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An Assessment of Capacity

March 2014

SASHN
SOUTH ASIA



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Institutional Arrangements for Nutrition in India

An Assessment of Capacity

March 2014

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Acronyms and abbreviations

ACDPO	Assistant Child Development Project Officer
ANC	Ante-natal Check-up
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
ASHA	Accredited Social Health Activist
AV	Audio-Visual
AWC	Anganwadi Center
AWH	Anganwadi Helper
AWTC	Anganwadi Level Training Center
AWW	Anganwadi Worker
BP	Blood Pressure
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
CCT	Conditional Cash Transfer
CD	Child Development
CDPO	Child Development Project Officer
CG	Chhattisgarh
CHC	Community Health Center
CMHO	Chief Medical and Health Officer
CMO	Chief Medical Officer
CMU	Central Monitoring Unit
CNI	Community Nutrition Instructress
CNW	Community Nutrition Worker
CRM	Common Review Mission
CV	Curriculum Vitae
DFPD	Department of Food and Public Distribution
DoHFW	Department of Health and Family Welfare
DHS	District Health Society
DOL	Division of Labor
DPO	District Project Office
DPMR	Disability Prevention & Medical Rehabilitation
DWCD	Department of Women and Child Development
DWS	Drinking Water and Sanitation
ECCE	Early Childhood Care and Education
ED	Executive Director
FNB	Food and Nutrition Board
FPS	Fair Price Shops
FGD	Focus Group Discussion
GMP	General Management Practices

GoI	Government of India
H&FW	Health and Family Welfare
Hb	Haemoglobin
HMIS	Health Information Management System
HR	Human Resources
IAS	Indian Administrative Services
ICDS	Integrated Child Development Services
ICPS	Integrated Child Protection Scheme
IEC	Information, Education and Communication
IFA	Iron-folic acid
IGMSY	Indira Gandhi Matritva Sahyog Yojana
ILS	Incremental Learning System
IMCC	Inter-Ministerial Coordination Committee
IMR	Infant Mortality Rate
INHP	Integrated Nutrition and Health Project
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
ISSNIP	ICDS Systems Strengthening and Nutrition Improvement Project
IYCF	Infant and Young Child Feeding Practices
JS	Joint Secretary
JSY	Janani Suraksha Yojana
JRM	Joint Review Mission
KM	Knowledge Management
LBW	Low Birth Weight
LHV	Lady Health Visitor
M&E	Monitoring and Evaluation
MCP	Mother-Child Protection Card
MCTS	Mother-Child-Tracking System
MEPC	Mission Empowered Program Committee
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MIS	Management of Information System
MLTC	Middle Level Training Center
MO	Medical Officer
MMR	Maternal Mortality Rate
MOCAPFD	Ministry of Consumer Affairs, Food and Public Distribution
MOFCS	Ministry of Food Civil Supplies
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MP	Madhya Pradesh
MPR	Monthly Progress report
MWCD	Ministry of Women and Child Development
NAC	National Advisory Council

NBA	Nirmal Bharat Abhiyan
NCAER	National Council of Applied Economic Research
NGO	Non-governmental Organization
NHEd	Nutrition and Health Education
NIPCCD	National Institute of Public Cooperation and Child Development
NMSG	National Mission Steering Group
NRC	Nutrition Rehabilitation Center
NRDWP	National Rural Drinking Water Program
NRHM	National Rural Health Mission
NTTF	National Training Task Force
ORS	Oral Rehydration Solution
P&LM	Pregnant and Lactating Mothers
PC	Planning Commission
PDS	Public Distribution System
PEO	Programme Evaluation Organization
PHC	Primary Health Center
PIP	Project Implementation Plan
PMO	Prime Minister's Office
PMPSU	Poverty Monitoring and Policy Support Unit
PNC	Pre-Natal Check-up
PRI	Panchayati Raj Institutions
PSE	Pre-School Education
RCH	Reproductive and Child Health
RDD	Regional Deputy Director
RTI	Reproductive Tract Infections
SABLA or RGSEAG	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
SAM	Severe Acute Malnutrition
SD	Standard Deviation
SMU	State Monitoring Units
SNP	Supplementary Nutrition
SOP	Standard Operating Procedures
SSA	Sarva Shiksha Abhiyan
STI	Sexually Transmitted Infections
STRAP	State Training Action Plan
STTF	State Training Task Force
THR	Take Home Ration
TINP	Tamil Nadu Integrated Nutrition Project
TNA	Training Needs Assessment
TSC	Total Sanitation Campaign
TT	Tetanus Toxoid
UT	Union Territories

VHIR	Village Health Index Register
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committees
VHSNC	Village Health, Sanitation and Nutrition Committees
WCD	Women and Child Development
WIFS	Weekly Iron-Folate Supplementation

Executive summary

1.1. The capacity of institutions can enhance or constrain their ability to fulfil their mandate and achieve intended outcomes. To assess the capacity of the nutrition service delivery system in India, this study undertook a capacity assessment of the two key programs, namely the Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM) that form the mainstay of India's nutrition delivery system. The ICDS is the responsibility of the Ministry of Women and Child Development (MWCD) and was restructured in 2012 to be implemented in a mission mode. However, the proposed strengthened organizational structures at the national and state level are yet to be established. The NRHM, a program of the Ministry of Health and Family Welfare (MoHFW), implements several health services, including selected nutrition services. Overall, nutrition as a sector is the responsibility of the MWCD, while the responsibilities for delivery of key nutrition services are shared between the ICDS and NRHM.

1.2. Although several evaluations and assessments document the weaknesses in design and implementation of the ICDS and the NRHM, a comprehensive institutional capacity assessment of the two programs, particularly with respect to nutrition services has not yet been undertaken, leaving a large gap. The present study is a first step in filling this gap.

1.3. The rapid expansion of the ICDS over the last few years, its recent restructuring and strengthening, the launch of two additional programs for nutrition to be implemented using the ICDS platform, namely the Indira Gandhi Matritva Sahyog Yojana (IGMSY)¹ and SABLA,² the approval of a multi-sectoral nutrition program in 200 high malnutrition burden districts, and the World Bank supported ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP) – all of which depend on the ICDS platform -- makes the capacity assessment of the ICDS critical and timely.

1.4. The study takes a management approach to capacity assessment that looks at capacity not in terms of what it is, but in terms of the factors that influence it. Such a definition helps identify constraints to capacity as well as the measures aimed at building capacity. For the purpose of this study, capacity is defined in operational terms. It lists the factors that must be observed if an agency or system has full capacity. Thus, an organization or agency has the capacity to deliver services only if it has:

- *Effective leadership and management;*
- *An optimal division of labor and structure;*
- *Financial resources matching its mandate, managed and utilized fully and efficiently;*
- *Human resources, physical resources and information matching its operational requirements and it manages and utilizes all of these fully and efficiently; and*
- *Appropriate work practices and processes followed by its personnel.*

The constraints to capacity in each of these areas have been assessed using operational indicators (Table 1.1, chapter 1, Introduction). The study draws upon data from a review of documentary material; semi-structured interviews and focus group discussions (FGDs); and systematic observation of selected service delivery.³ Much of the evidence is drawn from

¹ A pilot conditional cash transfer scheme launched in 2010 for pregnant and nursing mothers in 52 districts.

² A program for out-of-school adolescent girls launched in 2010 in 200 districts that *inter alia* provides nutrition counselling, food and micronutrient supplements.

³ The interviews and FGDs were conducted at the national level and in two states (Tamil Nadu and Bihar), each for two districts, two blocks and two villages, with the states and districts drawn from those surveyed in the HUNGaMA Survey, 2011.

available publications, and the purpose of the FGDs was to validate and support the findings from secondary data.

Key capacity constraints

1. Capacity constraint due to inappropriate division of labor as assessed by functional gaps, splits, overlaps, misplacements, differentiation and overload.

Conceptually, the institutional arrangements for delivery of direct nutrition services through the two programs, the ICDS of the MWCD, Government of India (GoI) and the NRHM of the MoHFW, GoI, optimizes the mutually synergistic services of the two departments. However, it does impose the need for coordination. Both programs are community outreach programs, target the same populations, and have common objectives in terms of reducing child mortality and undernutrition. Moreover, since many nutrition interventions, such as micronutrient supplementation, facility based treatment and management of children with severe acute malnutrition are integral to the NRHM package of maternal and child health services together with prevention and treatment of infection, it is appropriate to draw on these to complement the nutrition services offered by the ICDS. Functionally, this does not constitute a split or misplacement of functions and could in fact be a capacity enhancer if adequate coordination mechanisms are functional. There is also scope for mutual synergies to be expanded beyond what is currently defined, to achieve a reduction in child undernutrition.

Although the division of responsibilities for nutrition-related service delivery between the ICDS and NRHM are clearly spelt out, with several coordination mechanisms defined and institutionalized,⁴ adequate coordination between the two programs has continued to be a problem. While well stated on paper, on-the-ground coordination remains poor, largely due to weak supervision and management, inadequately defined work procedures, insufficient training, inadequate understanding of ‘how to’ coordinate, and functional overload of staff in both programs. This sub-optimal coordination has resulted in poor coverage and quality of service delivery.

The division of labor within the ICDS constrains its capacity to deliver nutrition services. Insufficient differentiation of critical functions and services, the lack of a dedicated organizational home or dedicated person to manage the function or service have led to under-developed and under-managed functions and services. Combined with the ICDS’ shortage of staff, the insufficient functional differentiation also leads to functional overload on the existing staff. Some functional splits also constrain capacity. For example, the training function is split between the ICDS training institution, the National Institute of Public Cooperation and Child Development (NIPPCD), and the training units in the MWCD and the state ICDS directorates. The ICDS in Mission mode appears to address the issues of inadequate differentiation and to reduce the functional overload at some levels. However, a systematic functional and workload analysis has not yet been undertaken and it is, therefore, not possible to assess the extent of workload optimization.

2. Leadership capacity as assessed by the existence and quality of a conceptual framework, vision, mission or strategy, and balance between continuity and change, agenda overload and vacancies at the leadership level.

⁴ The coordination mechanisms include monthly Village Health and Nutrition Days (VHNDs) conducted jointly by the functionaries of both programs, the establishment of Village Health, Sanitation and Nutrition Committees (VHSNCs), joint planning and training.

While at the national level India's policy documents provide a comprehensive policy and conceptual framework, and the national five-year plans clearly outline a vision and strategy for nutrition and define targets for reducing undernutrition, there are substantial leadership constraints at the MWCD, GoI which is India's nodal ministry for nutrition. The lack of a dedicated home for nutrition and a dedicated leader for nutrition in the MWCD, GoI and the absence of nutrition in the vision and mission of the ministry are some of the biggest constraints that have limited the leadership for nutrition as a sector. Furthermore, nutrition is also not included in the vision, mission, or objectives of the MOHFW, GoI, which is the other key ministry for delivering nutrition services. Nevertheless, it is laudable that despite this constraint, the MWCD, GoI has over the past few years demonstrated significant leadership in building commitment for nutrition and mobilizing resources for the sector. However, prior to this, leadership and direction for nutrition from the MWCD, GoI was constrained.

The ICDS has only recently, under the ICDS Mission, articulated clear nutrition objectives and targets with timelines. Nutrition is not reflected in the NRHM vision or mission and there are no nutrition-related objectives. The vision, mission, and objectives are not mere statements, but form critical assertions of aspirations and directions; they define for each person in the agency the purpose of their work, as well as the role each has to play in helping the organization achieve its mission. Besides, while staff down the ICDS chain is largely aware of the national and ICDS vision for nutrition, in the NRHM the national vision for nutrition is poorly understood, and NRHM functionaries do not see a role for themselves in improving nutrition. This also shows poor communication of the visions and is yet another leadership constraint.

Leadership constraints are also reflected in the choice of a strategy and its feasibility. The ICDS strategy, with its multiple services, has been overly ambitious. More recently, the addition of two more schemes to the ICDS platform has added to its delivery burden. The ICDS has not had the resources – financial, physical, and human – to match its ambitious mandate. Technically, it did not preferentially target pregnant women and children under two, (rather the focus was on older children). Nor did it prioritize the most effective interventions to improve nutrition, such as nutrition education for behavior change (rather it was focused only on supplemental food distribution). In addition, despite the known weaknesses of the strategy and without any change of strategic direction, the program was expanded significantly in an attempt to attain national coverage. It is only recently that the strategy and package of services have been revised, but there are still too many priorities. This also shows that continuity and not change has been the defining characteristic of the ICDS and that change has been hard to come by, even though it was needed to address known problems and ineffective strategies.

The NRHM's strategy focuses on prevention of micronutrient deficiencies and facility based treatment of children with severe acute malnutrition. It has been relatively dynamic in balancing continuity and change, and has begun to increasingly focus on nutrition, having introduced Infant and Young Child Feeding (IYCF) counseling by Accredited Social Health Activists (ASHAs).

Within the ICDS, another capacity constraint is the shortage of leaders and senior managers leading to their agenda overload. The overload, among other factors, contributes to compromised management and leadership. The situation, however, appears much better in the NRHM.

3. The capacity constraints due to general management practices (GMPs) as assessed by three management practices, namely supervision, accountability and work processes and procedures.

Much of the weaknesses in the implementation of the ICDS are due to the weak management practices in the program. The GMPs in the ICDS are poor and considerably constrain the management of key functions and services. Supervision in the ICDS is very weak and is largely directed at the supervision of Anganwadi Centers (AWCs), while supervision along the full chain of the ICDS hierarchy receives little attention. AWC supervision is 'control' focussed and the 'support' dimension is virtually non-existent. The key reasons for poor supervision practices are: (i) lack or non-existence of a supervisory framework for the complete function of supervision including support; (ii) lack of a culture of supervising as a practice along the hierarchy; (iii) deficient supervisory skills; and (iv) a shortage of staff, particularly at the supervisor level.

Although, in principle, a formal system of accountability - for conduct and performance - exists on paper in the Indian public service, including the ICDS, in practice accountability is poor, especially for performance. The practice of setting priorities or specific time bound objectives or targets for individuals, teams, and managers, and monitoring them is not prevalent, nor is that of holding people objectively accountable for performance. Corruption is pervasive and bad performance is widespread, but few are held accountable. It is the worker at the bottom of the chain, namely the Anganwadi Worker (AWW) who is mostly held accountable and faces action for non-performance or misconduct, and managers are largely not held accountable. The toleration of managers' non-performance has culminated in sub-optimal performance of various systems, as shown by the detailed analysis in the chapters of this study. The restructured ICDS focuses on ways to strengthen accountability in three key ways. These include: (i) community based monitoring and accreditation; (ii) internal monitoring; and (iii) concurrent external monitoring. In addition, a grievance redressal mechanism has been set up that includes arrangements at the village, block, district, state and national levels.

Work procedures in the ICDS are not satisfactorily designed and are not compliant with good work practices. There is a near absence in the ICDS of documented work processes as well as those detailing the nature and scope of each activity to be conducted, with registers, and checklists which are often not detailed enough to define the work procedures. As a result, there are large variations in how activities are conducted, particularly at the AWC and sector levels, leading to inefficient use of time and resources, loss of productivity or capacity, and variation in the quality of services delivered.

4. Human resource capacity as assessed by the size of the workforce, its knowledge, skills and level of motivation.

The size of the ICDS workforce is insufficient to accomplish the quantity and quality of work required to fulfil the ambitious ICDS mandate. The volume of work is too large for the sanctioned staff to accomplish with the resources and time at their disposal, the burden of non-ICDS tasks and the persistently large proportion of vacancies. While the ICDS Mission will provide additional staff at all levels, thus increasing the size of the workforce, it will also introduce additional activities to be implemented at the AWC level with no additional staff in the vast majority of the AWCs, thus further raising workloads. Given the absence of any functional or job analysis, it is not possible to assess the adequacy of the new norms, and the

extent to which the size of the workforce will be optimized. On the other hand, in the NRHM, the size of the workforce appears largely adequate and the vacancies are minimal.

A vast majority of the ICDS and NRHM workforce at all levels – field functionaries, managers and leaders – do not possess the necessary knowledge and skills to effectively and efficiently perform the functions expected of them. Workers lack the critical knowledge and skills to satisfactorily deliver nutrition services, and managers lack the management skills to manage the large and complex operation. The evidence indicates that the AWWs' knowledge of nutrition bears a positive association with the mothers' practice of appropriate child care behavior, and with the use of AWCs. These findings are significant – indicating that enhancement in the AWWs' knowledge could improve the child care practices of mothers, upgrade anganwadi services, and thus contribute to improving child nutrition outcomes. However, the knowledge and skills of the NRHM functionaries, especially those related to nutrition, are not adequate.

The ICDS recruitment policies and criteria are not suited to recruiting people with the right kind of skill mix, thereby placing the full onus of skill development on in-service training. The capacity of the training system to provide to the ICDS workforce timely, adequate, relevant and high-quality training has been severely constrained. The lack of a conceptual framework and vision, inadequate strategic planning and resource mobilization, and sub-optimal management are the key factors that have stalled the capacity of the training system in building adequate knowledge, skills, and competencies of the ICDS workforce. The ICDS acknowledges most of the issues outlined and is poised to undertake a training strengthening effort, including the World Bank supported ISSNIP.

The motivation levels of functionaries in the ICDS as well as in the broader health system are generally not high and are a constraint to optimal performance. The key factors contributing to the low motivation levels include: (i) the authoritarian top-down culture; (ii) lack of recognition, especially by managers who do not possess the skills to provide positive feedback; (iii) apathy at all levels to resolve problems; (iv) poor work conditions; and (v) the lack of adequate resources required to accomplish their tasks. It is clear from the dissatisfaction expressed regarding these factors that addressing them would result in a significant improvement in morale and motivation of the workforce, and hence in their performance.

The restructured ICDS proposes to undertake several actions to strengthen human resources (HR), such as developing a comprehensive human resource policy, creation of a dedicated HR cadre for the ICDS, career progression mechanisms, and benefits such as pension schemes. Strengthening the HR policy and management to address constraints such as work overload at the operational level, e.g., for Child Development Project Officers (CDPOs), supervisors and AWWs, and determining optimum number of positions based on a full functional analysis of all job categories is critical. This will strengthen the ICDS' service delivery and contribute to its results.

5. Monitoring, evaluation and information management capacity constraints as assessed in terms of the existence and quality of a conceptual framework, availability of relevant and reliable data and use of information.

The capacity of the ICDS and the NRHM to generate, analyze and use information to control operations and track progress towards nutrition outcomes has many constraints. The ICDS

lacks a conceptual Monitoring and Evaluation (M&E) framework, and the existing framework is inadequate. No qualitative information is gathered and the evaluation component of the ICDS M&E remains weak. While a considerable amount of data is generated, there are gaps that constrain comprehensive monitoring. In particular, the data generated falls short of providing the information needed to track the most crucial nutrition services and outcomes, and the accuracy of the collected data is below standard. There is inadequate analysis of the generated information and its use is marginal.

The M&E system of the NRHM does not mention nutrition in its conceptual framework. Although the two key components of the NRHM monitoring system relevant to nutrition, namely the Health Information Management System (HMIS), and the Mother and Child Tracking System (MCTS) capture some nutrition indicators, their conceptual frameworks are silent on nutrition. Concerns have been expressed regarding the accuracy of the NRHM data as well as the volume of data collected. The analysis and use of nutrition related information captured by the NRHM is limited.

The restructured ICDS, the revised Management Information System (MIS) being rolled out, and the World Bank supported ISSNIP have set the stage for a conceptually clear and strengthened ICDS M&E framework. The ICDS Mission suggests a more robust M&E framework, and expands its scope to include research and other information. The revised MIS being rolled out captures information that is more relevant to exercise control and track outcomes, provides clear guidance to capture and report data which is likely to improve data accuracy and has well-conceived data collection, management, processing and analysis systems to promote greater usage. While somewhat information-heavy, the revised MIS does reduce the volume of data currently collected and the associated opportunity cost. The HMIS and MCTS could potentially be expanded to incorporate nutrition related information critical to tracking and improving maternal and child nutrition.

Recommendations

While many recommendations have emerged from the study to strengthen the capacity of the nutrition system, this section includes only those that can be game changers. These are:

1. A dedicated organizational unit -- separate from that of the ICDS, or other nutrition programs -- appropriately staffed, resourced and empowered, should be created in the MWCD, GoI to provide national direction for nutrition, lend leadership for nutrition to other sectors, organize policy discussions, and evaluate the impact of policies. This will require providing the necessary technical and financial resources to enable it to exert the needed stewardship for nutrition.
2. A leadership development program should be instituted for leaders and top managers of the ICDS as well as the NRHM. For leaders, the content should include 'how to lead', 'how to develop conceptual frameworks and models', 'how to formulate vision statements, policies and strategies', and the importance of organizational culture. The management development program, applicable for all senior and mid-level managers at the national, state ICDS and district levels, should include the key management skills, such as 'how to set result-based objectives', 'how to develop operational plans', and the techniques for key analyses such as workload, feasibility, costing and work process. Simultaneously, all managers should be incentivized by their supervisors to use these skills.

3. Major reforms in the ICDS HR and training systems are required. Piecemeal strengthening of activities around the margins will not help. The following points are critical to the reform:

3.1. Examination of the existing ICDS staffing norms, including those proposed under the restructured ICDS is essential. This must be based on three key analyses, namely: (i) productivity analysis for each principal procedure undertaken by the functionaries such as supervision of an AWC, growth monitoring, and home visits; (ii) job analysis of each job, based on a clear conceptual framework of the role of each; and (iii) a systematic workload analysis.

3.2. The ICDS should consider bold revisions to its recruitment policies and criteria. For example, a minimum level of knowledge and skills ought to be specified as prerequisites for each position. This will result in the recruitment of better qualified and trainable staff, requiring shorter and less steep learning curves, and make the ICDS training more effective and less resource intensive.

3.3 Developing a well-conceived and full conceptual framework for the ICDS training function and system is essential to provide the building blocks necessary for systematic reform. Inter alia this will include: (i) Establishing 'proficient or skilled worker' standards for each category of the workforce based on a job content analysis; (ii) determining the skills gap, by mapping the skills at entry through a Training Needs Assessment (TNA) against the established standard; (iii) institutionalizing an appropriate quality assurance system that defines the requisite standards of quality across the system; (iv) incorporating a robust M&E system to routinely monitor key processes, trainee databases, and training outcomes; and (v) exploring strategic options to clear the large training backlog and train the many entrants expected to enter the ICDS workforce.

All this will be possible only by creating dedicated organizational homes for the HR and training functions. Each should be headed by a high-level manager with overall responsibility to change the face of HR and training in the ICDS. The HR reform will also enable a paradigm shift from the present personnel management thinking into the more modern HR development thinking. This essentially means moving from a view of personnel management as a marginal element in corporate or organizational planning towards the view that HR management is a central part of it.

Chapter 1

Introduction

1. Background and rationale for the study

1.1. **India has a five decade long history of programs to deliver nutrition services at the community level to improve the nutrition status of women and children.** Since the early sixties, India has had a plethora of national schemes for providing maternal and child nutrition services. The Applied Nutrition Program initiated in the early sixties, followed by other programs introduced in the seventies, such as the Composite Nutrition Program, Special Nutrition Program and the Balwadi Feeding Program, continued to provide nutrition services until the nineties. While the package of services, the scale, and the institutions for program delivery varied from program to program, each one had a supplemental feeding component and most incorporated some aspects of nutrition and health education. However, despite being national in nature and covering most states, actual coverage of the programs was patchy. Alongside these nutrition schemes, India, since the seventies, has also implemented national programs -- vitamin A supplementation, iron-folate supplementation and salt iodization -- to address micronutrient undernutrition. Coverage has also been a major issue with the micronutrient programs. With the advent of the ICDS in 1975, all earlier schemes were phased out or merged with the ICDS, and the micronutrient supplementation programs continue through the maternal and child health programs MOHFW, (GoI), earlier the Reproductive and Child Health (RCH) program and now through the NRHM.

1.2. **India has an enabling nutrition policy framework and the GoI has programs in all areas critical to addressing malnutrition. Yet, the progress in reducing undernutrition has been disappointing.** India's nutrition policy framework includes both direct and indirect nutrition interventions. In the direct category, where the ICDS and the NRHM are the main government instruments, supplemental feeding, reducing micronutrient deficiencies, food fortification and early child development (ECD) are addressed, while the indirect interventions include food security, health care, women's status and education, communication and safety nets. Similarly, national programs that address the other critical determinants of nutrition such as food security, water and sanitation, health care, and women's empowerment also exist. However, these programs, individually and collectively, have not been able to make a significant dent in reducing undernutrition. With one-third of the country's children born with low birth-weight, 43 percent under-fives being underweight, 48 percent being stunted and 20 percent being wasted, almost 75 percent under three are anemic (NFHS 3, 2005-06), 62 percent deficient in vitamin A (WHO, 2009) and over 13 million infants remain unprotected from iodine deficiency disorders (UNICEF, 2009). Despite the many programs in existence and the major investments, progress in reducing undernutrition has been poor.

1.3. **The capacity of institutions plays a key role in their ability to fulfil their mandate and achieve the intended outcomes.** The implementation of policies and programs can only be as good as the capacity of institutions responsible for them. The issues of capacity and the factors constraining capacity are especially crucial for nutrition services, given the inter-sectoral nature of the determinants of nutrition and that institutional arrangements for service delivery generally involve multiple institutions, often across different sectors, with the need to coordinate actions and interventions to ensure that they reach the intended beneficiaries with the full package of services, so as to achieve for nutritional impact. A World Bank

analysis, using data from the NFHS 3, 2005-06 and the HUNGaMA Survey 2011, indicates a strong association between the prevalence of stunting in children and their adequacy in terms of the triad of the determinants of nutrition at the immediate level, namely food intake, care for children and women, and environmental health. The analysis showed much higher stunting rates in children who do not have feeding, care or environmental health in adequate measure, compared with those who are provided all of these adequately (50.5 percent v/s 19 percent⁵). The analysis further indicates that according to NFHS 3, 2005-06 data, only 1.2 percent of the children are adequate in all dimensions, 63.4 percent are inadequate in all dimensions, and the remainder are adequate only in one or two measures. High levels of these inadequacies in children are also demonstrated by the data from the HUNGaMA Survey 2011 across the surveyed districts (Kathuria and Newman, 2014). This is only one example of the poor coverage of programs and the lack of effectiveness in reaching children with a package of services that address the key determinants of nutrition. One of the principal reasons that determine the coverage and effectiveness of programs is the overall capacity of institutions responsible for them, including – their leadership and management capacity, human resource capacity, capacity to manage financial, physical and information resources, and the capacity to deliver good quality services. A lack of these can limit the ability of organizations to fulfill their mandate, and compromise the success of the policies, strategies and programs. It is thus necessary to assess the capacity of the institutional arrangements that exist for the delivery of nutrition services in India.

1.4. The ICDS and the micronutrient programs delivered through the health system form the mainstay of India's nutrition service delivery system and are India's most significant investments in nutrition. India is just embarking on the development of institutional arrangements for multi-sectoral coordination for nutrition.⁶ So far, the two main programs and institutions involved in the delivery of nutrition services are the ICDS, implemented through the MWCD, GoI and the related departments in the states, and the NRHM, implemented by the MoHFW, GoI. This study therefore focuses on the capacity of the ICDS and the units in the NRHM that deliver nutrition and nutrition related services. Since the inception of the ICDS in 1975, India has steadfastly pursued its expansion in order to achieve national coverage– scaling up from 33 blocks in 1975 to over 7,000 projects in 2013. The most rapid expansion of the ICDS happened during the period 2005-2012 when its geographical coverage expanded from 700,000 habitations to over 1.3 million, thereby covering almost all habitations in the country. The ICDS has undergone major restructuring in the year 2012 and has received a large infusion of financial and human resources. To strengthen the implementation and impact by sharpening its strategies and implementation approaches, financial resources have increased from Rs. 444 billion in the 11th five year plan to an allocation of Rs. 1,774.6 billion during the 12th five year plan; and an additional 500,000 employees are added to its existing strength of 2.7 million⁷ employees.

1.5. While several evaluations document the weaknesses in design and implementation of the ICDS and the health sector, a comprehensive capacity assessment of its institutions does not exist. Several program evaluations have identified the weaknesses in design and, most importantly, in the implementation of nutrition services. The ICDS program itself has been the subject of a large number of internal and external reviews. While a large body of documentary evidence pertains to one or two aspects of the two

⁵ Demonstrated by NFHS-3 data analysis.

⁶The inter-ministerial group on ICDS Restructuring, chaired by Dr (Ms) Sayeda Hameed, Member, Planning Commission, included the GoI ministries of MWCD, MoHFW, Drinking Water and Sanitation, Panchayati Raj, and representatives of state governments and the Prime Minister's Office.

⁷ Includes anganwadi helpers, AWWs, supervisors, CDPOs and DPOs.

programs, a comprehensive institutional capacity assessment of the ICDS and NRHM programs, particularly with respect to nutrition services, has not yet been undertaken and is a large gap. The present study is a first step in fulfilling this gap and adds value insofar as it uses an operational and management approach to capacity assessment that looks at capacity not in terms of what it is, but in terms of the factors that influence it. It lists the factors that must be observed for an agency or system to have full capacity. Such a definition is better able to identify constraints to capacity and the measures aimed at building it.

1.6. The recent surge in investment and attention to nutrition programs, primarily the ICDS and other programs based on the ICDS platform, makes a capacity assessment timely and relevant. During the course of this study, a number of developments led to an expansion of the landscape of the institutional arrangements for nutrition service delivery. The most significant developments include: (i) consensus on a new national operational conceptual framework, namely ‘Addressing India’s Nutrition Challenge’, outlining the key nutrition issues including those within the purview of the ICDS and those that are multi-sectoral and currently beyond the ICDS, while also proposing options to effectively address these; (ii) the first meeting of the Prime Minister’s National Nutrition Council in 2010 and its recommendations that charted the key directions for nutrition; (iii) restructuring and strengthening of the ICDS in 2012; (iv) launch of two additional nutrition programs in 2010 to be implemented using the ICDS platform, namely a pilot conditional cash transfer scheme for pregnant and nursing mothers in 52 districts, the IGMSY and SABLA, an empowerment program for out-of-school adolescent girls in 200 districts that, *inter alia*, provides nutrition counseling, food and micronutrient supplements; (v) approval of a multi-sectoral nutrition program in 200 high malnutrition burden districts in 2013; and (vi) launch of World Bank supported ISSNIP in 2013. Underlying all these efforts has been a very serious attempt to identify the weaknesses in the current nutrition system, adequately address them and increase the resource allocation for nutrition. All these efforts to enhance nutrition service delivery are linked critically to the ICDS platform, thus making the assessment of capacity of the ICDS highly relevant and timely.

2. Purpose and objectives

The purpose of this study is to undertake an institutional capacity assessment of the nutrition service delivery system in India, with a view to identifying the key capacity constraints, as well as the necessary institutional reorganization, change and institutional strengthening critical to address them. Strengthening capacity is critical to achieving effective delivery of nutrition services and improving nutrition outcomes.

The key audiences for this study are policy makers, programmers, primarily the MWCD -- the nodal department for nutrition and implementer of the ICDS, the ICDS training institutions, the NRHM and the MoHFW, GoI and associated institutions, the Planning Commission, the World Bank, other development partners, civil society organizations and stakeholders with an interest in nutrition.

3. Scope of this capacity assessment

For the purpose of this study, the *nutrition service delivery system* is defined as the system, or set of systems to address undernutrition, including its actors, institutions, and resources that deliver direct nutrition interventions. The institutional capacity assessment will primarily

focus on the nutrition system comprising two principal channels of the ICDS and selected components of the health system.

3.1.1. Whose capacity is assessed and at what levels?

The study focuses on assessing the capacity of the principal channel or system delivering nutrition services to pregnant, nursing mothers and children under three. This system involves two agencies: the ICDS, a program implemented nationally by the Child Development Division of the MWCD, GoI, and the NRHM, a program of the MoHFW, GoI.

While all nutrition services are delivered at the village level, primarily at the anganwadi centres (AWCs), the capacity to deliver them depends not only on the centers but significantly also on the design and management of these services at the national and state levels, district and sub-district levels. The study therefore assesses capacity at all levels with respect to what each is required to do (see Table 1.1).

Level	ICDS, MWCD, GoI	NRHM, MoHFW, GoI
National	Child Development Division	Maternal and Child Health Division and NRHM Directorate
State	ICDS Division, Department of WCD or Social Welfare	RCH unit, State NRHM
District	District Project Office (DPO)	District RCH Office in the Office of Chief Medical Officer or NRHM District Office
Block	CDPO	Block Medical Officer
Sub-block	Sector Supervisor	Lady Health Visitors, Primary Health Center
Community	AWW	Auxiliary Nurse Mid-wife (ANM) and ASHA worker

3.1.2. Capacity to do what?

Of the many activities and functions undertaken by the two agencies mentioned, the study focuses only on the capacity of the ICDS and the NRHM to deliver the nutrition services for which each is responsible. This includes:

- Supplementary feeding
- Health and nutrition education
- Growth monitoring and promotion
- Immunization
- Ante-natal services for pregnant women
- Health check-ups and referrals
- Micronutrient supplementation

3.1.3. Which capacity areas will be assessed?

Of the operational capacity areas outlined in the conceptual framework presented below, the study focuses on assessing the constraints in the following areas:

- Division of labor in the nutrition system
- Leadership

- Human resources matching its operational requirements, their management and efficient utilization, including training as its sub-system
- Monitoring, evaluation and the management of information
- General management practices -- supervision, accountability and work practices

4. Methodology

4.1. Conceptual Framework

4.1.1. Defining capacity: For the purpose of this study, capacity is defined in operational terms. This definition looks at capacity not in terms of what it is, but in terms of the factors that influence it. It lists the factors that must be observable if an agency or a system has full capacity. Such a definition is more helpful in identifying constraints to capacity as well as measures aimed at building capacity. The operational definition of capacity is:

A public sector agency has the capacity to deliver services if, and only if:

- It has effective leadership and management;*
- It has an optimal division of labor and structure within it;*
- It has financial resources matching its mandate and manages and utilizes them fully and efficiently;*
- It has human resources, physical resources and information matching its operational requirements and manages and utilizes all of these fully and efficiently; and*
- Its personnel follow appropriate work practices and processes.*

4.1.2. Indicators of capacity constraints: Constraints to capacity in each of these areas and the indicators for each constraint used in this study are listed in Table 1.2.

