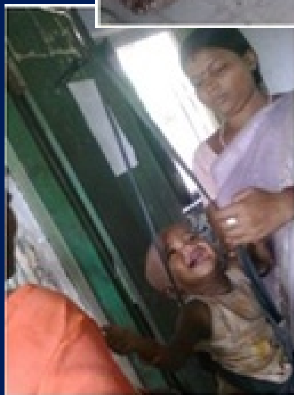

Performance Needs Assessment of Integrated Child Development Services Scheme in Jharkhand

Final Report

August 2012

Submitted by:
Child in Need Institute (CINI)
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List of abbreviations

AD	Assistant Director
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behavior Change Communication
CDPO	Child Development Project Officer
CINI	Child In Need Institute
DHFW	Department of Health and Family Welfare
DPO	District Program Officer
DSW	Department of Social Welfare
DSWO	District Social Welfare Officer
ECD	Early Childhood Development
GM	Growth Monitoring
GoI	Government of India
GoJ	Government of Jharkhand
ICDS	Integrated Child Development Services
IIPS	International Institute for Population Sciences
LS	Lady Supervisor
MCH-STAR	Maternal and Child Health Sustainable Technical Assistance and Research
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
MLTC	Mid Level Training Center
MPR	Monthly Progress Report
MWCD	Ministry of Women and Child Development
NHED	Nutrition and Health Education
NIPCCD	National Institute of Public Cooperation and Child Development
PI	Performance Improvement
PNA	Performance Needs Assessment
RCA	Root Cause Analysis
SN	Supplementary Nutrition Program
THR	Take Home Ration
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHND	Village Health and Nutrition Day
VSRC	Village Health Committee *Sahiyya* Resource Centre
WCD	Women and Child Development

Executive summary

Background: The Integrated Child Development Services (ICDS) scheme in Jharkhand has grown significantly, since the inception of the state in 2000, to reach every village. However, the overall effectiveness of the scheme in reaching its goals of reducing malnutrition and providing pre-school foundation for children remains limited. To help address challenges in ICDS implementation, the Department of Social Welfare (DSW), Women and Child Development (WCD), Government of Jharkhand (GoJ), in collaboration with Child In Need Institute (CINI)- Jharkhand launched an initiative to identify barriers to effective implementation of ICDS through a Performance Needs Assessment (PNA)[1].

Methodology: PNA is a component of a larger Performance Improvement (PI) process; the latter is guided by the belief that when organizations enable and motivate their employees to perform their self identified best, the quality of services improves. Stakeholder consultations identified desired performance indicators of providers, which were compared with actual performance obtained through direct observations and respondents' self reported data. The difference established the performance gap. Using a why-why-why method the root causes for these gaps in context of ICDS in Jharkhand were identified. The field study sample consisted of 60 *Anganwadi Workers* (AWW), 24 Lady Supervisors (LS), 12 CDPOs and 6 DSWOs from six districts. A total of 24 AWWs were observed as part of a facility audit. A review of select elements of the scheme from better-performing states, with respect to ICDS coverage and childhood nutritional status, was also done to identify best practices and innovations.

Findings: Several issues adversely affect the delivery of ICDS services through *Anganwadi Centers* (AWCs) in Jharkhand. The PNA study findings and subsequent root cause analysis revealed the problems in the following:

Policy and guidelines: While many guidelines have been issued at various points in time from the MWCD, at the GoI and GoJ levels, not all have reached the AWW at the AWC. Many of those that have percolated down to the AWC are not understood by functionaries. There is a lack of easy -to - understand operations guidelines that serve as ready reference for functionaries at all levels. Initially, a compendium of guidelines systematically updated for reference at the state level was missing - subsequently, this project has facilitated its availability.

Knowledge and skills: Inconsistent key messages on nutrition and care are being delivered by AWWs. Evidence shows AWWs lack knowledge and skills in growth monitoring and growth promotion, nutrition and health education, and in preschool education activities. These are attributed to inadequate training and a lack of supportive supervision on the job. The inconsistency in knowledge and skills is also a result of a lack of easy to understand, simple guidelines at the AWC level, inadequate and inconsistent advocacy of the ICDS and inconsistent communication of key messages to service providers and beneficiaries. There is also a lack of easy to use guides on growth monitoring and on counseling the various categories of beneficiaries on nutrition and care.

Physical Infrastructure: Poor quality and inadequate infrastructure in terms of space and equipment hamper the performance of the AWW and reduce the desire of local communities to access services from the AWC. Usable toilets and drinking water facilities at the AWCs are inadequate or absent. Storage and equipment are often not available at the AWC and when available, they required repair

[1] Technical and financial support for this initiative was provided by the United States Agency for International Development (USAID) funded Maternal and Child Health Sustainable Technical Assistance and Research (MCH-STAR) initiative.

and maintenance. Stock registers and account records are not user -friendly and consequently are not updated on time further compounding the problem of maintaining them. Hygiene and sanitation do not appear to be a priority to any functionary which is evident in the status of the AWCs and their immediate surroundings. Central guidance on layout of AWCs is unavailable at the district, block and at AWC level.

Supervision: Lack of adequate supervision in terms of monitoring and evaluation is having an adverse effect on the quality of services provided at the AWC. This inadequate supervision is attributed to a shortage of supervisory staff in the system, a lack of training on supportive supervision for existing supervisors and other administrative issues.

Convergence: The ICDS depends on convergence at the AWC service delivery level. However, poor convergence between water and sanitation, rural development, and the local panchayats result in a missed opportunity to make this a dynamic community driven program at the field level. There is a lack of systematic and sustained community based monitoring of services. There is limited evidence of initiatives to encourage sustainable village-level availability of seasonal vegetables and fruits suited for local conditions.

Advocacy and communication: Communication on key messages on health and nutrition are not consistent and clear resulting in the public receiving different and often conflicting messages from their service providers. All advocacy and communications, irrespective of its medium, for all services provided in the ICDS through the AWC needs to be made consistent and clear. State IEC budgets, which often go unspent, can be better utilized.

Motivation and incentive: Administrative issues such as delay in honoraria; delayed disbursement of funds for AWC management; vacancies in the supervisory and managerial levels; lack of travel support; lack of appreciation of those who are performing well; and lack of a systematic approach to identify and award good performance are reducing the motivation of functionaries within the ICDS.

Conclusion: A stakeholders' consultation held on June 27th 2012, to discuss the findings from the PNA exercise concluded that there were some simple yet concrete steps that could be taken to facilitate improved performance of ICDS functionaries in the state of Jharkhand. A review of what works in others states also provided potential solutions. The following table captures possible solutions reflected in the stakeholder meeting and the performing states review that the State of Jharkhand could consider to improve performance.

Potential solutions	
Policies and guidelines	▪ Constitute an ICDS cell within the Directorate. Review and update existing guidelines/ directives for selected services in accordance with current requirements in the field. Release periodic newsletters and update the state's ICDS website. ▪ Benchmark promotion policy from states that have shown a rapid reduction in vacancies. Use contractual hiring to fill supervisor vacancies immediately giving preference to AWWs with five years of experience. ▪ Make Treasury rules flexible to allow passing of bills from AWWs and the AWH counter signed by PRI members / village members. ▪ Until the state has a Mid Level Training Cent (MLTC), undertake supervisors' training at identified AWTCs or the regional NIPCCD training centre at Lucknow.

Potential solutions	
Knowledge and skills	▪ Improve the quality of training sessions and training infrastructure in the state ▪ Create a comprehensive training monitoring/tracking mechanism which offers information on trainers, trainings offered, participants, and follow up assessments of participants that can be used by functionaries across levels. ▪ Make available the AWW's handbook prepared by NIPCCD in the local language.
Physical infrastructure	▪ Ensure availability of uniform calibrated measuring equipment and storage facilities at all AWCs. ▪ Make central guidelines on layout, construction and maintenance of AWCs should be available at all levels. ▪ Ensure that the AWCs that are renovated or newly built have easy to clean and maintain surfaces. Use bright colours that appeal to children on all AWCs. Explore the feasibility of innovative techniques like the pre-fabricated AWC design. ▪ Partner and utilize inter sector/department programs at the village/block/district/state levels to renovate and /or provide needed physical infrastructure. Encourage utilization of funds from Integrated Action Plan Funds and Backward Region Grant Fund for the construction of new AWCs. Encourage utilization of funds from the VHSNC to enhance facilities by purchasing items like '*durries'* and toys or to repair weighing machines. Encourage community participation in the construction and maintenance of AWCs.
Supervision	▪ Adopt standardized protocols that clearly delineate the role of the supervisor in conducting VHNDs, AWC visits, and monthly cluster meetings. Make Supervisory tools, daily diary, records and checklists more accessible to the LS. ▪ Consider travel remuneration for the LS based on their varying catchment areas. Conform the catchment area of the LS to the norm. ▪ Create opportunities for regular and structured capacity building of functionaries to understand and review data and assess activities in terms of process, output and outcome indicators. ▪ Incorporate the five-tier monitoring and review mechanism proposed by the MWCD, GoI at all levels ▪ Explore using a mobile tracking system for activities at the AWC
Advocacy and communications	▪ Educate Self Help Groups (SHGs), CBOs and local NGOs on thematic issues to encourage demand generation and community based monitoring. ▪ Use education and communication budgets to effectively create awareness about ICDS in the community.
Convergence	▪ Create a district level committee chaired by the Deputy Commissioner and having representatives from the ICDS, SRHM, Health, Water and Sanitation, Panchayat and NGOs to ensure effective implementation of the ICDS. ▪ Strengthen people's involvement through entities like the Gram Vaarta and the Panchayati Raj Institutions and the Nigraani Committee. ▪ Conduct district level convergence workshops for staff members from all line departments.

Potential solutions	
Motivation and incentive	▪ Establish records of each worker. Reinstate the scheme for awarding better performing AWWs. Appraise AWW/LS/CDPO regularly. ▪ Create clear career progressions plans and clarify retirement rules ▪ Operational mechanisms for ensuring timely payment of remuneration to AWWs should be strengthened through regular review and follow-up at the Directorate level. ▪ Process for adoption of service rules should be expedited to regularize recruitments and promotions within the department workforce.

Chapter 1 Introduction

1.1 Background

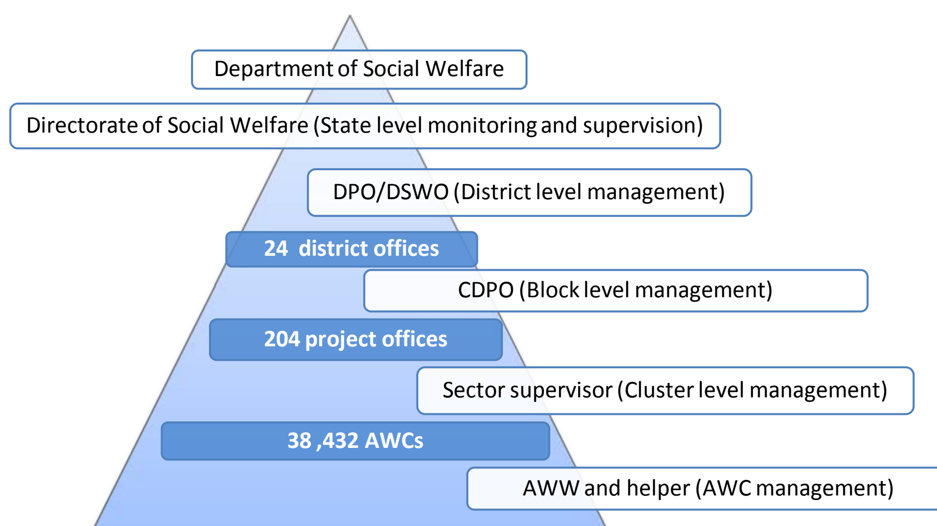
Launched in October 1975, the Integrated Child Development Services (ICDS) scheme is India's flagship program for early childhood development and nutrition. The scheme has expanded significantly since its inception from 33 projects in 1975 to 6719 projects in the year 2010. In the 2010, the scheme reported country-wide outreach to 91 million children, pregnant women and lactating mothers, through a network of 1.2 million *Anganwadi* Centres (AWCs).

ICDS in Jharkhand

Sanctioned by the Ministry of Women and Child Development (MWCD), Government of India (GoI), the ICDS scheme in Jharkhand is implemented by the Department of Social Welfare (DSW), Government of Jharkhand (GoJ). Currently, 204 project offices are operational in the state providing outreach services through a network of 38, 432 AWCs (DWCD, Jharkhand as on Oct 2011).

