to get things that are in reach • Shows no affection for caregivers • Doesn't respond to sounds around him • Has difficulty getting things to mouth • Doesn't make vowel sounds ("ah", "eh", "oh") • Doesn't roll over in either direction • Doesn't laugh or make squealing sounds • Seems very stiff, with tight muscles • Seems very floppy, like a rag doll

	9 months	• Stands, holding on • Can get into sitting position • Sits without support • Pulls to stand • Crawls	• Watches the path of something as it falls • Looks for things the baby sees you hide • Plays by laughing and smiling • Puts things in his mouth • Moves things smoothly from one hand to the other • Picks up things like cereal between thumb and index finger	• Understands "no" • Makes a lot of different sounds like "mamma" and "babies" • Copies sounds and gestures of others • Uses fingers to point at things	• May be afraid of strangers • May be clingy with familiar adults • Has favourite toys	• Doesn't bear weight on legs with support • Doesn't sit with help • Doesn't babble ("mama", "baba", "dada") • Doesn't play any games involving back-and-forth play • Doesn't respond to own name • Doesn't seem to recognize familiar people • Doesn't look where you point • Doesn't transfer toys from one hand to the other •
	1 year	• Gets to a sitting position without help • Pulls up to stand, walks holding on to furniture • May take a few steps without holding on • May stand alone	• Explores things in different ways, like shaking, banging, throwing • Finds hidden things easily • Looks at the right picture or thing when it's named • Copies gestures • Starts to use	• Responds to simple spoken requests • Uses simple gestures, like shaking head "no" or waving "bye-bye" • Makes sounds with changes in tone (sounds more like speech) • Says "mama" and "dada" and exclamations like	• Is shy or nervous with strangers • Cries when mom or dad leaves • Has favourite things and people • Shows fear in some situations • Hands you a book when he wants to hear a story • Repeats sounds or actions to get	• Doesn't crawl • Can't stand when supported • Doesn't search for things that she sees you hide • Doesn't say single words • Doesn't learn gestures

			things correctly; for example, drinks from a cup, brushes hair • Bangs two things together • Puts things in a container, takes things out of a container • Lets things go without help • Pokes with index (pointer) finger • Follows simple directions like "pick up the toy"	"uh-oh!" • Tries to say words you say	attention • Puts out arm or leg to help with dressing	like waving or shaking head • Doesn't point to things • Loses skills he once had
	18 months	• Walks alone • May walk up steps and run • Pulls toys while walking • Can help undress herself • Drinks from a cup • Eats with a spoon	• Knows what ordinary things are for; for example, telephone, brush, spoon • Points to get the attention of others • Shows interest in a doll or stuffed animal by pretending to feed • Points to one body part • Scribbles on his own • Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"	• Says several single words • Says and shakes head "no" • Points to show someone what he wants	• Likes to hand things to others as play • May have temper tantrums • May be afraid of strangers • Shows affection to familiar people • Plays simple pretend, such as feeding a doll • May cling to caregivers in new situations • Points to show others something interesting • Explores alone but with parent close by	• Doesn't point to show things to others • Can't walk • Doesn't know what familiar things are for • Doesn't copy others • Doesn't gain new words • Doesn't have at least 6 words • Doesn't notice or mind when a caregiver leaves or returns • Loses skills he once had

Stages	Period	Modalities for measuring physical development	Modalities for measuring cognitive development	Modalities for measuring language/ communication	Modalities for measuring social and emotional development	Measuring of disease/ Deformity/ factors to be reported to a doctor
	2 years	• Stands on tiptoe • Kicks a ball • Begins to run • Climbs onto and down from furniture without help • Walks up and down stairs holding on • Throws ball overhand • Makes or copies straight lines and circles	• Finds things even when hidden under two or three covers • Begins to sort shapes and colours • Completes sentences and rhymes in familiar books • Plays simple make-believe games • Builds towers of 4 or more blocks • Might use one hand more than the other • Follows two-step instructions such as “Pick up your shoes and put them in the closet.” • Names items in a picture book such as a cat, bird, or dog	• Points to things or pictures when they are named • Knows names of familiar people and body parts • Says sentences with 2 to 4 words • Follows simple instructions • Repeats words overheard in conversation • Points to things in a book	• Copies others, especially adults and older children • Gets excited when with other children • Shows more and more independence • Shows defiant behaviour (doing what he has been told not to) • Plays mainly beside other children, but is beginning to include other children, such as in chase games	• Doesn’t use 2-word phrases (for example, “drink milk”) • Doesn’t know what to do with common things, like a brush, phone, fork, spoon • Doesn’t copy actions and words • Doesn’t follow simple instructions • Doesn’t walk steadily • Loses skills she once had
	3 years	• Climbs well • Runs easily • Pedals a tricycle (3-wheel bike) • Walks up and down stairs, one foot on each step	• Can work toys with buttons, levers, and moving parts • Plays make-believe with dolls, animals, and people • Does puzzles with 3 or 4 pieces • Understands	• Follows instructions with 2 or 3 steps • Can name most familiar things • Understands words like “in,” “on,” and “under” • Says first name, age, and sex	• Copies adults and friends • Shows affection for friends without prompting • Takes turns in games • Shows concern for crying friend • Understands the idea of “mine” and “his”	