Constraint	Indicator
Division of labor in the nutrition system	
Lack of functional leadership: important functional areas are under-developed, under-performed and under-monitored	No dedicated organizational homes in the agency's structure, and functional overload
Lack of unified responsibility, accountability for operations and coordination	Split, fragmented and misplaced functions
Lack of clarity in allocation of responsibilities and authority	Lack of role clarity, role conflicts, overlapping and duplicate operations, and role abdication
Leadership	
Unclear or sub-optimal direction for action	Poor quality of conceptual framework, vision, mission, policies and strategies for the agency and its functional and organizational units
	Lack or inadequate prioritization of major courses of action at all levels
Imbalance between continuity and change in direction	Too frequent changes in direction, or vice versa – too slow changes relative to changing circumstances
Agenda overload at leadership and management levels	Too much time taken in attending to issues and making decisions
	Too few management levels in the agency's organizational structure
Leaders and managers not in place	Large number of vacant senior management level positions, or staffed by acting managers
General management practices	
Weak programming planning and lack of objectives	Poor or non-existent operational plans; limited or no attention to setting of objectives

Lack of staff empowerment	Delegation of authority absent and no attention paid to staff development
Weak coordinating action	Poor coordination
Weak supervision	Supervision lacking in frequency, intensity, quality and in support aspect
Lack of or inadequate accountability	Staff not held accountable for their performance and conduct
Poorly designed work processes and procedures	Results of step-by-step analyses in delivery of key services absent
Human resources	
Size of workforce	Sanctioned staff compared with needed staff, based on work load analysis
	Staff in position compared with number sanctioned
	Ratios of subordinates to managers
Shortage of skills and inadequate levels of competency among staff	Knowledge and skills of staff relative to the knowledge and skills required for their jobs
	Actual education and skills profile of staff at entry compared with required profile, based on job analysis
	Quantity and quality of training received in service
Poor motivation of staff	Care about and involvement in work, such as attempts to take initiative, attempts to resolve issues, frequency of incomplete work, frequency of calling in sick or coming late to work
Financial resources	
Weak capacity to project revenue and expenditure	Budget overruns and under-spending; excessive end-of-financial year spending
Weak capacity to mobilize financial resources and adjust mandate to fit available resources	Overall financial resources insufficient to meet operational requirements
Resources not allocated in line with operational requirements	Mismatch between operational requirements and financial resources available to carry out operations
Unreliable, irregular flow of funds from center to field offices	Interrupted service delivery
Expenditure not well controlled and contained	Lack of service by service-cost analyses
	Significant differences in unit costs of delivered services among different locations
	Leakages of funds and goods
Physical resources	
Quantitatively inadequate provision of infrastructure, equipment and supplies	Approved norms and standards for provision of physical resources do not compare well with desired norms and standards based on physical resources needs analysis
	Actual provision not in line with approved norms and standards
Qualitative inadequacies in resources provided	Differences between desired and delivered specifications
Poor condition of infrastructure and equipment	Under-utilization of resources and poor quality of service delivered
	Existence of service agreements with suppliers
	Existence of any form of asset management
Information resources	
Weak conceptual framework for information function	Lack of or inadequate conceptual framework
Data collected is not relevant and unreliable	Information available does not match information needed; data collected not accurate and aggregated data not available in time
Poor data analysis and use of data collected	Limited or no analytical work carried out on data collected and information not used for decision-making and development of policy or strategy

4.2. Data collection methodology

A comprehensive list of questions to capture the indicators outlined in the conceptual framework was developed. Data was collected through the following four channels:

- Review of documentary material
- Semi-structured interviews
- FGDs
- Systematic observation of selected service delivery

The interview and FGD questionnaires were developed and translated into Tamil for Tamil Nadu and Hindi for Bihar. Two teams, comprising one team per state and consisting of one supervisor and two researchers experienced in conducting FGDs, were trained in the use of the instruments, and collected the data over a 15-day period in each state. The staff of the World Bank visited both states to guide and supervise the work and conduct the senior level interviews. The data with which to address the capacity constraints was collected at the national level, and in each of the two states data was collected from two blocks and two villages. The states and districts selected were drawn from those surveyed in the HUNGaMA Survey, 2011. Since much of the evidence is drawn from available publications, the purpose of the FGDs was to support the findings through primary data.

The HUNGaMA Survey, 2011 collected district level data from 112 rural districts in the country that were selected on the basis of a child development district index developed for UNICEF, India in 2009 for malnutrition and a number of other indicators. A total of 100 rural districts were selected from the bottom of this index, located in six states, namely Bihar, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, and Uttar Pradesh and are referred to as the 100 focus districts in the HUNGaMA Survey, 2011. In addition, 12 rural districts ranked near the top of the index were also selected for data collection. Six of the top ranking districts are the top ranking rural districts in the six states (one district per state) with the 100 focus districts; the remaining six are the top ranking rural districts, two each from Himachal Pradesh, Kerala and Tamil Nadu, the three states whose rural districts led the all-India index ranking.

For this study, using the HUNGaMA sample, the following states and districts were selected for collecting primary data:

- (a) States: Tamil Nadu and Bihar, representing one top ranking and one bottom ranking state; and
- (b) Districts: (i) From Bihar, Munger (top ranking) and Jamui (focus district); and (ii) from Tamil Nadu, Kancheepuram (top ranking). Since, the HUNGaMA Survey, 2011 included only the two top ranking districts for Tamil Nadu, Villipuram was selected as a not so well performing district, in consultation with the ICDS officials in the state.

The blocks and AWCs, selected in each top ranking district for Tamil Nadu and Villipuram, were based on the criteria of one good and one poorly performing, from the list indicated by the ICDS officials at that level.

The interviews and FGDs conducted, processes observed and documentary material reviewed were as follows:

Semi-structured interviews:

- Central level: Joint Secretary, Child Development (CD) Division, MWCD, GoI; Joint Technical Advisor, Food and Nutrition Board; Ministry officials (ICDS Monitoring & Evaluation unit and CD Bureau); Assistant Commissioner, Maternal Health Division, MOHFW, GoI; Deputy Commissioner, Child Health, MOHFW, GoI; Advisor (Nutrition), Director General of Health Services (DGHS), MOHFW, GoI; Executive Director, National Health Systems Resource Center (NHSRC); Advisor, NHSRC; Joint Director (Training), National Institute of Public Cooperation and Child Development (NIPCCD).
- State level: Secretaries and Directors of the ICDS at the state level, and of the DOHFW, GoI and the NRHM.
- District level: District Project Officer, ICDS and District Managers, Chief Medical Officer (CMO) and District Head, NRHM.
- Others: Tamil Nadu Integrated Nutrition Project (TINP) officials.

FGDs were conducted with the following groups:

- Mothers' groups in the community
- AWWs
- Supervisors
- CDPOs
- ASHA
- ANMs
- Block Medical Officers (BMO)

Systematic observation was conducted for the following process:

- Village Health and Nutrition Day (VHND)

Documentary material

- Statistics about feeding days and, stock-outs
- Statistics about budgets and costs
- Statistics about HR
- Statistics about training and training infrastructure
- Description of information being collected and available for use
- Vision, mission, and strategy documents
- Evaluation reports
- Unit Terms of References (TORs) and job descriptions
- Government office orders and guidelines from the ICDS and the NRHM
- Published papers and research studies.

4.3. Data analysis and reporting

The data collected was collated and analyzed to identify the key capacity constraints, and proper measures to address the constraints. New statistical analysis was carried out using HUNGAMA Survey, 2011 data to determine the association and correlation related to the operational areas of capacity that were possible with the data.

5. Structure of the report

The report consists of the following seven chapters. The present chapter provides the context and the rationale for the study, and outlines the methodology. Chapter 2 describes the nutrition system in detail and discusses the capacity issues related to the division of labor (DoL) between the two primary programs of the nutrition system and within the ICDS. Chapter 3 delves into the factors that constrain leadership capacity at all levels Chapter 4 discusses the key capacity constraints related to HR that limit the effective delivery of nutrition services. Chapter 5 discusses the training system as a sub-system of HR and its capacity constraints, and Chapter 6 covers the capacity assessment pertaining to monitoring, evaluation and management of information in the nutrition system. Chapter 7 discusses the capacity constraints related to GMPs in the ICDS, especially focusing on supervision, accountability and work practices and procedures.

Each chapter follows a similar structure. After briefly introducing the topic of discussion, it presents a detailed conceptual framework for capacity assessment with indicators used to assess capacity, discusses the findings and offers suggestions to address the capacity constraints identified. Tables, figures and boxes are included to highlight time-trends and findings, good practices, and draw attention to specific issues.

A complete bibliography is provided at the end of the report.

CHAPTER 2

The Nutrition Service Delivery System and Division of Labor within the System

Introduction

The term nutrition service delivery system used in this capacity assessment study refers to the system or set of systems that deliver direct nutrition interventions to mothers and children under three to address undernutrition. It includes the actors, institutions and resources within the system that have a bearing on and reflect the capacity. Direct nutrition interventions are delivered through two principal channels, namely the ICDS and selected components of the health system. This chapter gives a brief description of the organization of the system, its role, functions and services – vertically from the national to the village and grassroots level, and horizontally at the national level for leadership, policy and strategic direction.

This description is followed by a detailed analysis of the DoL between the ICDS and the NRHM, the two primary programs that deliver nutrition services, and the manner in which it enhances or constrains capacity for the delivery of nutrition services.

For any service to be delivered effectively and efficiently, it is critical that: (i) all key functions⁸ associated with its delivery are identified; (ii) each functional area is adequately identified, developed, executed and monitored; and (iii) there is clear division of responsibilities, with coordination between the agencies delivering the service.

The lack of full functional clarity and sub-optimal design of work and its division among work units or organizations can result in poor performance and significant inefficiencies. Thus, it can be a capacity constraint.

In the context of delivery and outcomes of nutrition services in India, where the ICDS and the NRHM have key roles, an examination of the division of functions and their coordination is significant as this could be a capacity enabler or constraint. ‘Convergence’ of the ICDS and health services has remained elusive, despite several efforts by both programs to bring about effective ‘convergence’. Given this background, the present chapter seeks to answer the following broad questions:

- 1. How does the organization and distribution of functions between and within the two primary agencies responsible for delivery of nutrition services enhance or constrain the capacity of the system to deliver these effectively?***
- 2. What are the possible ways of addressing these capacity constraints?***

The conceptual framework, following the description of the nutrition system, examines the key factors associated with the DoL, between the ICDS and the NRHM, and within the ICDS that constrain capacity of the system, and suggests ways of overcoming these constraints. However, as the delivery of nutrition services by the NRHM forms only a small part of its

⁸A function is defined as a cluster of tasks that are linked together to produce an integrated, defined output or result. All tasks must be present for the output or result to be produced and all are often managed in a unified way in one organizational unit (or a cluster of units). A task is defined as a planned sequence of interlinked activities, the outputs of which serve as inputs to the performance of a function.

package of services, a full examination of DoL in the NRHM is outside the scope of the study. Thus, within agency DoL is limited to the ICDS.

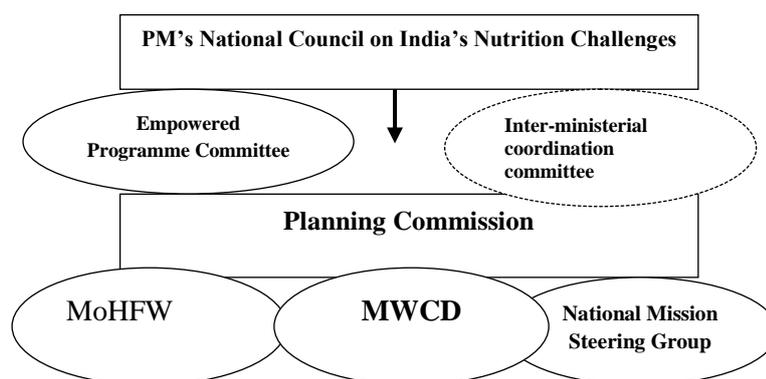
The Nutrition Service Delivery System

1. Key national level institutions for nutrition policy and programs (Figure 2.1).

1.1 The Prime Minister’s National Council on India’s Nutrition Challenges is the highest body for policy direction, review and coordination between multiple ministries concerned with nutrition outcomes. Constituted in 2008, the council is chaired by the Prime Minister and its members include the ministers of nine ministries⁹ with a key sectoral role for nutrition, the deputy chairperson of the Planning Commission (PC), GoI and representatives of civil society. Secretaries of the related line ministries are special invitees to the council. The council first met in November 2010.

In addition, a National Advisory Council (NAC) chaired by the president of the political party heading the national government has been providing policy direction and advice on programming of resources, focused on the development sector, since 2004. This supra-government advisory body consists mostly of eminent development and human rights experts and individuals from civil society organizations.

Figure 2.1: Key national level institutions for nutrition policy and programs



1.2 The Planning Commission, GoI plays a key role in determining government policies, priorities, strategies and allocation of resources. Also chaired by the Prime Minister, the PC set up in 1950 is responsible for developing five-year plans for the government, reviewing central and state annual plans, and determining the allocation of resources to the ministries and states. The PC has several divisions, with nutrition coming under two of them, namely health, family welfare and nutrition and, secondly, women and child development. The deputy chairperson is usually an eminent economist, social scientist, retired senior bureaucrat or senior political leader, its members are political appointees, generally eminent individuals of repute from civil society or former bureaucrats.

1.3 The MWCD is the nodal ministry for nutrition in India. The MWCD, GoI has overall responsibility for nutrition in India, with the mandate to: (i) set nutrition policy

⁹Human Resource Development; Agriculture, Consumer Affairs, Food and Public Distribution; Finance; Health and Family Welfare; Women and Child Development; Rural Development; Urban Development; Information and Broadcasting; and Panchayati Raj.

directions and programs; (ii) coordinate with other ministries on action relating to nutrition in their realms; (iii) undertake advocacy and education relating to nutrition; (iv) implement a portfolio of nutrition programs, the largest being the ICDS which is the national flagship program. The other programs with nutrition or nutrition-related components include IGMSY and SABLA, a national Information, Education and Communication (IEC) campaign to create awareness about nutrition and a multi-sector program in 200 high malnutrition burden districts. Additionally, the Food and Nutrition Board (FNB), a technical body under the MWCD, GoI provides some technical support to the ministry in nutrition related functions and in coordinating the implementation of the national nutrition policy.

1.4 The MoHFW, GoI is the other key ministry that, together with the ICDS delivers several nutrition services. The MoHFW, GoI with the MWCD, GoI oversees the delivery of health and nutrition services through the ICDS platform and mechanisms such as VHNDs that enable joint service provision by ICDS workers and health workers at the village level.

1.5 Institutional arrangements for multi-sectoral nutrition action and coordination have recently been defined. The National Mission Steering Group (NMSG) and the Empowered Program Committee (M-EPC) are the highest administrative and technical bodies for planning, implementation, monitoring and supervision of the key nutrition programs, namely the ICDS Mission and the recent Multi-sectoral Nutrition Program. An Inter-Ministerial Coordination Committee (IMCC) headed by the Cabinet Secretary is proposed to be created for coordinating nutrition matters at the national level.

2. The vertical organizational structure of the nutrition service delivery system. The set up of the vertical structure from the national level to the village level is described briefly below (Figure 2.2)

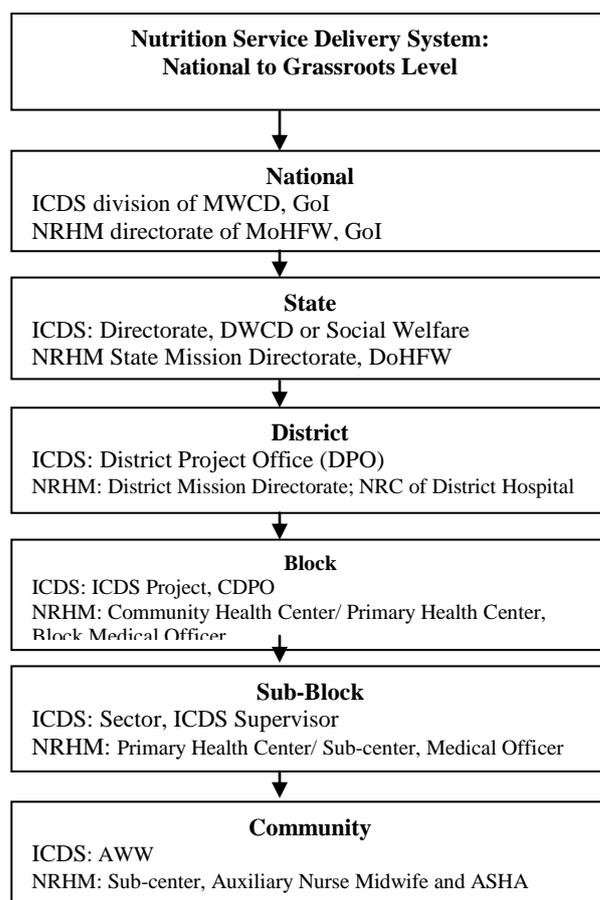
2.1. The MWCD, GoI and the MoHFW, GoI, the two ministries critical to the nutrition sector, operate at all levels as two different entities, as do their respective programs, namely the ICDS and the NRHM. At the national level, the ICDS is the responsibility of the MWCD, GoI, assigned to the Child Development (CD) division headed by a joint secretary (JS). The division and the JS handle programs and responsibilities besides the ICDS. The ICDS was recently restructured in 2012 for implementation in mission mode and full-fledged mission directorates at the national and state levels are to be established. The NRHM is the responsibility of the MoHFW, GoI and implements several health services of which nutrition services form a small component. It is headed by an additional secretary who is designated as its mission director. One official in the child health division of the MoHFW is designated as the nodal officer for nutrition.

At the state level: The ICDS in most states lies under the Department of Women and Child Development (DWCD) through which it is implemented. However, some states have placed the ICDS under their departments of social welfare. Nevertheless, in all states, the state director of the ICDS is responsible for managing the program and is generally drawn from the Indian Administrative Service (IAS) or the Central Services. Below the director are officials responsible for functional areas such as monitoring, training, IEC and administration but there are no technical persons either for nutrition or for Early Childhood Care and Education (ECCE).

In the states, the department of health and family welfare is headed by the Secretary (Health) and the NRHM has an executive director (ED) of the state health society (an IAS officer of

middle level seniority), who heads all H&FW operations under the program. Below the ED, NRHM are a number of technocrats (technical personnel, who are all doctors by training) with the responsibility of leading individual national health programs. The components of H&FW relevant to nutrition are covered under the maternal and child health program. In some states, under the ED there is a further position of Director, Public Health or Primary Health, NRHM, responsible for implementation of all health programs in the field.

Figure 2.2: The vertical organizational structure of the nutrition service delivery system



At the district level: The ICDS implementation is overseen by a district program officer (DPO) who reports to the State Director, ICDS. Some states also have a regional deputy director (RDD) between the district and state levels and three or four DPOs report to an RDD (who is a senior DPO but not an IAS officer). The staffing for the district project office is minimal, wherein the DPO's administrative support consists of one office superintendent, one statistical assistant, one accountant, and one clerk.

At the district level, the district health mission is headed by the chairperson of the zila parishad with the district collector as its co-chair and chief medical officer as mission director. To support the district health mission, every district has an integrated District Health Society (DHS). The operations of the health department are led by the Chief Medical Officer (CMO), usually the senior most doctor in public service in the state. In several districts, there are nutrition rehabilitation centers (NRCs), special units located at the district hospital for the treatment of severely acute malnourished children. The medical superintendent of the hospital has overall responsibility for the NRC activities.

At the block level: The CDPO is in charge of ICDS project with responsibilities for planning, managing, organizing and implementing the ICDS and the delivery of its services. S/he also plays the role of an educator and communicator for the staff and community. The ICDS supervisors (usually organized into a sector) support and oversee the management of approximately 25 AWCs, each of which is the primary service delivery unit of the ICDS program and caters to a population of approximately 400 to 800. Each AWC has an AWW assisted by an AWH, both being local women volunteers and not government employees and are each paid an honorarium. The BMO is in charge of health functions at the block level including the delivery of primary health care which consists of a three-tier structure, namely the sub-center which is the most peripheral and the first contact point between the primary health care system and the community, catering to a population of 5,000. The Primary Health Centers (PHCs) cater to a population of 30,000 and a community health care center (CHC) which serves as the referral for PHC and caters to a population of 120,000. From the health department, at the village level, it is the ASHA workers, who deliver health and nutrition related services. The ASHAs are women from the community who act as link workers and are trained in some maternal and child health issues. They are guided by ANMs who are health workers positioned at the PHC. While the ASHAs are paid performance based incentives for specific tasks performed, the ANMs are paid employees of the health department.

3.1 Four of the six ICDS services are delivered in coordination with the health sector. While nutrition as a sector is the responsibility of the MWCD, GoI, the implementation and provision of four key ICDS services is shared between the ICDS and the NRHM (Table 2.1). In addition, the NRHM within its overall maternal and child health mandate delivers several direct nutrition services such as iron-folic acid (IFA) supplements to pregnant women, Vitamin A and IFA supplements to young children, nutrition and health education, and treatment and management of severe acute malnutrition (SAM) at facilities including Nutrition Rehabilitation Centers (NRCs). It is therefore important that the division of functions and coordination between the two programs maximize mutual support to improving nutrition outcomes and optimizing efficient use of resources.

Table 2.1: Nutrition and health services delivered by the ICDS and the NRHM

Service	Target group	Service provider
Supplementary nutrition	Children below six years: pregnant and lactating mother (P&LM)	AWW and AWH
Immunization*	Children below six years: P&LM	ANM/MO
Health check-up*	Children below six years: P&LM	ANM/MO/AWW
Referral services	Children below six years: P&LM	ANM/MO/AWW
Pre-school education	Children between 3-6 years	AWW
Nutrition and health education	Women between 15-45 years	ANM/MO/AWW

* AWW assists ANM

This description of the system is followed by a discussion of capacity issues related to the DoL between the ICDS and the NRHM. A presentation of the framework for the DoL analysis then leads to the key findings and recommendations.

Analytical framework and capacity assessment indicators

For optimum productivity and efficiency of an organization, all functions and tasks required to fulfil its mandate must be fully identified, developed and grouped appropriately, and responsibilities of these be appropriately assigned to staff with appropriate skills. Table 2.2 lists the operational indicators used to assess the effectiveness of the division of work among organizations or organizational units. For detailed analytical framework, including glossary, see Annex 1.

Operational indicators to assess the effectiveness of DoL	Assessed by indicators
Functional gaps	Whether or not every key function has a designated 'organizational home' i.e., no 'functional gaps'
Functional split/fragmentation	<ul style="list-style-type: none"> • Whether or not activities/tasks/functions that do belong together as one integral task/ functions/ roles respectively are split among several organizational units or organizations. • Whether or not the split/fragmentation is technically feasible; and • Are there appropriate coordination mechanisms
Functional overlaps	Whether or not some activities are carried out unnecessarily in more than one organizational unit, i.e., no 'functional overlaps'
Coordination	Whether specific coordination needs identified, arrangements in place, and working
Functional misplacements	Whether or not functions that do not belong together are nevertheless placed together in the same organization or organizational unit
Functional differentiation	Whether each service finds a dedicated home in the organization and whether each function finds a dedicated home within it
Functional fog	Whether or not there is full clarity as to who is responsible for a task/function/role and what exactly is the task/ function/ role
Functional overload	Units with staff shortages and too many functions

Findings

1. DoL between the ICDS and the NRHM

An in-depth analysis of the division of functions and coordination arrangements between the ICDS and the NRHM indicates that the division of responsibilities for nutrition-related service delivery are clearly defined with several coordination mechanisms designed and institutionalized. However, on-the-ground coordination is sub-optimal and there is a need for greater role clarity and better coordination between the programs. There is an opportunity for the ICDS and the NRHM to expand mutual synergies. Going forward, these must be explored to maximize the efficient use of resources and reduce child undernutrition.

1.1 Conceptually, the DoL for the delivery of nutrition services between the ICDS and the NRHM optimizes the mutually synergistic services of the two programs. While this does not constitute a functional split, it does impose the need for coordination. Whereas the responsibilities for delivering direct nutrition interventions are divided between the two programs, for several reasons this division appears logical for using resources efficiently and achieving the desired outcomes, provided that effective coordination exists, as seen below:

- The ICDS is by design a program that seeks to achieve effective coordination of policy and implementation amongst various departments to promote child development. Similarly, the NRHM has a synergistic approach to achieving health which it relates to the determinants of good health, namely nutrition, sanitation, hygiene and safe drinking water;
- Since nutrition and infection are inter-related, the key health interventions, especially those that promote maternal and child care and prevent and treat infections, must reach all mothers and young children. These interventions lie in the domain of the NRHM, along with the treatment and management of children with severe acute malnutrition who need to be admitted to facilities. The AWCs, therefore, often serve as the hub for provision of health services, especially in villages where there are no health sub-centers;¹⁰
- Both programs are community outreach programs, target the same populations, and have common objectives of reducing child mortality and undernutrition. However, each provides a different set of services, for which the roles and responsibilities are clearly defined and differentiated, at least on paper.

In order to ensure that this DoL facilitates synergistic provision and uptake of services from the two programs, it is essential that: (i) roles and responsibilities of the two agencies are clearly defined and understood at all levels; (ii) coordination mechanisms are clearly defined, enforced and monitored; (iii) norms and standards for the services to be delivered are established; and (iv) time and work-loads of the two sets of functionaries at each level, in particular at the ground level, permits them to engage with and assist each other in accordance with defined arrangements.

Therefore, considering the overall schema of how nutrition and health services are placed, there is value in optimizing on the synergies of the two programs. This is distinct from a functional split. However, it remains important to have full clarity of roles, avoid overlaps and gaps and to ensure adequate coordination. Further, the synergistic placement of the two programs offer the scope for better linking of the two programs in ways beyond what exist now and for the health sector to play a larger role in improving nutrition than it does now. The synergistic maternal and child health services provided by the two programs listed in Table 2.3 highlights how they can optimize mutual service delivery.

1.2 The DoL between the ICDS and the NRHM and the responsibilities of each program are largely well articulated. However, some overlaps and gaps exist. The ICDS and NRHM guidelines both clearly lay out their roles and responsibilities for nutrition services, including those for the activities to be conducted jointly.

1.2.1 *Some overlaps exist at the frontline service delivery level.* The roles of AWWs and ANMs in the delivery of health and nutrition services through the ICDS platform were defined prior to the deployment of ASHAs. It was made it clear that the AWW would assist

¹⁰A health sub-center exists for every population of 5,000, but not in all villages, whereas the AWCs are based on a population of 800 and therefore exist in almost all villages, and many large villages have more than one AWC.

the ANM in identifying and registering pregnant women, immunization and referral services. After the deployment of ASHAs, in most states, some duplication of effort has emerged. For example, community mobilization for immunization, preparing due-lists for immunization, identification and registration of pregnant women, and IYCF counseling which were earlier done by AWWs have now been assigned to ASHAs by the NRHM. Furthermore, the ASHA's role is now expanding to include IYCF counseling. These overlaps were explicitly mentioned in the FGDs by the AWWs, who also felt that they should be relieved of these responsibilities since the ASHAs conduct these activities as well. In the states where there are no ASHAs, the AWWs and ANMs continue to work jointly for household surveys, registration of antenatal mothers, health and nutrition education, distribution of micronutrients, de-worming of children, immunization and diarrhoea management. There is no overlap in this case. Similarly, population surveys are done both by the ICDS and the NRHM and could become more efficient if done jointly. However, the boundaries of the NRHM and ICDS blocks in several states do not match, although some states have reconciled the boundaries.

1.2.2

Table 2.3: Nutrition related activities of the ICDS and the NRHM	
ICDS	NRHM
Child nutrition, health and development	
<ul style="list-style-type: none"> • Weighing children under six • Growth monitoring and promotion • Food supplementation • Identification and referral of children with 2SD and severe malnutrition to PHCs • Non-formal pre-school education • Health and nutrition education • Elicit community support and participation in running the program • Assist PHC staff in immunization of children (motivating mothers to bring children, and mobilizing all 0-6 year olds) • House visits to ensure appropriate feeding practices and attendance at AWCs • Surveys 	<ul style="list-style-type: none"> • Identify malnutrition among children (0-5) and manage or refer to PHCs • Provide ORS to children with diarrhea • IFA to infants and young children • Vitamin A solution • Immunization • Weigh and examine newborns as soon as possible after birth. • Health education • Health checkups • Treatment of sick newborns, LBW babies and young children • Surveys • Treatment and management of severely malnourished children at health facility
Maternal nutrition and health	
<ul style="list-style-type: none"> • Nutrition supplement to a sub-set of all pregnant and lactating women • Motivate all pregnant and lactating mothers to collect at the AWC for ANM visit • Nutrition and health education 	<ul style="list-style-type: none"> • Register and provide care to all pregnant women throughout pregnancy • Urine and Hb test, BP and three abdominal examinations • Refer complications and facilitate referral • Conduct three post-natal visits • Health education • IFA supplementation • Tetanus toxoid immunization
Other nutrition and health issues	
<ul style="list-style-type: none"> • Counseling and IFA distribution • Adolescent girls 	<ul style="list-style-type: none"> • Family planning motivation • Distribution of contraceptives • Referral for IUD or terminal methods • Follow up of users for side effects • RTI/STI education, recognition, and referral • Minor ailments treatment and referral

Source: Adapted from MoHFW, GoI, 2013

1.2.3 Some gaps exist in the nutrition-related policy and program guidelines as also in service delivery. The MoHFW, GoI has taken the leadership in developing policy and program guidelines and protocols for the prevention and treatment of micronutrient deficiencies, management of severe acute malnutrition (SAM) and treatment of associated

complications. Recent examples of these initiatives include the introduction of weekly iron-folate supplementation (WIFS) for anemia prevention in adolescent girls, through the ICDS and school health programs, zinc supplementation as an adjunct to oral rehydration solution (ORS) therapy during diarrhoea, and operational guidelines on facility-based management of children with SAM where such children are referred to the NRC, (MOHFW, GoI, 2011). Some areas where guidelines and clarity are further required include management of SAM children without medical complications at the community level, therapeutic foods for feeding children with severe and moderate acute malnutrition, and harmonization of NRHM and ICDS criteria for referral to NRCs. While over 79 percent of the children under three remain anemic (NFHS-3), iron-folate supplementation of children does not receive due attention, and delivery of zinc supplements in accordance with protocols together with ORS for diarrhea management is minimal. Despite both services being in place for several years, their delivery continues to be weak. Also, at the implementation level, primary data from Tamil Nadu indicated confusion between the AWW and ANM with respect to the responsibility for maintaining growth charts included in the mother-child protection card (MCP). As a result these were not being maintained by either.

1.3 Except the top leadership in the health sector and the NRHM, awareness of the role of NRHM functionaries in improving nutrition is poor. The FGDs indicated that NRHM functionaries did not see a clear role for themselves in the overall effort to reduce undernutrition or its prevention and considered this to fall in the domain of the ICDS. They perceived their role in the treatment of malnutrition at NRCs, and in the provision of micronutrients. However, on further probing, they did concede that they play an important role in providing allied health activities like pre-and post-natal care, IYCF practices, immunization, vitamin and mineral supplementation which are important for improving the nutritional status of mothers and children. At the field level, the FGDs and interviews indicated a lack of role clarity for activities conducted jointly by ICDS and NRHM functionaries such as maintenance of joint MCPs, growth charts, immunization records and antenatal care records. It also emerged that while the ICDS functionaries were largely clear about their own role as well as that of the NRHM functionaries in the delivery of nutrition services, this was not the case with NRHM functionaries. The possible reasons for this lack of clarity amongst NRHM functionaries include the lack of priority for nutrition under the NRHM as indicated by the absence of nutrition in NRHM vision, mission and most other documents (for details see discussion in chapter 3, Leadership) and the absence of any nutrition indicator amongst the core indicators regularly tracked by NRHM functionaries, and the lack of communication of their role up and down the NRHM hierarchy. Limited interactions between ICDS and NRHM at various levels could also contribute to the lack of clarity.

1.4 Despite the many coordination mechanisms defined to better coordinate the services delivered by the two programs, on-the-ground coordination is sub-optimal and continues to constrain the optimum delivery of nutrition services. The convergence of health and nutrition services has been a recognized but persistent problem, and both agencies have made efforts to institutionalize coordination mechanisms and develop common tools and guidelines. However, there continues to be a need to enforce better coordination and, in many instances, better define the operational level task regarding ‘who does what’. The key institutional mechanisms for coordination, namely the ICDS and NRHM services, are discussed below.

1.4.1 Village Health and Nutrition Days (VHND) are intended to be a collaborative monthly fixed-day fixed-site events at the AWC for delivery of the full set of health and nutrition services with the participation of ASHAs, AWWs, ANMs and Panchayati Raj Institution (PRI) members. The organization of VHNDs has increased from 3.7 million in 2006-07 to over 6.5 million in 2012-13 (MoHFW, GoI 2013). However, actual implementation of VHNDs remains largely limited to ante-natal checkup and immunization days. Growth monitoring and promotion activities, nutrition counseling and education, iron-folate supplementation of children and health check-ups are mostly neglected. The many key issues that constrain adequate coordination through VHNDs are:

- At the village level there is poor understanding of the VHND, each worker's roles and responsibilities, inadequate capacity, lack of training and support;
- At the block, district and state levels, there is poor enforcement of guidelines, inadequate supervision and monitoring of VHNDs by both agencies, and lack of attention to the quality of service delivery. These indicate poor management and necessitate strengthening the management of the VHND mechanism by both the ICDS and the NRHM.

Furthermore, while the VHND guidelines are very detailed and include checklists for the functionaries and supervisors of both agencies, there remain some gaps on the following points: (i) work procedures for the delivery of each service are not defined, (ii) there is little clarity on 'who does what' with respect to the services to be delivered by the triad of AWW, ASHA and ANM; (iii) and despite the emphasis on ensuring 'satisfactory quality of services', quality standards are not stated and monitoring is largely confined to tracking the number of VHNDs held. Senior managers at the national level should ensure that the VHND work procedures are defined, standard operation procedures (SoPs) are developed and quality standards are defined and disseminated. Senior managers at the state and district levels should ensure that the guidelines are disseminated further down in a timely manner and implemented in the right spirit.

1.4.2 VHSNC serve as coordination mechanisms for the ICDS, NRHM and PRIs. The VHSNC mechanism was created in 2011 by adding nutrition functions to the scope of the NRHM's erstwhile village health and sanitation committees (VHSCs). Its function goes beyond the coordination between the ICDS and NRHM and also involves the PRIs. While the VHSNC functions under the PRI, along with PRI members; NRHM and ICDS functionaries (female multipurpose health worker, ANM, AWW, ASHA) serve as key members, with the AWW often being the convener.

While more than half a million VHSNCs are functional (MOHFW, GoI, 2012), their effectiveness on the ground is limited. Although the roles and responsibilities of the committees and accountability mechanisms are well defined on paper, the primary data collected for this study indicates considerable variation in awareness about these committees amongst the functionaries designated as key members as well as the PRI representatives on the committee. For example, while most health functionaries were aware of the committee and its role, this was not the case with the ICDS functionaries. In Bihar, a majority of the ICDS functionaries were not aware of the existence of VHSNCs and their role, and had not met any VHSNC member in the past six months. In Tamil Nadu, the situation was mixed and while many CDPOs, supervisors and AWWs were aware about VHSNC, many CDPOs were not aware of the expanded scope of the VHSCs that included nutrition.

The lack of adequate training, non-timely flow of funds, dependence on the ASHA for functionality, weak participation and inadequate representation of marginalized communities

have also constrained the functioning of VHSNCs (6th CRM, 2012 and 8th JRM, 2011). The nutrition-related responsibilities of the VHSNC include *inter alia* tasks such as carrying out surveys on nutrition status and nutritional deficiencies, inclusion of nutritional needs in village health plans and promotion of best nutritional practices. These tasks require specialized skills, and the current capacities and lack of training of the members are constraints to the functioning of these committees.

The poor functioning of the VHSNCs, the lack of clarity on the ground, and inadequate training is a reflection of inadequate management of resources to build the capacity of the VHSNCs at the district and state levels. Clear work procedures for the proper functioning of the committee will enhance their functioning, coordination mechanisms between the three key departments at the district and state levels are needed to ensure appropriate attention and management by each.