Structure: Each AWCs is managed by a Anganwadi Worker (AWW), locally known as a*Sevika* and a *Anganwadi Helper* (AWH), locally known as a *Sahayika*. Sector supervisors, generally referred to as Lady Supervisors (LS),are positioned at the cluster level to conduct monitoring and supervision for groups of AWCs. At the block level, each project is managed by a CDPO and at the district level it is managed by District Program Officers (DPOs)/District Social Welfare Officers (DSWOs). The Directorate of Social Welfare operating from the state capital, is responsible for the overall management at the state level. The Directorate is headed by a full time Director, who is assisted by four Assistant Directors (ADs). A diagrammatic representation of the structure is given in Figure 1.1.

Figure 1.1 ICDS implementation and management structure in Jharkhand



The Directorate has established a nutrition cell, Management Information Systems (MIS) cell and a coordinator positions for Behavior Change Communication (BCC) and training with support from the United Nations Children's Fund (UNICEF).

Services: Table 1.1 lists the services provided at an AWC, the target population and the service providers responsible for these services. While the DSW is directly responsible for the provision of supplementary nutrition and pre-school education, health services such as immunization, health check-ups and referral services, are provided by the Department of Health and Family Welfare (DHFW). These activities require coordination between DSW and DHFW staff at all levels. AWCs host

a monthly event referred to as the Village Health and Nutrition Day (VHND) which is a fixed day, fixed site event organized at the AWC in coordination with DHFW staff. On this day take-home rations, health check-ups, routine immunization, and nutrition and health education (NHED) are provided to beneficiaries.

Table 1.1 ICDS services, beneficiaries and service providers

Services	Beneficiaries	Service provider
Supplementary Nutrition	Children 6 months to 6 years, pregnant women and lactating mothers	AWW and Helper
Immunization*	Children less than 6 years and pregnant women	Auxiliary Nurse Midwife(ANM)
Health Check-up*	Children less than 6 years, pregnant women and lactating mothers	ANM/ AWW
Referral Services	Children less than 6 years, pregnant women and lactating mothers	AWW/ANM/MO
Non-formal Pre-school Education	Children 3-6 years	AWW
Nutrition and Health Education	Women (15-45 years)	AWW/ANM

* AWWs help identify and mobilize communities
Source- http://wcd.nic.in/icds.html

Funding: The central government provides 90 % and the state bears 10 % of the total budget allocation for all components of the ICDS scheme except supplementary nutrition. The costs for supplementary nutrition are shared equally between the state and the central government. As more than half the total budget is allocated towards supplementary nutrition, it is a major component of the ICDS scheme. Of the remaining program budget, nearly 80% is devoted to salaries and establishment costs -- leaving a small amount for other activities including training costs.

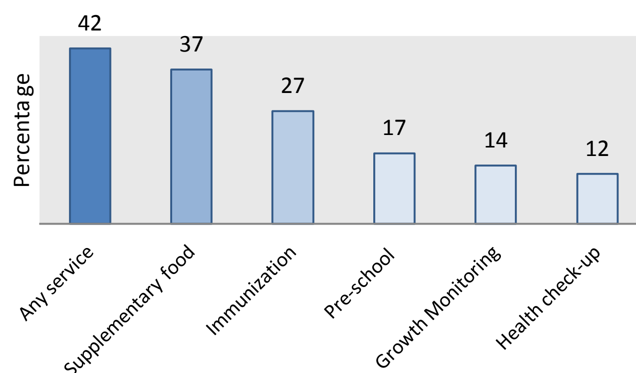
Roles and responsibilities: Roles and responsibilities for AWHs, AWWs, LS, CDPO and DSWO have been defined by the MWCD, GoI and circulated to respective state governments. The job training and refresher courses for staff members designed by the National Institute of Public Cooperation and Child Development (NIPCCD) include syllabi that are based on the roles, job responsibilities, qualifications (eligibility criteria) and skills required for each cadre of staff.

Monitoring and Evaluation: Data on progress of ICDS activities is collected from each AWC through Monthly Progress Reports (MPRs). Data from the MPRs are then compiled at the block and district levels and forwarded to the state, where they are processed through by the department's MIS cell and shared with the Ministry of Women and Child development (MOWCD), Government of India.

1.2 Rationale for study

In Jharkhand by 2011 the State was reporting that the 38,432 sanctioned AWCs were all operational. However, the effectiveness of the scheme in terms of achieving its' goals remained limited. While the State reported that 80.9 % of the funds for supplementary nutrition were utilized, according to 2005-06 NFHS-III, less than half of the under-six year old children residing in the AWC catchment area received services of some kind from the AWC.

Figure1.2 ICDS coverage in Jharkhand: percentage age eligible children receiving AWC services



Source: IIPS, NFHS-III, 2005-06

The same survey reported that 58% of under-six year old children were underweight the prevalence of stunting was over 40%. Among children under the age of three, the percent underweight actually increased between the 1998-99 NFHS-II and 2005-06 NFHS-III—rising from 54% to 59%.

To better understand the challenges in implementing the ICDS Scheme, the Department of Social Welfare (DSW), Women and Child Development (WCD), Government of Jharkhand (GoJ), in collaboration with Child In Need Institute (CINI) – Jharkhand launched an initiative in May 2011 to identify barriers to effective implementation of ICDS using a Performance Improvement (PI) approach[2].

1.3 Goal and objective

The goal of this project was to improve performance of ICDS functionaries in the state of Jharkhand[3].

The objectives of this project were twofold:

1. To identify factors affecting performance of ICDS functionaries in the state of Jharkhand.
2. To identify policy options to address factors affecting performance of ICDS functionaries based on evidence of what works.

1.4 Limitations of the study

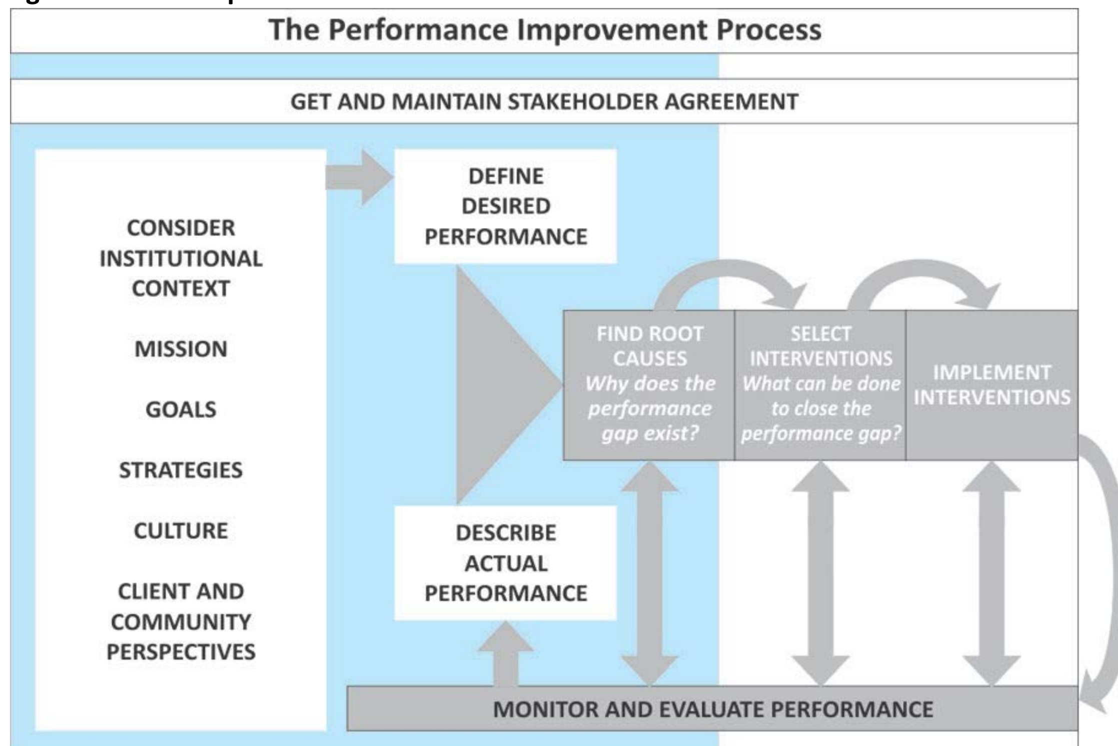
Due to the very short time awarded to conduct the PNA, the limitations of this study are three fold. Firstly, self reported performance of the ICDS functionaries was used in place of "actual performance". Secondly, in-depth observations of services provided and community feedback on the services received were not part of this studyThirdly,root causes were only identified for the gaps in services that were revealed through the investigation. .

[3] Functionaries include AWWs, LSs and CDPOs.

Chapter 2 Performance Improvement process

Performance Improvement (PI) is a process for achieving desired institutional and individual sustainable high quality services. It adopts a participatory approach to identify and address the needs of service providers and other staff members. Figure 2.1 provides the steps entailed in undertaking a PI exercise. The PI process has been extensively used by health care organizations in developing countries to address job related problems (Lande, 2002).

Figure 2.1 PI process



One of the most important steps in the PI process is the Performance Needs Assessment (PNA). A PNA compares desired performance to actual or current performance, to identify the performance gaps in a given area. Desired performance is determined by the stakeholders themselves and actual performance is measured through interviews with and/ or observations of stakeholders and/ or clients. PI process emphasizes the performance factors that an organization must have in place for service providers to perform well.

Within PNA, a critical step is identification of root causes that need to be addressed with appropriate strategies or interventions. Root cause analysis (RCA) attempts to identify the primary cause/s for a performance gap. Though various methods exist to conduct a root cause analysis, the why-why-why method is a simplistic but powerful technique to get a visual map of the cause/s in a linear fashion. The process entails enquiring “why” a particular gap exists, repeatedly, till the point the primary or root cause is reached. The facilitator of the process needs to be aware of evidence on actual performance to successfully steer this discussion to the root causes. This is followed by identifying appropriate interventions, implementing and then evaluating these interventions for further refinement.

Chapter 3 Methodology

3.1 Study respondents

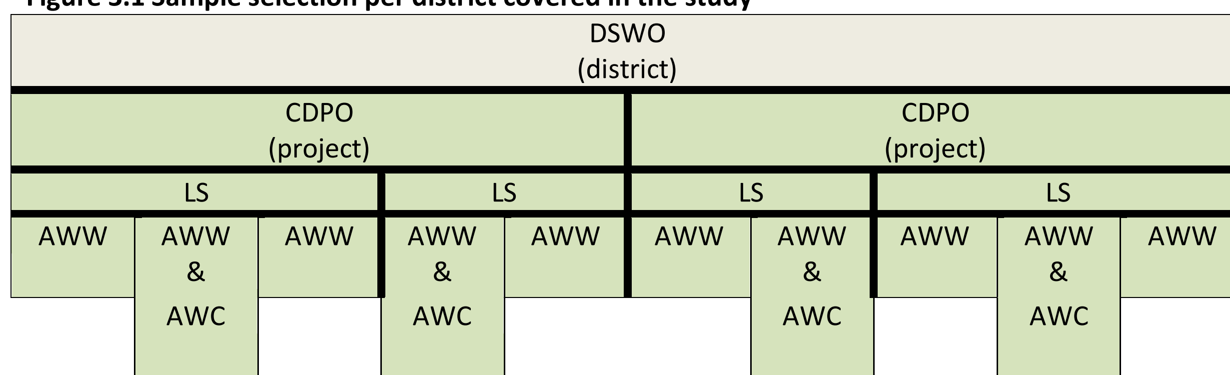
Information was collected from the following service providers and supervisors:

- Anganwadi Workers (AWWs)
- Lady Supervisors (LS)
- Child Development Project Officers (CDPOs) and
- District Social Welfare Officers (DSWOs)

3.2 Sample size and design

The study was conducted in six districts of Jharkhand: Dhanbad, Latehar, Ranchi, Sahebganj, Simdega and West Singbhum. The districts were selected based on representation of the five regions of Jharkhand covering tribal and non-tribal populations. Six districts where selected. In each of the six districts managed by a DSWO, two projects each managed by a CDPO were selected. Under each CDPO, four lady supervisors and, five AWWs were selected. These five AWWs were chosen three under one of the selected LS and two from the other selected LS under each CDPO. Under each LS from among the AWWs chosen one Anganwadi center (AWC) was chosen for a facility audit and basic observation of services provided. The diagram below shows the sample design for each district. The same was applied to selection in each of the six districts that spanned the five regions covered in the study.