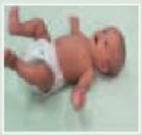
			what “two” means • Copies a circle with pencil or crayon Turns book pages one at a time • Builds towers of more than 6 blocks • Screws and unscrews jar lids or turns door handle	• Names a friend • Says words like “I,” “me,” “we,” and “you” and some plurals (cars, dogs, cats) • Talks well enough for strangers to understand most of the time • Carries on a conversation using 2 to 3 sentences •	or “hers” • Shows a wide range of emotions • Separates easily from mom and dad • May get upset with major changes in routine • Dresses and undresses self	
	4 years	• Hops and stands on one foot up to 2 seconds • Catches a bounced ball most of the time • Pours, cuts with supervision, and mashes own food	• Names some colours and some numbers • Understands the idea of counting • Starts to understand time • Remembers parts of a story • Understands the idea of “same” and “different” • Draws a person with 2 to 4 body parts • Uses scissors • Starts to copy some capital letters • Plays board or card games • Tells you what he thinks is going to happen next in a book	• Knows some basic rules of grammar, such as correctly using “he” and “she” • Sings a song or says a poem from memory • Tells stories • Can say first and last name	• Enjoys doing new things • Plays “Mom” and “Dad” • Is more and more creative with make-believe play • Would rather play with other children than by himself • Cooperates with other children • Often can’t tell what’s real and what’s make-believe • Talks about what she likes and what she is interested in	

	5 years	• Stands on one foot for 10 seconds or longer • Hops; may be able to skip • Can do a somersault • Uses a fork and spoon and sometimes a table knife • Can use the toilet on her own • Swings and climbs	• Counts 10 or more things • Can draw a person with at least 6 body parts • Can write some letters or numbers • Copies a triangle and other geometric shapes • Knows about things used every day, like money and food	• Speaks very clearly • Tells a simple story using full sentences • Uses future tense; for example, "Grandma will be here." • Says name and address	• Wants to please friends • Wants to be like friends • More likely to agree with rules • Likes to sing, dance, and act • Is aware of gender • Can tell what's real and what's make-believe • Shows more independence (for example, may visit a next-door neighbour by himself [adult supervision is still needed]) • Is sometimes demanding and sometimes very cooperative	

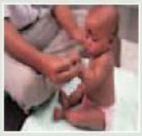
ANNEXURE II

Early detection of Developmental Delay (D1 & D2:-2-6 months)

2 – 4 Months

Gross Motor		Fine Motor	Hearing	Speech	Vision	Cognition & Socialization
						
D1.1 Moves both arms and both legs, freely and equally when awake	**D1.2** Raises the head occasionally when	**D1.3** Keeps his hands open and relaxed	**D1.4** Responds to sound	**D1.5** Vocalizes by cooing especially after feeding	**D1.6** Eye contact	**D1.7** Social Smile

4 – 6 Months

								
D2.1 Holds Head Straight while sitting or when held on shoulder		**D2.2** Reaches and tries to grasps an object	**D2.2** Grasp of the object is in the ulnar side of palm	**D2.3** When spoken to, responds by looking directly at speaker's face	**D2.4** Laugh aloud	**D2.5** Follows an object	**D2.6** Sucks on hands	

Early detection of Developmental Delay (D3 & D4:-6-12 months)

6 – 9 Months

Gross Motor	Fine Motor	Hearing	Speech	Vision	Cognition & Socialization	
						
D3.1 Roll over or turn over in either direction	**D3.2** Grasps a small object by using his whole hand	**D3.3** Locates source of sound	**D3.4** Child utters consonant sounds like "p" "b" "m"	**D3.5** Child watches TV without tilting his/her head	**D3.6** Child stretches his arms to be picked up by the parents	**D3.7** Child looks for a spoon or toy that has dropped

9 – 12 Months

						
D4.1 Child can sit without any support	**D4.2** Transfer object from hand to hand	**D4.3** Respond to his/ her name	**D4.4** Babbling example- "ba", "ba", "da", "da", "ma", "ma"	**D4.5** Avoid bumping into objects while moving	**D4.6** Child enjoys playing hide-and-seek (peek-a-boo)	

Early detection of Developmental Delay (D5 & D6:-12-18 months)

12 – 15 Months

Gross Motor	Fine Motor	Hearing	Speech	Cognition & Socialization		
						
D5.1 Reciprocal crawling on hands and knees	D5.2 Child picks up small object using thumb and index finger	D5.3 Child stops activity in response to "NO"	D5.4 Child says one meaningful word clearly like mama, dada	D5.5 Imitate action like bye-bye/clap/ kiss	D5.6 Child cries when a stranger picks him up	D5.7 Child searches for completely hidden objects