1.3.1 Joint planning, training, review meetings and field visits by the NRHM and ICDS functionaries are also mechanisms for bringing about the necessary coordination in the delivery of services. While government orders and guidelines have been issued from time to time, including jointly by the top leadership of the MWCD, GoI and the MoHFW, GoI, their implementation varies because of several reasons: (i) In many instances the geographical jurisdiction of the NRHM sub-center, the ICDS AWC and ICDS project and health blocks differ, making joint planning, action and monitoring difficult. Several states have harmonized these, but the issue remains a constraint in several areas; (ii) Joint training for NRHM and ICDS functionaries on integrated management of neonatal and childhood illnesses (IMNCI) have been conducted by the NRHM. However, the FGDs with AWWs in Bihar indicated that while the training helped enhance their knowledge on child care especially breast feeding practices, it did not lead to more effective joint work such as counseling of mothers, or improvements in referrals of undernourished or sick children; (iii) The MCP card, a recently rolled out tool to be used by both the NRHM and the ICDS to track mothers and children for health and nutrition purposes was used minimally by both ASHAs and AWWs, in Tamil Nadu.

1.4 Lack of effective coordination leads to many missed opportunities. The lack of coordination leads to insufficient coverage of beneficiaries and services, inconsistent data reporting and monitoring, insufficient utilization of resources and some duplication of work. The key areas that continue to suffer from poor or sub-optimal coordination include identification of undernourished children, their referral and management at the community or facility level, referral of sick children, nutrition and health counseling, identification and management of low birth weight children, vitamin A and iron-folate supplementation for children, administration of zinc supplements along with ORS for diarrhoea management. Although the NRCs exist, the weak referral systems prevent all children requiring admission to NRCs from being referred. Furthermore, there is lack of consistency between the referral criteria of the AWW (weight-for-age) and the entry criteria for the NRC (low weight-for-height or nutritional edema). Due to this mismatch many children are needlessly referred and sent back from the NRC (Prasad et al, 2012). Besides, the children treated at the NRCs need adequate follow-up at the community level to ensure that they do not slip back into severe undernutrition but this follow-up by both the ANM and the AWW is poor.

1.5 The NRHM can play a larger role in improving nutrition. As nutrition has an important role in reduction of maternal, infant and child mortality, and the fact that both the ICDS and the NRHM provide services to the same set of mothers and children, there are

many opportunities for the NRHM to coordinate with the ICDS in strengthening the nutrition service delivery such as: (i) MCTS, which at present does not adequately capture nutrition-related indicators, could track marginalized communities; (ii) Reinforcing the correct use of the recently introduced MCP card by both systems may help in strengthening growth monitoring and promotion; (iii) Janani Suraksha Yojana (JSY) offers a valuable opportunity to promote early and exclusive breastfeeding. A cadre of facility-based counselors could be created or existing staff equipped with skills to reach mothers availing of institutional deliveries (Ved and Jain, 2011).

2. DoL in the ICDS

Inadequate differentiation of functions in the ICDS is a significant capacity constraint. Several functions that ought to be separate are put together in the same unit or assigned to the same person and there is no dedicated functional home or personnel for most functions and services. The staff is required to perform multiple functions without necessarily having the skills to perform all of them. This results in creating heavy workloads for staff and compromised ability to perform all functions satisfactorily.

2.1 In the ICDS there is insufficient differentiation of functions and critical functions do not have dedicated organizational homes or dedicated persons to manage the functions. In the current organizational structure of the ICDS at the national and state levels, several unrelated functions are placed together in a unit and responsibilities for multiple functions, often un-related, are assigned to the same people, and individuals also work across several units. For example, at the national level, officials responsible for training or monitoring also deal with many other subjects. Furthermore, many functions, especially the technical functions, such as nutrition, growth monitoring, ECCE and Nutrition and Health Education (NHED) and the responsibility for developing a short- to medium- term vision for that functional area or serve its planning, control and evaluation are not assigned to any individuals, thus constraining the capacity of the program to deliver them optimally and achieve desired results. At the district level, there is further lack of differentiation. The district is the key level where management of the ICDS operation, district planning, training, monitoring, problem solving ought to happen. However, given the total lack of functional units or differentiated functional responsibility at that level, the management of functions at the district level is severely constrained.

2.2 Insufficient functional differentiation and shortage of staff has led to functional overload in the ICDS. Functional overload occurs in the ICDS at various levels and is due to two main reasons: firstly, due to the lack of functional differentiation and, secondly, because of the shortage of staff all functions get assigned to the staff in position. This results at all levels in staff being assigned multiple functions and carrying unmanageable workloads (see chapter 4, Availability, Competence and Management of Human Resources for a detailed discussion of workloads and staff shortage). Functional overload, coupled with inadequate skills and training for handling the diverse but specialized functions, and the shortage of staff, limit their capacity to adequately carry out the functions assigned to them.

2.3 Some functional splits and misplacement also exist in the manner of functional organization in the ICDS. There also are examples of functional splits in the ICDS. For instance, the training function is split between the MWCD, GoI training unit and the ICDS training institution, the NIPCCD. Whereas the ministry in coordination with states is responsible for the training of supervisors, AWWs, and AWHs, the NIPCCD is responsible

for CDPO training and training of trainers. As a result, planning, budgeting, monitoring for training conducted by the NIPCCD and the states happens separately and without coordination between them, making it difficult to get an overall picture of the training function that includes planning, budgeting and monitoring, thus contributing to the training capacity constraints. Besides, functional misplacements exist in the FNB, the technical body that assists the MWCD, GoI in nutrition. A recent assessment of the FNB supported by the World Bank noted that several FNB functions, such as operation of food quality control laboratories and directly conducting nutrition demonstrations on VHNDs that reach less than one percent of the women in program areas, are misplaced functions and are not aligned to meet the strategic policy and program support required of the FNB by the MWCD, GoI and the ICDS.

2.4 The institutional structures proposed under the restructured ICDS, to an extent, address the issues of inadequate differentiation but there appear to be some functional splits and the continued lack of dedicated homes or units. The proposed ICDS mission directorate organizational structures at all levels - national, state, district and block – show a good separation of key functions, with dedicated units and personnel to manage them. At the national level, dedicated units and personnel have been assigned for nutrition and health services, ECCE, monitoring and evaluation, research, policy and planning, coordination and logistics, and finance and expenditure, with additional arrangements for technical support in several key functional areas¹¹ through a proposed national ICDS mission resource center. The state and district level structures largely mirror the functional units at the national level, and at the block level also personnel are dedicated to coordinate health and nutrition services, ECCE services, monitoring and evaluation and nutrition surveillance. For health and nutrition, in the larger states, three sub-units -- nutrition, health and IYCF – are proposed, thus reflecting the establishment of functional homes for the priority areas related to nutrition. In this context, two issues become apparent: (i) it is unclear if there is a dedicated functional unit for HR at the national and state level, this being a very important function that the ICDS hopes to reform and strengthen; and (ii) training and IEC are placed in one functional unit, whereas IEC and training are two separate specialized functions that are not directly related, and require different skill sets, thus contributing to a potential functional misplacement that could constrain capacity (MWCD,2012).

2.5 The restructured ICDS is likely to reduce functional overload at some levels but at the operational level the problem appears to be compounded. New contractual positions - technical, managerial and operational - have been created at all levels to significantly augment the current sanctioned staff strength of the ICDS. For example, 25 contractual positions at the national mission directorate and 30 positions at the national ICDS mission resource center, 14 positions at the state level, six positions at the district level, and three positions at the block level will be added to carry out various functions. This is expected to considerably reduce the work overload of the ICDS staff and make it more manageable. However, a systematic functional and workload analysis has not yet been undertaken and it is therefore not possible to assess the extent of workload optimization. Moreover, there are no additional envisaged positions of CDPO, supervisor or AWW except for a second AWW in approximately 10 percent of the AWCs but, although with the addition of new activities, a greater functional overload than currently exists at these levels is expected.

¹¹These include policy planning, nutrition (IYCF and micronutrients), ECCE, health, advocacy and public education, monitoring and evaluation, training and capacity building and grievance redressal.

The restructured ICDS appears to largely address the key issues of insufficient functional differentiation and functional overload, including creating dedicated units and positions for many critical functions. However, the personnel leading the functional areas should also be empowered with the ability to perform their roles effectively and at the same time be held accountable for the achievement of results.

Recommendations:

This analysis clearly indicates that: (i) the intended synergy between the ICDS and the NRHM for nutrition service delivery is hampered by ineffective coordination; and (ii) DoL constraints in the ICDS need to be addressed to enhance its effectiveness. Thus, two sets of recommendations are presented here to address the two categories of DoL constraints.

A. To improve the effectiveness of the DoL between the NRHM and the ICDS:

i) Nutrition should not only be accorded a higher priority in the NRHM but also explicitly stated in its vision and mission documents, as well as in the job descriptions of its functionaries. The national and state leaders of the health system and the NRHM should clearly communicate the key role that the program plays in improving nutrition along with the ICDS to all levels in their respective organizations. Besides, inclusion of a nutrition indicator in the core NRHM indicator list will strengthen the focus on the program's nutrition related functions at the implementing level.

ii) To improve on-the-ground functioning of the two primary coordination mechanisms between the ICDS and the NRHM, namely the VHND and the VHSNCs, the following critical points must be addressed:

- Clearly define the roles of ICDS and NRHM functionaries in terms of 'who does what' at VHNDs, and the operational role of the VHSNCs;
- Define work processes and procedures, i.e., establish Standard Operating Procedures (SOPs) for VHNDs as well as supervision and monitoring of the functioning of VHNDs and VHSNCs;
- Establish quality standards for conducting VHNDs and for the functioning of VHSNCs.
- Clearly and frequently communicate the above to both sets of functionaries, and enhance supervision and monitoring to ensure implementation of the guidelines and SOPs to ensure delivery of the full package of services that ought to be delivered at VHNDs and not merely immunization and antenatal checks;
- Where required, the geographical boundaries of the two programs should be harmonized.

iii) Identification of malnourished children, their management and follow-up, especially for those requiring referral to facilities is a critical gap that needs to be urgently addressed. Given the important role, the ICDS and NRHM have in this respect, identification, referral and follow-up of undernourished children should be jointly undertaken during the VHNDs.

iv) The health sector can play a larger role in improving nutrition. With a greater number of deliveries now taking place at the facilities, the NRHM should ensure initiation of breastfeeding immediately after birth and counseling of mothers to exclusively breastfeed for

six months. The joint use of the NRHM's MCTS by both programs must be explored, and the use of MCP cards must be strengthened.

B. To address DoL constraints within the ICDS, particularly the key issue of insufficient functional differentiation, the following structure and function issues require further attention:

- Given the criticality of the HR function in the management and delivery of such a large and ambitious program, a separate functional home and leadership for HR in the ICDS mission is essential. The current ICDS mission's organizational structure does not specify where the HR function lies.
- The structure for several functions such as training, M&E, policy and planning, as well as technical services like nutrition, health and ECCE, appear to be split between two homes, namely the mission directorate and the National ICDS Mission Resource Center. The proposed framework does not specify where overall responsibility for the functions lies. Hence, in the new structure, the ICDS should develop high-level conceptual frameworks, or ToRs, for the organizational units as well as technically sound job descriptions in order to remove functional gaps and overlaps.
- A functional analysis of all ICDS job categories is required (see chapter 4, Availability, Competence and Management of Human Resources in the System).

Chapter 3

Leadership

Introduction

Leaders provide direction to the sectors, organizations and people that they lead. They define the vision for the future, develop strategies and plans, mobilize resources, guide the implementation of strategies and plans, and coordinate, control and evaluate the impact of the policies, strategies and changes required for greater effectiveness.

In recent years, India has demonstrated impressive leadership, including that at the highest level, to address its large undernutrition problem. In November 2009, the Prime Minister's National Nutrition Council for India's Nutrition Challenges outlined the key future directions for nutrition in the country.¹² The broad directions laid out by this council are being pursued through new programs and strengthening of existing ones, under the leadership of the MWCD, GoI which is the nodal ministry of nutrition in India.

Given the importance of leadership in providing direction to sectors, programs and organizations, this chapter focuses on leadership of the nutrition sector, and the delivery of nutrition services in particular. In this report, the term 'leaders' includes top level leaders in the national ministries of MWCD and MoHFW, the NRHM and the related departments and program structures at the state, district and project levels. The report seeks to answer the broad question:

What are the factors that enhance and constrain leadership capacity for: (i) nutrition as a sector in India; and (ii) the delivery of nutrition services through the two principal programs, the ICDS and the NRHM?

After briefly describing the analytical framework and indicators of leadership capacity used in the analysis, this chapter discusses the key factors that have enabled or constrained the capacity of leaders and managers to exert leadership, firstly, for nutrition as a sector, and secondly, for the ICDS and the NRHM components responsible for delivering nutrition services alongside the ICDS, at the national, state, district and block levels. It then suggests the ways in which the capacity constraints could be addressed.

Analytical framework and capacity assessment indicators

Leaders perform five key tasks and the quality of these serve as indicators of leadership quality. These are: (i) provide direction to the sector or organization and define its future in terms of desired outputs; (ii) develop strategies for achieving the desired outputs, ensuring that these are followed by careful planning; (iii) mobilize people and other resources for the implementation of the strategies and plans; (iv) continually articulate and communicate the

¹² These include: (i) strengthen and restructure the ICDS program to enable a special focus on pregnant and nursing mothers and children under three, provide flexibility for local action, and forge institutional convergence with other national programs in health and sanitation, particularly at the district and village levels; (ii) design a multi-sectoral plan in 200 high burden districts with institutional mechanism to converge the national programs at the state, district, block and village levels; (iii) implement a nation-wide information, education and communication campaign against malnutrition to address issues of the status of women, care of pregnant mothers and children under two, breastfeeding, and the importance of balanced nutrition, health, hygiene and sanitation; and (iv) the need for GoI ministries and departments of health, drinking water supply and sanitation, school education, agriculture and food and public distribution to bring about a strong nutrition focus in their programs.

direction, strategies and plans; and (v) ensure unity of effort and keep organizations in the sector, and people in the organizations on track, pursuing the direction given.

The extent to which each of these tasks is carried out can serve as an indicator of leadership capacity.

The tools that leaders use to provide direction consist of the conceptual frameworks, vision, mission and strategies. The existence of effective written statements of vision, mission and strategy are also indicators of the strength of leadership (see Box 3.1 for definition of effective vision, mission and strategy statements). Awareness of the importance of these tools, and the ability to formulate and use them are therefore necessary.

Box 3.1: Vision, Mission and Strategy

Vision is where a country or organization **wishes to be**, and **the role it wants to play**, usually in the medium to long term. An effective vision offers a timeframe for its achievement and guides the selection of strategies, helping to choose between those that take longer but deliver better results (sometimes even at a lower cost) and those that take lesser time but with less favorable results (sometimes at a higher cost). A vision is weak without a timeframe, making it difficult to set intermediate or shorter term operational goals and monitoring indicators, or being left with goals that are too modest to achieve the vision. This often results in poor performance as there are no time-related benchmarks against which performance can be measured, and even minimal progress ends up being viewed positively.

Mission is what an organization has to do based on its vision. It specifies targets, time and results, outlining in quantitative terms not only what must be done, but also what must be achieved and by when, and may include other performance parameters, such as quality and cost. It is the role of leadership to translate the long-term vision into shorter-term missions, to determine the costs of these missions and to mobilize the funds needed by submitting budgetary plans that reflect these costs. In practice, the full process is rarely followed. More often than not, governments and organizations skip the formulation of missions and go straight into making budgetary plans.

Strategy is the way or combination of ways that a country or organization sets out to achieve its vision. There is almost always more than one way of getting from one point to the other, and strategy is often about choice. It is important to find all potential ways for getting from one point to the other and to choose the most promising way or ways and prioritize them. There is rarely sufficient time, and there are rarely sufficient resources, to do everything that can be done. If priorities are not set for people in the organization, then the people set their own priorities. Since strategies generally consist of a relatively large number of actions, or strategic thrusts, leaders need to prioritize them. No strategy is complete without such prioritization.

Effective leaders develop comprehensive conceptual frameworks for the sector or each important function or problem that needs to be resolved. These articulate the working hypotheses of dealing with a complex phenomenon – a system, process, function or behavior. The working hypotheses describe, in particular, the structure of the phenomenon, its building blocks, the relationships in the building blocks, and the manner in which they work individually and collectively.

The vision, mission and objectives are not mere statements, but critical assertions of what any organization aspires to achieve, and these define for each person within the agency the purpose of their work, as well as the role each has to play in helping the organization achieve its mission. Therefore, communication of the vision, mission and strategy are important and effective leaders continually communicate the direction that they want the organization to follow, explaining the strategies behind their plans, the visions behind their strategies and the conceptual frameworks behind their visions. They incorporate messages of direction in daily briefings, utilizing every opportunity to link the specifics of a situation with the bigger picture. Not only do effective leaders talk about the direction, they also demonstrate their commitment to it by personal example and resource allocation. This helps bridge the gap between organizational strategy and the objectives of the average employee, often referred to

as the strategy-performance gap. Research indicates that less than 10 percent of all strategies are effectively executed, one of the reasons for the gap being insufficient communication and articulation of strategy (Kaplan and Norton, 1996).

Table 3.1: Capacity assessment indicators: Leadership

Operational indicators to assess leadership capacity	Assessed by indicators
Conceptual framework	<ul style="list-style-type: none"> • Existence of written, elaborated conceptual framework • Quality of conceptual framework – comprehensive, clarity • Dedicated organization home
Vision, mission and strategy	<ul style="list-style-type: none"> • Existence of written, elaborate statements • Quality of vision, mission, strategy statements: articulation of outcomes and outputs, targets and timelines, provide specific direction • Feasibility: <ul style="list-style-type: none"> • Technical - whether efficacious, not too complex • Financial – whether funds needed for their implementation can be realistically mobilized • Operational – whether human, physical and other resources needed for their achievement are available and can be realistically mobilized • Communicated often, through multiple media
Balance between continuity, change of policy, strategy and direction	<ul style="list-style-type: none"> • Whether pace of change realistic, i.e., too much or too little • Whether change and continuity informed by evidence, feedback and evaluation
Agenda overload at leadership and senior management levels	<ul style="list-style-type: none"> • Number of leaders relative to issues to be dealt with – whether adequate • Whether strategic leadership function separate from operational management
Vacant positions or acting leaders and senior managers	<ul style="list-style-type: none"> • Vacancy or acting situation in key leadership and management positions

Using these capacity indicators, the following section discusses: (i) the key findings related to the definition of India’s national vision and mission to improve the nutrition status of women and young children; (ii) the definition of the nutrition vision, mission and strategy for the two key programs delivering nutrition services, namely the ICDS and the NRHM; (iii) the balance between continuity and change; and (iv) the number of leaders required to take leadership of the sector and the key programs.

Findings

The absence of a dedicated organizational home for nutrition and a dedicated leader for nutrition in the MWCD, GoI, and the non-existence of nutrition in the vision and mission of the ministry are constraints for nutrition as a sector. Furthermore, nutrition is also not included in the vision and mission of the MOHFW, GoI, which is the other key ministry for delivering nutrition services. Leadership constraints are also reflected in the choice of strategy and its feasibility. The ICDS strategy, with its mandate to deliver multiple services, has been overly ambitious. The shortage of leaders and senior managers in the ICDS is another leadership constraint.

1. Conceptual framework and organizational home for nutrition

While at the national level India’s policy documents provide a comprehensive policy and conceptual framework for nutrition, the absence of a dedicated home for nutrition and a dedicated leader for nutrition in the nodal GoI ministry of nutrition, the MWCD,

constrains leadership for the nutrition sector in India. This key gap also exists at the state level.

1.1 India's policy documents provide the broad sectoral conceptual framework for nutrition. Several states have also outlined their own conceptual frameworks. The National Nutrition Policy (NNP) adopted in 1993 and the National Plan of Action for Nutrition (NPAN) formulated in 1995 spell out the conceptual framework for the nutrition sector in India. A more recent framework is reflected in the MWCD, GoI strategy paper, 'Addressing India's Nutrition Challenges' (2010), jointly developed by the MWCD, GoI, MoHFW, GoI and the Planning Commission.

1.1.1 The NNP and NPAN provide a fairly comprehensive policy and conceptual framework for nutrition. The framework includes both: (i) the direct nutrition policy instruments to address malnutrition in the short to medium term (e.g., expanding the safety net, improving coverage of the vulnerable, supplemental feeding, reducing micronutrient deficiencies and food fortification); and (ii) the indirect longer term institutional and structural arrangements that recognize the inter-sectoral nature of nutrition (e.g., food security, dietary improvements, food production and distribution, health and family welfare measures, communication, economic access, women's status, research and nutrition surveillance). The NPAN identifies the roles of approximately 14 different ministries and departments in improving nutrition, outlining specific areas and actions for their involvement and designates the MWCD, GoI as the coordinating agency for implementation of the plan.

1.1.2 The strategy paper 'Addressing India's Nutrition Challenges' (2010) outlines the most recent framework for improving nutrition. Developed jointly by the MWCD, GoI and MoHFW, GoI in consultation with the Planning Commission and the Prime Minister's Office, the paper re-affirms the GoI priority and commitment to nutrition. It focuses on preventive action during the first 1,000 days of life for addressing undernutrition, within a comprehensive framework of universal health care, women's empowerment and child development, and with a continuum of care across the life cycle, from the family and community to the AWC, carrying on to health centers and facilities. It further outlines the conceptual framework for multi-sectoral action to prevent and reduce undernutrition in a time-bound manner with the commitment of those involved.

1.1.3 Several states have articulated their own conceptual frameworks for nutrition. Drawing upon the national conceptual frameworks, several states, especially those with a high malnutrition burden have articulated their own nutrition conceptual frameworks to reduce undernutrition. Named differently in different states, such as nutrition mission document or framework, or state nutrition strategy, most have been prepared with the assistance of development agencies and they are the equivalents of a conceptual framework that articulates the hypothesis behind the action proposed to address undernutrition (see Annex 2 for examples of summaries of such documents from selected states).

1.2 The MWCD, GoI is the designated nodal organizational home for nutrition in the country. However, the ministry has no dedicated unit for nutrition, nor is there dedicated leadership for nutrition. This key gap also exists at the state level. The NNP assigns nodal responsibility for nutrition to the MWCD, GoI (earlier the Department of Women and Child Development) and the NPAN elaborates its role further 'to coordinate, monitor and, wherever required, regulate the implementation of the National Plan of Action on Nutrition' through an inter-ministerial committee chaired by the secretary, WCD, GoI. The

NPAN also outlines the setting up of a nutrition cell in the MWCD, GoI to enable it to function as the nodal agency for implementation of the NNP and the NPAN.

1.2.1 While the MWCD, GoI is the nodal ministry for nutrition in India, there is no dedicated unit or division for nutrition, nor is there a dedicated senior level leader for nutrition. The nutrition cell envisaged as the nodal agency for nutrition has not been set up in the MWCD, GoI even today. The sectoral responsibility for nutrition in the MWCD, GoI is bundled with the ICDS under one of the two child development divisions of the ministry. This is also the case with leadership for nutrition. As a result, sectoral responsibility for nutrition has not received the attention it deserves in the ministry or in the overall policy discourse and actions on nutrition, with the ICDS and, more recently, the other new nutrition-related schemes taking center stage with respect to leadership, discourse and actions.

1.2.2 The Food and Nutrition Board (FNB), amongst its many disparate functions, is also mandated to provide technical support for nutrition to the MWCD, GoI and the states, but does not have the capacity required to fulfill the desired role. An assessment of the FNB undertaken by the World Bank at the request of the MWCD, GoI points out that its current roles, responsibilities, structure and capacities do not meet the MWCD, GoI's need for technical support in nutrition. The report recommends a full reorganization of the FNB (World Bank, 2013).

1.2.3 The lack of a dedicated unit in the MWCD, GoI has constrained its ability to lead and coordinate nutrition action across various sectors. The role of the MWCD, GoI as the nodal agency defined in the NPAN remains to be fully implemented and several important leadership initiatives assigned to the MWCD, GoI remain unfulfilled, such as:

- The NPAN notes that the MWCD, GoI should establish a national nutrition surveillance system to monitor the nutrition situation at all levels through grassroot level workers and communities. It also assigns to the MWCD, GoI the responsibility for commissioning operational research on nutrition issues of national importance defined in the NPAN. Unfortunately, no action has been taken in these areas.
- The 11th five-year plan had outlined several thrust areas for nutrition. Two of these - food fortification and promotion of community and household production of fruits and vegetables - were not linked in the plan to any program or implementing agency and ended up being 'un-owned mandates', and therefore saw no progress. The MWCD, GoI as the nodal coordinator for nutrition across all agencies, should have ensured that the thrust areas were pursued and action implemented by the departments concerned.

1.2.4 In recent years, the leadership demonstrated by the MWCD, GoI for nutrition is critical and must be sustained. Despite the lack of a dedicated nutrition unit, over the past four years, it has demonstrated leadership in defining national priorities for nutrition. Engaging with other key ministries, including the PC, and other principal stakeholders, it led the effort to build consensus on options to address India's huge undernutrition challenge. This culminated in the high-level National Nutrition Council, headed by the Prime Minister, making important recommendations to improve nutrition (refer footnote 12). The MWCD, GoI laudably fulfilled its leadership responsibility and accomplished the following actions to pursue the four recommendations: (i) launched a national IEC multi-media campaign to create awareness about nutrition; (ii) led the ICDS reform and its restructuring; (iii) launched a new multi-sectoral nutrition program for 200 high malnutrition burden districts; and (iv) engaged with the allied ministries to lend greater focus on nutrition in their programs.

1.2.5 The lack of a dedicated functional home and leadership for nutrition at the national level is mirrored at the state level. As at the national level, the states too have no dedicated unit or leader for nutrition, being bundled with the ICDS under the same leader and the same unit. The consequences are similar to those at the national level whereby leadership, discourse and policy discussion are limited to the ICDS and the nutrition action in its domain, whereas the leadership for cross-sectoral nutrition thinking, action and coordination is marginal.

2. Vision, mission and strategy for nutrition

The national five-year plans outline a vision and strategy for nutrition and define targets for reducing undernutrition. However, the absence of nutrition in the vision, mission and objectives of the nodal ministry for nutrition, namely the MWCD, GoI and in the vision, mission or objectives of the MoHFW, GoI (which is the other key ministry for delivering nutrition services) reflects a key leadership constraint. As a result, nutrition receives low priority in the NRHM; the role of the NRHM vis-à-vis nutrition is poorly communicated down the program hierarchy, and the functionaries' awareness of their role in improving nutrition is poor. While ICDS functionaries are generally aware of the national vision to improve undernutrition, the lack of specific targets inhibits clarity of purpose. Furthermore, the ICDS program strategies have not prioritized the most effective interventions and the groups most vulnerable to undernutrition. Besides, the mismatch between its ambitious mandate and the physical, financial and human resources available have constrained the effectiveness of the program.

2.1 **India's national plan documents reflect strong vision statements and outline clear national strategies to improve nutrition.** India's national five-year plans articulate the country's five-year vision and priorities and the financial outlays for each of the sectors as well as for major national programs. The 10th, 11th and 12th five-year plans provide clear direction at the national level to reduce undernutrition (see Box 3.2).

2.1.1 Each five-year plan has set clear targets for the reduction of undernutrition within its timeframe. The five-year plans have set targets for key indicators, such as reduction in the prevalence of underweight in children and micronutrient deficiencies (Box 3.2). The plan documents further define clear sectoral and program strategies to move the country in the desired direction.

2.1.2 However, targets appear to be aspirational rather than realistic. The targets in the plans appear to be largely aspirational, since the magnitude of the reduction in undernutrition expected in each plan is too large to be achieved over a five year period. Moreover, the strategies outlined and the financial outlays provided do not match the targets. Thus, despite most strategies being in implementation for several years, they have not yielded the desired results. The largest outlays have been made for provision of supplemental food through the ICDS, a strategy that has not brought about much improvement in child or maternal nutrition. Furthermore, the plan documents do not indicate additional outlays for many of the strategies, including 'intensifying nutrition and health education to improve infant and child feeding and caring practices such as exclusive breastfeeding for six months and introduction of semi-solids at six months (10th five-year plan)', 'horticulture interventions, food fortification (11th five-year plan)' and 'combating micronutrient deficiencies and promoting optimal IYCF (12th five-year plan)'

Box 3.2: Vision, strategy and approach in the 10th, 11th and 12th five-year plans

The 12th five-year plan (2012 – 2017)

Vision: Prevention and reduction of undernutrition in children under three years to half of NFHS 3 level (40.4% under-weight, 22.9% wasted and 44.9% stunted as per NFHS -3 data) by 2017. The prevalence of under-weight children is expected to be 29 percent by 2015, and 27 percent by 2017 and reduction of anemia among women in the 15-49 year bracket to 28 percent.

Strategy:

- Convergent action on nutrition focusing on multi-stakeholder strategies
- Combating micronutrient deficiencies in a holistic manner: supplementation, food fortification, dietary diversification, horticultural interventions and IEC
- Strengthening and restructuring of the ICDS with special emphasis on pregnant and lactating mothers and children under three
- Promoting optimal infant and young child feeding practices

Approach: Re-design and reinforce the package of ICDS services, including a new component of Child Care and Nutrition Counseling for mothers of children under three years, increase focus on infant and young child feeding, health, hygiene, psycho-social care, early learning and care of girls and women, ensure convergence with related sectors such as NRHM, TSC, NRDWP, SSA, MGNREGA through joint planning, joint monitoring of key results and indicators and defined roles and accountabilities and strengthen training of anganwadi and ASHA workers on issues relating to nutrition; implement ISSNIP in 162 high burden districts; and link IGMSY to the umbrella ICDS mission.

The 11th five-year plan (2007 – 2012)

Vision: During the plan period, reduce malnutrition in children under three to half (from 45.9 percent to 23 percent), and reduce anemia in women and girls by 50 percent (from 56 percent to 28 percent).

Strategy: The plan outlines a five-pronged strategy to improve micronutrient deficiencies:

- Dietary diversification
- Nutrient supplementation
- Horticulture interventions
- Food fortification
- Public health measures

Approach: The NRHM and the ICDS to stress on implementation of these strategies; emphasize the monitoring of micronutrient deficiencies through district level household surveys and expansion of the National Nutrition Monitoring Bureau (NNMB) under the Indian Council of Medical Research (ICMR) and include de-worming of children as a strategy to be promoted through the ICDS and schools. It provides direction for ICDS restructuring and strengthening, with greater focus on children under three, district planning, engagement of local governments, panchayats, food procurement and supervision, improved fund flow to the district level, strengthening convergence between the ICDS and health and goes deeper in defining some ways to improve convergence.

The 10th five-year plan (2002-2007)

Vision: During the plan period, reduce under-weight children under three from 47 percent to 40 percent; reduce severe undernutrition in children of 0-6 years by 50 percent; reduce prevalence of anemia by 25 percent and that of moderate and severe anemia by 50 percent and eliminate vitamin A deficiency as a public health problem; and reduce Iodine Deficiency Disorders (IDD) to less than 10 percent by 2010.

Strategies:

- Strengthen specific services to address undernutrition, for example 'reaching children in the 6-36 month age group, pregnant and lactating women
- Intensify nutrition and health education to improve infant and child feeding and caring practices such as exclusive breastfeeding for six months and introduction of semi-solids at six months
- Administer vitamin A supplements according to schedule and iron-folate supplements when needed
- Identify and treat the undernourished, for example 'screening for nutritional deficiencies in vulnerable groups and initiating appropriate remedial measures, including screening pregnant women for undernutrition and anemia and providing appropriate interventions, and screening all children to identify and treat those severely undernourished, or whose growth is faltering, weigh all newborns soon after birth, identify low birth weight babies and refer to hospitals for treatment those with birth weight below 2.2 kg'.

Approach: The ICDS and the NRHM to lay stress on the implementation of these strategies, as well as enhancing the quality and impact of the ICDS substantially through training, supervision of ICDS personnel, improved community ownership and establishing a reliable monitoring and evaluation mechanism and improving inter-sectoral convergence.

2.2 While the national five-year plans define targets for reducing undernutrition, nutrition is not explicit in the vision, mission and objectives of either of the two ministries that have a key role in improving nutrition, namely the MWCD, GoI and the MOHFW, GoI. Each ministry is expected to state its priorities and outline its vision, mission and objectives, including the activities and outcomes to be achieved. An analysis of the results framework documents (RFDs) of the MWCD, GoI and the MoHFW, GoI indicates the following:

2.2.1 *The MWCD, GoI's strategic documents do not articulate a vision, strategy or objectives for nutrition, nor do they reflect its leadership role in nutrition.* Despite being the ministry in-charge of nutrition in India, with a clear mandate to set nutrition policy directions and programs, coordinate with other ministries on actions relating to nutrition, the MWCD, GoI RFD and its strategic plan (2011-2016) does not include any vision, mission or objective for nutrition beyond the ICDS, or with respect to its leadership role for the nutrition sector (see Box 3.3). The MWCD, GoI vision and mission are centered around its two divisions (besides the financial division), namely women and child development. Had there been a dedicated nutrition unit, the ministry's sectoral role might have been reflected in its RFD, with a higher chance of holistic nutrition objectives being formulated, rather than being confined to those related to the programs which the ministry implements.

2.2.2 *The MoHFW, GoI also has a key role in addressing undernutrition, yet its vision and strategy are silent on nutrition.* While several direct nutrition interventions and their delivery fall within the domain of the MOHFW, GoI, primarily the NRHM, such as delivery of micronutrients to pregnant, nursing mothers and children, nutrition counseling, and management of severe undernutrition, the ministry's RFD for 2013-14 has no reference to nutrition in its vision, mission or objectives (see Box 3.4).

Box 3.3: Vision and mission statement MWCD, GoI

Vision: Empowered women living with dignity and contributing as equal partners in development in an environment free from violence and discrimination and well-nurtured children with full opportunities for growth and development in a safe and protective environment.

Mission:

Women: Promoting social and economic empowerment of women through cross-cutting policies and programs, mainstreaming gender concerns, creating awareness about their rights and facilitating institutional and legislative support for enabling them to realize their human rights and develop to their full potential.

Children: Ensuring development, care and protection of children through cross-cutting policies and programs, spreading awareness about their rights and facilitating access to learning, nutrition, institutional and legislative support for enabling them to grow and develop to their full potential.

Objectives:

1. Laying foundation for development of children below six with focus on supplementary nutrition and pre-school, non-formal education and to enhance the awareness and capability of mothers for nutritional and health needs of the child;
2. Empowering adolescent girls and boys;
3. Providing a safe and secure environment for overall development of children who are in need of care and protection and children in conflict with the law;
4. Promoting a rights based approach in the formulation of policy for children;
5. Socio-economic empowerment of marginalized women;
6. Review of existing laws on discrimination against women;
7. Mainstreaming gender concerns in the policies and programs of GoI and state governments through gender budgeting.