Figure 3.1 Sample selection per district covered in the study



3.3 Study instruments

For each of the respondent categories (AWW, LS, CDPO, and DSWO) separate questionnaires were designed based on performance indicators for the six ICDS services. A facility audit and basic observation tool was also designed to obtain data on the infrastructure support for services and whether such services were being routinely provided as on the day of observation. The sample size and type of instrument used for each type of respondent per district is presented in table 3.1.

Table 3.1 Sample size and instruments used for different respondents in the study

Respondent	Tool	Number per district/ project	Total
AWW	In-depth interview	10 per district	60
AWW	Observations	2 per project	24
LS	In-depth interview	2 per project	24*
CDPO	In-depth interview	2 per district	12
DSWO	In-depth interview	1 per district	6

*Only 23 out of 24 responded.

After all tools were field tested and appropriately modified, a team of 18 field investigators were trained on the final tools over five days. Data collection was completed in a span of three weeks. Each team of data collectors was accompanied by a staff member from CINI to ensure quality of data collection. The data was then cleaned and validated to check for accuracy, reliability and completeness.

3.4 Study approach

The PI process was applied as detailed in Chapter 2. The following information describes how the PI process was applied to this project.

Getting and maintaining stakeholder agreement**:** Based on a request from the DWCD, GoJ a PNA study project was conceptualized and launched. The ICDS directorate was briefed on the process and involved in the process from the onset, that is, from setting the desired performance indicators to identifying the root causes for performance gaps.

Understanding the institutional context: Relevant documents at the national and state levels pertaining to ICDS were thoroughly reviewed to understand the expectations from the scheme as well as functionaries.

Defining desired performance**:** National and state policies and research relevant to the ICDS scheme were reviewed to develop the framework for desired performance indicators. Policy documents were obtained from Government websites as well as through personal communication with key officials. Desired performance indicators were ratified through a stakeholder consultation attended by field functionaries, officials from ICDS directorate and development partners on 10 May, 2011.

Describing actual performance**:** Based on the data collected from the six districts mentioned above, the "actual" performance as self reported by respondents was determined.

Finding root causes**:** Performance gaps were identified based on self reported "actual" performance data fitted against desired performance levels. A second stakeholder consultation was organized on 25 September, 2011 to discuss the identified performance gaps. Using the why-why-why approach, small groups of stakeholders -- comprising of AWWs, LS, CDPOs, DSWOs as well as representatives from other departments and training institutes -- were encouraged to arrive at root cause/s for each gap. A small scale consultation was organized on 9 November, 2011, to complete the root cause analysis.

Select interventions: In order to get evidence from other states on "what works" for improving performance of ICDS, five states (Chhattisgarh, Maharashtra, Orissa, Tamil Nadu, and West Bengal) were selected based on better use of ICDS services as well as better nutritional status of children aged five years or younger as compared to Jharkhand. ICDS policy documents and guidelines pertinent to the performance factors listed above, MPRs and other essential documentation such as annual plans and training updates, were sourced from these states.

In addition, a literature search was conducted through web-based search engines (Google and PubMed) as well as through agencies working with the ICDS like the NIPCCD. Key officials at the MWCD, GoI were also contacted to get access to evaluation reports from other states.

A stakeholders consultation was held as a conclusion to the study to discuss the findings from the PNA exercise and the feasibility of many of the select interventions. The meeting concluded that there were some simple yet concrete steps that could be taken by the state to facilitate improved performance of ICDS functionaries in the state of Jharkhand.

3.5 Challenges of the study

This project experienced several challenges that delayed the project. These included:

- Policy and related details from better performing states were unavailable from public domains. Consultants with inroads to the ICDS directorates of these states were recruited for gaining access to these documents.
- Data collection duration was extended due to unavailability of AWWs and transfer of DSWOs and CDPOs during the study period.

Chapter 4 Findings of the study

4.1 Respondent profile

Amongst the sampled functionaries, most of the AWWs and LSs and all of the CDPOs were aged 30 years or above. In the State of Jharkhand, minimum education criteria of 10th standard education for AWWs was established only in 2006. The only exception are for Scheduled Tribe (ST) and Scheduled Caste(SC), where a local resident of the village with below 10th standard education could also be selected for AWW. The sampled AWWs included some with less education than this requirement. Respondents profile is presented in table 4.1.

Table 4.1 Respondent profile

	Range/ limit	AWW	LS	CDPO
Age	≤ 30	3	1	-
	31-44	29	5	5
	≥ 45	18	17	5
Education	≤ 10th standard	42	-	-
	Intermediate	12	2	-
	Bachelor's degree	6	12	4
	Master's degree	-	9	6

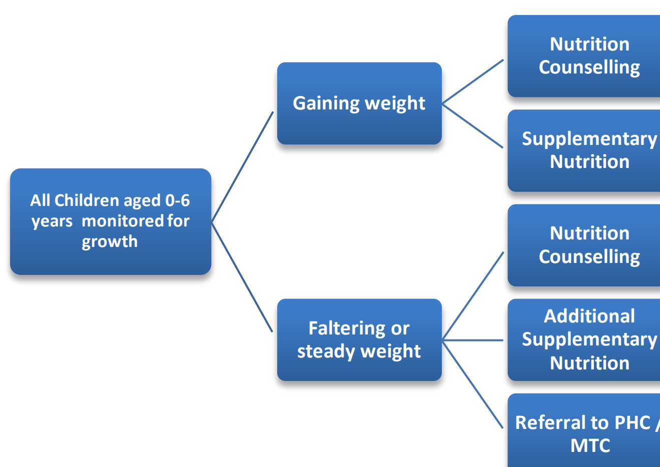
4.2 Performance Needs Assessment (PNA)

This section presents the findings on desired and actual (self reported) performance, performance gaps and root causes for the same for select ICDS services and activities covering Growth Monitoring (GM), Supplementary Nutrition (SN), Pre-School Education (PSE), Nutrition and Health Education (NHED), and the Village Health and Nutrition Day (VHND).

4.2.1 PNA findings for Growth Monitoring

The purpose of growth monitoring and promotion in ICDS is to detect growth faltering as early as possible and administer the necessary corrective measures. ICDS proposes that all children aged 0-3 years be screened every month for weight gain and thereafter screened every 3 months until the age of 6. For those with growth faltering, the interventions range from counseling to improve nutritional intake, to referral to health facilities. Children who come under Severe Acute Malnutrition (SAM) are referred to the nearest Malnutrition Treatment Centres (MTCs) depending on the severity of under-nutrition (Figure 4.1).

Figure 4.1: Intervention strategies for Growth Monitoring and Growth Promotion



Essentials for effective growth monitoring are functional weighing machines, growth charts, AWWs trained to monitor growth and intervene in case of under-nourished children, community and supervisory support to enable AWWs to effectively perform growth monitoring at the village level.

4.2.1.1 Desired performance indicators

The stakeholders identified the following indicators as desirable for assessing their performance:

1. Identified SAM children given appropriate services, like referral, extra ration,
2. Cumulative record for each child (below 6 yrs) is available at AWC,
3. Percentage of referred children graduated to normal status.

Together these capture the output and outcome of growth monitoring in the community.

4.2.1.2 Actual performance as self reported by respondents

Actual performance as reported by the respondents at the output level was addressed in the study however, assessing the impact of any ICDS service through the community or interviews with the beneficiaries was outside the purview of this short-term study.

Cumulative record for each child (below 6 yrs) is available at AWC:

- Even though 55 out of 60 AWWs reported that they used the growth chart for monitoring weight of infants and children half of all AWWs reported that they face problems in growth monitoring
- During the facility audit and observation 18 out of 24 AWWs were observed to be recording weights on growth charts.

Identifying and addressing the needs of children who are faltering in growth:

- 19 out of 60 AWWs who reported that they identify undernourished or malnourished children. Of these 19 only 11 reported that they referred them to a rehabilitation centre or health facility.
- 49 of the 60 AWWs reported that they counsel parents of children with faltering growth
- 11 of the 19 who identified undernourished children reported that they had referred them to PHC/MTC in the last one year
- 31 AWWs reported that they continue to give extra rations/cooked food till the child gains normal weight as defined by the growth chart
- Only half of the LSs who help AWWs in growth promotion indicated that they help by identifying and referring malnourished children to MTCs, and only eight mentioned helping AWW in making follow up plan for children referred to MTCs

4.2.1.3 Performance gap

Not all AWWs are updating growth charts using the correct weighing machines, providing extra ration to the identified under nourished children or referring them to rehabilitation centres/health facilities.

4.2.1.4 Root causes and evidence to support causality

A diagrammatic representation of the root cause mapping for the performance gap on growth monitoring is presented in Annex 1. Free-listing of potential causes for identified performance gaps were explored with stakeholders to arrive at the root cause(s) for children with faltering growth not receiving recommended care and treatment in select AWCs(Table 4.1)

Table 4.1 Perceived causes for children with faltering growth not receiving recommended care and treatment in select AWCs

Proximal causes	Root Cause	Supporting Evidence
Limited materials for Growth Monitoring	• No guidelines available for maintenance and repairs • Maintenance and replacement is still at CDPO level and so involves large time-lags	• Less than one third of AWWs had functional weighing scales for both infants and children. • The turnaround time for repairs of scales exceeded 3 months. • In most facilities no available guidelines

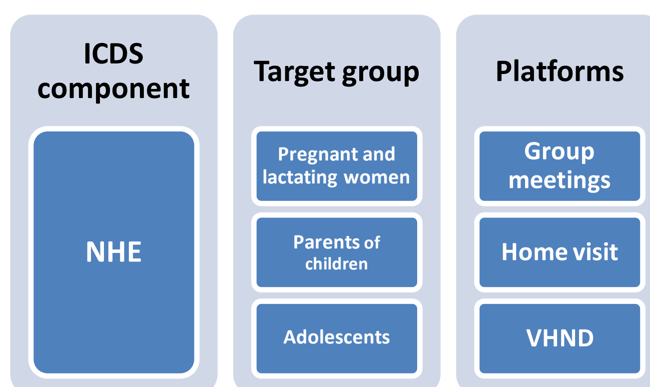
Proximal causes	Root Cause	Supporting Evidence
	• Unable to facilitate delivery of new charts to AWCs	for machines • 24 out of 60 AWWs reported not having the new growth charts
Incomplete and or inaccurate knowledge on Growth Monitoring	• GM has become increasingly complicated • Some AWWs not trained in GM • Lack of follow-up on GM training • Inadequate supportive supervision	• Half of AWWs interviewed reported problems with growth monitoring, many stating • One tenth of AWWs recalled receiving any training on the growth charts • No guidelines for counseling, referral and follow-up services for children with faltering growth • A little more than half of the sanctioned supervisor positions were filled as of March 2011 • No Mid-Level Training Centers (MLTCs) in the state • Supervisors interviewed reported a range of 36 to 182 AWCs in their jurisdiction despite recommended coverage being 20 to 25. • Fresh recruitment of supervisors has been frozen • Only three of the 24 supervisors recalled being trained on new growth charts. • Only half of the 10 CDPOs interviewed mentioned 'growth monitoring' to be one of the key job responsibilities of the AWWs.
Limited community awareness	• Lack of IEC material • Limited AWW outreach due far-flung settlements	• Only 15 of the 51 AWWs actually used IEC materials
Lack of client friendly services at referral centers	• Families pay for drugs, no waiting areas • No uniform guideline for growth monitoring • Referral not tracked in current MIS	
Supplementary food not distributed regularly	• Funds for SNP are insufficient • Funds for SNP are not available in time	• 3 of 60 AWWs, received SN funds on time. • 24 of 60 AWWs reported unavailability of funds is the main obstacle in SN distribution. • Despite the rules 26 of 60 AWWs report procuring food materials on credit
Lack of motivation for AWWs	• No recognition for good performance • Honorariums not timely • Excess workload of AWWs	• Over 90% of the AWWs interviewed reported delays in receipt of remuneration for 60% this delay was more than 4 months

Proximal causes	Root Cause	Supporting Evidence
		• The formulation of cadre based service rules for ICDS functionaries is not in place • no promotions for CDPOs, or LS • additional responsibilities(i.e. election and census duty, sanitation campaign, door to door surveys for identity cards)

4.2.2 PNA findings for Nutrition and Health Education

Nutrition and Health Education (NHE) seeks to enable individuals, families and the community to identify and address their nutrition and development needs. NHE comprises of basic health, nutrition and development information related to childcare and development, infant feeding practices, utilization of health services, family planning and environmental sanitation, and prevention and management of illnesses such as diarrhea, acute respiratory infections and other common infections of children.