15 – 18 Months

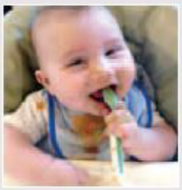
						
D6.1 Child walks alone	D6.2 Child put small things into a container	D6.3 Points to objects	D6.4 Follow simple one step direction, "Sit Down" , "Give me the ball"	D6.5 Child says at least two words other than mama or dada like dog, cat	D6.6 Child manipulates or explores a toy with his fingers like poking or pulling the toy	

Early detection of Developmental Delay (D7 & D8:-18-30 months)

18 – 24 Months

Gross Motor	Fine Motor	Hearing and Speech	Cognition & Socialization	
		 Mummy, Daddy, baby, milk, juice, hello, ball, yes, no, dog, cat, nose, eye, banana, biscuit, car, hot, thank you, bath, shoe, hat, book, all gone, more and bye bye.		
D7.1 Walks steadily even while pulling a toy	D7.2 Scribble spontaneously	D7.3 Says at least five words consistently even if not clear	D7.4 Imitates house hold tasks	D7.5 Points to one or more body parts

24 – 30 Months

				
D8.1 Child climbs upstairs and downstairs	D8.2 Child feeds self either with hand or spoon or drink from a cup	D8.3 Joins 2 words together like mama-milk, car-go	D8.4 Parallel play: Playing along with other children	D8.5 Simple pretend play eg feeding the doll

*RBSK(Rashtriya Bal Suraksha Karyakram). Ministry of Health & Family Welfare Government of India (August, 2014). Chil
Health Screening and Early Intervention Services National Rural Health Mission.
https://nhm.gov.in/images/pdf/programmes/RBSK/Resource_Documents/RBSK_Job_Aids.pdf

ANNEXURE III

IMMUNIZATION SCHEDULE FOR PREGNANT WOMEN, INFANTS, CHILDREN AND TEENAGERS		
Age	**Type of Vaccine**	**Prevents**
BEFORE PREGNANCY	Measles, Mumps & Rubella Vaccination should be taken 2-3 months prior.	
FOR PREGNANT WOMEN	Td-1 in Early Pregnancy	Tetanus and Diphtheria
	Td-2 (4 weeks after Td-1)	Tetanus and Diphtheria
	TD Booster (If received TT/ Td doses in pregnancy during last 3 Years)	Tetanus and Diphtheria
	TORCH SYNDROME DETECTION i.e., (T)oxoplasmosis, (R)ubella, (C)ytomegalovirus, (H)erpes Simplex and HIV	
FOR INFANTS		
At Birth (1st Time)	OPV-0 drops	Polio
	Injection Hepatitis B	Hepatitis B
	Injection BCG	Miliary Tuberculosis and Tubercular Meningitis
	Blood Test for Birth Anomalies due to hypothyroidism before discharge from maternity unit	
Six Weeks (2nd Time)	OPV-1 drops	Polio
	RVV-1 drops	Rotavirus Diarrhea
	Injection fIPV-1	Polio
	Injection Penta-1	Diphtheria, Pertussis, Tetanus, Hepatitis-B, Meningitis & Pneumonia due to Hemophilus influenza-B
Ten Weeks (3rd Time)	OPV-2 drops	Polio
	RVV-2 drops	Rotavirus Diarrhea
	Injection Penta-2	Diphtheria, Pertussis, Tetanus, Hepatitis-B, Meningitis & Pneumonia due to Hemophilus influenza-B
Fourteen Weeks (4th Time)	OPV-3 drops	Polio
	RVV-3 drops	Rotavirus Diarrhoea
	Injection f-IPV-2	Polio
	Injection Penta-3	Diphtheria, Pertussis, Tetanus, Hepatitis-B, Meningitis & Pneumonia due to Hemophilus influenza-B
Nine Months completed (5th Time)	Injection MR-1	Measles and Rubella
	Injection JE-1	Japanese Encephalitis
	Vitamin A-1	Vitamin A Deficiency/Blindness

IMMUNIZATION SCHEDULE FOR PREGNANT WOMEN, INFANTS, CHILDREN AND TEENAGERS		
Age	**Type of Vaccine**	**Prevents**
FOR CHILDREN UPTO 7 YEARS		
16-24 MONTHS/ WITHIN 7 YEARS	DPT BOOSTER-1	Diptheria, Pertussis, Tetanus
16-24 MONTHS/ TILL 5 YEARS	Injection MR-2	Measles and Rubella
16-24 MONTHS/ TILL 5 YEARS	OPV BOOSTER	Polio
16-24 MONTHS	Injection JE-2	Japanese Encephalitis
On 16th month, then one dose every six months/ TILL 5 YEARS OF AGE	Vitamin A-2nd to 9th Dose	Vitamin A Deficiency/ Blindness
FOR CHILDREN UPTO 7 YEARS		
5-6 YEARS	DPT BOOSTER-2	Diphtheria, Pertussis, Tetanus
FOR CHILDREN AT 10 and 16 YEARS		
10 YEARS & 16 YEARS	Td	Tetanus and Diphtheria
FOR TEENAGE GIRLS		
13- 26 YEARS	HPV + REGULAR CERVICAL SCREENING	Cervical Cancer
	RUBELLA VACCINE	
* Universal Immunization Programme- Modified to Meghalaya Context		