Nutrition Functions (extracted from the list of functions):

1. Implementing the ICDS;
2. Building capacities of anganwadi workers and helpers under the ICDS;
3. Providing nutrition, life skills education, health education, home based skills and vocational training to adolescent girls through the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, or SABLA;
4. Providing cash for part compensation of wage loss and for health care of mothers and infants with support for pregnant and lactating women through the Conditional Maternity Benefit Scheme or Indira Gandhi Matritva Sahyog Yojana;
5. Planning, research, data collection, training and capacity building, for better understanding of issues concerning women and children and for filling gaps in knowledge and capabilities in addressing their concerns

Excerpts from MWCD, GoI RFD, 2013-14

Box 3.4: Vision and mission of the DoHFW, GoI

Vision: Availability of good quality healthcare on equitable, accessible and affordable basis across regions and communities, with special focus on under-served populations and marginalized groups.

Mission:

1. To establish a comprehensive primary healthcare delivery system and well-functioning linkages with secondary and tertiary care health delivery systems.
2. To improve maternal and child health outcomes.
3. To reduce the incidence of communicable diseases and put in place a strategy to reduce the burden of non-communicable diseases.
4. To ensure reduction in the growth rate of population in order to achieve population stabilization.
5. To develop the training capacity for providing human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels.
6. To regulate health service delivery and promote rational use of pharmaceuticals in the country.

Objectives:

1. Providing universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary health care.
2. Improving maternal and child health.
3. Focusing on population stabilization in the country.
4. Developing human resources for health to achieve health goals.
5. Reducing overall disease burden of society.
6. Strengthening secondary and tertiary health care.
7. Reducing burden of leprosy with good quality services and enhance Disability Prevention and Medical Rehabilitation (DPMR) services.

Nutrition functions (extracted from the list of functions):

1. Policy formulation on issues relating to health and family welfare sectors.
2. Management of hospitals and other health institutions under the control of DoHFW.
3. Extending support to states for strengthening their health care and family welfare systems.
4. Reducing the burden of communicable and non-communicable diseases.
5. Focusing on development of human resources through appropriate medical and public health education.
6. Providing regulatory framework for matters in the concurrent list of the constitution such as medical, nursing and paramedical education and pharmaceuticals.
7. Formulating guidelines on issues relating to implementation of the Nation Leprosy Eradication Program and strengthening supervision and monitoring support to the states and UTs.

Excerpts DoHFW RFD, 2013-14

2.3 At the core of India's national strategy to address undernutrition is the ICDS program of the MWCD, GoI and the NRHM program of the MoHFW, GoI. The ICDS is the national flagship nutrition program and the key strategy to address undernutrition. Conceived as being an inter-sectoral program, the ICDS draws upon and coordinates with the services of other sectors, primarily the NRHM, and remains the largest program to address nutrition. Additional strategies have been adopted in recent years to improve nutrition of adolescent girls and increase the focus on pregnant and nursing mothers with the introduction in 2010 of two new pilot programs, namely the IGSMY, a conditional cash transfer scheme to promote better maternal nutrition and exclusive breast feeding, and SABLA, an adolescent empowerment program that includes nutrition education and anemia prevention. The nutrition related vision, mission and strategies of the ICDS and the NRHM are discussed in the following paragraphs.

2.3.1 Although being implemented for over 35 years, the ICDS has only recently defined clear nutrition objectives and targets with timelines. Until its recently approved restructuring, the ICDS vision and mission had not defined targets for improving nutrition. However, this gap has recently been addressed, and clear nutrition outcomes with indicators and targets are

now outlined in the ICDS mission framework document. In addition, the revised MIS for the program includes meaningful indicators to track nutrition outcomes.

2.3.2 *The ambitious ICDS strategy was technically, financially and operationally not very feasible and constrained in its impact.* The ICDS strategy places nutrition as an integral part of child development, in which nutrition services are delivered as part of a basket of services for pregnant-nursing mothers and children up to six years, in coordination with other sectoral programs, primarily the NRHM. The services include supplementary nutrition, nutrition and health education, immunization, ECCE, health check-ups and referrals. The large number of services in the ICDS package has made its mandate very ambitious.

(i) **Several studies and evaluations of the ICDS have pointed out the reasons for its failure in creating the desired impact** (Ahmed 2005; Gagnolati et al 2005; Right to Food Campaign 2007). The key reasons are that the strategy:

- did not preferentially target pregnant women and children under two and, instead, focused on older children;
- did not prioritize the most effective interventions to improve nutrition such as nutrition education for behavior change centered around feeding and caring practices, especially for pregnant women and young children; and
- was overly focused on supplemental food distribution that diverted effort, time and resources away from addressing the more important determinants of undernutrition.

(ii) **The ICDS did not have the financial, human and physical resources to match its ambitious mandate.** While this study does not focus on assessing the adequacy of financial resources for nutrition, the shortage of human resources and material resources shows that the ICDS does not have the wherewithal to implement its complex and ambitious mandate. For example:

- The size of the ICDS workforce comprising leaders, managers and frontline workers is inadequate to effectively implement the ICDS strategy. Primary and secondary data indicates that there is a huge mismatch between the volume of ICDS work and the people available to accomplish it and that functionaries at all levels work beyond their capacities. As discussed in chapter 4, Availability, Competence and Management of Human Resources: (a) an AWW spends more than 4.5 hours per day to perform a fraction of the full set of responsibilities; (b) supervisors are occupied with other ICDS and non-ICDS tasks and are left with only approximately five days to perform supervisory visits to AWCs, which is an important part of their job; (c) CDPOs are overstretched and spend approximately 26 days a month attending meetings, performing administrative tasks, apart from other WCD and non-ICDS tasks that add to their large volume of work; (d) sanctioned positions remain vacant for prolonged periods; and (e) data indicates that leaders are involved in operations, managers are stretched, and officials are assigned responsibilities for several functions.
- The shortage of material resources constrains the ICDS in implementing its strategy. The ICDS lacks the proper physical infrastructure, equipment and supplies necessary to deliver good quality nutrition services to its beneficiaries. The data indicates that not even 50 per cent of AWCs in the country operate from their own buildings, a large percentage do not have adequate space to carry out daily operations, basic amenities like toilet and clean drinking water are not available, as is also the case with availability of equipment and other

necessary supplies. The availability of resources is much worse in districts where nutrition outcomes are the poorest (see Figure 3.1 in Section 2.3.5).

2.3.3 While the weaknesses of the ICDS strategy were known, the program continued to be expanded without addressing the issues. In order to address undernutrition, the ICDS was expanded to ‘universalize’ its coverage by establishing an ICDS center in each habitation of the country. This strategic choice, while rapidly expanding the program and establishing AWCs in almost every village during 2005-2013, also meant that each new AWC and the total of approximately 1.3 million AWCs also inherited the weaknesses of the existing ICDS model, and the likelihood of the same sub-optimal impact. An alternate strategic option could have been to address the weaknesses, test the strengthened model and then expand the ICDS; yet another could have first targeted the high malnutrition burden areas with intensive effort. The restructuring and strengthening of the program has recently been undertaken, after achieving the proposed expansion. While in retrospect arguments can be made for or against either strategic option, a robust analysis of all strategic options remains critical to selecting the most appropriate one. It appears that such an analysis was not undertaken for the ICDS.

2.3.4 The restructuring of the ICDS and its implementation in mission mode, much like the NRHM, has addressed many technical weaknesses in its strategy and will have significantly more resources. However, it continues to have too many priorities. The ICDS mission addresses the key weaknesses in its earlier strategy to improve nutrition. It has improved the focus on pregnant, nursing mothers and children under three, and has designed a separate component for care and counseling, for community mobilization and awareness, and for health related services including strengthening referrals, and identification of malnourished children. It also outlines several new implementation approaches for the delivery of these services and several management reforms including decentralized planning, management and flexible architecture. It is considerably better resourced in terms of the physical and material, financial, technical and human resources and management structures, and outlines the strengthening of key systems, such as HR, training, M&E and accountability among others. However, the program continues to have too many priorities; and having too many priorities is equivalent to having none. Given the scale of the program and the huge change envisaged, the phasing of ICDS priorities needs to be based on a more robust analysis of the resources finally made available to the program.

2.3.5 The ICDS needs a deliberate strategy to prioritize the strengthening of nutrition service delivery in the worst off districts. Data from the HUNGaMA Survey (2011) conducted in 100 focus districts¹³ demonstrates striking differences in the levels of undernutrition and provision of nutrition services in AWCs across the three types of districts surveyed (Focus Districts, Best Districts in Focus States and Best Districts in Best States). The incidence of stunting is over 53 percent for children in Focus Districts, compared with 39 percent in Good Districts in Focus States, and 33 percent in Good Districts in Good States. There are differences in the household wealth index and the village development index (data not shown) across types of districts, which is likely to contribute to higher levels of undernutrition in the Focus Districts. However, the availability and quality of nutrition

¹³The districts were selected using a Child Development Index developed in 2009 by Indicus Analytics for UNICEF India. The 100 rural districts that ranked at the bottom of the index – referred to as the ‘100 focus districts’ - were surveyed. These districts belong to the following six states: Bihar, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, and Uttar Pradesh (referred to as the Focus States). The survey also covered the ‘best’ district from each Focus State and the six ‘best districts’ from the Child Development Index. The best districts comprised two each from Kerala, Tamil Nadu and Himachal Pradesh.

services also vary considerably across the types of districts (Figures 3.1 and 3.2). The analysis of the HUNGaMA data shows that nutrition resources and quality of services are also strongly correlated with the nutrition outcomes in the districts. Thus, where the need is

Figure 3.1: Nutrition resources and services by types of districts

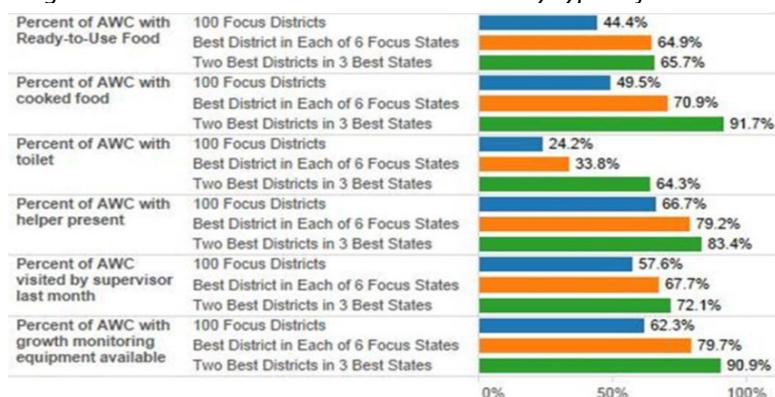
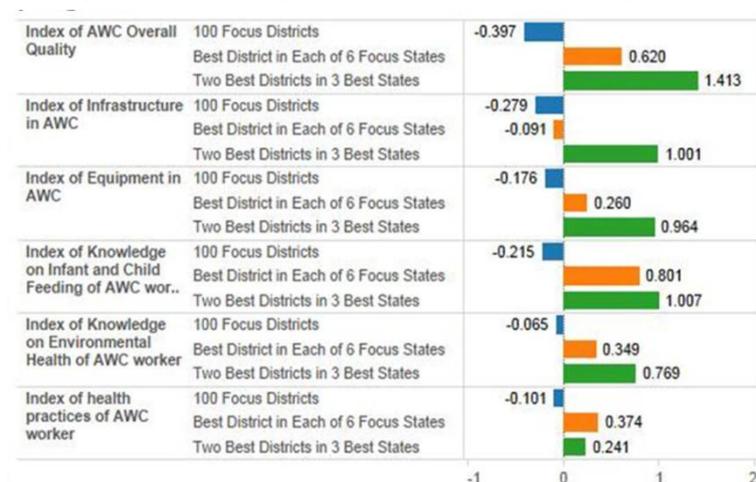


Figure 3.2: Quality of nutrition services by the type of districts



greatest, the implementation is weakest. The variation and strong association holds across individual elements of services (Newman, 2013). While the GoI has recently approved a multi-sectoral nutrition program for 200 high malnutrition-burden districts, the ICDS strategy should explicitly prioritize the high burden districts for improving the quality of its services through human resources, building their skills (training), physical and material resources, and ensuring regular supplies.

2.2.6 The NRHM vision, mission statements include no mention of nutrition. The NRHM, which is the key program that delivers several nutrition services alongside the ICDS, has no stated nutrition objectives or targets. While the NRHM program document (2005-12) does acknowledge

nutrition, sanitation, hygiene and safe drinking water as determinants of good health, and does include it as part of the preparation and implementation of an inter-sectoral district health plan, it does not include any specific nutrition outcome indicators. Although at the operational level, some nutrition related indicators such as iron-folate distribution to pregnant women and number of VHNDs are tracked, these are not included in the core list of indicators that are reviewed periodically and are thus accorded lower priority. A further discussion on these points is included in the chapter 6 on monitoring, evaluation, and the management of information in the nutrition system.

2.4 The NRHM strategy for nutrition focuses on the management of severely undernourished children and the prevention and treatment of anemia in pregnant women. The strategies pursued by the NRHM include developing technical guidelines for the management of severe undernutrition – both at facilities and at the community level, undertaking appropriate management of children with severe undernutrition at facilities through: (i) setting up and managing NRCs at district hospitals, especially in states and districts where the burden of undernutrition is particularly high; (ii) delivering micronutrients to mothers and children per policy and protocols; and (iii) coordinating with the ICDS for converging health and nutrition services, referral of sick and severely undernourished children. Recognizing that it could play a larger role in prevention of undernutrition, the

NRHM has adopted the strategy to train ASHAs in nutrition counseling. However, data collected from different levels in Bihar and Tamil Nadu indicated that the NRHM staff at various levels does not see a role for themselves in the prevention of undernutrition. As a result, coordination with the ICDS in the preventive aspects is sub-optimal, and even VHND strategy implementation dwells largely on conducting immunization. Thus, even the opportunity for the VHND to identify undernourished children, counsel their mothers, and refer severely undernourished children is not used. Most children in the NRCs come through hospital admissions whereas institutional referral linkage with the ICDS is weak. It is ironic that the NRCs in Bihar (at the time of field data collection) were sub-optimally utilized, even though Bihar has a high prevalence of severely undernourished children.

2.5 While most states follow the strategies of centrally sponsored schemes, namely the ICDS and the NRHM, some states have defined their own visions and targets for nutrition. As the ICDS and the NRHM are both centrally sponsored programs, the states follow the strategic directions laid out nationally. The GoI is responsible for policy and guideline formulation, allocation of funds, M&E, while the state governments are responsible for the delivery of all ICDS services, training, staff appointments, human resources, other administrative issues and monitoring and supervision of the programs. While most states merely implement the programs in the light of their high undernutrition rates, several states such as Haryana, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Tamil Nadu have formulated state-specific nutrition missions or strategies, targeted towards improvement of the nutritional status of children and women. Some states such as Madhya Pradesh and Tamil Nadu have given clear targets for reducing undernutrition in children and anemia among women of the reproductive age group. The nutrition documents of other states such as Haryana, Gujarat, Karnataka and Maharashtra lay down the overall goal of improving the nutritional status of children and women but do not provide definite targets or timelines. Though the states have articulated their nutrition strategies, their comprehensiveness varies as does the commitment of funds (see Annex 3).

2.6 While the staff at all levels of the ICDS hierarchy is aware of the national vision and its own vision for nutrition, in the case of the NRHM the national vision for nutrition is poorly understood. Among the workers at the block and central levels interviewed for this study, all ICDS workers were aware of the vision to reduce undernutrition, many health workers were not. Within the ICDS, the most frequently mentioned service to improve nutrition was ‘supplementary feeding’, while other services such as growth monitoring, counseling, IFA tablets, immunization were mentioned only when further probed. The FGDs and interviews indicated that except at the highest leadership levels in the MoHFW, GoI and the state H&FW departments, most officials including the senior level ones of the NRHM (in their first response) did not think of nutrition as a subject but as the responsibility of the ICDS. Invariably, the key service to address undernutrition was identified as ‘supplementary feeding’ by the ICDS. Only with prompting or deeper probing did they acknowledge the NRHM’s role in the distribution of micronutrients, treatment of severe undernutrition, and conducting monthly VHNDs. In this regard, the statements of a senior health ministry official that “there isn’t a clearly articulated nutrition vision,” or that of a chief surgeon who is “unaware of a vision for nutrition,” or BMOs who said they did not know of any vision for nutrition in the NHRM are quite telling. This again underscores the importance of including and repeatedly disseminating nutrition in the vision, mission and objectives of the MoHFW, GoI and MWCD, GoI and in the NRHM.

3 Balance between continuity and change

Until its restructuring in 2012, the ICDS has been a largely static program and has not been able to maintain a sustainable balance between continuity and change. While it has adopted some new approaches in improving service delivery, it was unable to change its strategy significantly. The NRHM, since its inception in 2005, has generally been able to strike a better balance and has added activities to increase its focus on nutrition.

3.1 Overall, continuity and not change has been the defining characteristic of ICDS strategies. The ICDS has until its recent restructuring been a relatively static program, and most strategies and operational policies have not been altered since its inception in 1975. It is the role of leaders to regulate the necessary direction of change, and its timing and pace. They need to keep a sustainable balance between the two needs – the need to change and the need to keep the pace of change realistic. The ICDS has not kept a sustainable balance between continuity and change. While some refinements in the implementation approach have been made, major strategic changes have remained elusive.

3.1.1 Even though strategies and operational policies have not undergone much change, the ICDS has adopted learning from good practices and refined its implementation approach. While the system generally lacked dynamism to bring about the required change, the ICDS has made efforts to introduce and institutionalize new implementation approaches based on learning from good practices, particularly from experiences in development partner-supported areas. Several states too have, within the existing strategic framework, introduced innovative approaches to enhance implementation. These include conducting VHNDs to bring about better coordination between the delivery of health and nutrition services, take home rations for pregnant and nursing mothers and children under three, and the use of local customs to promote appropriate infant and young child feeding practices.

3.1.2 In recent years, the ICDS has demonstrated the ability to change through several new initiatives. Over the past few years, the ICDS has undertaken several analyses and steps for major systemic improvements and filling the gaps. Some key initiatives include the design, testing and roll-out of a new MIS, a nutrition resource e-platform for knowledge sharing, an ECCE draft policy and curriculum framework, adoption of the WHO child growth standards and designing a joint mother and child protection card. The most significant and large change is the restructuring of the ICDS (see para 2.3.4).

3.1.3 The much needed change in strategies to address the known problems has, however, been slow. The ICDS is one of the most widely studied programs, and a large number of assessments, reports and papers by various stakeholders speak of its many weaknesses and the unsatisfactory impact of its strategies. These include the need for the ICDS to: (i) strengthen the focus on pregnant, nursing mothers and children under three to improve nutrition; (ii) increase the program focus on counseling and promote behavior change; and (iii) catch growth faltering early on to prevent undernutrition. Despite the extensive information available on the most effective strategies to address undernutrition, and shifts required in the ICDS strategies to enhance the nutrition impact, the ICDS has not, until its recent restructuring, introduced any major change in its strategy. Similarly, there are major shortcomings in the ICDS training system, borne out by evaluations and studies, which have offered recommendations to address the weaknesses, but little action has been taken. Currently, training reform is under consideration to address the key issues.

3.2 The NRHM has achieved a better balance between continuity and change. The NRHM, since its inception in 2005, has taken a number of steps to increase its focus on nutrition and to explicitly include nutrition-related activities in its annual plans. The annual program implementation plans (PIPs), which form the mechanism for annual planning in the NRHM, now include training for frontline workers on lactation management and the strengthening of convergence with the ICDS through platforms such as VHNDs. Recognizing the need to strengthen nutrition counseling at the community level, this was added to the training modules for ASHAs and, in 2011, the VHSC was expanded to include nutrition in its mandate and renamed as VHSNC.

4. Agenda overload and shortage of leaders

There is no dedicated leader for nutrition, or for the ICDS program, and leaders responsible for both have many other competing priorities. Since they are also responsible for operational issues, there is an agenda overload at the leadership level. In the NRHM, the overall situation appears better, although nutrition is not accorded a high priority by its leaders and officials.

4.1 The acute shortage of leaders and senior managers in the ICDS leads to an agenda overload for its leaders. The situation in the NRHM appears much better. Considering the ambitious and complex mandate of the ICDS, at the MWCD, GoI and state levels, leadership positions (including senior managers who are also leaders) are too few. Furthermore, the ICDS is only one of several programs, schemes and sectors entrusted to leaders in key decision-making positions. Thus, there is no dedicated top level leader for such a large and complex program. Besides, there are no technical advisors to assist the top leaders, there being only one or two senior manager or leader positions to fulfill mostly operational roles. However, all decision-making authority rests only with the top leader, usually the secretary or the joint secretary in the MWCD, GoI and the secretary or principal secretary in the states, and these include most operational decisions. As a result, leaders at the state and national levels are heavily involved with management and operational responsibilities and day-to-day problem solving, and critical leadership functions get neglected. Similarly, at the next level, senior managers are very few and usually not dedicated to heading their functional and technical areas such as training, monitoring, nutrition and ECCE.

4.1.1 At the district level, the paucity of staff (sanctioned positions and vacancies) compromises the DPO's ability to lead and comprehensively manage the ICDS. Interviews with officials at the district, state and national levels pointed towards the mismatch between the volume of work and people available to accomplish it, and the fact that everyone worked beyond their capacities. Similarly at the CDPO level, the key operational leadership and management position, the work overload is huge. For example, the staffing norms for the district project office provide for five administrative staff to support the DPO, who is expected to perform all functions such as monitoring, coordination within the ICDS and with other key departments, and supervision. A large number of sanctioned positions remain vacant for prolonged periods. In the test sample of 65 DPO offices, more than 30 percent of the positions for office superintendent and statistical assistant were vacant in 2011 (CAG, 2012). Regardless of the size of the project, which could have twice the number of AWCs, or more than the norm, there was only one CDPO sanctioned per project. This overload, among other factors, contributes to compromises in management (chapter 4, Availability, Competence and Management of Human Resources in the System). Thus, leaders are

involved in operations, managers are stretched, and officials are assigned responsibilities for several functions, regardless of existing workload, skill sets or training. The ICDS has expanded manifold and new programs added for the same managers, creating an agenda overload at all levels.

4.1.2 Vacancies, particularly at the senior and mid-management levels further aggravate the agenda overload of the leaders. While top level leadership positions at the national and state levels are filled promptly, the vacancies for managers at the national, state, district and block levels remain high (chapter 4, Availability, Competence and Management of Human Resources in the System). Since vacancies take long to fill, acting personnel are appointed to take care of critical functions, primarily to meet signatory functions. The most critical in terms of vacancies is the CDPO position that has to lead and manage on-the-ground implementation of the strategy envisioned by the top management. However, approximately a third of these are vacant and, as a result, the corresponding one-third of the program has no leadership at the operational level and the management suffers.

4.2 Under the NRHM, the situation appears much better. The establishment of the NRHM, well-staffed mission directorates with technical and managerial staff at the national, state and district levels and improved staffing in the field, has led to better availability of leaders and managers than that in the ICDS. Nevertheless, interviews with medical officers at different levels, especially in Bihar, did convey an agenda overload at the district and block levels, with one officer leading more than one program due to many vacant positions, and the shortage of medical officers.

Recommendations

Among the most significant factors that have constrained the leadership for nutrition in the country are the absence of a dedicated organizational home and lack of leaders. Even though during the past few years the MWCD, GoI has exerted laudable leadership in the nutrition sector, the capacity constraints discussed so far continue to hinder its leadership role. There are still several areas that require leadership and attention, including nutrition surveillance, research, evaluation of program strategies, food fortification, and the emerging double burden of malnutrition in the country.

In this scenario, the recommendations are:

1. It is critical to establish in the MWCD, GoI a dedicated organizational unit led by a senior official to: (i) take leadership of the sector; (ii) provide strategic direction including that related to other sectors; (iii) convene the necessary policy discussions; (iv) commission research and assessments; and (v) ensure surveillance of trends for both undernutrition, overweight and obesity. It is also important that the unit be appropriately staffed, resourced and empowered to take full stewardship of the sector. The GoI will, therefore, have to provide the necessary financial and human resources to enable it to exert stewardship. In the case of the MWCD, GoI this will essentially require separating the overall nutrition stewardship function from its function as implementer of the ICDS and other nutrition schemes.
2. The MWCD, GoI, being the country's nodal ministry for nutrition, must explicitly include nutrition in its vision and mission statements in strategy documents and RFDs. Nutrition should be at par with the two key areas, namely women and children, in the ministry's vision and mission statements. Similarly, the vision and mission statements of the

MoHFW, GoI and the NRHM must articulate their commitment to their role in improving nutrition.

3. Much of what is desired as change is already incorporated in the restructured ICDS implementation framework. The reform will be challenging and, if implemented well, can be a game changer. Leadership and its enabling factors will play a critical role in successful implementation. The ICDS mission strategy continues to be very ambitious, and also continues to have a large number of objectives and activities. Operationally, having too many priorities is tantamount to having none, since the time and resources available may hamper achieving all of them at the same time. It is, therefore, suggested that:

- as one of the first steps in the course of its implementation, the ICDS mission should align its priorities better with the resources available, and set clear and realistic time bound targets that should be communicated frequently down to the grassroot level; and
- since implementation takes place at the state level and results are measured by what happens on the ground, given the varying capacities, context and issues, with resultant differences in the targets that each state can achieve, it will be important to arrive at a common understanding of targets and timelines with each state.

4. Since the implementation and quality of the ICDS is weakest in the areas with the greatest needs, it must articulate an explicit strategy to prioritize the districts with the poorest health, nutrition and wealth indices, and develop clear guidelines for its implementation and management. It should spell out the implications of such a strategy, that enables: (i) provision of additional resources – physical, financial and human (including priority staffing of vacant positions) – in these areas; and (ii) tighter management, including monitoring and supervision.

5. One of the basic issues that the ICDS needs to resolve is the development of written conceptual frameworks for each functional area as these would guide the holistic development of each area. The top leaders should ensure that senior managers, who are also leaders, develop these so that each function is fully built up and operationalized.

6. Implement a leadership development program for top leaders and senior managers. For leaders, the content should include experiential learning on how to lead, how to develop conceptual frameworks and models, how to formulate vision statements, policies and strategies and set the tone for organizational culture, both through direction to the organization and personal example.

CHAPTER 4

Availability, Competence and Management of Human Resources in the System

Introduction

The capacity of an organization to deliver its mandate is influenced, among others factors, by its human resources (HR). Human resources are the most valuable of all resources in any organization or agency, and their effective management is one of its most critical functions.

This chapter focuses on an analysis of the critical issues that enable or constrain the current workforce in the ICDS and the health system to adequately and efficiently deliver high quality nutrition services, under their respective mandates, to improve the nutritional status of pregnant nursing mothers and children under three years of age. Using an analytical framework described in the first section below, the next three sections discuss the three key capacity constraints outlined in the conceptual framework, followed by the final section outlining some suggestions to improve the availability, management and motivation of human resources in the nutrition system. The three key questions sought to be answered here are:

- 1. Do the people working currently for the ICDS and the National Rural Health Mission (NRHM), at operational and management levels (from the village to the district), have adequate capacity to carry out their agency's mandate to improve nutrition, fully and effectively?*
- 2. Do the MWCD and the relevant departments in the states managing the ICDS HR function have the ability to recruit people with such capacity or with adequate potential capacity and then: (a) develop them to the level necessary; and (b) engage them productively? If not, what are the constraints?*
- 3. If the ability is not strong enough, what can be done about it?*

The analysis presented in the following pages leads us to conclude that the shortage of staff with required knowledge, skills and motivation to deliver the ambitious ICDS mandate is one of the most important constraints limiting its capacity to improve the nutrition of women and children under three years. The lack of professional management of the ICDS HR function has affected its ability to plan, recruit and develop its huge and increasing workforce to match the program's growing needs. The recently restructured ICDS proposes to reform the ICDS HR system, a step that could make a critical difference to fulfilling its mandate. The findings and suggestions discussed in this chapter are relevant to the proposed reform.

Analytical framework and capacity assessment indicators

The combined effect of three key factors, namely the size of the workforce, its knowledge and skills and level of motivation, enables or constrains an agency's ability to function effectively and achieve its mandate. The size of the workforce should be based on a systematic and objective analysis of workloads at each level or unit; personnel at each level should possess the right mix of knowledge and skills to enable them to carry out their tasks

effectively and efficiently; and they must be well motivated to achieve their goals. Each of these factors is discussed in detail in the analytical framework described in Annex 1.

The following indicators are used to assess the effectiveness of HR (Table 4.1):

Table 4.1: Capacity assessment indicators: Human Resources	
Operational indicators to assess the effectiveness of HR	Assessed by indicators
Size of the workforce	Number of sanctioned staff relative to the volume of work required
	Ratios of subordinates to managers – norms
	Number of staff in position compared to the number sanctioned
Skills and levels of competency	Knowledge and skills of staff relative to the knowledge and skills required for their respective jobs <ul style="list-style-type: none"> • Recruitment criteria, norms and practices • Training – quantity and quality
Motivation of staff	Care about and involvement in work, such as attempts to take some initiative, attempts to resolve issues, frequency of incomplete work, frequency of calling in sick or coming late to work

The following sections discuss each of the three constraints at length in terms of the present situation, their causes and consequences on nutrition services, and offer suggestions to address the constraints.

Findings

Evidence from the primary and secondary sources discussed in the following sections, leads to the conclusion that inadequate HR capacity is one key reason that constrains the capacity of the ICDS to deliver nutrition services efficiently and effectively. The staff at their current levels of efficiency is insufficient for accomplishing the volume of work in the time allocated with the resources at their disposal. Most do not possess the knowledge and skills needed to perform their roles fully and effectively. Moreover, their motivation levels are low. The HR capacity in the NRHM to deliver nutrition services, while better than that in the ICDS, is also constrained by sub-optimal knowledge, skills and motivation.

1. Size of the workforce

The size of the ICDS workforce appears insufficient to accomplish the quantity and quality of work required to fulfill the ambitious ICDS mandate This is because the volume of work is very large for the sanctioned staff to accomplish with: (i) the resources available to them; (ii) the time at their disposal; (iii) non-ICDS tasks adding to the volume of work; and (iv) a large proportion of sanctioned positions remaining vacant for prolonged periods.

1.1 The time required by the AWW, supervisor and CDPO to accomplish their full range of mandated activities exceeds the time available to them.

1.1.1 While several studies speak of the high workload of the AWW, most provide time estimates for her daily tasks or only some of these. No systematic workload analysis is available that provides comprehensive estimates of the full range of tasks assigned to the AWW. Table 4.2 lists the AWW's ICDS tasks and notes the time estimates from two reports for the activities with available data. Table 4.2 clearly indicates that even though the time

estimates do not cover the full range of the AWW's daily tasks, and do not factor in the time for activities to be performed periodically, the time actually spent by the AWW exceeds the time of 4.5 hours of work sanctioned to the AWW in almost all states. Furthermore, it indicates that PSE supplementary feeding and record keeping take up a very significant portion of the AWW's time.

Table 4.2: Time estimates of AWWs' tasks

Tasks	Frequency	ICDS suggested time allocation*	DB Gupta, 2007 [#]	Planning Commission 2011
PSE	Daily	120 min	150 – 192 min	89 min
Preparation and distribution of SN	Daily	30 min	24 -37 min	51 min
Treatment of common childhood illness/ailments & referrals	Daily	30 min	NA	NA
Growth monitoring and promotion activities	Daily	NA	NA	NA
Assist ANM in ANC/PNC services and immunization	Monthly	NA	NA	NA
Filling up records and registers	Daily	30 min	12- 23 min	99 min
Minimum 2-3 home visits	Daily	60 min	34 -63 min	NA
Attend sector and block-level meetings	Monthly	Not available NA	NA	NA
Organize program for adolescent girls		NA	NA	NA
Organize VHND	Monthly	NA	NA	NA
Conduct village survey	Annually and update quarterly	NA	NA	NA
Total		4.5 hours (270 min)	3.9 – 5.4 hours (234 – 324 min)	3.9 hours (234 min)
<i>NA: Not Available</i>				
<i>*Source – Hand Book for Anganwadi Workers –NIPCCD (2006).</i>				
<i>[#] Study commissioned by the World Bank. The data was collected through structured questionnaire administered to AWWs in the states of Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh.</i>				
<i>Note: Under the restructured ICDS, the working hours are proposed to be extended to six hours with four hours dedicated to PSE.</i>				

1.1.2 For the supervisor or CDPO, we found no data for their volume of work or time-work estimates. In order to obtain some indicative data and arrive at preliminary estimates on the time spent by supervisors and CDPOs on various tasks, primary data was gathered from a small sample of supervisors¹⁴ and CDPOs.¹⁵ While the sample is small and has limitations, given the dearth of data on supervisor and CDPO workloads, these estimates serve as pointers to the likely mismatch between the time required to perform the various tasks assigned to supervisors and CDPOs and the time available to them, and underscore the need for a larger and more systematic time and work study to assess workloads of supervisors and CDPOs. Table 4.3 presents the data in this analysis.

¹⁴ This is based on a small sample of 33 supervisors in one district of Andhra Pradesh through structured questionnaires. This district offered the opportunity to estimate workloads in a situation where most supervisor staffing was relatively better, and additional AWC supervision load modest (approximately 50% of the supervisors had additional AWCs to manage and the average number of AWCs for the sample was 25); also none of the supervisors reported that they were assigned additional administrative or clerical tasks at the block level.

¹⁵ Based on a small sample of 20 CDPOs from five states (Maharashtra, Rajasthan, Gujarat, Haryana and Himachal Pradesh).

	CDPO* n = 20	Supervisor# n = 33
Activity	Average time taken (Days/month) (Range)	Average time taken (Days/month) (Range)
Administrative work including planning and reporting	11.7 (2.2 – 27.2)	1.4 (0.04 - 3.1)
Sector meetings	0.8 (0.3 – 3.5)	1.7 (1.1 – 2.4)
Other meetings	6.8 (1.7 – 12.7)	3.6 (1.3 – 3.6)
Other activities	1.4 (0.0 – 6.0)	1 (0 – 9.7)
Non-ICDS (SABLA & IGMSY)	2.4 (0.6 – 5.2)	8.4 (1.0 – 24.0)
Other WCD activities	2.7 (0.1 – 9.5)	0.7 (0.04 – 3.1)
VHND	-	1 (0.1 – 2.7)
TOTAL (excluding AWC visit)	25.8	17.8
Days remaining to carry out AWC visit	-	5.5
Average time per AWC visit	9.0 hours (Travel: 3.6 hr; Visit: 5.4 hr)	4.8 hours (Travel: 1.1 hr; Visit – 3.7 hr)
Possible number of visits in remaining days	None	9
Average of workers days a month	An average of 23 working days per month is calculated: Subtracting 18 gazetted + 2 restricted holidays + 10 days of annual and 10 medical leaves from the maximum possible work days of 312 every year (@6 days a week); dividing the 272 days per year thus arrived at over 12 months	

1.1.3 The volume of work of the ICDS at district offices, state directorates and at the national level is too large to be managed by the number of positions sanctioned. While the ICDS has expanded manifold in terms of its geographical coverage, the sanctioned complement of officials and staff at the central, state and district level continues largely as before. The district office is the most appropriate unit for comprehensive management of the ICDS operations, including planning, implementation, coordination, monitoring, ensuring quality and problem solving. However, the staffing pattern for the district project office (Table 4.4) is minimal and does not appear to enable it to appropriately perform these

Staff	Number
District project officer	1
Office superintendent	1
Statistical assistant	1 (2 for districts with >10 projects)
Accountant/ UDC	1
LDC	1
Peon	1

Source: MWCD, 2010

functions. Interviews with officials at the district, state and national level pointed to the mismatch between the volume of work and the people available to accomplish it and there was recognition that everyone was working beyond their capacities. Thus, leaders are involved in operations, managers are stretched, and

officials are assigned responsibilities for several functions. Responsibilities for all functions and tasks are assigned to the staff in position regardless of their existing workload, skill sets or training, and each member of the staff holds responsibility for several functions.