Figure 4.3: NHE strategy



4.2.2.1 Desired performance indicators for NHE

The stakeholders identified the following indicators as desirable for assessing their performance:
All pregnant women & associated family members are aware about:

- Early registration of pregnancy and Birth Preparedness
- Need for nutritious balanced meals & increased intake
- Initiating breastfeeding within 1 hour of birth & exclusive breastfeeding for six months.
- Dangers of using strong medication during pregnancy
- Danger signs during pregnancy
- All lactating women are aware about:
  - Exclusive breastfeeding for 6 months
  - Complementary feeding after 6 months

The field investigation was designed with the provider's perspective (refer to methodology) while the indicators identified by stakeholders are community oriented. Actual awareness of beneficiaries cannot be determined through this methodology. Thus, the desired performance indicators were modified to reflect the delivery of NHED service which is under the control of the AWW. Instead of measuring awareness of beneficiaries, the indicators now measure what, how and where they provide nutrition and health education.

4.2.2.2 Actual performance as self reported by respondents

Provision of nutrition and health education services:

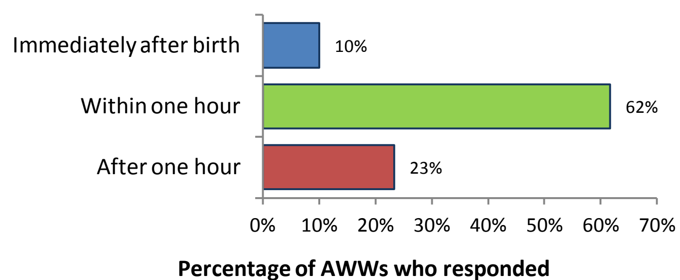
- Nearly one-third of all AWWs reported that they provide NHE on VHND.
- 55 of the 60 AWWs reported that they provided nutrition and health education to women and adolescent girls. The range of varied responses on key messages on included: immunization; child care; breastfeeding; balanced diet; use of boiled drinking water; consuming of nutritious food / green vegetable; and regular ANCs.

- 39 of the 60 AWWs reported that they provide information based on the needs of the beneficiaries and the rest reported that they disseminate information when approached with queries by community members or based on training themes.
- Of the 51 AWWs who responded on how they provide NHE 40 reported providing NHE verbally, 15 used IEC materials and 6 said they demonstrate during counselling.
- 58 AWWs reported that they educate pregnant and lactating women on breastfeeding and its importance.
- 39 AWWs reported that women do not approach them with any problems related to breastfeeding and 21 AWWs stated that they counsel those who come with problems and refer them to health facility if required.
- 51 AWWs responded on how they provide NHE; 34 AWWs responded that they provide NHE verbally, while 12 reported using IEC materials; 6 AWWs said that they demonstrate during counselling.
- 27 of AWWs reported that they use IEC materials during home visits.
- 36 of AWWs reported that they receive support from their supervisors in providing nutrition and health education.

Messages on Breastfeeding and family planning methods:

- Most AWWs report they educate pregnant and lactating women on breast feeding and its importance.
- The messages that AWWs give on when breastfeeding should be initiated vary and are shown in figure 4.3.
- 50 of 60 AWWs reported that women seek family planning services information from the AWC.
- Though half of the AWWs interviewed stated that they were aware about the use of exclusive breastfeeding as a method of contraception, none of them were able to state the criteria for breastfeeding to work effectively as a birth spacing method.

Figure 4.3 AWW's responses on when breast feeding should be initiation



Home visits to provide nutrition and health education:

- 31 of 60 AWWs reported they conduct home visits daily. Of these 16 reported they conduct home visits at least once a week; and 6 said that they conduct home visits monthly or occasionally. A small percentage of AWWs responded that they conduct home visits when they get time.
- 27 of 60 AWWs reported using IEC materials during home visits.

4.2.2.3 Performance gap

Several performance gaps were identified. Firstly, there were inconsistent responses on messages on infant and young child feeding and on birth spacing for lactating women given by AWWs. Secondly, all platforms for nutrition and health education were not being fully utilized by functionaries.

4.2.2.4 Root causes and evidence to support causality

A diagrammatic representation of the root cause mapping for the performance gap on NHED is presented in the flow chart in Annex 2. The stakeholders identified root causes for this performance gap as presented in table 4.2.

Table 4.2 Perceived causes for inconsistent responses on messages on infant and young child feeding and on birth spacing for lactating women given by AWWs

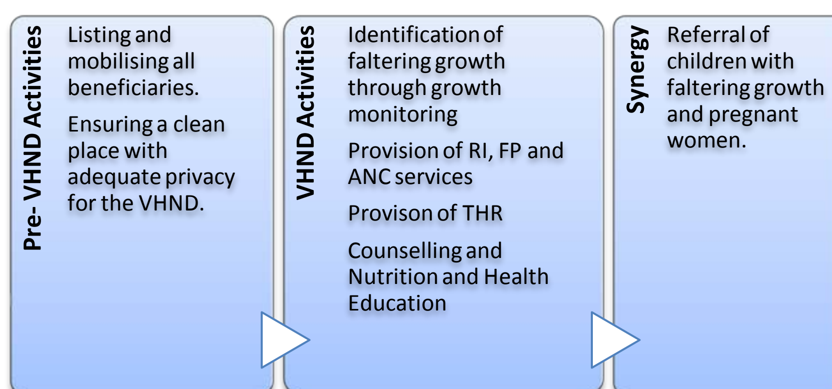
Proximal causes	Root cause	Supporting evidence
Discrepancy in critical messages	• AWWs receive conflicting messages on IYCF in trainings organized by different agencies and departments • lack of coordination between the Departments of Health and Social Welfare • No inter department cohesive action on NHE	• 62% reported that breast feeding should be initiated within an hour of birth, 10% reported that it should be initiated immediately after birth and 23% reported that it should be initiated after one hour of birth.
No on the job training	• Supervisors not skilled in providing NHE • Supervisors not skilled in training staff • There is a huge backlog in training of supervisors as the state has no MLTC.	• One of the 23 LSs described the purpose of her accompanying as observing and supervising AWW during counseling • During VHND LS s report "doing" activities like GM, counseling but not observing the AWWs' management and delivery of services • 36 of the 60 AWWs reported that they receive support from their supervisors in providing nutrition and health education. • 19 of 23 LS interviewed responded that they advise mothers of children suffering from malnutrition to go to malnutrition treatment centers (MTCs). • 15 of 23 LS mentioned 'counseling' and 11 said 'weighing and growth monitoring' as the responsibilities of the AWW. The other responsibilities of AWWs as indicated by LSs include: distribution of Take Home Ration (THR) (10), filling-up registers (7), immunization (5) and community mobilization (2).
Lack of training:	▪ Lack of clear guidelines for utilization of funds for training purposes.	
Training not delivered as per norms:	• There is no training needs assessment and therefore no identification of non performers. • No training rosters or training tracking system in place • Training process is not participatory • Instructors do not use local languages • Poor monitoring of training	• No mechanism for assessing training needs of AWWs • 4 of 23 LS reported not having any list of trainings attended by AWWs in the last five years. • 19 of 23 LSs did not state explicitly if they had a list but mentioned they were aware of the trainings conducted in the last five years.

Proximal causes	Root cause	Supporting evidence
	quality	
Education level of AWWs not uniform	▪ Education was not an eligibility criteria earlier	• Of the 30 out of 60 AWWs that experienced difficulty with growth charts all had completed 10th standard thereby meeting the new minimum education criteria.

4.2.3 PNA findings for Village Health and Nutrition Day

Organized at each Anganwadi Centre (AWC) on a fixed day every month, the Village Health and Nutrition Day (VHND) is an important converging point for service delivery of both ICDS and NRHM. The target groups include women, children and adolescents. The major services provided by the ICDS on VHND are: Growth Monitoring of children aged 0-6 years; provision of 'Take Home Ration' to children aged 6 months to 3 years, pregnant and lactating women, and adolescents; and Nutrition and Health Education. The ANM provides Antenatal Care (ANC), Routine Immunization (RI) and Family Planning (FP) services. The provision of this basket of services ensures convergence and synergy between the DHFW and the DWCD.

Figure 4.4: VHND Activities



4.2.3.1 Desired performance indicators

Stakeholders identified the following desired performance indicators with regard to VHND:
VHND is organized every month wherein:

- All pregnant women are registered
- All pregnant registered women are given ANC
- All eligible children below one year receive immunization
- Vitamin A solution is given to children in the age group nine months to five years
- All children are weighed and their weight is plotted on the new growth charts
- All eligible couples are provided contraceptive services or referrals for the same as per their choice
- Supplementary nutrition is provided to eligible beneficiaries as per norms
- NHED is provided to community
- Health check-ups are carried out and referrals are made to the nearest health facility or MTC
- Simple medicines are distributed for treatment of diarrhea, malaria and other common illnesses

The combination of these indicators ensures that all basic recommended services are delivered on VHND, thereby guaranteeing that the community has access to such services at least once a month.

4.2.3.2 Actual performance as self reported by respondents

VHND is organized every month

- 49 of 60 AWWs reported that they organized VHND once every month while 3 AWWs reported that they organized it twice a month; one responded that she organizes VHND only when she gets funds; 7 AWWs were unclear in their responses to frequency of conducting VHND
- Only half of the AWWs reported facing no challenges in organizing VHND.

All eligible children below one year receive immunization

- 50 of the 60 AWWs mentioned that they prepare/update due-list for immunization of children on VHND.
- Of all activities that have to be organized on VHND, immunization and THR distribution were cited by 39 of the 60 AWWs

All children are weighed and their weight is plotted on the new growth charts

- In spontaneous recall of activities conducted in VHNDs, weighing of children was mentioned by 22 of the 60 AWWs
- In response to a direct question about GM 43 of 60 AWWs reported they conduct growth monitoring during VHND

Supplementary nutrition is provided to eligible beneficiaries as per norms at VHND

- Of all activities that have to be organized on VHND, immunization and THR distribution were cited by 39 of the 60 AWWs

NHED is provided to community at VHND

- 9 of 60 AWWs reported they conducted Nutrition and Health Education sessions during VHND

Health check-ups are carried out and referrals are made to the nearest health facility or MTC at VHND

- Only a few AWWs mentioned counseling and health checkups.

4.2.3.3 Performance gap

Not all mandated components of health and nutrition services in VHND take place consistently

4.2.3.4 Root causes and evidence to support causality

A diagrammatic representation of the root cause mapping for the performance gap on VHND is presented in flow Annex 3. Stakeholders identified three main reasons for the recognized gaps on VHNDs. These were further investigated to arrive at the root causes described in the table 4.3.

Table 4.3 Perceived causes for why not all mandated components of health and nutrition services in VHND take place consistently

Proximal causes	Root cause	Supporting evidence
AWWs mainly involved in THR distribution which results in general chaos and disorder at the AWC	• Lack of coordination between the DHFW in highlighting the package of health and nutrition services mandated for VHND in their advocacy strategies • Poor supervisory support for coordination and planning for VHND.	▪ 36 of the 60 AWWs mentioned crowd management and flow of beneficiaries as one of the major challenges during VHND. • Only half of the AWWs said that LS visits on VHND day • 33 of 60 AWWs reported that Sahiyyas helped them to mobilize the

Proximal causes	Root cause	Supporting evidence
	• Lack of *sahiyyas* incentives for community mobilization. • No policy/ guideline on THR processing and/or pre-packaging of THR in Jharkhand. • AWWs do not receive support from the AWH because they are of different caste groups • AWWs do not receive support from the AWH because they have similar educational qualification and old age of some AWH.	community for RI/ANC ▪ 49 of 60 AWWs reported that VHCs were actively involved in RI and 34 reported community involvement for immunisation
Poor GM record keeping	See section on Growth monitoring in page 18	See section on Growth monitoring in page 18
Poor infrastructure	▪ Poor state investment in infrastructure creation	• Most of the centers are located in rented buildings and don't support large gatherings. • only 30% of functional AWCs were housed in government owned buildings as of 31 March, 2011 • Only 64 % of the allocated costs for construction of project buildings and AWCs was spent in 2010-11 • Only 20% of the sanctioned AWC's in the Left Wing Extremist (LWE) districts had been built as of November 2010

4.2.4 PNA findings for Supplementary Nutrition

To improve the health and nutritional status of children in the age group of 6 months to 6 years, pregnant women, lactating mothers and adolescent girls, supplementary nutrition has been integrated as one of the most important components of the ICDS programme. Malnutrition, endemic poverty and low household incomes over the years have resulted in poor nutritional status, food distress and food insecurity in the population. Growing infants, children, pregnant women and nursing mothers face greater risk and vulnerability from the nutritional depletion than others. Hence, providing nutritional support to these groups has become essential to reducing morbidity and mortality among the vulnerable population.