ANNEXURE IV

ECD Educators under Meghalaya's Early Childhood Development Mission

With an aim to further the objectives of the Meghalaya Early Childhood Development Mission, a need for involvement of 'participatory communication' through involvement of existing Self-Help Groups (SHGs) is felt. There is some evidence of effects of such approaches on self-reported antenatal, delivery and postnatal behaviours. These Self-Help Group Volunteers (SHG-Vs), through the Participatory learning and Action (PLA) approach have been shown to reduce neonatal and infant mortality, as well as underweight in infants and young children.

To affect the Meghalaya ECD Mission, one active member (male and female or only female?) from an SHG and/or VO would be required to work in close collaboration with Anganwadi centres. In the remaining 1500+ villages where there are no Anganwadi centres, these active women SHGs of SHG-Vs will play the role of Anganwadi centres and they will be paid under the ECD mission.

These SHG-Vs will be selected by the MSRLS/VOs/VHCs of the respective villages. The honorarium/salaries will be disbursed through the Mission

The shortlisted SHG-Vs will undergo a 2-month-long training where they will be versed with the basic concepts of ECD mission in Meghalaya. Here, they will be provided with modules and training tools to be able to effectively disseminate information and knowledge for implementation of ECD missions at the grass root level.

Following the completion of training, an assessment will be conducted to ensure the effectiveness in deliverance of the message. Post this exercise, the SHG-Vs will then further their service. The scope of the work is given below:

Scope of work:

1. Sensitizing people about the ECD mission through extensive trainings and as Early Childhood Educators

Take forward the vision and mission of Meghalaya's Early Childhood Development (ECD) Mission by sensitizing people on the importance of ECD and the dos and don'ts in this regard. SHG-Vs are expected to train and guide children from 6 months to 6 years at Anganwadi Centres or, in case of non-existence of anganwadi centres, arrangements will be made for creation of spaces such as early learning centres for the purpose. The training duration is set at 10 months, wherein ECD-GVs will cover 240 Hrs to cover all relevant topics. Another 2 months will be the follow up period.

The SHG-Vs will be providing ECD services and will perform all other tasks that an Anganwadi worker performs under the ECD-Mission.

2. SHG members meeting the following eligibility criteria would be selected as SHG-Vs:

- The SHG member must preferably hold a graduate degree in any discipline from a reputed institution.
- The SHG-Vs will assist the Anganwadi workers in villages covered under ICDS. In villages not covered under ICDS, the SHG-Vs will take up the role of early childhood educators.
- The SHG member must be a resident of Meghalaya, preferably an SHG member of the same village.

- The SHG member must be willing to set aside 240 hours for a period of 10 months and another 2 months as a follow up period.
- The SHG member must be above --- and not more than --- years old.
- The SHG member should be proficient in either of the following languages- English, Hindi, Garo, Jaintia, Khasi.
- The SHG members who have demonstrated prior public speaking skills may be preferred.
- She/He must be willing to travel within the State as and when required.
- The individual should believe in the ability of children to transform the future of the State and drive the ECD training with the objective of attaining the vision and mission of the ECD mission.

3. Period of Engagement

- The SHG-Vs will be required to dedicate 8 hours per day at the early learning centres.
- The engagement would last as long as the ECD mission is being implemented.
- It is mandatory to serve two months' notice period in case the volunteer wishes to back out of the engagement before the completion of one (1) year period. The MSRLS would then make arrangements for onboarding of new SHG-Vs.

4. Financial Engagement

- All SHG-Vs will receive a monthly honorarium of INR 4000 per month (Subject to achievement of targets).
- Work-related travel, accommodation and appropriate out of pocket expenses will be covered by the selection committee.

5. Selection Process

The MSRLS will facilitate selection of Self-Help Group volunteers under ECD from among the Self Help Groups in every village, prioritizing the 1500+ villages that are not covered under the ICDS.