1.2 Many non-ICDS tasks, including several related to other WCD schemes, add to the volume of work of ICDS staff. AWWs are called upon to assist in other government programs such as socio-economic surveys, sanitation campaign, facilitation of self-help groups, collection of village level data, various public health programs, census, elections is well documented (Desai et al, 2012; Planning Commission, 2011; Thakare et al, 2011; Pratiche India, 2009; Citizens' Initiative for the Rights of Children Under Six, 2006; Dash, 2006; Gragnolati et al, 2005). Recent estimates from 20 states show that while there are variations from state to state, on an average an AWW spends approximately six hours a day for about 14 days in a year on non-ICDS work. Of particular concern is the data from Odisha, Maharashtra, Bihar and Uttar Pradesh¹⁶ (Planning Commission, 2011). Supervisors and CDPOs also get drawn into additional tasks such as elections, conduct of public examinations, government events, and campaigns. Besides, they have also been assigned responsibilities for other WCD schemes that include IGMSY, SABLA and ICPS which, while complementing the ICDS, add to their regular workloads. Primary level data from Andhra Pradesh indicated that supervisors spend on an average nine days per month for work related to the IGMSY as it involves cash transfers and requires intensive work. The CDPOs spent approximately five days per month on work related to domestic violence, child marriage and child rights. During the FGDs conducted as part of this study, the AWWs, supervisors and CDPOs confirmed that their involvement in non-ICDS duties added to their workload, diverted them from ICDS tasks, and at times non-ICDS tasks assumed greater importance than their core ICDS responsibilities. This is also substantiated by studies (Midstream Marketing and Research Pvt Ltd, 2005). Although at the district and state levels, additional staff is sanctioned for implementation of the IGMSY, at the project level the scheme is implemented through the ICDS functionaries.

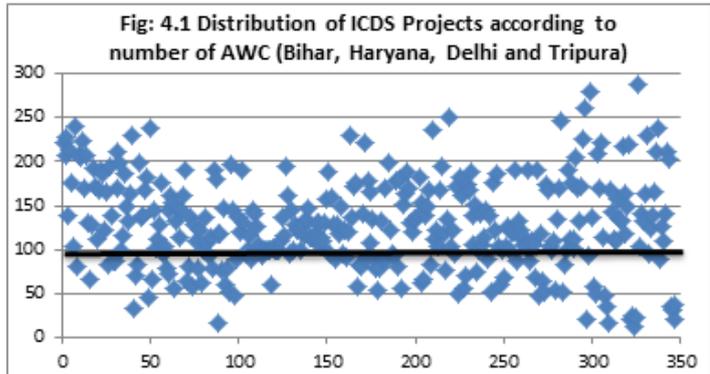
1.3 The restructured ICDS, recognizing the shortage of staff in the ICDS provides for additional positions at the national, state, district and block levels. However, it also adds several tasks to the AWW's and Supervisor's list of tasks, thereby adding further to their volume of work. To improve the availability of personnel, the restructured ICDS has increased the size of the workforce at the national, state and district levels, while also allowing the states to fill positions temporarily on contract until regular appointments are made, so as to avoid interruption in service delivery due to vacancies. However, there is little additional support for on-the-ground implementation; and no change in the CDPO, supervisor or AWW staffing norms even though several new tasks are added for the AWWs to accomplish and for the supervisors and CDPOs to supervise. For example, a monthly ECCE day, Sneha Shivirs and additional counselling are proposed to be conducted. Further, the total working hours of the AWC are proposed to be extended by 1.5 hours daily (from the current 4.5 hours to six hours per day), with PSE hours extended by two hours (from 2 to 4 hours). This creates an additional daily crunch of half an hour further skewing the AWW's work-time ratio. Under the restructured ICDS, a second AWW is sanctioned in 10 percent of the project areas, primarily in the high malnutrition-burden areas, alongwith some additional technical support for counseling in these blocks. However, the norm for the number of supervisors and CDPOs in these areas too remains unchanged, even though the number of AWWs for the supervisor to supervise is twice that of the existing numbers. Further, in the

¹⁶ Odisha: 3 hours per day for 59 days per year; Maharashtra: 4 hours per day for 21 days per year; Bihar: 7 hours per day for 21 days per year; and Uttar Pradesh: 7 hours per day for 16 days per year.

remaining 90 percent of AWCs, the additional tasks will have to be done by the same AWWs. As the large body of evidence suggests, the workloads of the AWW, supervisor and CDPO cadres are unmanageable and the existing staffing norms unrealistic. However, no objective workload analysis has been undertaken even to support the ICDS restructuring.

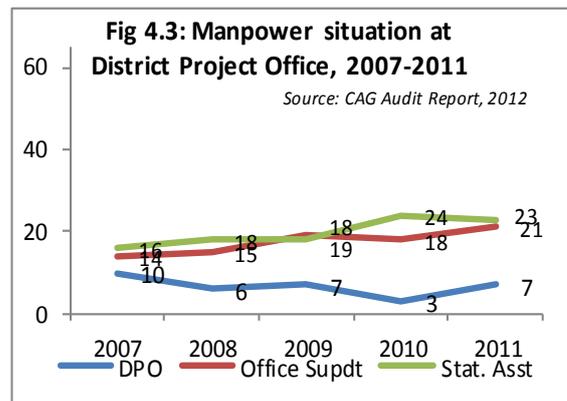
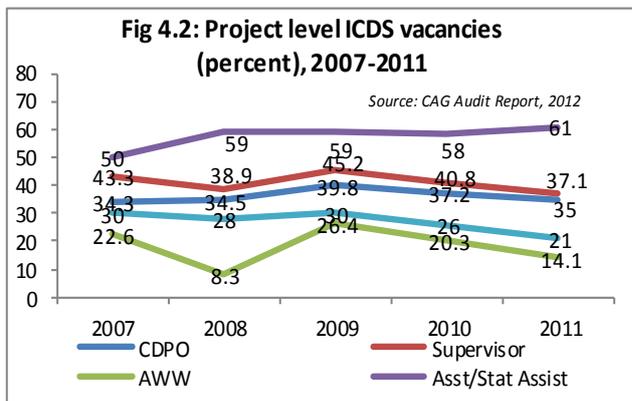
1.4 The norms for the ratio of subordinates to managers, particularly at the project level are not rational.

1.4.1 *The staffing norms for CDPOs do not take into account the number of AWCs under their jurisdiction.* Notwithstanding the number of AWCs under a project, only one CDPO position is sanctioned. The system applies the same staffing norm to all projects regardless of size. Figure 4.1 illustrates the considerable variation in the number of AWCs under the projects, and the large proportion of projects exceeding the norm of approximately 100 AWCs, several with AWCs almost twice the norm. Thus the number of AWWs and supervisors that they are required to supervise is twice that of the CDPOs who have to manage approximately 100 AWCs.



1.4.2 *Staffing norms for district offices are also uniform across districts irrespective of the district size and number of projects they have.* District offices with a very small staff sanction are expected to exercise supervision of and provide leadership to all projects in the district. Again, the staffing norms are not based on the number of ICDS projects to be supervised, but are the same across all districts, except that one additional statistical assistant is provided in districts with more than 10 projects.

1.4.3 *The pervasive, persistent and large numbers of vacancies exacerbate the shortage of staff in the ICDS.* Figures 4.2 and 4.3 show the consistently large number of vacancies of supervisors, CDPOs, project staff (totaling 254) and in district offices (totaling 65). In 2012, several states had large number of supervisor vacancies. For example, Bihar, West Bengal, Assam and Uttar Pradesh had 86 percent, 54 percent, 44 percent and 35 percent supervisor positions vacant (MWCD, GoI, 2012). Although vacancies at the AWW level are proportionately lower, given the very large number of AWCs, this translates into 59,000



AWCs operating without an AWW as of March 2012.¹⁷ Owing to the large number of vacant supervisor positions, supervisors are assigned responsibility of supervising AWCs additional sector(s)/sub-sectors. Besides, they may also be assigned direct responsibility for AWCs when AWW positions are vacant, and administrative and clerical duties at the project office, including preparing bills, getting them cashed in the treasury, consolidating reports, especially where statistical assistant, assistant and clerical positions remain vacant. Analysis of the MWCD (2012) data showed that the effective average workload of a supervisor is 40 centers¹⁸ against the norm of 25 AWCs.

1.4.4 Owing to the large number of vacant CDPO positions, several CDPOs are assigned an additional charge of blocks, and their workload increases exponentially depending on the number of blocks for which they hold additional charge. Data from MWCD indicates that on an average a CDPO is in charge of 220 AWCs¹⁹ against the norm of 100 AWCs.

1.4.5 The many vacancies at the district ICDS offices add to staff shortage. While there are inter-state and intra-state disparities in the staffing of sanctioned positions at the district level, data from a sample of 65 DPO offices (Figure 4.3) indicates the persistently large shortage of staff at the district offices due to sanctioned positions lying vacant.

1.5 The mismatch between supervisors and CDPOs workloads and the time at their disposal constrains their ability to exercise optimal supervision. For supervisors, high workload and time constraints limit the time and attention they can give to the primary responsibility of supervising the functioning of AWCs. Supervisors interviewed during the FGDs for this study noted that the multitude of other tasks sometimes prevented their visiting AWCs for 10-15 days at a stretch. Thus, the most important function of supervisory visits to AWCs was compromised, entailing the number of visits, or the quality of visits, and often both.

The most recent evaluation of the ICDS notes that CDPO visits to AWCs are minimal, averaging only one visit in six months, and focused largely on checking records and registers (Planning Commission, 2011). Data from the CDPO structured questionnaires indicates that the paucity of time and the pressure of meeting the norm of visiting 100 AWCs per quarter do not allow monitoring and supervision of all activities required. Consequently, supervision is limited to undertaking a few activities, thereby also compromising the quality of AWC visits.

1.6 Several factors have constrained the ability of the ICDS to ensure and manage the availability of the right numbers of staff.

1.6.1 Staffing norms are not supported by workload analysis. The ICDS has thus far not undertaken any assessment of the number of persons required at different levels to carry out the functions and tasks required to fulfil its mandate. The data in the foregoing sections clearly shows the unmanageable volume of work to be accomplished by the sanctioned complement of staff. However, staffing norms established since the inception of the ICDS continue to be followed without assessment of workloads. Regardless of the volume of work, the ICDS was required in the 10th five -year plan to reduce program staff by at least 20 percent, as a result of which positions at the projects and district offices were reduced, thereby increasing workloads of the CDPOs and supervisors (see Table 4.5). However, no

¹⁷ Computed from MWCD data, 2012 (operational AWC, AWW and AWH in-position).

¹⁸ Computed from MWCD data, 2012 (operational AWC/supervisors in-position).

¹⁹ Computed from MWCD data, 2012 (operational AWC/CDPO in-position).

additional resources or mobility support was provided to enhance the efficiency of the staff in managing the increased workloads, nor were the norms for AWC visits revised to accommodate the additional workload. If a solid workload analysis had been available, it might have helped the ICDS to better justify the staff positions.

1.6.1.1 Furthermore, the ICDS has continued to add new responsibilities for other schemes to

its existing staff such as their involvement in SABLA and IGMSY. Moreover, vacancies continue for prolonged periods at the ICDS departments in the states and at the ICDS division in the MWCD. Replacements for staff that retire, or transfer to other departments or are on long leave, are either highly

Table 4.5: Staffing norms for ICDS block-level positions	
Block-level position norms prior to 2003	Block-level position norms after 2003
CDPO ACDPO Assistant Statistical assistant Supervisor (one per 20 AWCs) Clerk/typist Driver Peon	CDPO Assistant/statistical assistant Supervisor (one per 25 AWCs) Clerk/typist Peon

delayed or not made, thus adding to the workload of existing staff. For example, the Monitoring and Evaluation Unit (M&E) at the MWCD consists of five people to monitor the data of over 1.3 million AWCs across India. In 2004-05 there were 0.7 million AWC and CD bureau (under whose jurisdiction ICDS lies) had five assistant level staff in 2012. Today, with over 1.3 million AWCs there are only two assistants.

1.6.2 Prevailing recruitment practices and processes are not efficient and have constrained the timely appointment of staff to fill sanctioned positions, and in retention of appointed staff.

The MWCD provides recruitment criteria and guidelines to the states, and the states are responsible for recruiting staff for projects and districts offices. Since the ICDS lacks policies to appoint its own dedicated cadre for the CDPOs, with the exception of a few states who directly recruit CDPOs for the ICDS, the CDPOs get drawn from other departments on deputation, generally for a few years. Therefore, long-term retention of CDPOs is a problem. Supervisors are usually recruited through state public service commissions and the recruitment cycle can be quite long. Moreover, 25 percent of supervisor positions, reserved to be filled through promotion from the ranks of the AWW, conditional on ten years of satisfactory performance as an AWW, remain vacant for prolonged periods. Delays in constituting selection committees, political interference and corruption could also lead to positions staying vacant for long. In many instances, appointments are challenged by candidates or other citizens on grounds of impropriety and an injunction obtained from the court to stay the appointment and it can be years before the appointment can stand. The lack of an integrated personnel information system and poor personnel/ human resource sections within the department makes proper planning or monitoring impossible. Most ICDS departments are serviced by a manually operated database of staff. As a result, ad hoc measures are taken regarding deployment of staff which usually means ‘easy’ posts are filled up and posts in more remote/difficult areas are not. (Biswas and Verma, 2009). Kickbacks for transfers and postings to preferred locations were also mentioned during FGDs as a reason for poor deployment.

1.7 In the NRHM, largely established population coverage norms are met and staffing of frontline workers is generally satisfactory. The delivery of nutrition services constitutes a very small part of the overall services delivered by the health system, and is thus

a relatively small component of the overall volume of work of the functionaries of the system. Therefore, the study does not attempt to assess the overall workload of the health functionaries to assess the adequacy of the sanctioned positions and, instead, limits the scope to an examination of two key factors which could constrain the ANM's ability to extend the required nutrition services to mothers and children, and the access of pregnant women, sick and undernourished children to healthcare facilities, namely: (i) the actual coverage of populations by health facilities; and (ii) the staffing of field level positions against the norms.

1.7.1 The effective coverage of rural populations by health sub-centers and primary health centers is generally close to the established norms. While ASHAs provide services on a village basis, the effective population to be served by ANMs, and thus their volume of work, is determined by the population covered by the health sub-center. Table 4.6 indicates that the

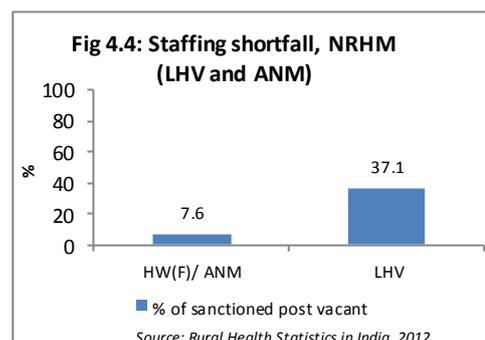
ANMs' volume of work as assessed by the average population served by the sub-center appears to be satisfactory, although it is possible that there exist state, district and block differentials, which could constrain the ANMs' ability to provide services, in quantity and quality, to all the mothers and children covered by them. Similarly,

	Norm	Average coverage (March 2012)
Sub-Center	3000 – 5000	5615
Primary Health Center	20000 – 30000	34641
Community Health Center	80000 – 120000	172375

Source: Rural Health Statistics in India, 2012

the average coverage of the primary health center (PHC) which is the first referral facility at which medical doctors are available, while somewhat higher than the norm, could be considered generally adequate. Therefore, the absence of health care centers is not a constraint in the access of sick and undernourished children to a doctor and this has to be seen in the light of vacant positions.

1.7.2 **Vacancies for ANMs are few, but those for their supervisor, the lady health visitor are high.** The availability of key staff associated with the delivery of nutrition services at the village level, that is the ANMs and ASHAs, is generally satisfactory (Figure 4.4). Therefore, assuming that the overall norms of NRHM for population coverage and staffing are reasonable in terms of workloads, the ANMs do not appear to be additionally burdened by having to cover substantially larger populations than the norm. However, over a third of the LHV positions are vacant and thus the ones in position are stretched by having to deal with the additional load of covering larger areas and supervising more ANMs than the norm. As on March 2012, only four percent of PHCs were without a doctor but in the CHCs the shortfall of specialists was acute in most states (Rural Health Statistics in India, 2012).



To conclude, although the staffing in the NRHM appears largely satisfactory, ICDS capacity has been very constrained by its shortage of staff. Data suggest that the sanctioned complement of staff is inadequate to deliver its mandate. Even though the restructured ICDS has augmented the staffing at all levels, it remains important for ICDS to conduct workload analysis of all positions to inform staffing norms. Given the persistent and large number of vacancies and the delays in recruiting people, the ICDS must consider improving its

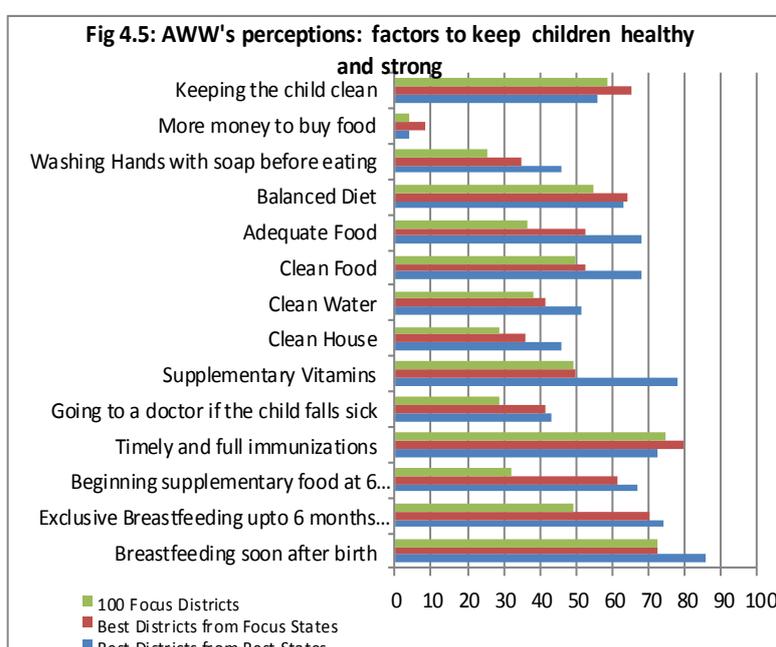
recruitment processes and making them more transparent. Needless to say, the absence of necessary staff has adversely affected the implementation, administration, monitoring and supervision of the scheme and has contributed to the many shortcomings in the ICDS.

2. Knowledge and Skills

A triangulation of existing data, reports and the FGDs undertaken as part of this study indicates that at all levels – amongst field functionaries, managers and leaders – a vast majority of the ICDS and NRHM workforce does not possess the necessary knowledge and skills to effectively and efficiently perform the functions expected of them, specifically those pertaining to delivery of nutrition services.

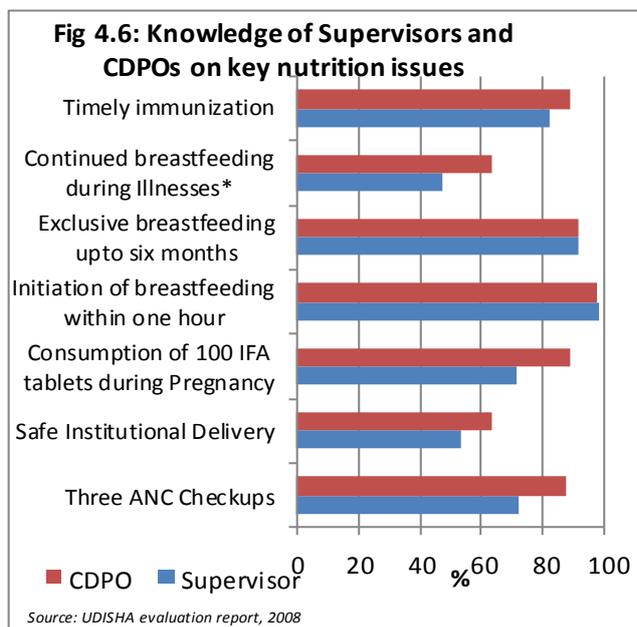
2.1 AWW knowledge and skills are poor in several critical areas that impact nutrition.

According to the HUNGaMA Survey (2011) that covered 3,149 AWCs and 2,207 AWWs across three categories of districts, namely focus districts, best districts focus states and best districts best states, drawn out of six states, from the most remote and impoverished areas of India to its most shining examples of progress shows that while 96 percent of AWWs had heard the term ‘malnutrition’, only 42 percent could correctly define it. The only two interventions about which almost 70 percent of the AWWs across the three types of districts were knowledgeable were, early initiation of



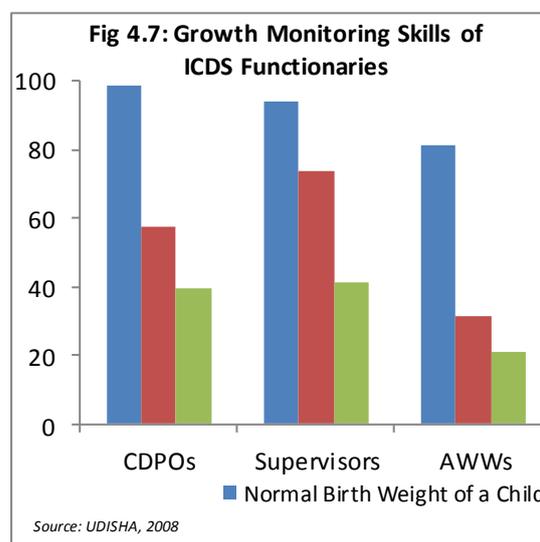
breastfeeding and timely and full immunization. Knowledge related to exclusive breastfeeding for six months and timely complementary feeding, seeking medical treatment for a sick child, and food and environmental hygiene appears to be particularly poor amongst a large proportion of workers’ (Figure 4.5). While the AWWs’ knowledge of nutrition is not satisfactory even in the best districts of the best states, the knowledge gaps are highest in the districts with the worst nutrition indicators. Further, there are differences between the knowledge of workers in the focus districts and the best districts in those states, indicating that workers in worse off districts even within the same state have a poorer knowledge of nutrition. Several studies have documented the shortcomings in the AWWs’ knowledge in areas critical to nutrition, such as growth monitoring and promotion, antenatal care, iron and folic acid supplementation during pregnancy, importance of institutional delivery and continued breastfeeding of children during illness.

2.2 Knowledge gaps also exist amongst CDPOs, supervisors and ICDS managers; and the knowledge and skills most crucial for improving nutrition are the weakest. The CDPOs and supervisors are responsible for technical and administrative guidance and support



to AWWs, therefore they need to possess the knowledge and skills about crucial nutrition interventions. The UDISHA evaluation, one of the very few reports on the knowledge and skills of CDPOs and supervisors, measured the knowledge of CDPOs and supervisors in certain areas (Figures 4.6 and 4.7) after the massive UDISHA training effort which trained large numbers of ICDS functionaries and made efforts to improve training quality (UDISHA, 2008). The evaluation points to knowledge gaps, particularly in areas such as the importance of institutional delivery, steps for growth monitoring, and use of growth charts. The poor knowledge and skill of CDPOs for

interpreting growth charts is also documented in another study (Kapil et al, 1991). Growth monitoring and promotion (GMP), while one of the most crucial interventions, is also one of the weakest. The AWWs lack competence in plotting and interpreting growth charts and using them to counsel mothers (Citizens' Initiative for the Rights of Children Under Six, 2006; Chattopadhyay, 2004; NIPCCD, 2004; Nibha Rani Burman, 2001; Vasundhara and Harish, 1993; Gopalan, 1992). Another area where AWW competencies are poor is 'record keeping' It is perhaps for this reason that AWWs spend a great deal of time in the maintenance of records, especially in states with low literacy levels such as Bihar, Jharkhand and Rajasthan where in a number of instances registers were maintained by supervisors, and in others the AWWs relied on their husbands or brothers to maintain records (Planning Commission, 2011). During FGDs conducted in Tamil Nadu and Bihar, AWWs expressed a need to build their skills in record maintenance. The FGDs and interviews with ICDS and health functionaries in Bihar and Tamil Nadu, conducted as part of this study, also indicate that skills for growth monitoring, counseling, community mobilization, identification and management of moderately and severely undernourished children require strengthening, particularly for AWWs and supervisors. The supervisors expressed a need to strengthen their skills in planning and problem solving, preparation of audio-visual material and updating their knowledge on nutrition interventions during the first thousand days of life and for adolescent girls. There are gaps in the literature regarding the knowledge and skills of functionaries and officials, and knowledge and skills related to on complementary



feeding, even though the topic of complementary feeding remains critical in India given the poor status of quality and quantity of complementary foods given to young children.

2.3 Critical knowledge and skills regarding nutrition require attention in the health system: The literature on nutrition, maternal and child health related knowledge and skills of health personnel, particularly MOs, ANMs, and ASHAs, are sparse. Only a few small-scale, state-specific studies throw light on the issue. Thus, not surprisingly, depending on the location and sample size, the findings from these are mixed. Some studies found ANMs and ASHAs to have good knowledge about breastfeeding techniques, exclusive breastfeeding, initiation of breastfeeding and its advantages, and confidence in managing breastfeeding related problems. (Breastfeeding Promotion Network of India, 2009, Shrivastava and Shrivastava, 2012). Others indicate gaps and the need to strengthen the knowledge and skills for all categories of personnel in clinical, technical and managerial aspects, particularly in conducting referrals and behavior change communication (Tamil Nadu Health Systems Project, 2004). With particular reference to ASHAs, despite training, the lacunae in their knowledge regarding various aspects of child health morbidity were noted, for instance over 67 percent lacked knowledge of vitamin A deficiency and its prevention, and over 20 percent were unable to identify the need to refer sick children, particularly those with diarrhoea and unable to drink or breastfeed, and with acute respiratory tract infections (Shrivastava and Shrivastava, 2012). The FGDs conducted as part of this study in Tamil Nadu and Bihar pointed to the need to build the knowledge and skill of leaders in the ICDS and health systems. A senior official from the health department in Tamil Nadu remarked, “All staff needs training in nutrition, including the Commissioner.”

Health workers’ knowledge is crucial to the efficacy of the health system. A study in Uttar Pradesh found a positive correlation between health workers’ knowledge and household practices of newborn care, including breastfeeding in the first hour of life. Mothers visited by ANMs with higher knowledge were more likely to show better care behavior such as ante-natal checks, early initiation of breastfeeding and the newborn receiving a check by a skilled provider in the first week of life, than those visited by ANMs with poor knowledge (Agarwal et al, 2012). Similarly, ASHAs educated up to intermediate level and above performed more of the assigned responsibilities than those with high school education or lower levels. The ASHAs with schooling below grade eight also had difficulty in maintaining the records (Kansal et al, 2012).

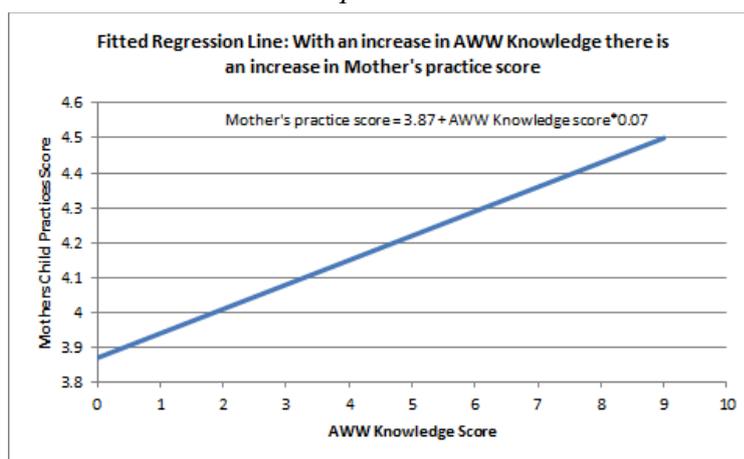
During FGDs conducted as part of this study, the ANMs reported that they do not have required skills to treat malnourished children, and are particularly unable to find the root cause of undernutrition when counselling mothers. The ASHAs reported difficulties in managing pregnancy related complications. Medical officers felt that health workers, in particular ANMs and ASHAs, lacked effective communication and counselling skills, and required periodic training in these areas. Large numbers of health functionaries also lack the knowledge about the role of zinc supplementation in management of diarrhoea, were unaware of protocols for zinc as an adjunct to diarrhoea management, IFA supplementation for children and their skills in managing diarrhoea needed significant strengthening (8th JRM, 2011).

2.4 The gaps in knowledge and skills of functionaries contributes to constraining the nutrition impact of ICDS. New analysis of the HUNGaMA survey data throws valuable light in this regard.

2.4.1 The AWWs' knowledge of nutrition bears a positive association with the mothers' practice of appropriate child care behavior, and with use of AWCs; therefore their poor knowledge is a significant constraint to important nutrition services. Analysis of the HUNGaMA Survey data indicates that the AWWs' knowledge is related in two ways to pathways that have the potential to improving child nutrition:

(a) there is a positive association between AWW's knowledge and mothers' knowledge, as well with the practice of appropriate child care behaviors by mothers (controlled for village index, type of district, AWW experience, supervision visits), i.e., there is an increase in mother's practice of appropriate child care behaviors with an increase in AWW's knowledge of health, nutrition and hygiene practices (see Figure 4.8). For this analysis, the AWW's knowledge of health and nutrition practices was measured using a composite AWW

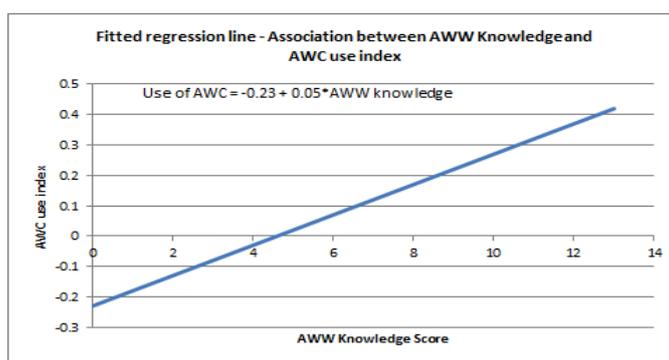
Figure 4.8: Association between AWW knowledge and mother's practice score



knowledge Index²⁰ and appropriate child care behavior was measured as a composite Child Care Practice Index.²¹ There is also a positive association between the use of counselling services by mothers and their knowledge; and

(b) A similar regression analysis controlling for the AWWs' age, AWWs' experience, supervision visits, village index and type of district, indicates a positive association between AWW's knowledge and AWC use,

Figure 4.9: Association between AWW knowledge and AWC use index



that is, an increase in AWC use is seen where AWWs have better knowledge (Figure 4.9). These findings have great significance – they indicate that improving the AWWs' knowledge could potentially play an important role in improving child care practices of mothers, as well as improve the uptake of anganwadi services. The Tamil Nadu Integrated Nutrition Program (TINP) has also demonstrated those community-based workers' skills in weighing children; plotting curves and growth monitoring can contribute to the success of large-scale nutrition programs.

²⁰ The variables used in the AWW knowledge index include: (i) breastfeeding soon after birth; (ii) exclusive breastfeeding up to six months; (iii) beginning supplementary food at six months; (iv) supplementary vitamins; (v) adequate food; (xi) balanced diet; (xii) timely and full immunization; (xiii) going to doctor if child falls ill; and (ix) washing hands with soap.

²¹ The variables used in the Child Care Practice Index include: (i) child's first food; (ii) breastfeeding within an hour; (iii) colostrum feeding; (iv) exclusive breastfeeding for six months; (v) complementary food introduced at 6-8 months; (ix) child breastfed for at least 12 months; (vii) child taken to doctor when sick; (viii) adequate dietary diversity; and (ix) adequate use of soap.

2.4.2 Inadequate knowledge, skills including supervision and management skills constrain focus on the most critical nutrition activities. Inadequate understanding of the most effective ICDS interventions to improve nutrition has contributed to the lack of focus on activities such as micronutrient supplementation, growth monitoring and promotion, nutrition and health counselling through home visits and group counselling sessions with mothers. Furthermore, the supervisors' and CDPOs' lack of knowledge and skills limits their ability to provide the necessary technical guidance and support to the AWWs. The positive association between supervisor visits and AWWs' knowledge suggests that knowledgeable and skilled supervisors could play a critical role in enhancing AWWs' knowledge and building their skills (see chapter 7, General Management Practices).

Critical to the effective delivery of interventions for preventing undernutrition, identification of undernourished children and their appropriate management, are skills in communication and counselling, the full set of growth monitoring and promotion skills including identification of growth faltering, its management and referrals as necessary. However, the foregoing paragraphs illustrate that these skills are among the weakest in ICDS across the cadres of AWWs, supervisors and CDPOs.

2.5 Two underlying factors – inadequacy in the recruitment criteria and practices, and insufficiency in training – have contributed to the poor status of knowledge and skills.

2.5.1 The ICDS recruitment policies and criteria are not suited to recruiting people with the right kind of skill mix, thereby placing the full onus of skills development upon on-the-job training. Besides, the efficiency of recruitment practices and process could be improved.

2.5.1.1 Recruitment criteria are generic, and largely specify only the educational qualifications required. There is a very insufficient defined selection criterion, beyond minimum educational qualifications, for the recruitment of AWWs, AWHs, supervisors and CDPOs. An inference from this is that the focus of the ICDS recruitment policy is to appoint trainable people whose skills and competencies ICDS could build through training (see Box 4.1) An implicit assumption here is that the requisite school and further educational qualifications equip the candidates for a basic understanding of concepts that are essential to each job level, and that they can therefore be trained to develop job-specific knowledge and skills. However, there are strong indications that this assumption may not be valid. For example, while approximately 79 percent of the AWWs meet the minimum educational level of matriculation, and 83 percent have completed grade eight, the educational level required for AWWs prior to 2007 (HUNGaMA Survey, 2011), yet, despite training AWWs continue to have difficulty in plotting growth charts and in maintaining records. It is plausible that despite meeting the prescribed educational qualifications, they do not have the necessary competence in plotting graphs and interpreting them or in accounting. The assumption behind recruiting matriculates is perhaps that they would come with a basic understanding of plotting and interpreting graphs and charts and can maintain the required records. The recruitment criteria should therefore include a set of basic skills for each category based on the job description for which candidates must be tested prior to recruitment. In addition, some further basic skills such as computer literacy could be considered as prerequisites, at least for all block, district and state-level positions. Nevertheless, many years after the IT revolution, the ICDS continues to bear the burden of training even current recruits in basic computer literacy which in most organizations is a qualification that candidates must possess to become eligible for applying.

Box 4.1: Recruitment criteria for ICDS functionaries

AWW: A female volunteer in the age group of 18-42 years residing in the said village or AWC area. The minimum educational qualification required is matriculation which is relaxed to Class VIII for tribal and SC candidates (DWCD, Odisha, 2007).