Under the ICDS scheme, supplementary food is provided with an aim to meet the calorie and protein gap in the actual and recommended daily allowance for children below six years, adolescent girls, pregnant women and nursing mothers. Supplementary food has to be provided 300 days in a year which equates to six days every week or 25 days in a month. Recommendations on amount of supplementary food vary with the level of under-nutrition of the child; severely undernourished children receive twice as much supplementary food as moderately undernourished children.

The type of food provided depends on local availability, beneficiaries, location of the project, administrative feasibility etc. It is recommended that all pregnant and lactating women, and children from six month three years receive Take Home Ration (THR) fortnightly and children in the age-group of three to six years receive hot cooked meal and morning snack daily. *Anganwadi worker* is

responsible for procurement, safe storage, hygienic preparation, distribution and promotion of healthy eating and is assisted by the *Anganwadi* Helper in the preparation of meals.

4.2.4.1 Desired performance indicators

The stakeholders identified the following indicators as desirable for assessing their performance:

- All children between six months to three years receive THR.
- All children in three to six years age group receive cooked food at AWC.
- All expectant and lactating mothers in the purview of the AWC receive THR.
- All adolescent girls receive THR.
- All severely malnourished children receive extra ration.
- All expectant and lactating women are aware of locally grown / available food items that they can use to prepare nutritious food.
- AWW is able to access the funds for operating the AWC.

The indicators are output indicators. As stated before, studying the outcome or impact of any ICDS service was beyond the scope of the PNA study which limited itself to analyzing the output indicators.

4.2.4.2 Actual performance as self reported by respondents

All children between six months to three years receive THR

- 59 of 60 AWWs reported that they are providing supplementary nutrition to children of age group six months- three years.

All children in three to six years age group receive cooked food at AWC

- 59 AWWs reported that they are providing THR to children of age group 3 years – 6 years.

All severely malnourished children receive extra ration

- 31 AWWs provide extra THR/cooked food to severely malnourished children until they reach normal weight

AWW is able to access the funds for operating the AWC

- 26 of 60 AWWs face problem accessing funds
- Only 3 out of 60 AWWs reported a timely receipt of funds from the department
- On what do you do if you don't get the funds in time 47 stated they get a loan on credit, one stated she borrowed cash, one stated that supplier manages, three AWWs stated that they close the THR, and two AWWs stated that they use their own money to buy rations for distribution.

4.2.4.3 Performance gap

Not all AWWs are providing supplementary food as per recommendation.

4.2.4.4 Root causes and evidence to support causality

A diagrammatic representation of the root cause mapping for the performance gap on SN is presented in Annex 4. Free-listing of the potential causes for identified performance gaps in SN we explored by stakeholders to identify root causes. This is outlined in table 4.4.

Table 4.4 Perceived causes for why all AWWs are not providing supplementary food as per recommendation.

Proximal cause	Root cause	Supporting evidence
Funds provided for SN are inadequate	▪ Rates for all components of SN not revised since 2009.	• The allocated budget for fuel wood is INR 40 per AWC per month. The current market price for 8-9 days supply (20 kg) is INR 150 reflecting a monthly fuel requirement of at least INR 600. • 26 of 60 AWWs faced fund problem

Proximal cause	Root cause	Supporting evidence
Problems in procurement:	• Delays in receipt of funds because mode of fund release changed from advance to reimbursements. • The lacunae in the formulation, revision and communication of guidelines at the district, block and AWC levels.	• 70% of those AWWs who stated they faced challenges in providing SN attributed it to delays in receipt of funds. • Delays exceeded 3-4 months. • 10 of 60 AWWs said that they stopped food distribution if funds were unavailable for more than three months. 48 of the 60 AWWs interviewed in the study confirmed that they operated their centres through credit drawn from the market when funds are delayed. Most of the AWWs reported that they don't have any written instruction for procurement of food/rations; they got only verbal instructions from LS & CDPO. • Eg. Supreme Court and Ministry's directives on SN procurement decentralized the process to the local level, and exempts purchases from the Jharkhand Sales Tax (JST)/ Central Sales Tax (CST) However vouchers were not approved unless they complied with tax registration requirements.
Difficulties in distributing, cooking and storing food	• lack of adequate materials for SN. • AWWs also reported that they did not have any materials or funds to purchase materials for storing food materials at the centres.	• none of the centres visited had standard measures for distributing THR. AWWs used locally available materials such as cups or containers to approximate the measurement standards.
Lack of community awareness regarding concept of THR as supplementary food	• Poor beneficiary involvement in group meetings discussing THR importance because of : • cultural sensitivities regarding pregnant or lactating women attending public meetings • engagement of women in household work	
Beneficiary coverage norm of 40 children continues to be followed in many AWC's in spite of directive of universalisation	• funds for SN are inadequate to allow coverage of all eligible children in the catchment area • lack of accountability mechanisms due to poor community involvement in ICDS activities. • poor monitoring and supervisory support because of a lack of service rules for	• 26 AWWs stated that LS helps in THR distribution & food procurement, • 13 AWWs stated that LS provides suggestion, advice & counselling, • Three AWWs stated that LS verifies quantity, voucher & stock register, • One AWW stated that LS helps in procurement, • 20 AWWs stated that the LS does not help • One stated that the Mahila Mandal president helps in procurement

Proximal cause	Root cause	Supporting evidence
	the department of WCD in the state.	

4.2.5 PNA findings for Pre-School Education

ICDS is the only vehicle through which States' are accountable for pre-school education (PSE) for children in the age group of 3 to 6 years.

Preschool Education in ICDS is conducted through play way activity approach using toys, play equipments' etc. which are of indigenous origin and inexpensive. It focuses on the holistic development of the child through: providing a stimulating play environment for his/her physical, cognitive, and psychosocial development; encouraging interaction with the environment; promoting active participation in group activities; and enhancing problem solving abilities.

Anganwadi workers are expected to organize two hours of non-formal PSE session daily. A curriculum and kits for children are made available through the scheme for the AWW to deliver this service effectively. In addition she has to develop toys with locally made material, ensure children use the materials and have open and safe place to play and learn.

4.2.5.1 Desired performance indicators

The stakeholders identified three indicators for assessing their performance. These were:

- All children in the age group 3-6 years (those not attending private nursery school) from the local community are encouraged and enrolled in the AWC.
- PSE is to be conducted for two hours per day, 300 days a year.
- AWWs design and make toys and play equipment of indigenous origin for use at the AWC.

4.2.5.2 Actual performance

All children 3-6 years (not attending private nursery school) from the local community are encouraged and enrolled in the AWC.

- 10 out of 60 AWWs are unable to register all children in the age group of 3-6 years in their work area for PSE; reported reasons for non-registration of children included migration and location of the AWC in respect to the child's home.
- 37 AWWs reported they promote PSE during home visits.

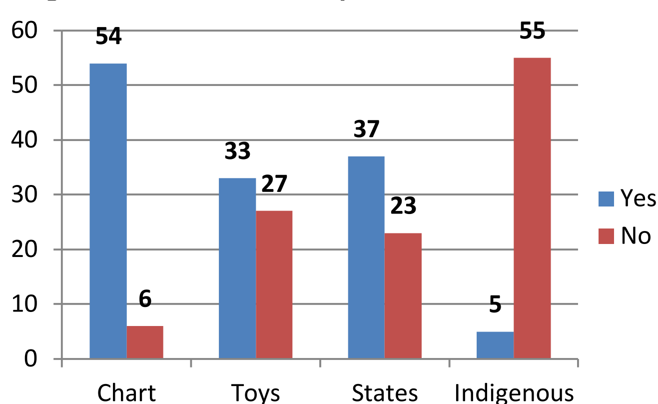
PSE is to be conducted for two hours per day, 300 days a year.

- All the 60 centers cary out some form of preschool education.
- Of the 60 AWWs interviewed, 18 do not organize PSE daily for the stipulated two hours, 18 AWWs devote one hour daily for PSE, while the remaining reported two hours or more of PSE activity daily.

AWWs design and make toys and play equipment of indigenous origin for use at the AWC.

- The use of materials is presented in the graph below. Only 5 of the 60 AWWs reported that they used indigenous materials for PSE.
- 46 out of 60 AWWs reported designing learning/play materials. 12 out of 46 AWWs mentioned that community was engaged in making learning/play materials. Six AWWs mentioned involving children and an equal number mentioned adolescents/mahilamandal/sahiyya.

Fig 4.5 Materials used for pre school education



4.2.5.3 Performance gap

Our research shows that not all children in the age group 3-6 years receive PSE as per norms.

4.2.5.4 Root causes and evidence to support causality

A diagrammatic representation of the root cause mapping for the performance gap in delivering PSE is presented in Annex 5. Free-listing of the potential causes for identified performance gaps in PSE were further explored by stakeholders to arrive at the root causes. These are presented in table 4.5

Table 4.5 Perceived causes for not all children in the age group 3-6 years receive PSE as per norms

Proximal causes	Root cause	Supporting evidence
Parents do not send their children to the AWC for PSE because: 1. parents' perception that AWW teaches songs and games only, poor quality of PSE 2. insufficient space within AWC to organize PSE activities, 3. they prefer private schools 4. and they misrepresent their children's ages to start formal school earlier. 5. Poor facilities and lack of space within AWCs	• Disproportionate focus on other aspects of ICDS in their advocacy strategies at the cost of PSE. • Lack of curriculum at AWCs was reported to be a major factor for why AWWs did not apply focus and innovative techniques of instruction • inadequate investment in infrastructure development and maintenance as cited in an earlier section on VHND. • parents were influenced by the incentive of uniforms, mid-day-meals and stipends offered to students • Improved coordination between the departments of WCD and Education • lack of guidelines on supervision at the department of WCD in the state. • Lack of training on PSE. • No institutional mechanism that ensured stock taking, monitoring, and reporting on PSE materials	• Only 37% of AWWs had a syllabus for PSE and 43 had a timetable for PSE activities. • 39 of 60 AWWs reported that they conducted classes for all children together without separate tasks being given to children per their learning levels. ▪ 42 out of 55 AWWs reported that they have inadequate supply of PSE materials. ▪ 15 AWWs reported that they have problem for performing PSE due to lack of supplies. ▪ Only 2 out of 60 AWWs reported that they got training on PSE. ▪ Only 7 of the 60 AWWs received written instruction for conducting PSE. ▪ 59% AWWs get support from their lady supervisors in the area of PSE.
Seasonal migration:	• Poverty and lack of sustainable employment opportunities.	

Chapter 5 Innovations and potential strategies

Performance improvement suggests potential strategies to address root causes. We identified some potential strategies from talking to key experts (add list in annexure) and are in the process of gathering needed evidences for the same

Community based monitoring for Supplementary Nutrition (SN): Decentralization of monitoring and supervision mechanisms that involve the community need to be initiated to ensure accountability and balance workload on a staff force that is already dealing with the implications of inadequate human resources. As an example, the DWCD, Government of Odissha (GoO) has provided for a village level *Jaanch* committee to certify the quantity and quality of foodstuff provided in the feeding programs. The guidelines for *Jaanch* committees are included in the guidelines for SN and provide details for composition, selection, roster of visits conducted by the committee and role of the committee.

Promoting community involvement in ICDS activities: Many states have demonstrated innovative strategies for promoting community involvement in ICDS activities. Tamil Nadu has elicited community support for the construction and maintenance of AWCs. The Dular program piloted in five districts of Jharkhand has engaged groups of neighborhood-based volunteers called local resource groups (LRGs). These groups are formed by, on average, four to five village women who assist the AWWs with food preparation, education, and household visits and help the AWW in identifying households with pregnant and lactating women. The LRGs serve as crucial channels for initiating BCC activities in the villages on an intensive scale.

Opportunities for cross learning: Cross learning opportunities that allow staff members to learn about best practices initiated in other states need to be incorporated to encourage the department to innovate and explore avenues for replication. The DWCD, Government of West Bengal allocates for exposure visits of staff members to other states to learn from their innovative practices.