Bibliography

Chyne, D. A. L., Meshram, I. I., Rajendran, A., Kodali, V., Getti, N., Roy, P., Kuhnlein, H. V., &Longvah, T. (2018, January 22). Nutritional status, food insecurity, and biodiversity among the Khasi in Meghalaya, North-East India.**https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.12557**

Nair, M. K., & Mehta, V. (2009). Life cycle approach to child development. Indian Pediatrics, 46, S7-S11. **https://www.indianpediatrics.net/suppl2009/S7.pdf**

Cusick, S., &Georgieff, M. K. (n.d.). The first 1,000 days of life: The brain's window of opportunity. UNICEF-IRC. Retrieved November 17, 2020. **https://www.unicef-irc.org/article/958-the-first-1000-days-of-life-the-brains-window-of-opportunity.html**

Early Childhood Development Milestones, Centre for Disease Control and Prevention
Heckman, J. J. (2011). The Economics of Inequality. 6.
Heckman, J. J. (2013, July 12). Invest in Early Childhood Development: Reduce Deficits, Strengthen the Economy. The Heckman Equation. **https://heckmanequation.org/resource/invest-in-early childhood-development-reduce-deficits-strengthen-the-economy/**

Kumar, S., Villasmil, R. A., Harvard Kennedy School, Meisnner, D. N., & Harvard Graduate School of Education. (2013). Interventions in Self Help Groups in India, Effects of Brain Science Informed and Collaborative Impact Based Economic, Social Leverage, and Early Childhood Development Interventions in Self Help Groups in Uttar Pradesh, India.

National Education Policy 2020, Human Resource Development, Government of India **https://www.education.gov.in/sites/upload_files/mhrd/files/NEP_Final_English_0.pdf**

National Scientific Council On The Developing Child. (2020). Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health Are Deeply Intertwined.**https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/wp15_health_FINALv2.pdf**

Nongrum, M. S., &Kharkongor, G. C. (2015). HIGH PREVALENCE OF VITAMIN A DEFICIENCY AMONG CHILDREN IN MEGHALAYA AND THE UNDERLYING SOCIAL FACTORS. Indian Journal of Child Health, 02(02), 59.

*RBSK(Rashtriya Bal Suraksha Karyakram). Ministry of Health & Family Welfare Government of India (August, 2014). Child Health Screening and Early Intervention Services National Rural Health Mission. **https://nhm.gov.in/images/pdf/programmes/RBSK/Resource_Documents/RBSK_Job_Aids.pdf**

Schweinhart L.J., Montie J., Xiang Z., Barnett W.S., Belfield C.R., Nores M. (2005). The High/Scope Perry Preschool Study Through Age 40 Summary, Conclusions and Frequently Asked Questions

https://nieer.org/wp-content/uploads/2014/09/specialsummary_rev2011_02_2.pdf

Universal Immunization Programme, National Health Mission- **https://www.nhp.gov.in/universal-immunisation-programme_pg**

Sri Sumarnia, Shelly Tri YuniPertiwib, Rukiyahc ,WindiDwiAndikad, RuriTriaAstikae , Abdurrahmanf , RofiqulUmamg. (Volume 8, Issue 8, 2019). Behavior in Early Childhood (2-3) Years: A Case Study on the Use of Gadgets in Social Environments: International Journal of Innovation, Creativity and Change.**https://www.ijicc.net/images/vol8iss8/8823_Sumarni_2019_E_R.pdf**

Storrs, C. (2017). How Poverty Affects the Brain—Scientific American. Retrieved November 17, 2020, from **https://www.scientificamerican.com/article/how-poverty-affects-the-brain/**

United Nations Development Programme Report, 2014. Human Development Report
Yale University. (2012, August 9). Natural birth -- but not C-section -- triggers brain-boosting proteins. ScienceDaily. Retrieved December 23, 2020 from **www.sciencedaily.com/releases/2012/08/120809090652.htm**

Summary of EARLY CHILDHOOD DEVELOPMENT (ECD) Mission

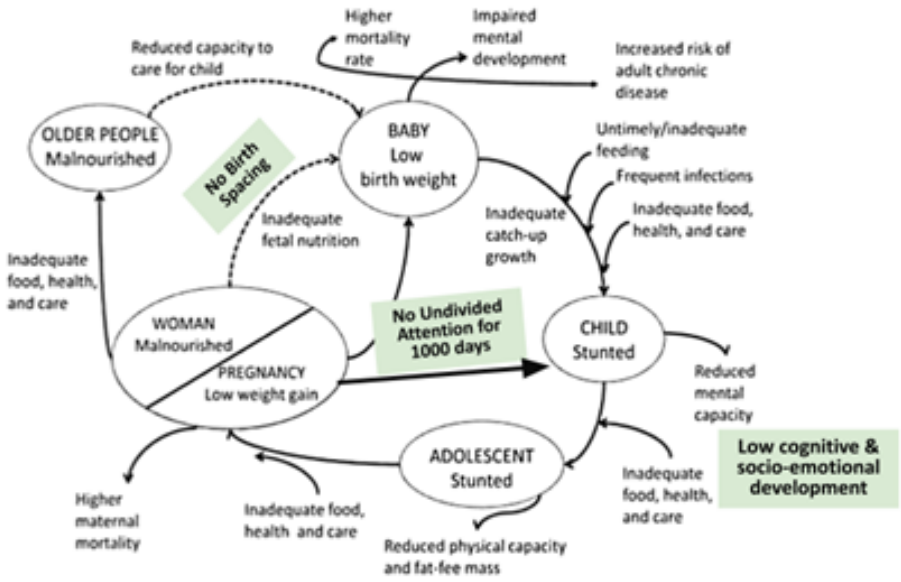
Vision

*Enable Meghalaya's children to achieve their **full long-term potential** by ensuring they receive good health care, nutrition and cognitive development support during the critical years of early childhood (0-8 years)*