Supervisor: A female in the age-group of 21-45 years, preferably a graduate in social work, home science or related field. Should have an aptitude to work in rural or tribal areas (NIPCCD, 2006)

CDPO: A female with a master's degree in Child Development, Social Work, Home Science, Nutrition, any other allied field. She is also required to have abilities to get along with other members of project team, voluntary workers and leaders and other non-officials. A CDPO has not to be necessarily 'desk bound' but should be able to reach people as she has to supervise clientele, workers and community leaders over 100 villages or slum sub-units. (NIPCCD, 2006)

2.5.1.2 Appointment by promotion often results in hiring candidates who are not suitable (FGDs). For example, AWWs who are promoted as supervisors when nearing retirement may not be able or willing to travel. Another example is the appointment or promotion to CDPO rank from various bureaucratic streams, such as clerical or other staff from diverse departments (mostly male) with little exposure to child development and without the necessary technical skills.

2.5.1.3 Recruitment criteria are often violated and the recruitment politicized. The criteria in place for recruitment of ICDS workers, even though generic, are often violated in practice. The 'local residence' criterion concerning AWWs, for example, was violated in 20 percent of AWWs nationally and by 53 percent in West Bengal and 44 percent in Tamil Nadu (Planning Commission, 2011). Submission of fake certificates is reportedly not uncommon in Bihar (FGDs). Politics and graft in the recruitment of AWWs is also common. During the FGDs it was widely reported that substantial bribes, up to Rs. 200,000 are paid for these appointments.

2.5.2 *The quantity and quality of training imparted to ICDS functionaries has not produced the desired outcomes in terms of building the required knowledge, skills and competencies.* The ICDS has failed to develop the knowledge and skills of its workforce up to the necessary level. Thus, workers lack critical knowledge and skills to satisfactorily deliver nutrition services, and managers lack management skills to manage the large and complex operations. Section 2 highlights the lack of required knowledge and skills amongst functionaries and managers. Since, the ICDS does not recruit pre-qualified people for most jobs, it depends on its training system to develop the knowledge and skills of its workforce. In such a scenario the training and the training system assumes great importance. Thus it is discussed in detail as a subset of the HR system, in chapter 5.

To sum up, a large percentage of the ICDS workforce do not possess the required knowledge and skills to effectively perform their functions. The positive association between workers' knowledge and positive child care practices of mothers indicates that with better knowledge and skills of workers, the potential impact of the ICDS to improve nutrition could be significantly enhanced. Therefore, the ICDS must invest in building a workforce that has the necessary knowledge and skills to perform their roles.

3. Motivation

The motivation levels of functionaries in the ICDS as well as in the broader health system are generally not high.

3.1 The level of motivation of ICDS functionaries is generally not high. While there is widespread acknowledgement of the poor motivational levels amongst ICDS and health functionaries, some of which is documented, no data speaks to any specific indicator of motivation, including the two outlined in the analytical framework. The discussion, therefore, draws heavily on information obtained through FGDs and interviews conducted during this study. Information drawn from the FGDs in Bihar and Tamil Nadu and the review of literature indicates that the motivational level of AWWs to carry out their tasks is not very high. However, in Tamil Nadu, the motivational levels of AWWs were rated quite high for over 60 percent of the cadre. The motivational levels of supervisors in Bihar were mixed, being rated ‘not very high’ by some CDPOs and ‘good’ by others. The motivational levels of CDPOs are also not high. On the other hand, in Tamil Nadu, the motivational levels of CDPOs were reported to be ‘high’, ascribed mainly to the fact that a large number of CDPOs were earlier Community Nutrition Instructresses (CNI) from TINP.

3.2 Poor work conditions, lack of adequate resources required to accomplish their tasks, and organizational culture contribute to the low motivational levels. These were found to be the key reasons for the poor motivation levels of the ICDS functionaries.

3.2.1 For AWWs, the reasons for low motivational levels are poor remuneration, delayed payment of salaries, work overload, assignment of non-ICDS work, low community status and the voluntary nature of the job (Sampath, 2008; FORCES, 2006; Gragnolati et al, 2005; CBGA and UNICEF, 2011 and FGDs). The FGDs in Bihar revealed that ‘fear of suspension’ was the largest demotivating factor for the AWWs, followed by insecurity regarding retirement. The context in Bihar for the fear of suspension at that time was the state government’s drive to make unannounced visits and suspend AWWs for any deviation in the functioning of the AWC, particularly if the center was found closed or had discrepancies in the accounting of supplemental food. In Tamil Nadu, despite the promotional avenue to the rank of supervisor offered to them, most AWWs had no desire to opt for it, because of issues associated with pension rules that would lead to a lower pension if they retired as supervisors.

3.2.2 The FGDs and a review of literature indicated that lack of promotional opportunities and lack of travel support for the required travel to distant places are also major contributors to the low motivational levels of supervisors in Bihar. The supervisors in Tamil Nadu felt that appreciation of their work and joint visits with CDPOs to AWCs were important in raising their motivational levels.

3.2.3 Some of the major reasons cited for the low motivational levels of CDPOs were poor work conditions including low quality office infrastructure, lack of transport, lack of promotional avenues, fear of transfers to more ‘difficult areas’ with even fewer resources, and having to perform clerical work in addition to their technical and managerial duties (Rani and Devi, 2004). While the Bihar FGDs support these findings, the CDPOs in Tamil Nadu had high motivational levels and TINP evaluations show that TINP was able to create a cadre of highly motivated individuals. In this context, it is possible that the former CNIs brought the motivational attribute to their current positions.

3.2.4 While the MWCD has made efforts to address some of the factors contributing to the low motivation levels in the ICDS, a larger and more comprehensive effort is required. Efforts made by the MWCD include enhancing honoraria for AWWs, although this is still on the lower side of market wages. In states, such as Tamil Nadu, the state contributes to the AWWs’ honoraria and has in lieu introduced extended work. Several benefits such as paid

maternity leave, insurance, and scholarships for children have been introduced together with awards at the national and state levels to recognize exemplary workers. Though helpful, these efforts are few and far between. A larger, holistic effort is required.

3.3 The level of motivation of NHRM functionaries from the district level downwards is varied, with some categories of workers less motivated than others. Most information on the motivation levels of NRHM functionaries comes from the FGDs and presents a mixed picture. These indicate that medical officers and ASHAs, particularly in Bihar, have low motivational levels. For ASHAs, the temporary form of their appointment, poor incentive structure with payments often delayed, and the lack of regular remuneration were reportedly the main demotivating factors; while for ANMs low salary structure and lack of promotion avenues were the key factors. For medical officers, the low motivational levels resulted from low remuneration, high patient load and the high work load due to large number of vacancies, administrative work including difficulty in dealing with routine administrative procedures such as having leave sanctioned, resource constraints, and lack of promotional avenues.

The appointment of contractual employees under the NRHM has contributed considerably to better availability of human resources. However, this has also led to a general sense of demotivation, primarily among contractual employees due to the differential remuneration and terms of appointment between regular and contractual staff although both categories perform the same functions (NRHM, 2011 and 2012).

For the ASHAs, one study notes that the three main motivating factors for becoming an ASHA are financial incentives, the prestige attached to the position and improvement in health facilities of the area (Bajpai and Dholakia, 2011). However, these factors did not emerge in the FGDs conducted for this study.

To sum up, motivational levels across the ICDS are largely not very high and are a constraint to optimal performance. The key factors contributing to the low motivation levels include the authoritarian top-down culture, lack of recognition, especially by managers who do not possess the skills to provide positive feedback, and apathy at all levels to resolve problems. It is clear from the dissatisfaction expressed regarding these factors that addressing them would result in a significant improvement in morale and motivation of the workforce, and hence in their performance. Given that motivation levels were generally higher among all ICDS staff in Tamil Nadu, for AWWs, supervisors and CDPOs, an in-depth understanding of the motivational factors operating in Tamil Nadu possibly such as higher pay, better and continuous training, better supervision and support, could provide learning for the ICDS.

The high workload of the staff, the consistently large proportion of vacancies, the lack of people with required skills mix at all levels, and the low levels of motivation of the workforce indicates that the MWCD and the relevant departments in the states managing the ICDS HR function have been unable to ensure availability of a workforce of the right size and skills to deliver its ambitious mandate. Like several public sector programs, it has not been able to provide the right incentives and work environment to develop a motivated workforce.

The HR policy reform proposed under the restructured ICDS could be a potential opportunity to address motivation issues as part of broader reform. The proposed development of a comprehensive human resource policy, including creation of a dedicated HR cadre for the ICDS, providing for career progression, and benefits such as pension schemes are key factors

that could improve motivation levels. Strengthening the HR policy and management to address some of the constraints discussed in this chapter, such as issues related to work overload at the operational level, that is, for CDPOs, supervisors and AWWs and a full functional analysis under the restructured ICDS will be important, and will benefit strengthening ICDS service delivery and contribute to achievement of results.

Recommendations

1. Reform of the ICDS HR system is proposed in the restructured ICDS. It is recommended that the ICDS take bold steps in this direction and use the opportunity to make a paradigm shift from the current personnel management thinking into the more modern HR development thinking. This essentially means moving from a view of personnel management as a marginal element in corporate or organizational planning towards the view that HR management is a central part of it. As part of this shift, it will be critical to move the HR focus from: (i) legal and contractual relations with personnel towards a focus on human interaction and relations; (ii) monitoring and containing the ‘poor’ behavior of staff towards nurturing, developing and facilitating ‘good’ behavior; (iii) passively following given directions and instructions by personnel to their actively taking initiative; (iv) formal organizational procedures towards organizational value and culture; and (v) individual performance towards team performance.
2. Given its more than 2.7 million workforce, one of the most immediate actions that the ICDS must take is to develop a computerized database of employees. This is critical to detect vacancies and their location, know the training status of staff and managers, and thereby assess realistic training needs and targets, enable transparency in transfers and promotions.
3. Examination of the existing ICDS staffing norms, including those proposed under the restructured ICDS is essential. The norms for all key jobs in the ICDS, not just the jobs of AWWs, supervisors and CDPOs must be assessed to determine the number of positions in each job. Three key analyses outlined below should be undertaken to establish staffing norms:
 - (i) Productivity analysis for each key procedure undertaken by functionaries for example, supervision of an AWC, growth monitoring, and home visits, to see if it can be improved, made more efficient, and if necessary redesign the process (detailed discussion on ‘work practices and procedures’ is included in Chapter 7, General Management Practices) ;
 - (ii) Job analysis of each job, based on a clear conceptual framework of the role of each, and that takes into consideration the redesigned processes, involved in that particular job . Besides, all non-ICDS tasks must be detached from all jobs. Based on this analysis, the content of each job must be redesigned, if necessary. The job content so analysed and/or redesigned will also serve to form the basis for revising job descriptions and recruitment criteria discussed under recommendation 4;
 - (iii) Workload analysis must be carried out to determine: (a) the number of beneficiaries that are to be served and the number of units of service that must be delivered in every service area, assuming full coverage; and (b) the number of units of standard level service that can be delivered by a job holder within a given period of time in each job.

4. The ICDS should consider bold revisions to its recruitment policies, criteria and processes. Key measures include:

- (i) Redesign guidelines and instructions for recruitment in line with the job analysis and revised job content for each position as recommended above. Professionally and technically sound job descriptions must be written, specifying all the key skills and competencies of a ‘fully qualified worker’. The recruitment criteria, that is, the fundamental skills and competencies that all new recruits for each job must possess, should be distilled from the fully qualified worker profile, and should include requirements such as communication skills and basic computer literacy, at least for the positions of supervisor and above.
- (ii) A minimum level of knowledge and skills ought to be specified as prerequisites for each position. Recognizing the difficulty in finding candidates possessing prior knowledge related to child development and nutrition, the ICDS could consider developing and making publicly available study material for prospective candidates to prepare to compete for positions based on merit. This will result in recruitment of better qualified and trainable staff, requiring shorter and less steep learning curves, and make ICDS training more effective and less resource intensive. Further, at least for positions of supervisors and upwards, basic computer skills should be a prerequisite.
- (iii) Recruitment should be streamlined, including promotional avenues, made more transparent and efficient. Setting timelines for each step, holding those responsible accountable for delays, public website display of the results of each step and the time taken are some possible steps that can be taken.

5. Action to improve motivation must be taken. In this context, it is necessary to change the authoritarian top-down culture and implement good HR management practices. This will require consistent effort from leaders, including leading by example, sensitization of managers and providing them with incentives to motivate the staff managed by them. A module on motivation must be incorporated in the leadership and management development program for leaders and managers. Managers may be held accountable for the results and performance management may be included in the contracts of the employees at least for the contractual staff. The ICDS should also experiment with performance based incentives to motivate employees to perform well. Ensuring that working condition standards are met, especially in remote and resource poor areas will be important.

6. Given the huge skills gap, it is critical to build the skills of ICDS personnel. Recommendations pertaining to training to improve knowledge and skills of the ICDS workforce are outlined in chapter 5, The Training Sub-System.

Chapter 5

The Training Sub-System

Introduction

Training plays a key role in equipping the workforce of an organization with the knowledge, skills and competencies required to carry out their jobs. The chapter on Human Resources and their Management demonstrated that the knowledge, skills and competencies of the ICDS workforce, in general fall short of what is required for them to fulfill their roles effectively and deliver the mandate of the ICDS. Further, the ICDS recruitment criteria and policies are not specific and do not specify entry level knowledge and skills, other than a minimum level of schooling. In such a situation, training is central to building the necessary knowledge and skills of recruited personnel, including leaders and managers, to effectively perform their jobs.

This chapter assesses the capacity of the ICDS training system, with particular attention to two key questions:

1. *Has the ICDS training system been able to provide its workforce (field functionaries, managers and leaders) with timely and adequate training in terms of quantity, relevance and quality to develop the knowledge, skills and competencies required for them to perform their functions fully and effectively?*
2. *If not, what are the constraints in the training system and what can be done to address them?*

This chapter includes an assessment of the training capacity of the ICDS only and does not analyse the capacity of the training system of the NRHM. The scope of the health systems training is vast, with the delivery of nutrition services forming only a fraction of the maternal and child health package, as also the fact that the health system recruits skilled personnel (nurses, doctors and paramedics), therefore its analysis has not been included in the scope of the study.

The conceptual framework and indicators for the training capacity assessment are described briefly below, followed by the key findings and capacity gaps, the reasons for the constraints, and suggestions to address the gaps.

Analytical framework and capacity assessment indicators

Availability of timely, relevant and adequate training in terms of quality and quantity is essential for human resource development, performance and motivation of staff. Training outcomes or the gains in learning, skills, and competencies are the best direct measures of training quality. However, no data on these measures is available. Therefore, to assess the quality of ICDS training, this study uses indirect measures, such as the factors that contribute to the quality of training. Table 5.1 outlines the key indicators to assess training capacity.

<i>Table 5.1: Capacity assessment indicators: Training sub-system</i>	
Operational areas/indicators of training capacity	Assessed by indicators
Availability of timely and adequate quantity of training	<ul style="list-style-type: none"> • Numbers trained vs targets – initial and refresher training • Status of training backlog
Relevance of training	<ul style="list-style-type: none"> • Extent to which curricula and content match job needs • Extent to which curricula and content match skill gaps
Quality of training	<ul style="list-style-type: none"> • Adequacy of training infrastructure, facilities, materials and tools • Availability of knowledgeable and skilled trainers <p>(Note: Given the absence of information on the extent to which the content taught is learned and skills acquired, which are the direct measures of training quality, the factors tabulated above and influence training outcomes are used.)</p>

Findings

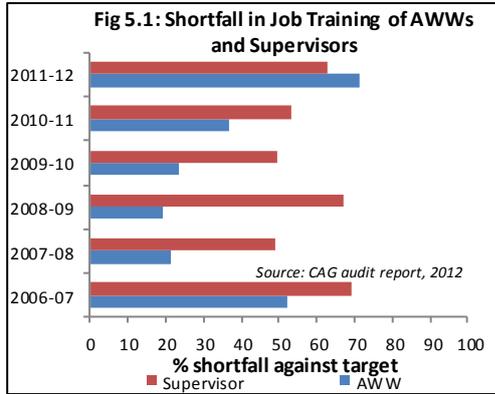
A review of the data indicates that the capacity of the training system to provide timely and adequate training that is relevant and of high quality to the ICDS workforce has been severely constrained. The lack of a conceptual framework and vision, inadequate strategic planning and resource mobilization, and sub-optimal management are the key factors that have hindered the ICDS system in building the knowledge, skills, and competencies of its workforce, which in turn limits the ability of the program to achieve results.

1. Availability of timely and adequate quantity of training

The training system has not been able to deliver the required training to the ICDS workforce in a timely manner. The large backlog in training, for both initial and refresher training, and the persistent shortfall in meeting training targets indicate that a large proportion of the ICDS workforce does not receive initial training in time, and a substantial number of them do not receive the training or refresher training in accordance with established norms.

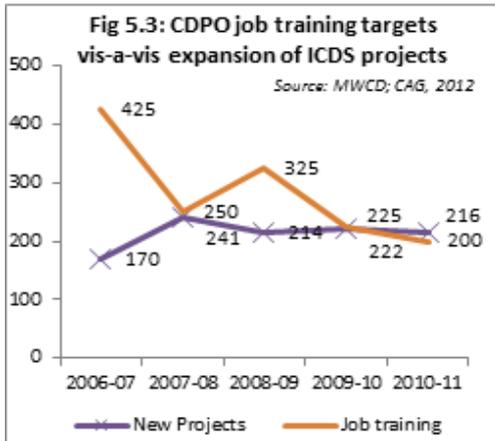
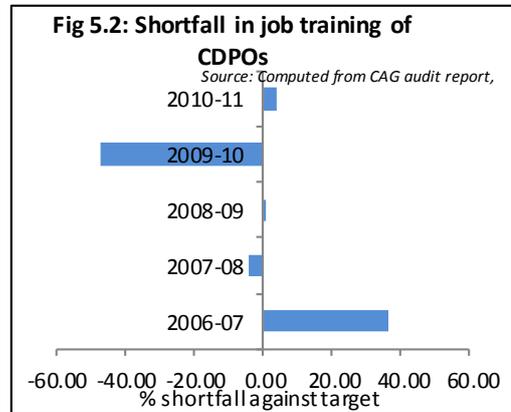
1.1 Training of functionaries has persistently fallen short of annual targets. No standard methodology is prescribed for setting training targets. Most states and union territories set their training targets based on considerations of the number of untrained personnel at the time, the planned number of personnel to be recruited during the year, and often also the number of operational training facilities in their states. The NIPCCD, which is responsible for CDPO training, sets its own targets, often without consulting the states regarding their CDPO and ACDPO training needs. The ICDS does not maintain a training registry or trainee database and hence the exact numbers of untrained personnel at any time is difficult to ascertain, either to set training targets by the state or to review the training plans of the ICDS (CAG, 2012). The lack of this information and a prescribed methodology for setting annual training targets makes target setting appear arbitrary (MWCD, GoI, 2012). Nonetheless, since the states factor in the number of operational training institutions while setting targets, the targets are likely to underestimate the actual numbers requiring training, and the estimates of untrained functionaries based on the achievement of targets are likely to be conservative. For the initial job training courses, an argument could be made that the

shortfalls are due to delays in the planned recruitment. While this argument might hold to some extent for job training courses, there certainly is a large gap between the 2011-12 annual targets for refresher training of CDPOs, supervisors and AWWs, and the actual numbers requiring refresher training (see 1.2).



1.1.1 The shortfalls in achieving training targets for job training of supervisors and AWWs have continued to be large (Figure 5.1). (CAG report, 2012; MWCD, GoI data 2011-12). Given the scale of ICDS operations and the very large numbers of supervisors and AWWs, the percentage of shortfalls for the year 2012 translate into 30,559 AWWs and 2,188 supervisors not having received the planned job training.

1.1.2 For CDPO training, the targets for job and refresher training were largely met (Figure 5.2). A comparison of the targets for initial training of CDPOs with the number of new projects made operational every year shows that the targets are not very different from the number of CDPOs joining the workforce due to expansion of the ICDS (Figure 5.3). However, the number of CDPOs requiring job training will be larger than newly recruited CDPOs, given the high CDPO turnover

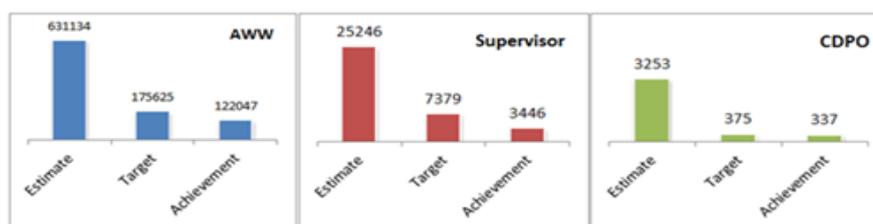


rates due to several of them returning to their home departments from where they were deputed, and others coming in. Given the absence of personnel databases in the ICDS, this information is not available within the system, so it is not possible to assess the actual numbers of CDPOs requiring training every year. Nevertheless, using the data for new ICDS projects as an indicator of the CDPOs requiring training, the backlog in CDPO job training might be small.

1.2 The refresher training backlog is very large and indicates too little training compared to the norm. There is also a need to re-examine the norms. According to ICDS refresher training norm of one refresher training for each functionary in two years, approximately half of the ICDS workforce is eligible for refresher training every year. A snapshot of the estimates of the workforce to be trained in 2012 against the targets show that the targets were a small fraction of the requirement, with the achievement forming a very small portion of the workforce (Figure 5.4). A recent report has pointed out that at the current pace of refresher training, the CDPOs, supervisors, AWWs and anganwadi helper (AWHs) would receive refereshar training once in 14, six, eight and nine years, respectively compared with the requiriement of training which is once in two years (CAG report, 2012). Given the extensive lack of knowledge and skills even amongst those who have been trained, it is

necessary to examine the adequacy of the refresher training norms of six days of refresher training every two years for AWWs, five days for the AWHs, and seven days every two years for supervisors and CDPOs.

Figure 5.4: Refresher Training Status, 2011-12



1.3 Leaders and managers in the ICDS, other than the CDPOs, receive almost no training to equip them with management skills for managing the large and complex program. There is no formal training program or training norms for leaders and managers in the ICDS beyond the rank of CDPO. The NIPCCD does conduct some orientation training for DPOs, but the efforts are not mainstreamed or institutionalized, neither is there any defined curricula or content, and the focus is primarily on providing an orientation to the ICDS program, its functioning, and new upcoming schemes and programs of the Ministry. Good management training is seriously lacking for managers throughout the ICDS and the management of every function in the ICDS is constrained due to the lack of managerial skills of the managers. The status of GMPs in the ICDS point to the dire need for such training to be provided to all ICDS managers and good leadership training to the senior leaders (see chapter 7, General Management Practices). Given the absence of leadership and management training, the leaders and managers in the ICDS do not possess the skills to develop conceptual frameworks, articulate and communicate the program and their units' vision to the staff they lead and manage, set objectives for them, empower them, mentor, coach and supervise them, and manage their performance.

1.4 With the ICDS restructuring and the large number of new staff to be added at all levels, the demands on the training system will increase manifold. Over 5,00,000 new functionaries are proposed to be appointed under the restructured ICDS. Although an augmentation of the training infrastructure and system is proposed as well and discussions on the reform of the training system are on, the development of training programs for new cadres and training such large numbers will be very challenging for a system that presently cannot cope with the training requirements of even the current numbers of CDPOs, supervisors, AWWs and AWHs, and lacks norms and provision for management training for middle level and senior level officials (MWCD, 2013).

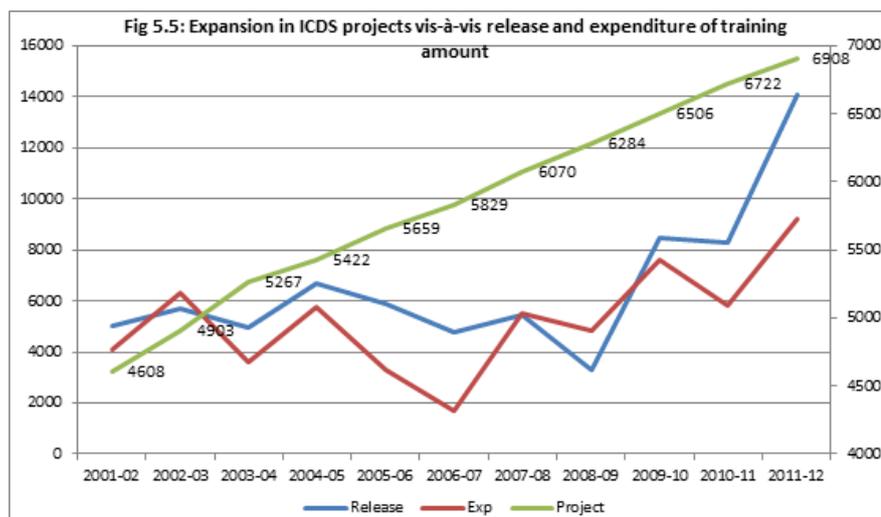
1.5 Several factors constrained the capacity of the ICDS training system to deliver adequate quantity of training. While the ICDS program expanded rapidly, the constraints of the training system, inadequate resource allocation, shortage of training institutions and inefficient fund flows prevented it from providing the requisite training to the ICDS functionaries.

1.5.1 *Financial resources were constrained. While the training requirements increase manifold due to the ICDS expansion, financial allocations remained constant.* Over the past decade, although the number of ICDS projects increased every year, the training budgets remained constant and, in fact, declined after the World Bank-supported training program UDISHA ended in 2004 (Figure 5.5). The steep increase in 2009-10 is on account of the revision of financial norms rather than an increase in training facilities or numbers trained. Between 2004-05, that is after the end of UDISHA, financial allocations for training

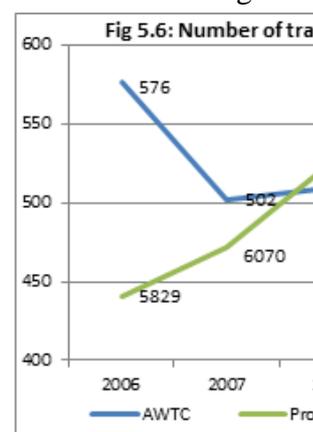
calculated per block almost halved, from Rs. 0.123 million per project in 2004-05 to Rs. 0.52 million in 2008-09.

1.5.2 With training loads increasing exponentially due to the ICDS expansion, the number of functional AWTCs and MLTCs decreased instead of increasing.

Although the number of functionaries to be trained increased rapidly, after the end of UDISHA in 2006, instead of an increase in the number of institutions to train frontline workers and supervisors, the number of training institutions decreased (Figure 5.6). The training infrastructure was poor in



Note for Fig 5.5: The 2001-2004 figures indicate the release and expenditure under training programme UDISHA-ICDS in India



Source: Indiastat, CAG audit report (2012), MWCD

some states. For example, during 2006-11, there were no MLTCs in Jharkhand, and therefore no training was provided to supervisors, which meant that over 52 percent of the 694 supervisors in the state at the time had not received the initial job training (CAG, 2012). This situation was due to closure of some inefficient institutions, and the lack of interest on the

part of NGOs to start additional institutions.

1.5.2.1 The reasons for the lack of expansion of training infrastructure include the sanction of an inadequate number of institutions and the inability of the system to operationalize the full strength of sanctioned institutions (Table 5.2). The responsibility for planning and setting up new training institutions is shared between the MWCD, GoI, the states and the apex training institutions for ICDS training. The state ICDS departments are

Status as on	AWTC		MLTC	
	Sanctioned	Total	Sanctioned	Total
March 31 2007	661	502	43	29
Sept 30 2009	663	510	64	31
March 31 2011	NA	498	NA	28

Source: CAG Audit Report, 2012; NA – data not available

responsible for opening new training centers based on requirements, after the approval of the MWCD, GoI which is provided after a satisfactory verification of facilities proposed by the NIPCCD. Table 5.2 shows that out of the 161 AWTCs sanctioned between 2007 and 2009, merely eight became functional, over a period of 30 months, and the rest remained non-functional. In the case of the MLTCs, two were operationalized and 12 remained non-operational. Besides, despite the sanction of an additional 21 MLTCs in September 2009,

none could be operationalized over the next 18 months and, in fact, 12 AWTCs and 3 MLTCs were closed. This operational distortion has arisen due to: (i) poor coordination between different levels; (ii) poor management; (iii) inefficiency and lack of accountability in the system of establishing and closing training institutions; (iv) lack of interest in NGOs to accept short-term annual training contracts offered by the ICDS to run AWTCs and MLTCs, given the investment required to set up the institution; and (v) opening and closing of AWTCs and MLTCs at the whims and fancies of officials in the states (Gopal, 2009).

1.5.3 Erratic flow of funds and poor coordination deter the full utilization of existing training institutions. Even though the State Training Action Plan (STRAP) cycle is not coordinated with the financial cycle, the training calendars are prepared according to the financial year. Thus, approximately two quarters are lost before STRAPs are approved and training begins, even though the states might request the use of unutilized resources from the previous year. Since the release of funds to training institutions is delayed in several states, many institutions are unable to run training programs for the expected 300 days in a year. Several states prepare training calendars without any consultation with training centers, and there is a lack of coordination between the state ICDS directorate, training centers and districts and blocks to ensure timely deputation of the required number of trainees. Very often, trainees who have already received initial training are deputed again for the same training (Gopal, 2009).

1.5.4 The ICDS training resources were also partially redirected to cover training for several new schemes of the ministry. In the year 2010, the MWCD, GoI launched several new schemes which were to be implemented using the ICDS infrastructure. These included SABLE, a scheme for adolescent girls in 2010, Indira Gandhi Matratva Samridhhi Yojana (IGMSY), a CCT for pregnant nursing women in 2010, and the Integrated Child Protection Scheme (ICPS) in 2010. Instead of creating additional training institutions and capacity or augmenting the capacity of existing institutions, the already stretched ICDS training resources were diverted for providing the training related to these schemes. Furthermore, the effectiveness or impact of vertical training, a new category introduced recently, has not been assessed. While innovations in training are desirable, their continuation and expansion without objective information on their effectiveness or impact, diverts scarce capacity from timely delivery of even the bare essential courses to the workforce.

2 Relevance of training

The relevance of ICDS training – both in terms of the extent to which curricula and content match job needs and the extent to which they match the skills gap – is not known, although there are indications of likely problems.

2.1 Training curricula and content have not been systematically assessed for their relevance to job needs or trainees' needs. The lack of systematic assessment of curricula and content continues to be a big gap. While the curricula have been designed on the basis of job descriptions of different categories of functionaries, no systematic assessment of the curricula and content, including the duration of the training, has been undertaken to determine the adequacy to build their required job skills and competencies. However, disregarding the absence of this information or systematic testing of trainees' knowledge and mapping their competencies, the curriculum and course durations have been progressively reduced. (This is discussed further under quality of training in section 3).

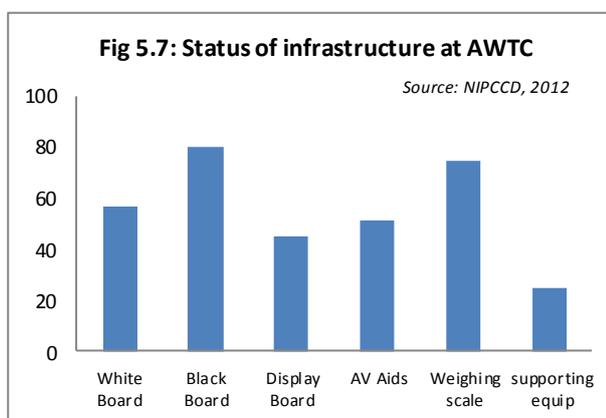
2.2 The training programs are not backed by systematic Training Needs Assessment (TNA). Despite the training operations carrying on beyond 30 years, with specialized training institutions, and recommendation resulting from the evaluation of UDISHA, the ICDS has yet to conduct the critically important TNA. In the absence of TNA, the expectation that trainees will, on completing the training program, imbibe the knowledge and develop the expected level of skill is unreliable.

3 Quality of training

An examination of the factors contributing to the quality of training suggests that the quality of ICDS training is poor because of: (i) inadequate training infrastructure; (ii) shortage of instructors and their deficient knowledge and skills; (iii) inadequate attention to monitoring of training facilities and trainers; and (iv) lack of assessment of pedagogy, curriculum and content.

3.1 Training institutions, primarily AWTCs and MLTCs have poor infrastructure and many lack even basic facilities for training and living. The major difficulties in organizing effective training as identified by trainers are: (i) most AWTCs lack basic facilities including audio-visual aids, reference books, space for demonstration, provision of supplies for preparing teaching and training aids; and (ii) old editions of books and other training and communication material (Gadkar and NIPCCD, 2006; NIPCCD, 2005a,b). Figure 5.7 shows the availability of teaching infrastructure at the AWTC (NIPCCD, 2012). Besides, a test check by the CAG audit team in Andhra Pradesh found that six out of the 12 AWTCs and MLTCs checked did not have white boards, flip charts, display boards and supporting equipment, such as printers and photocopiers (CAG, 2012).

3.2 Trainers at the AWTCs and MLTCs do not possess the requisite qualification and experience. A recent evaluation of AWTCs in 23 states notes that approximately 60 percent of the instructors in AWTCs possess the qualifications stipulated in the guidelines issued by MWCD, GoI, namely master's degree in social work, nutrition or child development (NIPCCD, 2012). The UDISHA evaluation, perhaps the only one that tested the knowledge of instructors in AWTCs and MLTCs, found that only 51percent knew the correct steps of growth monitoring, 53 percent were aware of the importance of institutional delivery and 81 percent knew about exclusive breastfeeding (UDISHA, 2008). State-specific AWTC evaluation studies conducted by the NIPCCD found that instructors did not have the prescribed qualifications, their educational background did not match the subjects they taught, and they had no field knowledge or experience of the ICDS. Besides, vacant instructor positions, high turnover of staff at the training centers and untrained instructors remains a persistent problem (Gadkar and NIPCCD, 2006; NIPCCD, 2005 a, b). The poor availability of trained and knowledgeable staff at the AWTC training facilities is largely due to high staff turnover because of less than market pay, poor facilities at the institutions, and insufficient training of the instructors (MWCD, GoI, 2009). The ad hoc opening and closing of training centers in some states also is one of the reasons



for the loss of trained manpower that had gained not only sufficient experiences but deep insights into the training process (Gopal, 2009). An example from Rajasthan, where most trainers were men and untrained, shows the importance of socio-cultural factors, as the men-only training teams could hardly be expected to provide effective guidance to AWWs in Rajasthan (Circus, 2006).

3.3 Lack of comprehensive monitoring of training institutions, training courses and training outcomes, has affected training quality. Although monitoring mechanisms exist at the central and state level, they are not well conceived, coordinated and pay little attention to quality and efficacy is suspect. The bodies for review and monitoring of training, namely the National Training Task Force (NTTF) at the central level and the State Training Task Force (STTF) are largely non-functional. The monitoring of training at the state level is poor and visits to the training centers by state officials, if any, are perfunctory and there is no feedback or follow-up to the visits. (Gopal, 2009). The NIPCCD, which is the agency with primary responsibility of providing technical support to the AWTCs and MLTCs has a dedicated Central Monitoring Unit (CMU) and State Monitoring Units (SMUs) in 24 states, set up through formal MOUs with approximately 60 medical or home science colleges. The defined functions of the CMU-SMU construct include monitoring of training institutions, namely the AWTCs and the MLTCs, through visits, data verification and consolidation, preparing periodic monitoring reports and providing on-the-spot guidance and capacity building. Since 2008, four consolidated AWTC monitoring reports have been generated that essentially capture data on components, such as administration and management of AWTCs, staff position, infrastructure, availability of training learning material and equipment, library facilities, training methodologies and evaluation of trainees. These visits, however, do not pay attention to monitoring efficiency, overall performance, training outcomes, skills of trainers, and delivery of training. Besides, apart from the mere collation of information from SMUs, there is no system for review of findings and instituting corrective action. The training division at the MWCD, GoI receives and reviews quarterly progress reports from the states. However, detailed annual reviews of state training performance by the training division, introduced as part of UDISHA have been discontinued over the past few years. Thus, a complete monitoring system that tracks training performance, quality and outcomes and uses the information to bring about necessary changes is lacking.