Decentralized processing and packaging of THR: The DWCD, GoO has introduced decentralized processing and packaging of THR by SHGs. The THR packaging is also color coded by target group. This eases distribution and reduces the workload on AWWs on the day of THR distribution.

Targeted initiatives for tackling malnutrition: In order to effectively improve the nutritional status of women and children, special focus on regions with high incidence of malnutrition may be required. The Nutrition Operation Plan (NOP), initiated by the DWCD, GoO with support from DFID, focuses on 15 ‘high malnutrition burden’ districts of Orissa. All 15 districts have a team consisting of four qualified consultants who provide technical support for program implementation. A baseline study was initiated in the 20 districts (15 high burden and 5 control districts) to measure the impact of the action after NOP implementation and to set a baseline on nutrition related indicators. Furthermore, under the NOP, a concurrent monitoring has been taken up for the entire state which will be compared with the data obtained through the MPRs.

Promoting community kitchen gardens: Targeted initiatives to improve sustainable availability of locally grown seasonal vegetables and fruits through the institution of kitchen gardens in the community has recently been shown to increase overall agricultural yield as well as increased nutritional yield in some vitamins. At Jhargram Village, Gumla, kitchen garden was raised and cared for by contributions from villagers. The community owned it and raised funds for it by selling their junk to junk yards. However, in the area covered by the PNA study only two out of 60 AWW’s reported getting food from kitchen gardens.

Chapter 6 Conclusion

This chapter provides synthesis of the PNA findings and evidence-based suggestions for addressing the identified root causes. The PNA exercise conducted for the ICDS scheme in Jharkhand linked the root causes of performance gaps to the following domains: These are:

- Policy and guidelines
- Knowledge and skill
- Supervision
- Physical infrastructure
- Advocacy and communication
- Convergence
- Motivation and incentive

6.1 Policy and guidelines

Staff performance is positively associated with clarity in expectations from the employee. Most AWWs in Jharkhand do not have a copy of their job descriptions. In addition, PNA findings indicate the following lacunae with regard to guidelines/ provisions pertinent to delivery of critical services by the AWW: 1) guidelines have not been drafted, 2)if these exist, have not been revised in accordance with changing requirements or 3) are inaccessible at the point of application(AWC.)Though a communication channel from the Directorate to the AWW exists, letters and directives from the Directorate to all DSWOs, CDPOs and DCs, at times do not reach the AWW.

The unavailability/inaccessibility/ inadequacy of guidelines adversely affects delivery of all services provided through the AWC.

Guidelines that are unavailable

- Simple easy to follow guideline in the form of an algorithm for growth monitoring and promotion
- Counseling caregivers on nutrition and care of children with faltering growth and malnourished children
- Counseling on nutrition and care for pregnant and lactating women
- Counseling on nutrition and care for infants and young children
- Monitoring and tracking of training, follow-up and assessment of trainees
- Guidelines for implementation of ICDS in left wing extremist affected areas.

Guidelines that are inaccessible

- Procurement and accounting pertinent to Supplementary Nutrition SN funds
- Tracking care and/or treatment received and follow-up, of referrals to MTCs or health facilities
- Curriculum for PSE

Guidelines that are inadequate (not updated/ unclear to AWW)

- Repair and maintenance of weighing machines at local level
- Rate list for food and fuel for SN

Suggestions for strengthening policy and guidelines

- Constitution of an ICDS cell within the Directorate has been recommended in the state PIP 2011-12 to strengthen overall planning, implementation, monitoring and evaluation of the ICDS scheme. The establishment of an ICDS cell as an exclusive resource centre for the ICDS could also ensure framing and updating of guidelines according to the emerging needs, assuring quality in services provided and documenting challenges. Odisha, Tamil Nadu and

West Bengal have dedicated cells/ committees for reviewing ICDS implementation and operations.

- Directorate should review existing guidelines/ directives for selected services and update these in accordance with current requirements in the field.
- Release periodic newsletters and calendars that provide necessary instructions/ guidance to AWWs on service delivery. The newsletter could provide information about policy guidelines, key messages for AWWs including best practices, nutritious recipes and legal provisions for women and children. Maharashtra and West Bengal have developed compendium of all implementation guidelines that are made available to the LS and AWWs. Better performing states also release periodic newsletters and calendars that provide necessary instructions/ guidance to AWWs on service delivery. Directorate should consider these options for making sure that communication gaps in transfer of information on new/ revised guidelines from state till AWC are bridged.
- Update the ICDS website with all current policies and guidelines.
- The fund flow involves two departments – ICDS and the Treasury. The Treasury rules have to be made flexible. A clause indicating the following should be included on the bills produced by the AWW for purchase: 'the bill should be signed by the AWW and the AWH and counter signed by PRI members / village members'. These signatures will authenticate the bill. This is being practiced in Ramgarh district.

6.2 Knowledge and skills

Though identified as a cause for underperformance, knowledge and skills of AWW did not emerge as the root cause for the performance gaps. The root cause of limited knowledge and skills was lack of availability of consistent key messages on nutrition and care in print form at the AWCs, supportive supervision, training and post-training follow-up and in some case the inaccessibility of guidelines.

- Infrastructure for AWW training is limited and resources available in existing AWTCs are not sufficient for delivering training as per norms (Source: NIPCCD-Research on ICDS, Volume 3; RCA)
- Training needs of AWWs are not identified by supervisors (Source: Field study, RCA)
- There are backlogs in training for AWW, supervisor and CDPO training (Source: STRAP 2008-11)
- Key messages on Health and Nutrition are not consistent and universally available at the AWCs (Source: Field study, RCA)

Suggestions for enhancing knowledge and skills

- A detailed study of the quality of training sessions and training infrastructure in the state should be undertaken to assess the status and identify the needs for meeting the training requirements of ICDS staff members in the state.
- A comprehensive training monitoring/tracking mechanism which offers information on trainers, trainings offered, participants, and follow up assessments on participants should be developed and used by functionaries across levels.
- The AWW's handbook prepared by NIPCCD should be made available to all AWWs in the local language as has been done in Maharashtra.

6.3 Supervision

Lady Supervisors are the primary supervisors for AWWs within the ICDS framework. Evidence indicates that lack of supervisory support has adversely affected AWWs' performance in terms of monitoring growth of children, delivering NHED, implementing SN, planning VHND in an organized manner, and conducting PSE as per norms.

Thus, lack of supervision is one of the common causes for gaps in service delivery at the AWC. The challenge is both the availability and the effectiveness of supervision.

Availability: Vacancy rate for LS as per sanctioned posts is close to 50% (Source: MPR, March 2011). Catchment area for LS is 1.5 to 5 times more than GoI recommendation (Source: GoI guidelines for monitoring and supervision and field study).

Effectiveness:

- LS lack clarity about their role in supervising AWWs; instead of supervising, they mostly supplement AWWs' works in the field (Source: Field study).
- Supervisory tools such as observation checklists, grading list of AWCs and AWW training rosters are not available to LS (Source: Field study and RCA).
- LS do not receive timely remuneration for travel and find the amount of remuneration to be inadequate (Source: RCA).
- Existing LS have not been trained for the last three years (Source: STRAP 2008-10). These include induction and refresher trainings.

Suggestions for improving supervision

Short and long term options for addressing challenges of availability and effectiveness of supervision are presented below.

Availability:

- State needs to institutionalize the mechanism for recruiting and retaining LS in ICDS as a long term measure. Since Jharkhand is in the process of drafting a promotion policy, options from states like Odisha, which has reduced LS vacancy rate from over 50% in 2009 to less than 30% in 2011,should be reviewed. Odishahas based 100% CDPO recruitment on promotion of LS and 30% LS recruitment based on promotion of matriculated AWWs with 10 years of service.
- In the short term contractual hiring of supervisors is also an option which Odisha has used effectively over the last few years by creating additional supervisor posts that are being filled through contractual appointment of graduate AWWs with five years of experience.

Effectiveness:

- Standardized protocols clearly delineating the role of the supervisor in conducting VHNDs, AWC visits, and monthly cluster meetings have been developed by CARE and have been adopted by Andhra Pradesh and Chhattisgarh (CARE & USAID 2010).State should consider review and inclusion of these in the implementation guidelines and LS should be trained in using these.
- Supervisory tools and checklists available at the directorate need to be made accessible to the LS through the respective project offices.
- Though the catchment area of the LS should conform to the norm, the state should consider travel remuneration for the LS based on their varying catchment areas.
- Directorate should allay demotivating factors like delays in receipt of travel remuneration and recognize good performance for LS through national and state awards.
- In order to mobilize the department staff force and inspire them to work collectively towards the attainment of program goals, the state should create opportunities for regular and structured capacity building of functionaries to understand and review data and assess activities in terms of process, output and outcome indicators.
- The proposed five-tier monitoring and review mechanism proposed by the MWCD, GoI should be incorporated at all levels ranging from the state to the AWC to ensure regular monitoring and review of ICDS implementation and strengthen the coordination and convergence with other line departments. West Bengal and Odisha have initiated ICDS planning, monitoring and coordination through state and district level committees that monitor program activities on a quarterly basis.
- Until the state has an MLTC, supervisors' training could be undertaken at identified AWTCs or the regional NIPCCD training centre at Lucknow.

- The Nigraani (community based monitoring) Committee in Jharkhand should be empowered and strengthened like its counterpart the Jaanch Committee in Odisha.
- Self Help Groups should be educated on thematic issues to generate demand for services and to monitor services as is done in Bihar.
- The LS should be provided with a Diary to record the details of her activities on a daily basis. Based on this Diary, a weekly report should be presented to the CDPO. This is being practiced in Bihar.
- Bihar is using a Mobile Tracking system for activities at the AWC – The AWW has been provided with a mobile phone equipped with a 2 megapixel camera and internet connectivity. She provides pictograghic report of activities at the AWC directly to the CDPO on fixed timelines. This practice could be adopted in Jharkhand.

6.4 Physical infrastructure

Space and upkeep of the AWC and maintenance of tools and equipment are critical for the delivery of services through the centre. Cleanliness of space and equipments needs to be gi ven special attention.

GoI has developed norms for layout and construction of the AWC which has been adapted by states according to local needs. Lack of adequate space and equipment was identified as one of the root causes for gaps in delivery of PSE and VHND in Jharkhand. The RCA discussions concluded that inadequate infrastructure was linked to lack of guidelines and poor state investment and utilization of budget for infrastructure development and maintenance.

In addition to the infrastructure, availability of equipment such as functioning weighing machines and standard measures for distribution of THR were identified as causes for performance gap on GM and SN.

- Less than 30% of the AWC are in government owned buildings.
- Less than 50% of the AWWs interviewed had functional weighing machines for infants.
- In the financial year (FY) 2010-11 the state used approximately 60% of the allocated budget for AWC and project building construction.
- Central guidance on layout of AWCs is unavailable at district and block level.Equipment for measurement of THR was not found to be uniform during field investigations. There were no calibrated measurement utensils at any AWC.
- Most \AWWs \ reported that they take care of regular cleanliness and maintenance of AWC through sweeping, wiping or washing, however only 4 reported that dusting is done on a daily basis while 19 reported dusting on a weekly basis and 16 reported dusting is hardly undertaken

Suggestions for strengthening physical infrastructure

- Uniform calibrated measuring equipment and storage facilities should be available at all AWCs.
- All AWCs should have working weighing scales for infants, children and adults at all times.
- Central guidelines on layout, construction and maintenance of AWCs should be available at all district and block offices and AWCs to inform ICDS staff members of the norms for AWC buildings. Ensure that the AWCs that are renovated or newly built have easy to clean and maintain surfaces.
- Community participation in the construction and maintenance of AWCs should be encouraged as has been demonstrated in Tamil Nadu where community members, other government departments and private enterprises have contributed towards construction, painting, furniture, toys and other materials at AWCs.
- Encourage utilization of funds from Integrated Action Plan Funds and Backward Region Grant Fund for the construction of new AWCs as is done in some districts of Jharkhand

- AWCs should be painted in bright colours that appeal to children. Innovative techniques like the pre-fabricated AWC design introduced in Maharashtra should be studied and explored for applicability to Jharkhand.
- Partner and utilize inter sector/department programs at the village/block/district/state levels to renovate and /or provide needed physical infrastructure.