Meghalaya **Performs Poorly on Human Development** Indicators

Health		Nutrition		Education	
MMR	197 (India: 113)	Children Stunted	46.5% (India: 35.5%)	Std V can who read Std II level text	50.1% (India: 50.3%)
IMR	34 (India: 32)	Children Wasted	12.1% (India: 19.3%)	Tenth Pass percentage	50.3%
Life Expectancy	62.3 years (India: 68.5)	Anaemia among women	53.8% (India: 57%)	School Dropout at secondary level	22.4%

Life-Cycle Model shows that all challenges are **interconnected**



MOST INDICATORS ARE INTERCONNECTED AND IMPACT ONE ANOTHER

	Lack of the following :	Can lead to:	Resulting in:
EXAMPLES	Adequate Nutrition	• Stunting • High risk pregnant mothers • Anaemic Women • Retarded growth • Development Delays	• High MMR, IMR and NMR • Low cognitive function, IQ and EQ • Low life expectancy • Weaken immune system • Greater risk of serious diseases like cancer and diabetes
	Socio-Emotional support	• School drop outs • Poverty • Poor nutrition • Teenage Pregnancy	• High IMR • High Neonatal Deaths • Low economic productivity • Social inequality • Crime and anti -social behaviour
	Poverty alleviation	• Poor nutrition • School drop outs • Teenage pregnancy	• Anaemic pregnant mothers • Stunting and wasting in children • SAM & MAM children • Low economic productivity • Low life expectancy

The Early Childhood Development Mission is part of a larger initiative:

The **State Capability Enhancement Project (SCEP)**, which seeks to strengthen state capacity to solve complex development challenges.

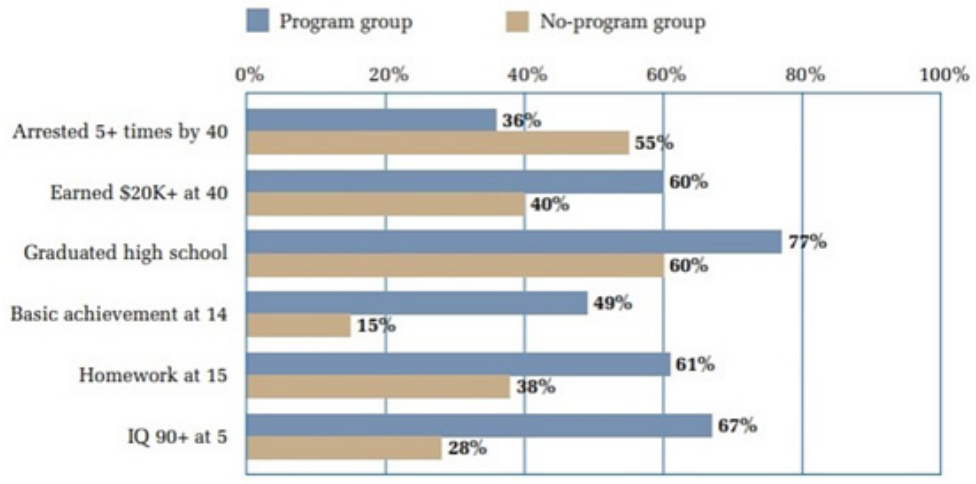
Why We Should Invest in **Early Childhood Period**

Investing in Early Childhood leads to	→	Important Short-Term Gains	→	Critical Long-Term Impact
• Adequate Nutrition • Joyful Learning & Other Mental Stimulation • Counseling on Positive Parenting		• Lower rates of stunting, underweight and wasting • Better preparedness for schools		• Higher Earnings in life • Lower Crime Rates • Better Health & Education Outcomes

Science of Early Childhood Development

Research Shows Importance of Early Childhood Development

The High/Scope Perry Preschool Study found major benefits for children who received a specialized ECD preschool program



Children in the **program group** had:

- **Better education** outcomes
- **Higher IQ & EQ**
- **Lower crime** rates
- **Higher earnings** later in life
- Better long-term **health outcomes**

The intervention
2-hour classes everyday with trained graduate teachers
Using “Joyful Learning” methods

Research Shows Importance of Early Childhood Development

The Heckman Equation

+ Invest
Invest in educational and developmental resources for disadvantaged families to provide equal access to successful early human development.

+ Develop
Nurture early development of cognitive and social skills in children from birth to age five.

+ Sustain
Sustain early development with effective education through to adulthood.

= Gain
Gain a more capable, productive and valuable workforce that pays dividends to the economy for generations to come.