3.4 Ad hoc changes in training program duration have affected quality. Table 5.3 shows the reduction in duration of job training courses for ICDS functionaries over time. It is disconcerting that changes in the length and duration of training were neither backed by any assessment nor has the impact of the changes on training quality been assessed. Apart from the UDISHA evaluation, virtually no

Table 5.3: Duration of ICDS training courses

ICDS Functionaries	Before 2002	2002	2005
CDPO and ACDPO	44	45	26
Supervisor	64	45	26
AWW	72	45	26

information is available on an assessment of the sufficiency of the duration of ICDS training courses. The UDISHA evaluation has observed that the reduction in the number of job training days (for AWWs from 72 to 52 in 2003-04 and 52 to 30 in 2005-06 has adversely affected the quality of training (UDISHA, 2008). It further noted the need to revisit the course curriculum in order to improve the quality of training imparted to ICDS functionaries as well as the trainers, and recommended that the training include more practical sessions and field visits to improve the skill sets of AWWs and supervisors. It also introduced flexibility in

the curriculum by allowing the states to modify the curriculum by 25 percent, which enabled innovations in training.

3.5 Training programs are not systematically assessed, nor are the knowledge and skills developed by trainees post-training systematically evaluated. There is no system for regular feedback on training programs or other methods of assessing training programs in terms of their objectives. While generally at the end of training, the knowledge of trainees is tested, there is no follow up with trainees who require further skill building in specific areas, either by the training system or in the field. Moreover, the certificate given to trainees on completion of training is one of participation, instead of certification of a ‘skilled worker’. Mentoring and coaching by supervisors, while extremely important for continually building capacity, remains weak (see chapter 7, General Management Practices). The workers therefore come for training and return, without the system at all ascertaining if they became equipped to perform their jobs satisfactorily.

3.6 Weakening of the capacity of the national training institution has affected training quality. While a full review of the capacity of the NIPCCD has not been carried out so far and falls outside the scope of this review, there are indications of weakening of capacity of this apex institute for ICDS training. This has occurred particularly in view of the reduction in human resources due to financial constraints, and relocation of some of the faculty to a new regional center, whereas the demands on the institute have gone up with the expansion of the ICDS, its recent restructuring and launch of several new schemes. This has affected the development of new training material, monitoring of training at AWTCs and MLTCs and research related to the ICDS (MWCD, GoI, 2013; MWCD, GoI, 2012).

4 Overarching constraints to the quantity and quality of training.

The lack of leadership and management of training are the two key constraints that have affected training. At the leadership level, the lack of a conceptual framework, vision, strategy and dynamism to evaluate and change have limited the capacity of the training system. Management constraints include the lack of adequate management structures, management skills, staff shortage, functional overload of managers responsible for training, and poor GMPs.

4.1 The lack of a conceptual framework in the ICDS training system is a key reason for its inability to deliver high-quality training in adequate amount to ICDS functionaries and build a skilled workforce. A written conceptual framework would have spelt out both the theory and the role of the training function, and in doing so outlined all the elements required by the system to ensure effective training and ensured the development of a good training system. To illustrate, for effective training a requisite in the conceptual framework would have been to analyze the roles of all categories of workers and determine for each the key skills and competencies required. Had this been spelled out, by implication, the system would have established for each category a ‘proficient worker standard’. Similarly, recognizing the theory of timely training, if initial training is delayed, people will work inefficiently and may (often do) acquire sub-optimal or even dysfunctional work habits and practices that have to be undone later on making training much more difficult, the system would have developed and implemented strategies to deliver timely initial training. Likewise, recognizing the need to deliver good quality training, the development of quality standards would have been ensured. Such a conceptual framework would, at a minimum, have ensured

that the basic essentials for any training system, such as a trainees' database, and a TNA system in the ICDS is not missed out.

4.2 Inadequate strategic planning ahead to expand training capacity to train the large, but anticipated volume/load of training due to the expansion of ICDS. During 1999-2006 under UDISHA, in a national training program supported by the World Bank, more than 927,600 functionaries received job training and 759,250 received refresher training, and this cleared the then large training backlog (UDISHA, 2008). However, these gains were not sustained and the backlog has again accumulated as the ICDS expanded rapidly from 4,608 projects in 2001-02 to 6,908 projects in 2012 and a large number of functionaries entered the ICDS workforce. Training such a rapidly increasing workforce is a daunting task, requiring good strategic planning, consideration of new options and ways of doing business. However, despite the existence of bodies such as the NTTFF at the central level and STTF at the state level to provide strategic direction, there continued to be a lack of effective strategic planning and mobilization of required resources. This hampered the expansion and capacity building capability of the training system to train the rapidly increasing ICDS workforce. Had all strategic options been considered, including building of strategic partnerships, approaches such as the use of IT and blended learning programs to deliver quality and timely training, it is probable that the situation would have been far better.

4.3 The training system has lacked dynamism to address known weaknesses and gaps. Beyond strengthening the training system under UDISHA, the system has demonstrated little dynamism to institute change to either meet the changing needs of the ICDS or to address the weaknesses in the system that were evaluated. For example, the UDISHA program evaluation made several recommendations to strengthen the training system, including TNA to guide curriculum setting, computerized state and district level trainee databases, examining training backlogs, conducting mop-up training, strengthening and empowering state training teams to take policy decisions, strengthening curriculum in growth monitoring and management of children with malnutrition where the knowledge and performance of ICDS functionaries was particularly weak, according priority to training of trainers and improving funds flow to the training institutions. However, so far these recommendations have not been implemented. Over the past two years, leaders and senior managers in the training system have assessed the weaknesses of the training system and have shown commitment to undertaking a reform of the training system.

4.4 Management structures for training are weak at all levels.

4.4.1 At the national level, training management functions are split between two agencies but the two need to be better coordinated. At the national level, the management structure and functions are split between the training division in the MWCD, GoI and the NIPCCD. The training division in the ministry is responsible for functions, such as budgeting, financial allocation, revision of norms, periodic reviews and monitoring of physical and financial progress. The NIPCCD is responsible for managing the aspects related to training courses, curriculum, content and teaching methodology and monitoring of training institutions and quality. While, such a division of responsibilities has some merit in that it brings in technical expertise from the NIPCCD to the management of training, it also has problems, in so far as it is unclear who is ultimately responsible for planning, periodic reviews, monitoring and evaluation, and follow-up. For example, for a holistic picture, although CDPO training targets and budgets should be reflected in the STRAP, these do not form part of the STRAP and are prepared by the NIPCCD virtually with very little consultation with the states. As a

result, the targets are likely to be arbitrary and the states have little engagement in CDPO training, except for deputing CDPOs in accordance with the NIPCCD's request.

4.4.2 At the national, state and district levels, structures appropriate to the functions required for managing training do not exist. The training division at the national level includes five persons, none being exclusively assigned for training or with roles and responsibilities clearly defined, apart from being assigned other responsibilities as well. At the state level, there is no separate ICDS training cell within the directorate of WCD or Social Welfare (Gopal, 2009). With the exception of a few states, such as Tamil Nadu, at the state level, an official in the rank of assistant director or deputy director in the WCD department is designated as the state nodal training officer, with the training nodal function being one of several other functions assigned to him/her. Again at the district level, most states have no management structure or manager who is responsible for training management. Given the decentralized system of the ICDS training, the state and district level functions are critical to adequate management of training in planning, implementation, monitoring and coordination. Thus, the lack of appropriate training management structures at these levels is a critical gap that contributes to the poor management of training.

4.4.3 Several HR issues, including shortage of staff, lack of management skills and the lack of role clarity constrain adequate management of training at all levels. There is a shortage of HR for training management, there being five persons in the national training division, each with multiple responsibilities of which training is only one. Besides, a single person is designated as nodal training officer but performs many other functions, and no one at the district level is assigned training responsibilities, it is rolled into the role of the DPO. What is expected of them in terms of training management is not clearly defined. Their heavy workloads limit their ability to devote adequate time and attention to training. They themselves receive no training, either in management or in fulfilling their roles (Gopal, 2009), and thus lack essential management skills to manage the training, and are also not empowered to make decisions. Lack of clearly defined roles and responsibilities, lack of time and management skills and the absence of a decision making authority has compromised the ability at all levels to adequately manage the key functions required for holistic management, namely adequate planning, supervision, monitoring and coordination. Many of the issues discussed earlier, such as the lack of trainee databases, delays in establishing training centers, and their sub-optimal monitoring are examples of leadership and management constraints.

4.5 Three key developments in recent years hold the promise of strengthening the ICDS training system. These are: (i) the ICDS mission which acknowledges the need to strengthen ICDS training and incorporates several key measures to do so, including upgrading the training infrastructure, strengthening the training institutions (NIPCCD, AWTCs and MLTCs and setting up state training institutions in 10 states), creating a separate ICDS training resource center (ICDS-TRC), establishing strengthened training management structures at the national, state and district levels and building the capacity of officials managing training. It also notes strengthening curricula and content backed by a TNA; (ii) the World Bank supported ISSNIP, which as part of its efforts to reinforce systems includes strengthening of the training and capacity building systems of the ICDS. This, inter alia, includes review and revision of training modules, TNA, and testing innovative capacity building approaches; and (iii) a national consultation on training led by leaders and managers from the MWCD and NIPCCD during October 2013 to outline the agenda for training reform. The consultation included officials from the states, and multiple stakeholders and comprehensively examined the gaps and weaknesses in the training system, acknowledged

them with remarkable candour, and developed an action plan to strengthen ICDS training. However, strong leadership and technical rigor during the implementation of the reform will be important.

To conclude, the gap between the required and actual training capacity is large and has resulted in large numbers of untrained or insufficiently trained workers being placed to perform functions for which they are not qualified. The evidence highlighted in section 2 on knowledge and skills in chapter 4 (Availability, Competence and Management of Human Resources in the System) shows the positive association between AWWs' knowledge and mothers' practices for feeding and caring of infants and young children, which in turn shows a positive association with prevalence of stunting in children. Further, four best-practices in the ICDS that demonstrated a positive though modest impact on nutrition outcomes indicate that building capacity of workers and volunteers to enhance their skills and competencies was critical. While each approach used a mix to build capacity, such as systematic training sessions, joint health and ICDS training and mobile training teams, each had also ensured support for skill development and supportive supervision to supplement the ICDS training (Micronutrient Initiative, 2007). Thus, the constraints in the ICDS training capacity, including the expansion of the ICDS, without commensurate augmentation of training capacity and quality has affected the ICDS implementation and impact and proved costly for the program.

Recommendations

The findings in this chapter clearly indicate the need for major reforms in the ICDS training system, and that piecemeal or marginal strengthening of training activities will not help. The need for reform is acknowledged by the ICDS and there is a serious attempt to address the weaknesses identified. The ICDS Mission framework recognizes training as one of the key areas to be strengthened and the national consultation on training, October 2013 was a further step towards reform. Since much of the existing system needs reform, it will be important to plan the reform sequence carefully to ensure that activities critical to a holistic approach are prioritized. These are enumerated below:

1. The foremost need is to develop a well-conceived conceptual framework for the ICDS training function and system. This will serve to provide the theory or hypothesis of the training function, and its implications for the ICDS training system, thus providing the building blocks for a strengthened system, and charting the key actions required. A few of the critical ones are outlined below:

- (i) Establishing 'proficient or skilled worker' standards for each category of the workforce based on job content analysis for that category, and define the skills level to be built during pre-service training and then through follow-up in-service trainings. The job analysis and proficiency standards should not be limited to just CDPO, supervisor, AWW and AWH job categories, but also include managers performing different functions.
- (ii) Determining the skills gap to be addressed through training by mapping skills of staff at entry (determined through a TNA) against the proficiency standard referred to in the previous point. The skills gap should form the basis of defining training curricula, content and norms such as frequency and duration of training.
- (iii) Institutionalizing a quality assurance system that defines appropriate standards of quality across the system for trainers, training institutions, pedagogy, and monitors these on an ongoing basis, and enables corrective action. Accreditation such as ISO 9001 could

be considered in each case to assess quality needs to be assured, define those in measurable terms and determine the means of periodic measurement.

- (iv) Incorporating a robust monitoring and evaluation system to routinely monitor key processes, trainee databases, and training outcomes, that is, the gains in knowledge and skills as a result of the training, and periodically evaluate the impact of the strategies being implemented.
- (v) Exploring strategic options to clear the big training backlog and train the large numbers of entrants expected to enter the ICDS workforce (discussed further under recommendation 5).
- (vi) Therefore, the first strategic step would be to get the people and the data in order to develop conceptual frameworks, vision and strategies discussed further in the second and third recommendations.

2. The next recommendation is to cost the overall reform and mobilize the financial resources required to undertake the reform. No strategy is ever cost-free and only a well-costed and well-funded strategy determines the success of all downstream steps and their impact. The ICDS therefore needs sufficient, earmarked allocation for training, commensurate with the magnitude of reform needed and the numbers to be trained. The costs must be based on rigorous data and methods to stand the test of scrutiny for allocations.

3. It is necessary to establish a dedicated organizational home or unit for training. The unit must be headed by a high-level manager who is provided with the resources needed and reports to the ICDS Mission Director, with overall responsibility to change the face of training in the ICDS, develop the conceptual framework, vision and all other lower level strategies and plans, implement and manage them. Ideally, the incentive structure for this manager should be tied to ambitious but realistic performance targets with corresponding rewards and penalties.²²

4. The training structures proposed under the ICDS Mission directorate are unclear regarding whether the key responsibility of training lies with the directorate's training unit or with the national ICDS Mission resource center under the NIPCCD. As presently proposed, both units report independently to the Mission Director and this perpetuates the existing functional split of the training function between the ministry and the NIPCCD with resultant leadership ambiguity for the function. Similarly, the role of the national and state level taskforces, their composition, interface and accountability vis-a-vis the top training manager is unclear and should be carefully considered and spelt out.

5. Clearing the backlog and gearing up to train a large number of entrants, including the development and delivery of several new categories of courses will require a mix of approaches, including new ones, such as:

- (i) Determine the backlog and the capacity of the training infrastructure such as physical facilities, trainers and materials to train the number required, and estimate the cost of clearing the backlog. While this exercise would have to be undertaken at the state level, the methodology for such an assessment could be developed at the national level and provided to all the states with clear guidance. On provision of this information and a

²² To illustrate, appointing the person on a fixed term contract that is not automatically renewed and can be terminated if the person has not delivered satisfactorily and, on the other hand, having an escalating salary that is agreed upon prior to appointment, which goes up when objectives are fully met.

- multi-year plan to clear the backlog, the states should be given a one-time grant to clear the backlog, and the initiative should be managed nationally by a full-time manager.
- (ii) Augment the existing capacity of the training system through new approaches such as:
- Optimizing the efficiency of existing training institutions to train larger numbers through improved management, that is planning, timing, and improved funds flow;
 - Dealing on priority with poor quality of trainers and the development of ‘teacher-proof’ teaching material;
 - Using blended learning courses that deliver some modules through new approaches such as mandatory distance learning preferably with the use of IT, prior to deputation for face-to-face training. This may reduce face-to-face learning duration, thus allowing existing institutions to train larger numbers in the same period. For AWWs and AWHs, where IT training might be a constraint, developing and providing self-learning material that contains much of the knowledge and skills needed by new recruits, who would be tested for achieving a certain level of knowledge and skills prior to face-to-face training. Similarly, as part of periodic in-service training, the provision of IT training modules and tools and development of interactive self-learning modules could be considered;
 - Developing mobile training teams to impart training in the field, and prioritizing districts with the largest loads of untrained functionaries. There are examples from states such as Tamil Nadu where mobile training teams support the overall training effort (see Box 5.1); and
 - Delivering refresher or on-going training at the block level by two or three trained supervisors and the CDPO. Use of videos and IT in training, and ‘teacher-proof training material’ could make this a possible and effective option. Continuous training and capacity building by supervisors and trainers at the field level is also an option, such as in the TINP where CNWs received initial and regular in-service training by CNIs (see box 5.2) and the incremental learning system in Andhra Pradesh (see Box 5.3).
6. Several points that apply to the overall ICDS system are also critical to strengthen training, the most important being:
- (i) The need for adequate management structures and the right number of people at different levels to undertake the training function. Although augmented management structures have been proposed under the ICDS Mission’s broad framework, it is also necessary to evaluate the norms based on the functional analysis recommended in the chapter 4, Availability, Competence and Management of Human Resources in the System; and
- (ii) As with all managers in the ICDS, those responsible for training need to undergo a good management development program. This will build their management skills and contribute to changing the management culture in the ICDS.

Box 5.1: TINP Training Model

Training of frontline workers under the Tamil Nadu Integrated Nutrition Project (TINP)

One of the TINPs had a unique field-based system of training, including continuous training for frontline workers. The community nutrition workers (CNWs) received their initial training as well as regular in-service training at the block headquarters by the community nutrition instructress (CNIs).

Initial training of CNWs: the CNWs were given a two-month training in small groups of 25 trainees. The emphasis was on practical training with a 300-hour curriculum divided as follows: 115 hours of practical work, 72 hours of field work and 113 hours of theory. The content included substantive segments on growth patterns, health problems, nutrition and prevention of dehydration as well as on administration of community nutrition centers and communication skills. Training was delivered by the CNI, nutrition supervisors and health staff. The final week of initial CNW training was also attended by female MPHWS from the same area in light of the linkage of their roles.

In-service training of CNWs: Each CNW received three in-service training sessions each month. The first was a regular three-hour session run by the instructress for 50 CNWs and five supervisors in each block. In addition, the instructress provided afternoon in-training sessions twice a month for each group of CNWs and their supervisor to sharpen their skills in weighing, plotting curves and keeping records. Special attention was paid to workers whose performance was weak. Also, trainees learned in a situation with which they were familiar. The trainer built up a long-term relationship with workers, enabling them to modify their training plan to suit trainees' needs and make training evaluation integral to the process.

Community Nutrition Instructress: Each CNI was responsible for initial and in-service training of 50 CNWs and five nutrition supervisors in the assigned block, and supported nutrition education in the block. The CNI held a postgraduate degree in nutrition, home science or related fields, preferably with experience in teaching field workers. The CNI received two months job training, the key elements of which included: objectives of project and methods of implementation; teaching techniques; organization of practical and field work; measurement of weight, height and arm circumference; checking and maintenance of equipment; recording results on growth charts and their interpretation; protein energy malnutrition diagnosis with difference between stunting and wasting; ORT; diagnosis of vitamin A deficiency and nutritional anaemia; use of communication media and materials; use and preparation of teaching aids and training material; health services available to community and liaison; preparation and delivery of supplementary foods; relationships with community and public officials; supervision and management; and project administration, financial control and reporting.

Box 5.2: Tamil Nadu Decentralized Model of Training

Tamil Nadu's ICDS training model is different from that of other states. While the training is funded by the GoI as in other states, following GoI norms, curriculum, duration and budget, the state has taken the initiative in assuming full responsibility for the training of the ICDS workforce and has institutionalized a system where the entire frontline worker training is decentralized down to the block level. The key features of Tamil Nadu's training system are as follows:

- A state training institute (STI) at Chennai, on par with the NIPCCD, has overall responsibility for all of the state's ICDS training needs. It conducts on-site job and refresher training for CDPOs, district officers, training of trainers for block and project level trainers including orientation and refresher training. The STI is also responsible for preparation of guidelines and curriculum. The STI has a lean faculty comprising a joint coordinator for training, assistant director for training, senior instructress, junior instructress and warden cum instructress.
- Supervisor training (both job and refresher) is conducted by MLTCs, as in other states.
- All frontline workers, AWWs and AWHs are trained at the block level. Instead of establishing AWTCs to train AWWs, Tamil Nadu has developed a well-trained and experienced cadre of block and project level trainers, located them at the project level for providing job and refresher training to AWWs, orientation and refresher training to AWHs, and other innovative training like IYCF training. There is one trainer for every block and project, and most trainers are highly experienced in nutrition, health, child development and are continuing since the TINP-1. In addition, two mobile training teams, each with three instructors conducts training in projects where there are no trainers.
- District level training teams, consisting of four members supervise the project level training, guide the trainers and also go to the field and conduct follow-up visits to AWC.

Advantages of the decentralized training pattern: Since trainers are available in each project, AWW and AWH training is carried out simultaneously across all projects. Therefore, it is timely and there is little backlog. Training is offered on an ongoing basis, and is hence regular. As the trainers are located at the project level, they are aware of the training needs of workers, and thus impart training that is responsive to their needs. It is also of better quality as the trainers have training as well as field experience.

Box 5.3: Incremental Learning System in Andhra Pradesh: a system for continuous knowledge and skill building for ICDS functionaries

The Incremental Learning System (ILS), implemented in Andhra Pradesh as part of the USAID-CARE supported Integrated Nutrition and Health Project (INHP), was conceptualized in response to the many challenges faced by INHP in bringing about and sustaining change in knowledge, skills and implementation practices of ICDS functionaries, particularly:

- The content focus of ICDS (and RCH) training in the selected interventions was diffused, and one or more training sessions, however intense, were insufficient to bring about substantial change;
- Sustaining change in implementation practices of frontline workers required corresponding changes in supervision and monitoring practices at successively higher levels as well;
- Since the program monitored only the inputs, there was little clarity on how program inputs were linked to outcomes, and building this clarity meant considerable unlearning besides new learning;
- To be effective, facilitation had to be almost continuous. Without consistent follow-up and hand-holding, things tended to quickly flow back to business-as-usual;
- Supervisors were the most appropriately positioned to be facilitators of change, provided they in turn could be helped to change.

The ILS was thus developed as a carefully structured, sequential cascade of capacity and skill-building sessions at all operational levels of the ICDS. It entails:

- Restructuring of the monthly meetings of ICDS and RCH personnel at district and block levels and enabling joint ICDS-RCH sector meetings to include discussions on the selected interventions to be strengthened;
- Creation of district and block-level resource groups, constituted largely by program staff from ICDS and RCH, to function as facilitators;
- Development of standardized tools and processes representing the ‘good practices’ to be replicated;
- Creation of separate modules for at least eight monthly learning cycles, each module comprising incremental content built upon the previous one, and potentially extendable to more cycles;
- Develop a two-day training session for each level, with instructions for the first steps of change, and assignment of specific implementation tasks. At each subsequent interaction, the previous content was reviewed to see if satisfactory progress was achieved. Only after progress was seen, fresh content from the next module was layered;
- Tracking of quality of learning in the cascade through a mobile monitoring team, consisting of a small subset of the facilitators.

The ILS in Andhra Pradesh demonstrated high level of energy among all functionaries and there was always a demand for repeating the cycles of the ILS. The ILS meetings provided a very useful operational structure for convergence between ICDS and RCH functionaries. Some of the district and block officials of Andhra Pradesh who participated in the ILS process have gained substantial operational and technical capacities within a short period of time.

Chapter 6

Monitoring, Evaluation and the Management of Information in the Nutrition System

Introduction

Monitoring and evaluation are core functions in organizations. In modern organizations, these form part of the broader knowledge management (KM) function which is the process of capturing, analysing, developing, sharing, and effectively using organizational knowledge.

One purpose for which information is captured and analysed is that of control, to ensure that the organization is following the planned direction, operations are progressing as planned, on time, and at the anticipated cost – this is the function of monitoring. Another purpose of capturing information is to determine whether intended outcomes and impacts are being achieved – this is the function of evaluation.

Monitoring helps identify areas requiring improvement and is used extensively by managers to control daily operations, while evaluation helps identify the success or failure of strategies and interventions in achieving the desired outcomes. This information is useful for ascertaining if changes in strategic direction are required to better achieve outcomes.

The scope of the KM function in the ICDS has so far been limited to monitoring and evaluation. However, the new ICDS Mission framework does allude to an expanded scope, adding research to the functions of monitoring and evaluation. Since the scope of KM in the ICDS so far was limited to monitoring and evaluation, this chapter focuses on monitoring and evaluation as well as management of information. Given the important role played by monitoring, evaluation and the management of information in the control of operations, apart from adaptation and change when the original objectives, design and plan do not achieve the desired outcomes, they are important contributors to the capacity of organizations.

This chapter focuses on the following key questions:

Do the ICDS and the National Rural Health Mission (NRHM) have adequate capacity to monitor and evaluate nutrition services and their delivery to ensure the achievement of desired child nutrition outcomes? If not, what action can be taken to strengthen the monitoring, evaluation and management of information in the system?

This section presents briefly the conceptual framework and indicators used to analyse the ICDS and the NRHM monitoring and evaluation systems. The findings that emerge from the analysis follow in the next section. In the end, suggestions are offered to address the constraints diagnosed in the analysis.

Analytical framework and capacity assessment indicators

The KM function encompasses capturing, analysing, developing, sharing and effectively utilizing organizational knowledge to inform organizational direction, policies, resource allocation and development and implementation of plans and programs. Monitoring is a generic management process for exercising control in organizations and to ensure that

activities are implemented according to the operational objectives, design and plan, and are ‘on track’. Evaluation is used to draw conclusions and usually focusses on assessment of outputs and outcomes. Its primary purpose is to improve operations or change course. Monitoring and evaluation are inter-related. It is thus paramount that the monitoring and evaluation framework differentiates between: (i) the information and data to be monitored for control of activities and for evaluating results; (ii) the frequency with which data is to be collected, analysed, and used; (iii) the users of the information; and (iv) which information would be analysed by whom and used in which manner.

Table 6.1 lists the indicators used to assess monitoring capacity.

<i>Table 6.1: Capacity assessment indicators: Management of Information System</i>	
Operational indicators of Management Information Systems (MIS) capacity	Assessed by indicators
Conceptual frameworks for the generation, management, and use of information	<ul style="list-style-type: none"> • Existence of an explicit conceptual framework for the generation, management, and use of information • The quality of the framework - clarity and comprehensiveness • Clear understanding of conceptual framework at all levels in the organization
Availability of relevant and reliable data	<ul style="list-style-type: none"> • Congruence of information collected with information needed by users • Timely availability of complete aggregated data • Accuracy of information collected
Use of information	<ul style="list-style-type: none"> • Analysis of data (extent, relevance, and quality) • Use of information and analysis in (i) operational decision-making; and (ii) policy and strategy development (extent)

Findings

The capacity of the ICDS to generate, analyse and use information to control operations and track progress towards nutrition outcomes has many constraints. It lacks an adequate conceptual framework for the M&E function; the most crucial data required to track progress of nutrition activities and outcomes is not gathered; the data generated through the system is not reliable; and there is minimal analysis and use of the information gathered. The proposed strengthening of the system under the ICDS Mission and the revision of the ICDS MIS have seemingly overcome many of these constraints, paving the way for collection of meaningful and reliable data, its appropriate analysis and use. The M&E system of the NRHM does not mention nutrition in its conceptual framework and gathers data on very few nutrition indicators. However, in coordination with the ICDS, it does offer opportunities to meaningfully track nutritional indicators to ensure early and appropriate action for preventing and managing undernutrition.

The findings related to each of the key areas of capacity constraints and indicators are discussed in the following sections:

1. Conceptual framework

The current ICDS M&E system lacks an explicit conceptual framework, and the implicit framework on which it is based is weak. A revised MIS is being rolled out, and the proposed architecture for the M&E system under the ICDS Mission indicates a more

comprehensive conceptualization of the function. The NRHM monitoring and data management system while conceptually well developed, tracks only a few indicators pertaining to nutrition. Expanding the scope of the system to include information relevant to improving nutrition, in coordination with the ICDS will be valuable for both the NRHM and the ICDS programs.

1.1. The ICDS does not have a written and explicit framework for its M&E function, and the implicit framework is inadequate. The impact framework on which the current M&E is based is inadequate as indicated by the many gaps in the system. While the design of the existing M&E system and the MIS may have been guided by an implicit framework, this was evidently not examined methodically and remained inadequate. In the absence of an adequate M&E conceptual framework for monitoring, the data collected is not fully aligned with the data needed for better operational decisions, analysis and tracking of outputs, outcomes and impact, and for better policy and strategy analysis. Besides, there is very little analysis and use of the data, as discussed later (see section 3).

1.2. There is no dedicated functional home for M&E and no dedicated leader for the function. As discussed earlier (chapter 2, The Nutrition Service Delivery System and Division of Labor within the System), there is not enough functional differentiation within the ICDS, and as is the case with several other functions, no unit or division or leader is dedicated to developing and managing the M&E function. If the ICDS had a dedicated leader and organizational unit with adequate human resources and expertise, it would have better chances for the ICDS to have a better conceptualized and designed the M&E system to manage, monitor, and evaluate information.

1.3. There is a poor understanding of the M&E framework amongst the staff, who therefore do not appreciate the full purpose of collecting data and using it. The monitoring framework does not spell out the hypothesis or theory for the use of information in decision-making. Neither does it clearly articulate the information needed by each to control operations effectively for achieving their objectives, or how to use the information. As a result, functionaries and managers do not fully understand the purpose of the information they collect and report, or its relevance for the control of activities and operations or to detect problems or achievement of the ICDS' overall policy objectives, strategies, and desired outcomes. Instead, they see only three activities, namely making AWC visits, collecting, collating and reporting monthly data through monthly progress reports (MPR) and conducting review meetings at specific levels, as monitoring activities, and perform each as an activity with no purpose other than only to meet the need to report. Furthermore, since at the operational level they receive no feedback or outputs of the analyses of the data they collect, or see its use for action, their perception of the purposelessness of collecting the data is reinforced.

1.4. The evaluation component of the ICDS M&E is weak. Of the five major evaluations of the ICDS conducted since its inception in 1975,²³ two were commissioned by the MWCD, GoI. This shows that the evaluation component in the ICDS M&E framework does not lay down the conduct of periodic and regular evaluation. However, evaluation of ICDS projects or of specific components therein supported by development agencies have been undertaken from time to time, ostensibly because evaluation was incorporated in those

²³ Program Evaluation Organization of the Planning Commission in 1982, National Evaluation of ICDS Scheme conducted by NIPCCD in 1992, Evaluation of ICDS by National Council of Applied Economic Research (NCAER) 1998-1999, recent PEO, Planning Commission 2011 report.

project frameworks. For example evaluations of various World Bank-supported projects – ICDS III, UDISHA and USAID-CARE supported INHP have been conducted. This demonstrates the importance of a strong evaluation component as part of the M&E framework to ensure that it is periodically undertaken to inform the program strategies and policies. Besides, the ICDS is one of the most widely assessed programs, and a large number of assessments, reports and papers by various stakeholders speak of the impact of its strategies and their implementation, including the most recent evaluation by the Programme Evaluation Organization (PEO) of the Planning Commission and the HUNGaMA Survey that surveyed several aspects of the program. There are also examples from some state WCD departments such as in Rajasthan²⁴ and Karnataka²⁵ that commissioned assessment and evaluation of the ICDS by external agencies. While recently cognizance of the findings of major studies and reports has been taken to inform the ICDS restructuring, the use of evidence to examine its implication for the program has not been a usual practice in the ICDS.

1.5. Three recent initiatives, namely the restructured ICDS, a revised MIS that is being rolled-out, and the World Bank supported ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP), have set the stage for conceptual clarity in the ICDS evolving a sound monitoring and evaluation framework. Whereas the restructured ICDS lays out the broad architecture for its future monitoring and evaluation system, a newly designed MIS is being incrementally rolled out, and the World Bank supported ISSNIP project will further strengthen monitoring and evaluation in the ICDS.

1.5.1. The M&E framework under the ICDS Mission suggests the outline of a more robust M&E framework. It also expands its scope to include research and other information, recommending the evolution of a KM system. The architecture outlined for the M&E and research system in the ICDS Mission suggests efforts to strengthen many of the weaknesses in the earlier M&E such as: (i) the outlining of a set of input, output, and outcome indicators for evidence based monitoring; (ii) a five-tier monitoring and review mechanism from the central to AWC levels with review committees at each of the five levels, namely national, state, district, block, and anganwadi, using real time data through ICT and mapping; (iii) conducting annual program reviews jointly with the NRHM and other stakeholders; and (iv) community monitoring mechanisms to gather qualitative data. The framework also defines the evaluation aspect, proposing third party evaluation to review the impact of the program, with periodic external, household and facility surveys to track the effectiveness of activities. Though the research element proposed with M&E is not further defined, it is necessary that the ICDS mission develops not only a comprehensive M&E and research conceptual framework, but also considers developing a full-fledged KM framework. A few key points illustrating a conceptual framework for KM are shown in Box 6.1.

1.5.2. The revised ICDS MIS, while not yet having articulated a conceptual framework for the system, provides the nearest equivalent of a conceptual framework in one of its training manuals. The manual provides conceptual clarity on all aspects of the generation, management and use of information, its relevance and importance. It specifies the type of data and information to be collected, when and from where, and assigns clear responsibilities for collection and analysis of data and information. From the control perspective, it has been focussed on the critical tasks to be accomplished for achieving the ICDS outcomes, particularly in health and nutrition education and behavior change. To provide conceptual

²⁴ Quick review of working of ICDS in Rajasthan by the Society for Economic Development and Environmental Management, 2005.

²⁵ Evaluation of ICDS in Karnataka by Institute for Social and Economic Change, 2006.

Box 6.1: Conceptual framework on the function of information management

Use of information to:

1. **Provide direction for action** – the information will be used to help leaders and managers develop visions, missions, policies, strategies and strategic plans.
2. **Help obtain resources** – the information will be used to convince the government and external providers to provide financial and other resources.
3. **Allocate resources** – the information will be used to link resource allocation to operational requirements that is to norms and standards.
4. **Implement plans and programs** – the information will be used to develop operational plans and then monitor daily operations; information will also be used for exercising accountability.
5. **Conduct research studies and evaluation** – the information will be used to monitor the utilization and efficiency of resources, as well as the working of processes over time; it will be used to evaluate costs, outputs, and outcomes.
6. **Manage change** – the information will be used to validate the need for change and to convince people that the change is needed.

Users of the information:

1. Managers in the organization's headquarters.
2. Managers at other high levels in the organization.
3. Managers at de-concentrated or decentralized field offices of the organization.
4. Customers and clients of the organization.
5. External users in relevant categories.
6. Other stakeholders, such as international aid agencies, civil society agencies, researchers at universities, and the media.

Key tasks involved in the function, for which it is necessary to have adequate capacity:

1. **Design** the types of information to be used and determine the sources of this information, the methods of collecting, storing, moving, accessing, and using it.
2. **Collect** the information at source and aggregate it.
3. **Process** the information for use.
4. **Store** the information in data banks.
5. **Move** the information to users when needed.
6. **Provide** access to the information for all users when needed.
7. **Actually** use it for decision-making.

clarity to all functionaries, the induction training program provides detailed orientation to ICDS officials and by deliberate design makes the ICDS supervisor central to managing the induction training. The training takes the functionaries through the purpose, relevance and the conceptual framework of the new MIS. It will now be important to expand the conceptual framework by including incremental features to complement the MIS.