6.5 Advocacy and communication

Though ICDS has been in existence for 36 years, universalization and expansion of ICDS projects is a recent phenomenon dating a few years. Stakeholders involved in the RCA contended that the relevance of ICDS services is yet to be completely understood by the community. Stakeholders attributed this to limited advocacy and communication strategies, focusing on the primary audience- the beneficiaries. Specifically, insufficiency of advocacy was associated with:

- Lack of understanding on concept of supplementary nutrition.
- Perception of VHNDs as primarily an event for ration distribution
- PSE provided through ICDS not considered important for ECD

The AWWs' role in counseling, along with other field workers positioning for community mobilization is unparalleled. However, having an agent/ mobilizer from outside the community such as health department or NGO staff is more effective at times. With increased penetration of mass media, stakeholders also feel the need to use this form of communication for advocacy on ICDS.

- Poor focus on package of health and nutrition services mandated for VHND in advocacy strategies.
- Lack of IEC materials for growth monitoring.
- Poor utilization of the budget allocation for publicity education and communication. The state used approximately 73% of the allocated budget in the FY 2010-11.

Suggestions for improving advocacy and communications

- The central and state guidelines should be made available for public access through the department website as has been accomplished by the DWCD, Government of Odisha (GoO), through their website e*pragati*.
- Better performing states have used their education and communication budgets effectively to create awareness about ICDS in the community and for dissemination of critical health and nutrition messages. This has been done through mass and mid-media and using local channels by developing pamphlets, posters etc. The directorate has a range of options to choose from; choice could be made based on review of what has been effective in behavior change, ease of usage and costs of using different mechanisms.
- As mentioned previously, periodic newsletters in the local language with key messages for AWWs including nutritious recipes, best practices, guidelines and legal provisions for women and children should be introduced in the state. Newsletters are an important feature of the ICDS scheme in all better performing states like Chattisgarh, Maharashtra, Orissa, Tamil Nadu and West Bengal.
- In the State of Bihar, Bachpann Diwas is organized at the AWC on each Saturday, where thematic issues like maternal health, child health, complementary feeding etc. are discussed. The PRI members attend such meetings and a report of the day's events is sent to the LS. This could be adopted in Jharkhand. A Gram Vaarta (Ekjut model) could be used across the state to bring about an awareness on malnutrition through SHGs.

6.6 Convergence

The core to reducing malnutrition related morbidity and mortality is effective coordination amongst ICDS, health, education and other departments. There is a lack of mechanisms to ensure

convergence between the various line departments in the state resulting in inappropriate care and treatment for undernourished children and poor coordination on PSE and NHE.

- ICDS and health department use different criteria for identification of undernourished children which results in differing diagnosis.
- ICDS and health department staff convey conflicting messages, particularly on new born care.
- Children miss out on PSE which is essential for ECCD in the race to enter formal schools at an early age.

Suggestions for increasing convergence

- As implemented in West Bengal, convergence workshops for staff members from all line departments such as Social Welfare, Health, Education, Rural Development, District administration staff and local development partners should be organized at district levels to develop better coordination among the various stakeholders.
- At the district level there should be a committee chaired by the Deputy Commissioner and having representatives from the ICDS, SRHM, Health, Water and Sanitation, Panchayat and NGOs to ensure effective implementation of the ICDS. West Bengal has constituted a state level co-ordination committee under the chairman ship of the Social Welfare Minister. This committee comprises of representatives of Health & Family Welfare, PHED, School Education Panchayat and Rural Development departments. In addition, representatives of various development partners like UNICEF, CARE, and DFID are also members of this committee. The objective of the committee is to formulate policy and ensure effective implementation of ICDS. Furthermore, convergent planning and review forums like the 'District Level Monitoring Committee' under the chairmanship of the District Magistrate have also been constituted with members from all relevant development partners and line departments at the district level.
- Encourage utilization of funds from the VHSNC to enhance facilities by purchasing items like '*durries'* and toys or to repair weighing machines.
- The community should be encouraged to organize kitchen gardens at the AWC or at the village as is being done at Jhargram AWC, Gumla.
- In Odisha, the Mahila Mandals are engaged in packaging of THR. The packaging is transparent with labels on the content and specificity for children or mothers using color codes. This could be adopted in Jharkhand to ease workload of AWW in the distribution of THR.
- Clear and consistent messages on health and nutrition need to flow down to field staff of all departments.

6.7 Motivation and incentive

Major factors of employee motivation include salary, reward mechanisms, professional development, career progression and organization support in terms of human and physical infrastructure and systems. The findings of the study revealed that majority of the AWWs and half the number of LSs and CDPOs interviewed, reported delays in receiving their remuneration. Incentives in the form of awards for best performing AWWs have not been implemented regularly. Promotions for staff members are not taking place due to absence of service rules that outlined promotion criterion and procedure.

- The delays in remuneration exceed a period of 4 months for more than 60% of the AWWs interviewed.
- The central norm for awarding best performing AWWs with INR 5000.00 had not been implemented in Jharkhand since 2008.
- There have been no promotions of staff members due to absence of service rules.

Suggestions for enhancing motivation and incentives

- Operational mechanisms for ensuring timely payment of remuneration to AWWs should be strengthened through regular review and follow-up at the Directorate level.
- The existing scheme for awarding better performing AWWs should be reinstated.
- Process for adoption of service rules should be expedited to regularize recruitments and promotions within the department workforce.
- A feedback mechanism that includes appreciation of work well done along with suggestions for improvement with mentoring support needs to be instituted.
- In Bihar, the performance of AWWs are graded and the best performer within a cluster is awarded every month. This practice could be reviewed and adopted in the state.

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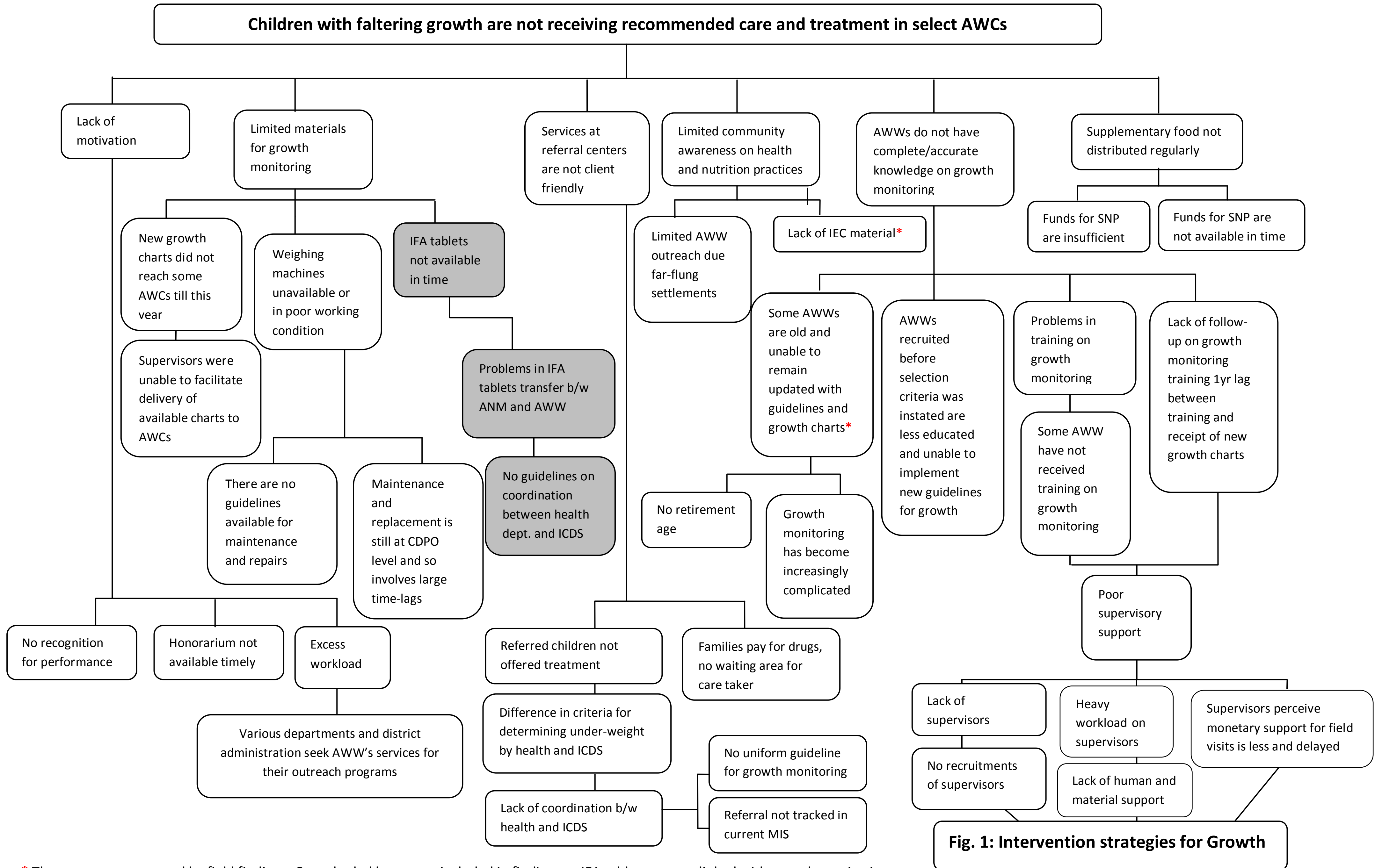
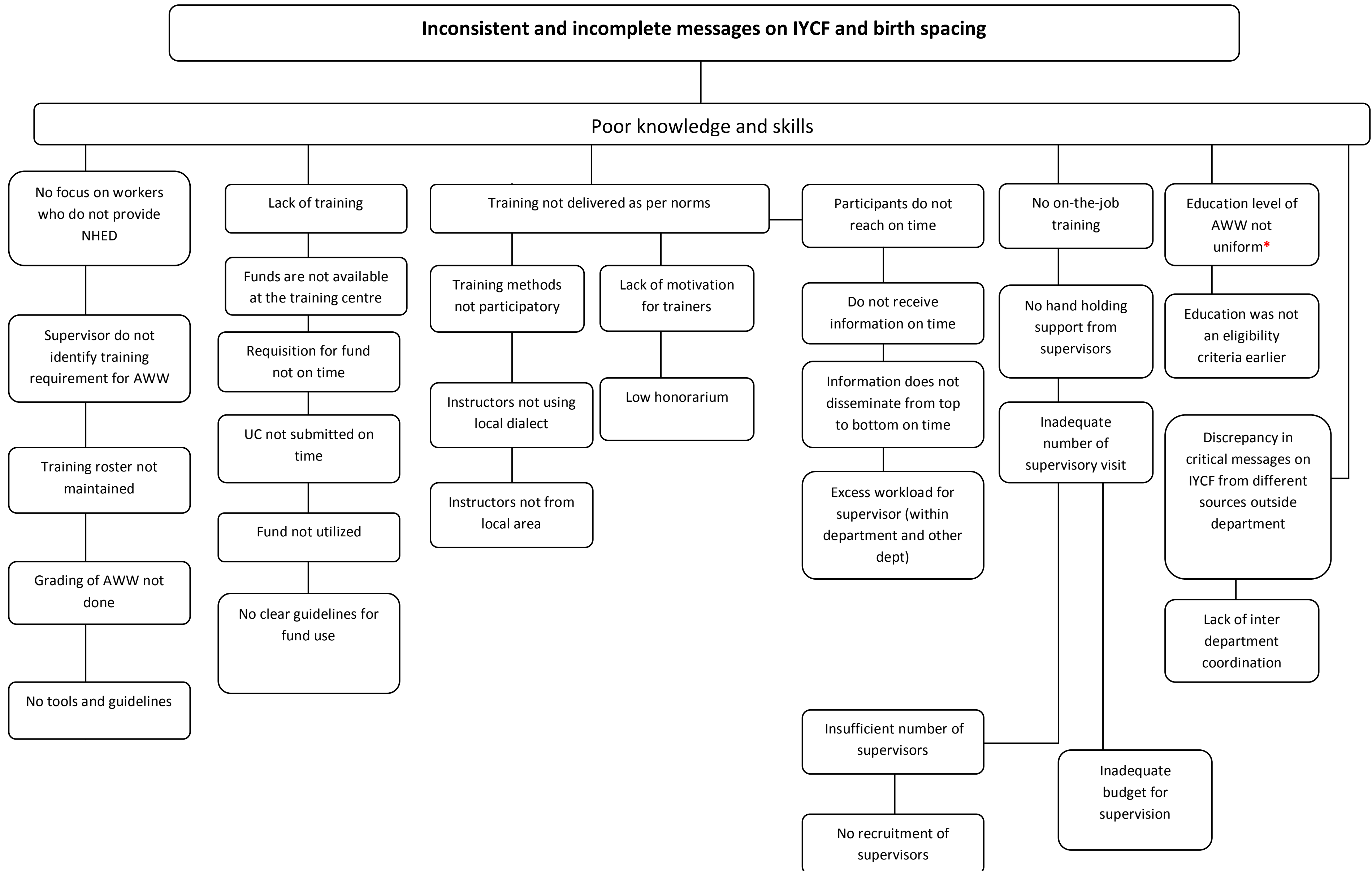
Annexure