Economist and Nobel laureate James Heckman had the following research findings*:

- Access to high-quality early childhood education (ECE) **can break the cycle of poverty across generations**
- Children who receive high-quality early childhood supports **have significantly better life outcomes** and pass the **positive effects on to their children**
- Early investments in high-quality programs for disadvantaged kids **pay for themselves over time**
- **Home environment matters** more than neighbourhood for adult outcomes
- There are **significant gains in employment & reduction in crime**, both for participants AND their children

** Heckman et al, "Perry Preschoolers at Late Midlife: A Study in Design-Specific Inference"*

EKJUT Study in Jharkhand & Odisha

- Creches that functioned for 8 hours
- Children were given 1 Hot-Cooked Meal & 2 Snacks
- Parents were counselled in groups & in home visits

of time spent in a clean & stimulating environment

of child's nutrition provided at the centre

Key Impacts

27% Reduction in **Stunting**

40% Reduction in **Underweight**

27% Reduction in **Wasting**

Meghalaya's ECD Mission
Key Components

1 Human Resources

- Train ECD Educators (SHGs), AWWs, ASHAs & Teachers
- Augment capacity of AWCs to provide ECD services to children upto 3 years
- Expand & Train block teams to facilitate and supervise
- Extend services to uncovered villages

2 Infrastructure & Material

- New Anganwadi Centres in 1500 villages that are currently uncovered
- Upgrade existing Anganwadi Centres to be Early Childhood Education Centers
- Additional nutrition (egg, green vegetables) and learning materials for AWC

3 Build State Capability

- Facilitate collaboration across departments through **State Resource Centre for Developing Child**
- Build local leadership through practice, iteration, learning & adaptation (PDIA)
- Institutionalize practices such as positive parenting

1 Building Up Human Resources

Village Health Council

- Provides local leadership on identifying health challenges
- Village-level community institution with active participation of women's SHGs
- Mobilizes community action and behavior change, eg. on birth spacing, teenage pregnancy
- Implements local level health initiatives, eg. tracking pregnancies, starting nutri-gardens
- Builds health seeking behavior in the community through sensitization, eg. Kangaroo Mother Care, Positive Parenting, proper nutrition, etc

Extending Supplementary Nutrition Programme to 1500 uncovered villages

- Mobilizes and train SHGs to survey their villages, distribute SNP benefits, and record health data of beneficiaries
- Enlist Lady Supervisors / CDPOs, BPMs (NRLM), and AWWs in following tasks:
  - Maintaining & updating village records
  - Coordinating provision of health & nutrition services
  - Handholding & coaching support to SHGs

Skill building of AWWs & Teachers

- Training of teachers in active learning
- Introducing early childhood education curriculum in primary schools
- Training of AWWs in improved pre -school curriculum, positive parenting, Active Learning, Learning Through Play and responsive caregiving

ECD Educators

- SHG members selected from each village, and trained in ECD approaches & methods
- Will support AWWs in providing ECE at AWCs
- Sensitizing and counseling VHCs, SHGs, and families
- Home-based counseling & home visits
- Socio-emotional support to vulnerable families

2 Improving Infrastructure & Materials

Construction of **new** Anganwadi Centres in **1500 uncovered villages**

- Creation of dedicated play spaces for promoting physical and barrier-free activities among children
- Provision of books, toys and other materials for play and cognitive development
- Materials and space for kitchen garden
- Building and equipment for onsite kitchen
- Ensure clean and functioning toilet

Renovate all Anganwadi Centres to be **Early Childhood Education** Centres

- *Ensure provision of the same quality of rooms, materials, equipment and spaces as described for the new Centres*
- Repair of any degraded equipment and buildings

3 Enhancing State Capability

We will apply SCEP principles to transform how state institutions collaborate to provide ECD services

Key Institutions

Meghalaya Human Development Council

State Resource Centre for Developing Child
- Research & Documentation team
- Facilitation team

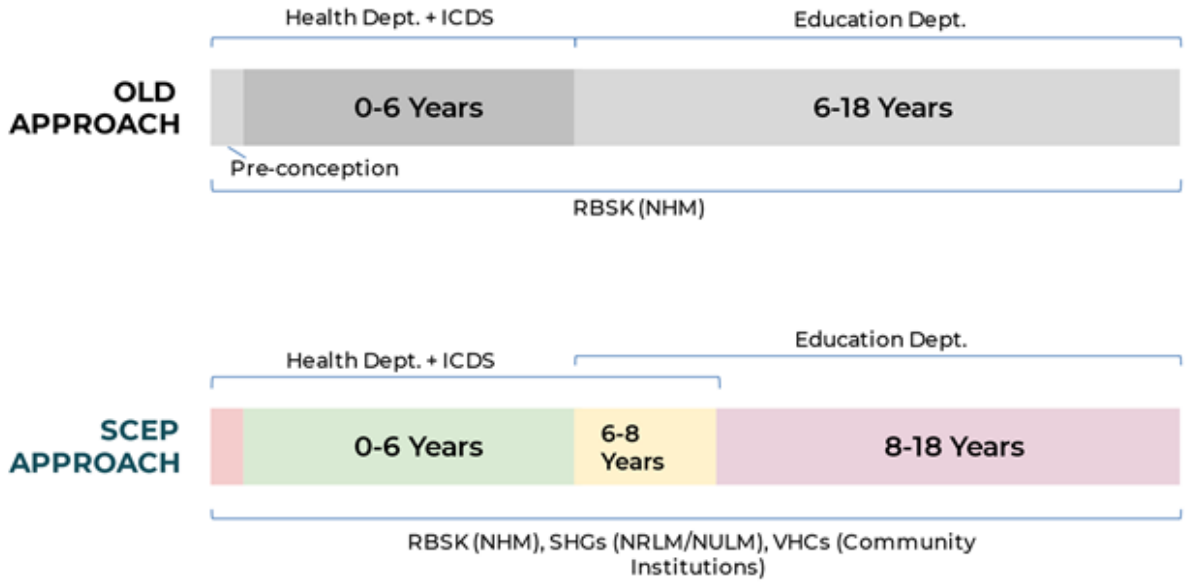
State ECD Convergence Committee
- Dept of Health
- Dept of Social Welfare (nodal dept)
- Dept of Education
- Dept of Community & Rural Development
- Dept of Urban Development

Community Institutions
- Village Health Councils, SHGs

How we will work

- System of regular cross-department check-ins at block, district and state:
  - **Develop action** plans
  - **Review challenges** & learnings
  - **Adapt implementation**
- Work across departments and with communities will be **actively facilitated by SRCDC facilitation team**
- Facilitation team will mentor programme staff and will work with line departments to support community mobilization

Coordination Across Departments For Enabling ECD



Meghalaya's ECD Mission
Key Interventions

Cluster Team to train & Facilitate **Village Health Councils** to

- Discuss and **address local challenges** in health and nutrition
- **Hold accountable:** ECD Educators, AWW, ASHA & Teachers

ECD Educator to lead weekly SHG group discussions and home visits to:

- **Disseminate practices** such as KMC, positive parenting and healthy nutrition, home-based child care and mental health
- **Generate demand for AWC services** and target children who need more attention
- **Identify problems** to be taken up by **VHCs and Sector Teams**

AWW & ECD Educator to

- Closely **monitor growth** and **provide nutrition** (eggs, green vegetables) to children up to 3 years
- **Counsel** on nutrition, positive parenting and other practices
- **Provide ECD programming** such as joyful learning & active learning

Interventions Will Enable Strong ECD Services

Key Services & Programmes

1. **Positive Parenting** courses and **Parent Counseling**
2. **Nutrition & Health** Programming
3. **ECE preschooling** at AWC
4. **Community sensitization** on importance of childhood development

Programmes will emphasize the following content:

- **Quality Healthcare**
  - Importance of the First 1000 Days
  - Basic infant care
  - Immunization
  - Checklists for physical/ gross/ motor milestones
- **Quality Nutrition**
  - Sensitization programmes
  - Nutri-gardens
  - Reducing SAM/MAM cases
- **Cognitive & Socio-emotional Development**
  - Positive parenting
  - Improved Pre-School Curriculum
  - Active Learning & Learning Through Play
  - Responsive Caregiving
  - Serve-and-Return
  - Safety & Security

Expected Results

- Reduced MMR
- Reduction in dropout rates
- Reduced SAM and MAM children
- Reduced Stunting
- Reduced violence and juvenile issues
- Increased employment in the long run
- Reduced poverty in the long run
- Increased community collective action, harmony and citizenship
- Higher economic productivity
- Overall, better life outcomes and with positive effects passed on to future generations

Progress Made Under ECD Mission

- **World Bank ECD pilot completed in** Rongram Block, West Garo Hills, through National Health Mission (NHM) and National Rural Livelihood Mission (NRLM).
- **State-level ECD committee** constituted.
- **State ECD Mission is a registered society** under the Meghalaya Societies Registration Act., 1983.
- **Secured ADB assistance** in all parameters for the age group of 0-6 years.
- **Joint curriculum development** ongoing by ICDS and external agencies for the age group of 3-8.
- Critical gap funding for procuring **Growth Monitoring Devices and hiring of ICDS functionaries.**
- **Streamlined recruitment processes** to get right manpower for the mission.
- I**dentification of priority blocks/villages** for roll-out in process. Priority where high prevalence of SAM/MAM children, stunting and anaemia, and extreme poverty.
- **SNP extended to 1574 villages** which had never been covered under ICDS. As part of this, **1357 SHGs/VOs** have been trained.
- **Launch of Village Health Councils throughout the State is ongoing.**
- Multi-sectoral Assistance for covering the **Adolescent wellbeing, employment and resilience** under process.

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Government of Meghalaya