Annex 1: Cause mapping for GM



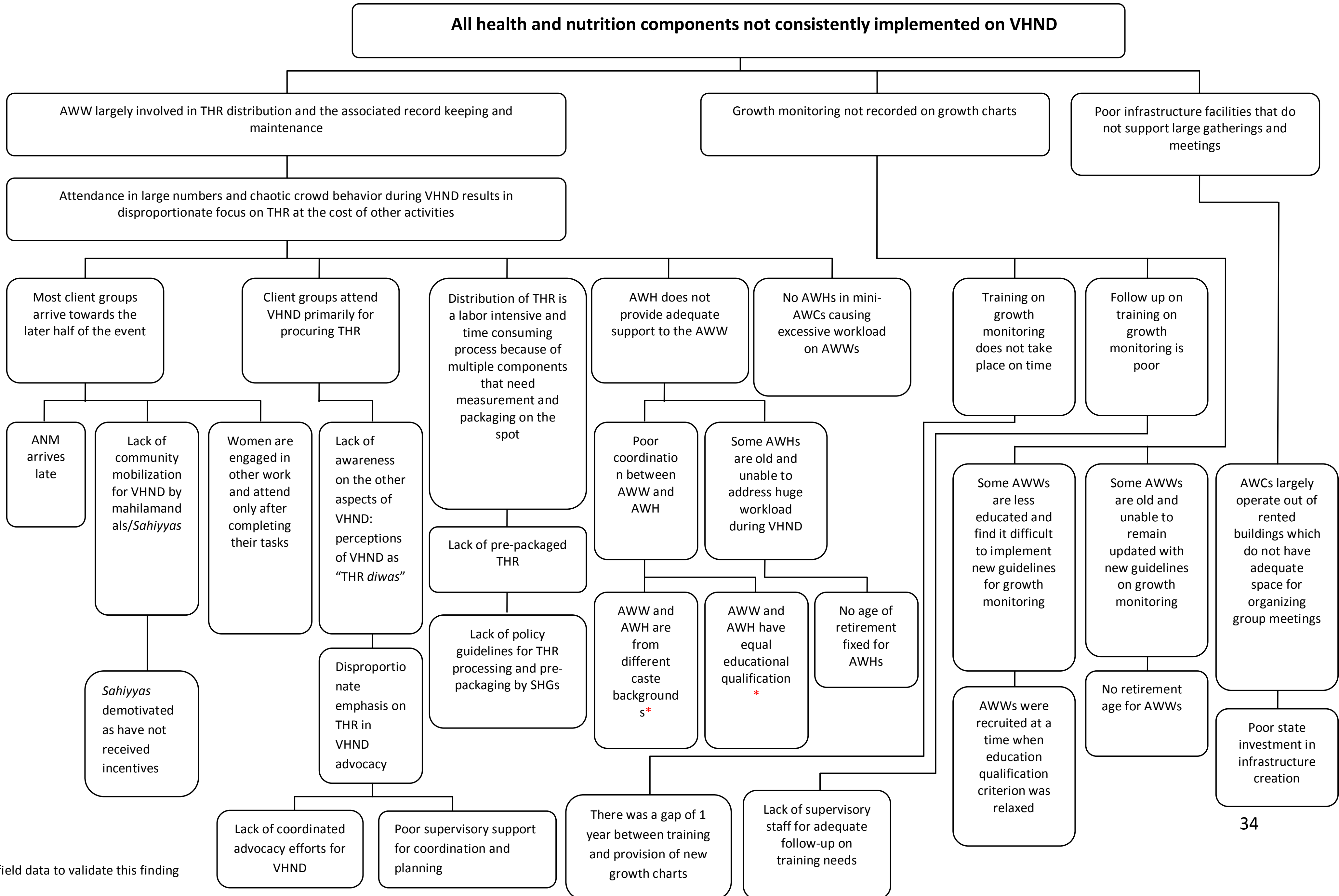
* These are not supported by field findings. Grey shaded boxes not included in findings as IFA tablets are not linked with growth monitoring.

Annex 2: Cause mapping for NHE

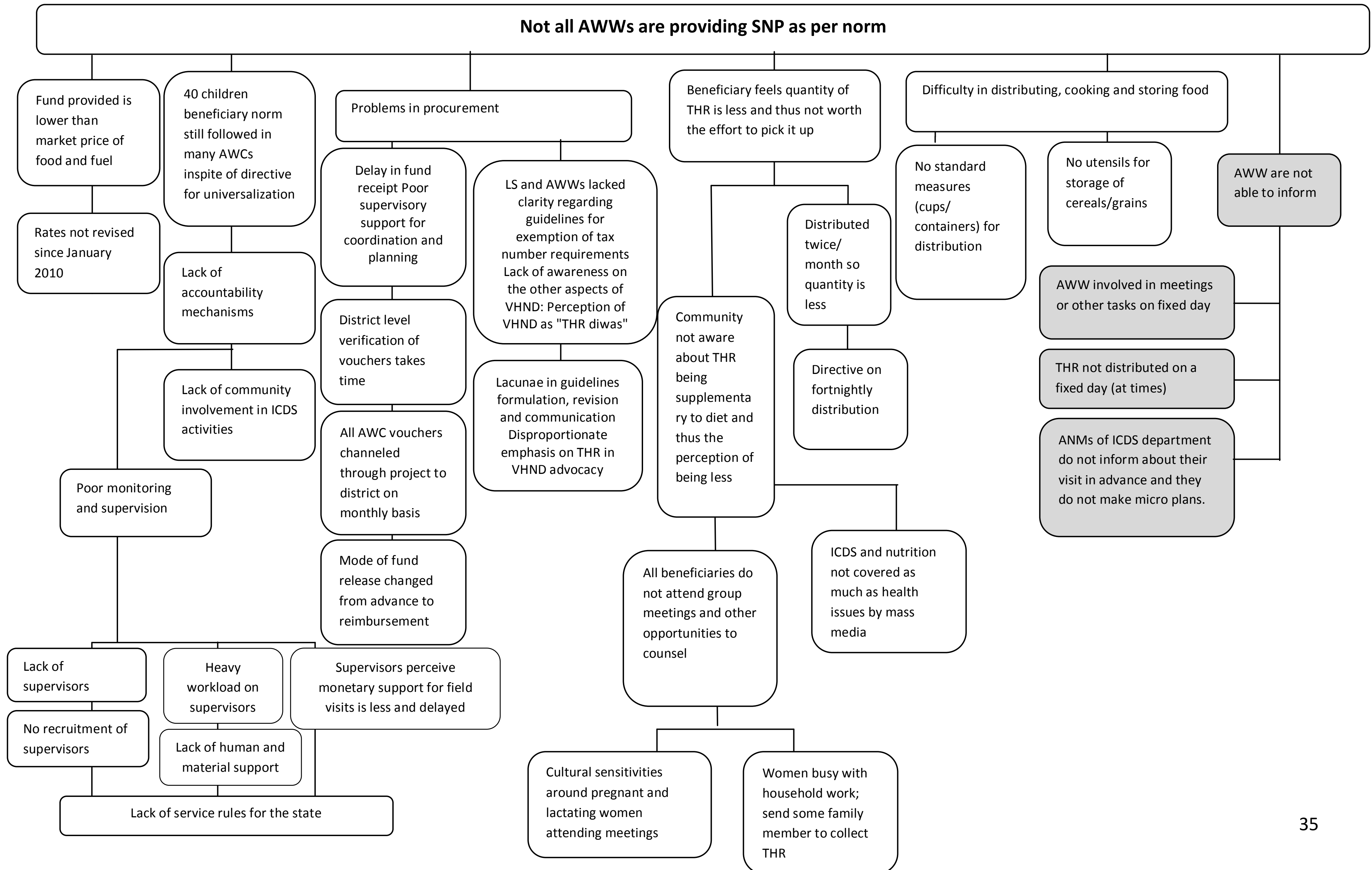


* Not validated by field findings

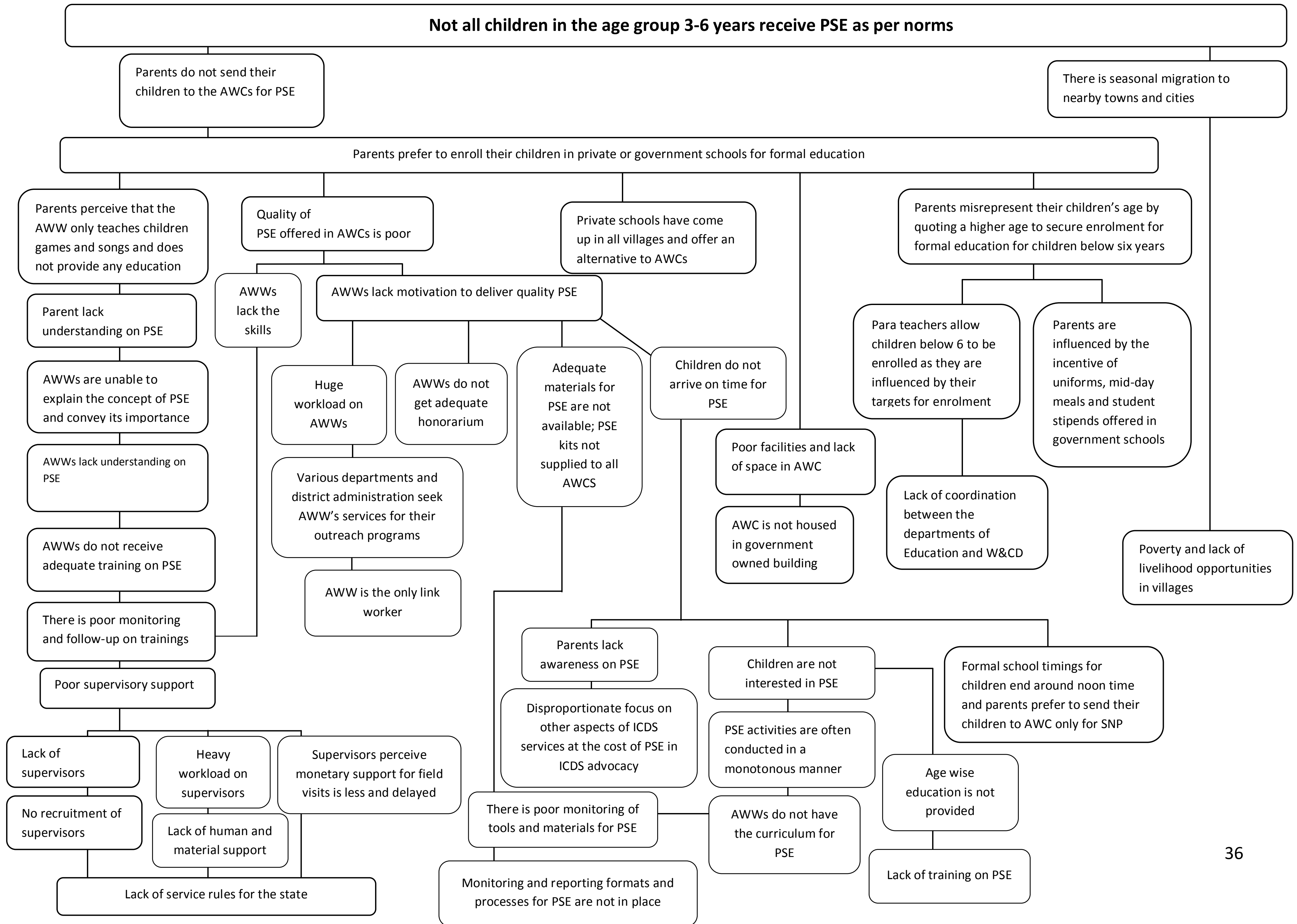
Annex 3: Cause mapping for VHND



Annex 4: Cause mapping for SNP



Annex 5: Cause mapping for PSE



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