1.5.3. *Under the mission, dedicated monitoring, evaluation and research units at the national and state levels headed by a program manager are proposed.* At the national level, a small M&E unit in the ICDS Mission Directorate, complemented by an M&E unit at the national ICDS Mission Resource Center is proposed. The purpose of the resource center is to provide technical assistance and expertise to the national and state ICDS Missions. However, it is not clear where the leadership for the M&E and research function lies. From the management perspective clarity of roles, responsibilities, and coordination between the two will be critical. At the state and district level, dedicated staff has been assigned for M&E and, at the project level, a nutrition surveillance coordinator has also been assigned. The assignment of staff for M&E at all levels will fill a crucial existing gap, namely that of functional leadership and dedicated staff for M&E.

1.6 Although the NRHM has a well-defined conceptual framework for M&E of the program's health components, nutrition finds a marginal place in it. Overall the program's M&E framework is comprehensive, describing the aspects to be monitored, by whom and at what periodicity the required data is to be generated, its analysis, use and storage, and arrangements for training of staff. Functionaries at different levels are aware of the indicators and their frequency to be monitored. Dedicated units for M&E exist at the national, state, district, CHC and PHC levels and senior managers have been assigned at the national and state levels to lead the M&E function. (MoHFW, GoI, 2008).

1.6.1 While the two key components of the NRHM monitoring system relevant to nutrition, the Health Information Management System (HMIS), and the Mother and Child Tracking System (MCTS) do capture some nutrition indicators, their conceptual frameworks are silent on nutrition. The HMIS, designed to capture public health data from both public and private institutions in rural and urban areas across the country, is envisaged as a single window facility for all public health data for the MoHFW, GoI. The MCTS, which is essentially a name based tracking system enables tracking ante-natal care check-ups (ANCs) and the immunization status of individual pregnant women and, following their delivery, that of their children. The MCTS incorporates a feature to provide the frontline health functionaries, namely ANMs and ASHAs, with lists of all pregnant women who are due to receive their ANCs and post-natal care checkups (PNCs) and of all children due to receive their vaccinations. Between the two systems, few nutrition related indicators are captured, namely: (i) for pregnant women: IFA supplementation and presence of anemia, birth-weight of infants, and whether breastfeeding was initiated within one hour after birth; and (ii) for children: immunization and administration of vitamin A supplements. However, the conceptual framework of each does not include a specific reference to nutrition, either in terms of monitoring objectives or in the manuals for functionaries. This is indicative of the low priority to nutrition in the health sector and is likely to contribute to the large proportion of health functionaries at all levels in the health system not seeing themselves as having an important role to play in improving nutrition.

1.6.2 The HMIS and MCTS could potentially provide some critical information relevant to tracking and improving maternal and child nutrition. Since nutrition and health are closely related and nutrition has a key role in reducing maternal, infant and child mortality, which is a shared objective of both programs, and the fact that both the ICDS and the NRHM provide services to the same mothers and children, it is necessary to expand the health monitoring systems, particularly the MCTS, to include other nutrition indicators. As the MCTS tracks each child by name, it should be expanded in coordination with the ICDS to track children's growth, to enable early detection of faltering growth followed by action in coordination with the ICDS. This could contribute significantly to prevention of undernutrition and in tracking children with severe acute malnutrition (SAM) who need referral to health facilities but could be managed at the community level. Facility-based management of children with SAM is the direct responsibility of the NRHM, but there are gaps in the referral of these children to health facilities. The ICDS weighs children periodically and the MCTS could use this information for the tracking system, and explore options for inter-operability of the system with the ICDS. This would bridge the information gap between the ICDS and health systems and ensure that every child needing attention for nutrition is known to the health and ICDS functionaries and managers for support to become well nourished.

1.6.3 The NRHM's periodic Common Review Missions (CRM) and Joint Review Missions (JRM) have made some observations to strengthen the NRHM's role in improving nutrition.

The CRMs and JRMs, conducted by the NRHM with stakeholder engagement are opportunities to holistically review all aspects of the NRHM, gather qualitative information, understand key issues and agree upon solutions. The JRMs and CRMs have in their review observed that while Nutrition Rehabilitation Centers (NRCs) were operational at the district and block levels, their utilization needed improvement, given the large number of malnourished children, and the need to link the NRCs with community-based treatment of malnutrition (8th JRM, 2011). The need was also noted to make the NRCs functional by providing for trained staff and strengthening its linkages with the VHNDs, so that children with SAM could be identified and referred to the NRCs for treatment (6th CRM, 2012).

2 Availability of relevant and reliable data

While a large amount of data is generated in the existing ICDS M&E system, there are gaps that constrain comprehensive monitoring. In particular, the data falls short on accuracy and relevance to track the most crucial nutrition services and outcomes. The revised MIS being rolled out attempts to address these concerns and includes more meaningful indicators. In the case of NRHM, very little information relevant to tracking nutrition indicators is generated; the volume of data generated is large and there are concerns regarding the accuracy of the data.

2.1 The information collected by the current ICDS MIS is not fully congruent with information needed to exercise adequate control or tracking of the most important outcomes at the operational level. Whereas far too much information is collected, it falls short of the requirement for monitoring all activities important to improving nutrition.

2.1.1 Only selected activities are tracked and the system does not allow comprehensive monitoring of all key activities to improve nutrition. The maximum focus of gathering, collating and reporting information is on the data related to supplemental feeding. However, information relevant to some crucial activities to improve nutrition such as counselling and making home visits is not tracked. Furthermore, no data is collected on the critical behavior and practices of feeding young children, which could help at the frontline level, to gauge whether counselling is effective or how it could be improved. The system does gather information and report on the nutritional status (grades of undernutrition based on weight-for-age) of children up to six years but this is only a snapshot of the aggregate numbers of children in each category of undernutrition and does not show the extent to which undernourished children improve month to month, or how many slip into undernutrition. Such information would be relevant and meaningful to AWWs and their managers in addressing undernutrition.

2.1.2 No qualitative information is gathered. Qualitative information plays an important role in understanding why things may or may not work well. This input is essential for appropriate changes at the operational level to improve processes, efficiency and the result of activities. Although the intent of including interaction with the community during AWC visits by the supervisors and CDPOs appears to be to gather qualitative information on the program performance and its responsiveness to community needs, there is no systematic way of capturing it, collating it, triangulating with quantitative information and using it.

2.1.3 Frequent requests for information indicate that some of the required information might be missing. The FGDs in Bihar and Tamil Nadu indicated that functionaries get frequent requests for information over and above what is reported through the formal system.

This shows that all information needs of the higher levels are not met through the system or that the required information is not available at that level due to problems with data flow, processing and accessibility.

2.1.4 *Too much unnecessary information is collected and reported, the opportunity cost of which is very high.* The existing ICDS MIS generates a huge amount of data transcribed from registers maintained at AWCs, varying from 11-35 in number, depending on the state and includes *inter alia* information pertaining to demographics, resources available and in use, PSE activities, and nutritional status of children up to six years. Besides, the states MPRs provide project wise status of operational AWCs, including staffing, number of beneficiaries, and nutrition status of children. The AWWs therefore spend a disproportionately high amount of time filling registers and maintaining records (ranging between 12-99 minutes per day), while a large part of time at sector meetings is devoted to MPR review and completion, and then to the review at block level, and at times at the district and state levels too. All this time spent, much of it taken away from implementation and service delivery, results in virtually no corrective action. Thus the system has abnormally high opportunity cost.

2.2 **High priority at all levels to submission of MPRs ensures that the complete set of aggregated and reported information is available in time.** Information from the FGDs shows that the one priority which is clearly understood by AWWs, supervisors and CDPOs is submission of MPRs within the stipulated date. For example, AWWs from Bihar reported that failure to submit monthly reports by the due date resulted in threats of deduction of salary, providing a written explanation for the delay (*spashtikaran*) or criticism in meetings which would be highly degrading or frustrating. Sector meetings devote almost all the time to collecting, reconciling and consolidating sector MPRs and the aggregated national MPRs show that data is regularly generated from over 90 percent of the AWCs and aggregated at the state level.

2.3 **The accuracy of information collected through the system is suspect.** Several studies point out the lack of accuracy and reliability of data reported through the ICDS MIS (Planning Commission, 2011; District Health Society of Valsad, 2009; Saxena and Srivastava, 2009; SEDEM, 2005). As seen earlier, AWWs lack the skills and competencies in maintaining records and reporting. This is likely to be one of the several reasons for the poor quality of data. State level officials in Tamil Nadu reported during the FGDs that, as grassroot level workers are overloaded, the data is collected hurriedly and therefore neither reliable nor updated regularly. They also said there is a tendency to provide false information in order to avoid adverse comments during monthly meetings. Moreover, as the data is not scrutinized or used, its accuracy continues to be poor.

2.4 **The new MIS eliminates many of the constraints of the existing MIS.** The revised MIS is designed to gather information that is more relevant and meaningful to users at each level and, though still information heavy, is likely to improve data relevance, reliability and use.

2.4.1 *The system is designed to capture information that is more relevant to exercise control and track outcomes.* The system captures both quantitative and qualitative data related to the most crucial work processes and services delivered at the AWCs. It focuses on information about outcomes, inputs and processes, and the indicators are congruent with the process indicators outlined in the ICDS Mission's broad framework for implementation, such as increase in the percentage of early initiation of breastfeeding within one hour of birth,

exclusive breastfeeding till six months of age, timely introduction complementary feeding after six months and children's weight. However, information pertaining to undernutrition continues to be collected in the earlier way, showing only the number of children in each grade. However information pertaining to how many undernourished children improve or do not improve month to month, or how many children are becoming undernourished, which is more relevant for field-level functionaries, is not included. In line with the changes, the AWC registers have been redesigned to help the AWWs capture the required information, and the AWC monthly progress report and the block monthly progress report formats have been modified.

2.4.2 Accuracy of data is likely to improve because of clear guidance to capture and report data. The training manual for the revised MIS induction training provides clear instructions on how and when to record data and information for each information head in all 11 prescribed registers of the ICDS. The manual leaves no ambiguity about the revised MIS, and is therefore likely to result in more accurate and reliable data, although actual improvements remain to be seen. As part of the strengthening of the M&E system under the World Bank project, ISSNIP, the development of data validation mechanisms have been proposed to improve the accuracy and reliability of data. The revised MIS has been piloted and tested in approximately 1,000 AWCs (one block each in six states), thus providing reasonable assurance that the formats prescribed are workable, structured to record the required data, convenient to use, and can be filled in by workers in reasonable time (MWCD, GoI, 2012).

2.4.3 The revised MIS does show some promise of reducing time and opportunity cost, although it continues to be information heavy. The revised MIS has attempted to reduce the human and opportunity costs of monitoring by simplifying and streamlining registers, and making them easier for AWWs' use, including reporting on only relevant and required data. Thus, other than the information on the total population of the project, the revised MPR does not require reporting data that is unlikely to change on a monthly basis, and this reduces the time and burden of reporting. As all information from the AWC MPRs is not transmitted upwards, it reduces the time spent in preparation of the block MPR and its review at every level in the ICDS.

2.5 Concerns regarding accuracy of the NRHM data as well as the volume of data collected. The JRMs and CRMs have noted concerns regarding the lack of accuracy and poor quality of the NRHM data pool. The reasons for poor data quality are related largely to issues such as poor internet connectivity, insufficient staff, lack of clarity, system design issues and weak supervision (6th CRM report, 2012). The issue of lack of consistency in recording formats within the state and between states has been neglected. The large volume of data collected has also been noted. For example, some states had as many as 38 registers at the sub-center level (8th JRM report, 2011).

3 Use of information

Currently, there is very little analysis and use of information generated either by the ICDS system or the nutrition related information of the NRHM M&E system. However, the revised ICDS MIS, structured to promote the required analysis and use of information relevant to each user's job, is expected to improve data analysis and use.

3.1 Under the existing monitoring system, there is little analysis beyond collation of data and the use of information is minimal. There is almost no processing and analysis of

data to translate it into meaningful information or output reports. For example, while each state prepares an MPR with the project-wise status of the number of operational AWCs, staffing, number of beneficiaries reached, nutrition status of children amongst others, the information and data is not compared with targets for the reporting month and neither is there any trend analysis (World Bank, 2007). Besides, no analysis is undertaken to make the information useful for operational decision-making, or to review progress towards achieving the ICDS objectives. Since there are no clear targets or plans at the operational level (there are only coverage norms), there are no benchmarks against which to track progress, making it impossible to measure or judge if operations are progressing as planned, on-course and on time and to identify other variations in cost or scope. The reasons for minimal use of information include a lack of skills to manage and interpret information, and not enough appreciation of the value of information for decision making. Several studies document the poor use of data (CAG, 2012 and Biswas and Verma, 2009), including the poor use of nutritional status information to take steps to improve nutrition (Clifton D'Rozario, 2011).

3.2 Nonetheless, there are some good examples of use of data. The FGDs highlighted examples of good review of data and its use for taking corrective action. In Tamil Nadu, the state level review of the MPR is used to identify gaps in the field and corrective actions proposed. Similarly, CDPOs in the state reported that the DPO reviews the block's performance every month, with focus on the numbers of severely and moderately underweight children, comparing the progress with the previous month and with achievement of targets. During the district review, discussions pertaining to observations from AWC visits, including suggestions to improve performance, are undertaken and CDPOs with innovative and successful strategies and best practices are shown appreciation and asked to share the information with the others.

3.3 Under the revised MIS, data management, processing and analysis systems are well conceived to promote greater usage. Unlike the existing MIS, not all data collected at the AWCs, and reported in the AWC MPRs is transmitted upward, and only data relevant to the next level is sent up. For example, the system clearly lays out, among other aspects, data pertaining to 'Analysis of Important Behaviors and Services' is not meant to be transmitted up and is meant for discussions between the supervisor and the AWW to improve the latter's work processes and service delivery. Similarly, the new block MPR is designed to provide reporting on process level indicators that are in line with those defined in the ICDS Mission. It also includes a section to note achievements, problems faced and resolved during the month by the CDPO. The block MPR not only collates the AWC MPRs, but also processes the information, converting it to percentage achievements and efficiencies, thereby making it more meaningful for M&E and corrective action.

3.4 The NRHM HMIS and MTS have constraints of data analysis and usage. Several reports note the sub-optimal use of HMIS data. While some states analyse the information from the HMIS, and use the analysis for the preparation of their PIPs, the HMIS is largely not used for monitoring the program at PHC, block, district or state level (8th JRM, 2011). Poor data quality and problems related to the technical design of the HMIS system limits local analysis and these are some of the key reasons for the limited analysis and usage of data especially at the district level (6th CRM, 2012). The absence of integration of the MCTS with the HMIS, software and hardware issues need to be addressed to improve data usage and avoid duplication of effort (8th JRM report, 2011). The analysis and use of nutrition related information captured by the NRHM is limited. The state PIPs focus on 21 indicators which

are called state-specific goals and service delivery targets. These are not regularly reviewed at most levels.

Recommendations

The ICDS mission framework lays out the architectural contours of the ICDS' future M&E system, and proposes to set up a dedicated functional unit at the national and state levels to design and manage the ICDS M&E function. The ICDS MIS has been revised and is currently being rolled out. The revised MIS addresses many of the constraints and shortcomings of the existing ICDS MIS, and the ongoing World Bank support to the ICDS includes further strengthening of the M&E system. These developments present an unprecedented opportunity to give the ICDS a new generation M&E system, as well as set the stage for the ICDS to integrate it within a broader KM system.

1. The ICDS Mission information framework has added research along with the M&E function. It also refers to the use of *jan sunvais* and other community-based monitoring mechanisms, reviews and assessments such as joint review missions, that will generate information. For effectively organizing, processing, sharing and using the information from all sources, the most important step is for the ICDS to develop a conceptual framework, ideally for KM, but at a minimum for the M&E function. The importance of a comprehensive written conceptual framework to ensure that relevant data is collected, processed, analysed and used on a timely basis to control operations, track outcomes and determine if policies and strategies have the desired impact, has been shown in the discussion on conceptual framework. Box 6.1 provides some key points that serve as building blocks for developing a good framework. In order to move in this direction, it will be important to appoint a high level manager with principal responsibility to develop the conceptual framework for the design of the system, and oversee its design, implementation and management.

2. The content of the new MIS should be reviewed against the conceptual framework developed with a view to prioritizing what needs to be reported and how frequently. This might result in reducing the volume of data generated, and possibly make space for other information of higher importance. One of the missing pieces at this point is periodic tracking of changes in the nutritional status of individual children. While this is supposed to be done through individual MCP cards, for bringing this information into the monitoring system to enable appropriate action, it is important for AWWs to report periodically on the nutritional status of each child or pregnant mother under her care by name, so that the supervisor can monitor progress (or lack of it) and support the AWW in this critical task. Similarly, if each supervisor has to report the status of these children and mothers under the care of subordinate AWCs, there will be an incentive to pressurize the AWWs in these centers to deliver the results. Such tracking of the nutrition status of individual children and mothers might be best done by integrating this information with the MCTS (see recommendation 6).

3. The revised MIS has already taken steps to improve the reliability and accuracy of data, such as providing clear guidance and direction, good training, and emphasis on the use of data at each level. This should lead to improvements in data reliability. In addition, the revised MIS should consider instituting some data validation mechanisms, such as random checks, verification of a specified percentage of data. Pilots to test data validation mechanisms are planned under the ISSNIP project, to inform the ICDS M&E of such methods and enable their use throughout the program.

4. Given the minimal data analysis and use for exercising control and decision making, the ICDS should make serious efforts to promote data analysis and its greater use at each level. This may involve developing standard data analysis templates, building the skills of personnel at all levels to interpret and use data for decision making. A beginning in this direction has been made with the revised MIS. The ICDS must promote a culture that values data analysis and use. This could be done in several possible ways. One way would be to start at the top. High level managers should start using analyses on a national or state level and present their analyses to the next level of managers, and require them to use similar analyses with personnel at the next lower level and for their own entities, such as districts heads for CDPOs, CDPOs for supervisors, and supervisors for AWWs. Another way is to mandate that all work plans be based on the analysis of specific data relevant to the work plan.

5. The ICDS must also use effectively, any data generated by any organization that could potentially throw light on any aspects of the program, including performing its own analysis on the raw data, if necessary, such as from the HUNGaMA Survey and ICDS evaluation. It must acquire expertise that will support undertaking such analyses.

6. The potential for use of the MCTS as a system to track the nutrition status of children, pregnant mothers and adolescent girls as well as include other important nutrition indicators should be seriously explored. Inter-operability of information between the NRHM and ICDS programs will not only be efficient but will also serve each program's interest. Since the ICDS and the NRHM target the same set of mothers and children, it is in their common interest to track indicators that support both programs in health and nutrition of mothers and children. A common tracking system will help ensure that the most vulnerable and the ones needing attention are on the radar screens of the functionaries and managers of both, the ICDS and the NRHM.

Chapter 7

General Management Practices

Introduction

Management practices are the practices that managers follow when they manage people, resources and operations. Some management practices relate particularly to the management of specific groups of people, specific operations and specific resources; many are however common to the management of all people, resources and operations. Such practices, called general management practices (GMPs) are practised by managers and leaders. The number of GMPs is large. It is, therefore, useful to group them in smaller number of categories. They can be grouped into the following seven categories: (i) setting of objectives; (ii) operational planning; (iii) empowerment; (iv) supervision; (v) coordination; (vi) accountability; and (vii) sound work processes and procedures.

GMPs are indicators of institutional capacity, the rationale being that good management practices enhance capacity while poor ones constrain capacity. Therefore, this chapter addresses the following key question:

To what extent do managers in the ICDS follow good GMPs? What, if any, are the factors that constrain managers in following good GMPs, and how can these be overcome?

The chapter presents a brief GMP conceptual framework and capacity indicators, and then makes a detailed examination of three of the GMPs, namely, supervision, accountability and work practices and procedures.

Analytical framework and capacity assessment indicators

The cumulative effect of seven highly interdependent GMPs, namely setting of objectives, operational planning, empowerment, supervision, coordination, accountability and work practices and procedures, can greatly enhance or constrain the capacity of an organization. The detailed analytical framework for GMPs is described in Annex 1. Operational indicators to assess the effectiveness of these seven GMPs are outlined in Table 7.1. The chapter examines three of these GMPs.

Operational indicators to assess the effectiveness of GMP	Assessed by Indicator
Setting of objectives	Limited or no attention paid to the setting of objectives
Operational planning	Existence and quality of operational plans
Empowerment	Delegation of authority and attention to staff development
Supervision	<ul style="list-style-type: none">• Oversight:<ul style="list-style-type: none">○ Frequency and intensity of supervision○ Quality of supervision, that is, what is focused on• Support: mentor, train, build skills
Coordination	Coordinate action well, within and between teams
Accountability	Holding staff accountable for: <ul style="list-style-type: none">• Performance• Conduct
Work practices and procedures	<ul style="list-style-type: none">• Quality of design of work proceedings• Documented and supervised

Findings

Findings pertaining to the three GMPs, namely supervision, accountability and work practices and procedures are discussed below.

1. Supervision

Supervision is one of the most important generic tasks of management. All managers supervise their immediate subordinates. It is necessary to distinguish between this generic task, which ought to be carried out by all managers at all levels in the ICDS and Health, and the job of the immediate managers of all AWWs who are called supervisors. This discussion concerns the generic task and how it is carried out by all managers, including the supervisors.

The supervision analytical framework

Supervision combines two elements, namely, oversight and support. Oversight refers to the activity of watching the performance of subordinates when they carry out operations for the purpose of control. Support refers to the activity of guiding, coaching, mentoring and motivating subordinate staff. Most of the time, support is given as an integral part of oversight.

The effectiveness of supervision depends on: (i) what managers watch while supervising; (ii) what they focus on while supporting; and (iii) the frequency and intensity of supervision. Good managers watch what their subordinates devote their time and effort to, making sure that these are in line with organizational priorities. They pay attention to how their subordinates carry out their jobs, looking for opportunities to improve the tools and methods of operation. Having identified such opportunities, managers move into the support mode and guide and train their subordinates to perform better. However, even good managers often fall into the trap of focusing only on what is being monitored by their organizations. Thus, if their organizations monitor only the 'how much' and not the 'how well', or 'at what cost', they too tend to watch only the 'how much' and spend supervision time on ways to enhance it, to the exclusion of the other two imperatives.

Finally, since supervision is a generic management task carried out by managers at different levels of management, what managers focus on while supervising also differs. When top managers supervise senior managers under them they focus on how the senior managers interpret strategy and manage operations; when operational managers supervise workers, they focus on how the workers carry out specific work tasks.

Findings

Overall, there is a weak culture of supervision in the ICDS. It is generally focussed only on the supervision of AWCs, while supervision along the hierarchy receives little attention. Further, supervision is focussed more on the control dimension, whereas the support element is weak; the frequency of supervision is sub-optimal and the quality of supervision is weak. Key reasons for the weak supervision are shortage of staff and lack of supervisory skills.

1.1. Supervision in the ICDS focuses primarily on supervision of AWCs and at other levels the practice of supervision is almost non-existent. Most, if not all, literature on

supervision in the ICDS, deals with supervisory activities only at the AWC level – whether exercised by the supervisors, or by visiting CDPOs and DPOs. They seem to ignore the fact that supervision is required at all levels and make no comment on how executives at the level of state ministries supervise the DPOs, how DPOs supervise the CDPOs and how CDPOs supervise the supervisors. The evidence suggests that high level ministry officials seldom visit DPOs, the DPOs seldom visit CDPOs, and the CDPOs seldom visit supervisors. However, the opposite is true whereby supervisors go to meetings with the CDPOs and CDPOs go to meetings with the DPOs. These meetings are often described as supervisory in nature, but unlike effective supervision meetings, are conducted in large groups, not one-on-one, and consist predominantly of oversight, not support.

1.2. Even at the AWC level, there is not enough supervision, and its quality leaves much to be desired. There is ample evidence in the literature and in this study that the supervision of AWCs is one of the weakest points of the ICDS. (Haddad and Zeitlyn, 2009; Saxena, 2009; Pratiche (India) Trust, 2009; Huff-Rousselle et al, 2007; Srinivasan et al, 2007, Gragnolati et al, 2005). These study reports refer to it as ‘poor’, ‘lacking’, or ‘non-existent’. The main weaknesses of supervision in the ICDS are:

1.2.1. It is highly ‘oversight-centric’, and the ‘support’ aspect is minimal, if not absent. Visits to the AWC form the primary mechanism to exercise supervision. There are norms for the number of visits to be made by supervisors, CDPOs, DPOs and other officials (see Table 7.2), and checklists for visits lay out what should be ‘overseen’ during the AWC visit. Approximately 50 percent of the CDPOs and supervisors admitted that they did not provide any support and guidance during their AWC visits (UDISHA, 2008). The AWWs generally have low literacy levels, coarse skills which need continuous training, are overburdened with many activities, have low levels of motivation, and are ultimately held responsible for the timely and effective delivery of all services under the ICDS. This makes the supervision of AWC activities by the supervisor and other officials an important task, which if carried out systematically, would help in both effective delivery of services and in enabling the AWW develop and refine her knowledge and skills.

Table 7.2: Supervision and monitoring guidelines by MWCD, GoI

Official	Guidelines for visits
Supervisor	A minimum of 50% of AWCs under the supervisor’s jurisdiction every month
CDPO/ACDPO	100 AWCs once in a quarter on a rotational basis and to cover all AWCs at least twice a year
DPO	Touch base with all blocks of the district each quarter by covering at least 15% of the AWCs in a year, spreading them equally across the year
Joint visits	
Supervisor and ANM/LHV	At least 10% of the AWCs every month
CDPO/ACDPO and MO	25% of the AWCs once a quarter
DPO and CMHO	5% of the AWCs once a quarter
<i>Source: MWCD, GoI, 2010.</i>	

1.2.2. Despite the focus on the number of visits, the frequency of supervisory visits to the AWCs by all categories of officials falls short of the prescribed norm. Despite the focus on the number of visits, a large number of reports document the erratic patterns of visits to the AWCs by all categories of supervisors. Although the HUNGaMA Survey 2011 reports that 70 percent of the AWCs had received a supervisor’s visit in the one month prior to the survey

(HUNGaMA Survey Report, 2011), several other reports note much poorer supervision statistics. Data from 20 states shows that on an average a supervisor made only five AWC visits in six months, ranging from two in Bihar to eight in Haryana. In the case of CDPOs, on an average only one visit to an AWC was made in six months, ranging from two in Chhattisgarh and Haryana to none in Assam. The DPOs had not made even one supervisory visit to any AWC (Planning Commission, 2011). Several reports have documented that a large proportion of AWCs are not visited by any functionary for prolonged periods (Planning Commission, 2011; Pratiche (India) Trust, 2009; Gupta, 2007; Biswas and Verma, 2009; IIMR, 2000 and Usha, 2006).

1.2.3. *The quality and content of supervision is weak.* The effectiveness of the supervisory visit depends on what the supervisors, CDPOs and DPOs focus on, or do not focus on, during their visits. A central preoccupation of the supervisory visit is checking records and registers, and too much time is spent on this with too little time devoted to other activities including mentoring and providing guidance (Planning Commission, 2011; UNICEF, 2007 and 2009; Pratiche (India) Trust, 2009; Gangur, 2007; FOCUS, 2006; Gupta, 2007; IIMR, 2000). Supervisors tend to focus – both in their oversight and support tasks - on the indicators being monitored by the system, that is, the numbers of beneficiaries and foodstock. Several reports suggest that supervision visits are often very short, their quality rather weak, and the number of visits too few (see Box 7.1). While supervisory checklists prescribe checking aspects, such as infrastructure, cooking and distribution of food, as well as activities, such as immunization, food distribution, pre-school education, weighing, health checkups, VHND observation and interaction with the community, the information collected from the field and from documents indicate no concrete evidence to show whether these checklists are used in practice.

Box 7.1: Quality of supervisory visits

“Visits made by the CDPO were found to be very low in almost all the states, with the average being just one in six months” – *Planning Commission, 2011*

“Only 29 percent centers were reportedly visited by Child Development Project Officers (CDPO) in the year prior to the survey..... While asked about visits by officials’ many AWWs responded – ‘konodini aseni’ - ‘the officials never visited’.” – *Pratiche (India) Trust, 2009*

“It is observed almost two third of the AWCs were supervised at least once in a month, with nearly 13% being never visited by the Supervisory staff....In Bihar, the CDPO had visited the AWCs only once in a year. The frequency of visit by the DPO to AWCs was almost conspicuous by its absence, though the DPO did visit some AWCs once in a year or once in six months” – *DB Gupta, 2007*

“More than three-fourth of the supervisory staff were found to be unable to move in the field or make any visits to the Anganwadi center” – *GoB and UNICEF, 2007*

“In Jharkhand, almost half of the sample AWCs were never visited, and only 13% of the AWCs were visited once in a month by the supervisor” – *DB Gupta, 2007*

“It was found that visits by CDPO Supervisors to the AWCs were inadequate and some AWCs were never visited by CDPOs in a span of three years” – *Biswas and Verma, 2009*

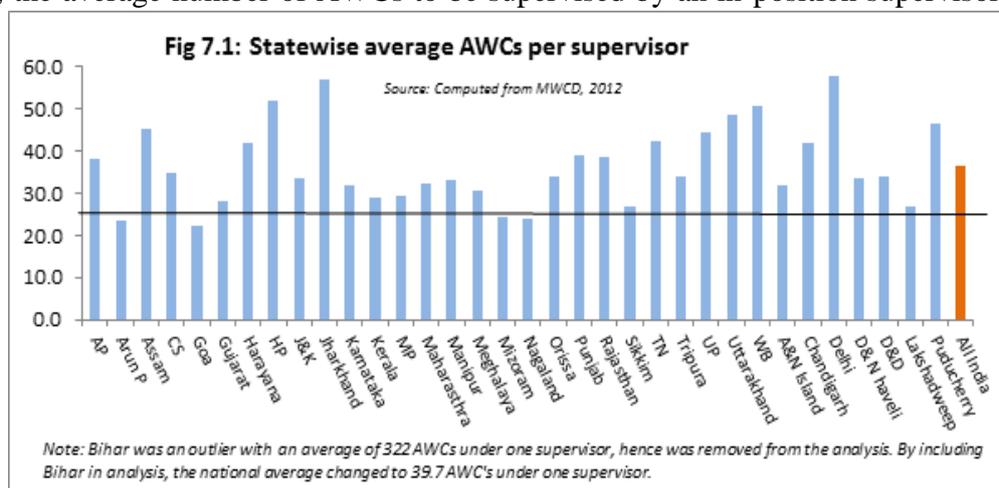
“Around 93% of AWWs said that supervisors visits once in 3 months and around 98% of AWWs said that ACDPO and/or CDPOs visit their centers once a year” – *MN Usha, 2006*

“The numbers of visits made by the medical officer was quite low, with the average for six months being only one” – *Planning Commission, 2011*

1.3. The reasons for weak supervision in the ICDS are many and include, among others, a weak culture of supervision, staff shortage and lack of skills and resources.

1.3.1. Shortage of staff, heavy workload, and lack of vehicular resources affect the number of supervisory visits that officials can make. Several studies and field data collected for this study indicate stark differences in the frequency of visits made by the supervisors, ranging from one per week to one per month. Owing to the large number of vacancies at the supervisor level, the average number of AWCs to be supervised by an in-position supervisor varies

considerably (see Fig. 7.1) ranging from 22 centers per supervisor in Goa to 322 centers per supervisor in Bihar. The large number of vacancies of supervisors and CDPOs



and their heavy workloads (discussed in detail in HR) combined together considerably limit the number and of quality visits to AWCs that they can undertake. Further, lack of vehicles for supervisory visits, highlighted during and the added travel time due to use of public transport for supervisory visits further limits their time for actual supervisory activities.

1.3.2. Lack of supervisory skills and supervisory tools is one of the key reasons for poor supervision. The manner and quality of supervision in the ICDS discussed earlier, including the lack of emphasis on the ‘support’ aspect of supervision and the lack of setting objectives by supervisors is, among other factors, due to a lack of supervisory skills amongst managers. During the FGDs, supervisors emphasized that their problem-solving and counselling skills needed to be strengthened. The supervisory guidelines do not sufficiently strengthen supportive supervision and, in fact, only focus on the number of visits to be undertaken. There are no uniform and comprehensive checklists for supervisors or managers to guide them in the critical areas to be supervised during visits to the AWCs. The analysis of the training curriculum of CDPOs and supervisors also indicates that supportive supervision does not get due emphasis.

1.3.3. The general weakness of supervision at all levels, starting at the top, contributes to poor supervision in the system. If supervision by the supervisors at the AWC level is weak, this is among other reasons, due to the fact that supervisors are themselves poorly supervised by the CDPOs who, in turn, are not supervised well, or perhaps not at all, by the DPOs; this sequence continues. There is a chain of causality: managers supervise subordinates on those things which they are supervised on, and this happens all along the hierarchy. The lack of supervision at each level indicates that the managers are detached from what is actually happening in the field level.

1.4. The ICDS restructuring and the revised ICDS MIS emphasize the support aspect of supervision as well as the right things to focus on. Recognizing the lack of support in

the supervision framework, the restructured ICDS proposes to strengthen ‘supportive supervision’. The revised ICDS MIS system, with its focus on monitoring details of activities carried out at the AWC, at the Village Health and Nutrition Day, including indicators of behavior change will draw attention to these during supervisory visits, and the training focuses on building an understanding of the content of monitoring and supervision, and the reasons for this focus. With the aim to strengthen supervision, in the ICDS Mission, a cluster office is proposed be set up in strategically located AWCs for managing a cluster of 17-25 AWCs. At present, the supervisor has not been assigned any specific office and performs the work only by field visits made from block office. It is expected that, if strategically located, the supervisor will be able to supervise and monitor the work of AWCs much better and also become available to the AWWs for guidance and consultation. However, the focus of supervision still continues to be ‘supervision of the AWW by the supervisor’ and not the supervision of all levels in the chain. Besides, many constraints such as shortage of field supervisory staff, CDPOs, supervisors and their workloads, and lack of transport remain unaddressed.

To conclude, the ICDS is without a good, systematic, well-thought conceptual framework for the function of supervision. Such a framework should not only distinguish between the specific role of supervisors at the bottom of the pyramid and the generic task of supervision at all levels of management, it should also provide guidance on what needs to be supervised at each level. It must inform not only the supervisors about what to look at when they visit a center, but also the CDPOs about what to look at when they supervise supervisors.

2. Accountability

In the context of management practices, accountability refers to the requirement of public officials taking responsibility for their actions. It is defined as “*a proactive process by which public officials inform about and justify their plans of action, their behavior, and results and are sanctioned accordingly*” (World Bank, 2005). According to the World Bank (2003), accountability is ensured when the incentives to service providers are aligned with the ultimate preferences of citizens, and when providers are made directly accountable to people.

This section analyzes ‘accountability’ in the ICDS and NRHM and examines whether it is practised as a good GMP and the extent to which officials in the ICDS and NRHM are held accountable. It then suggests ways in which accountability could be strengthened.

Accountability Analytical Framework

From the management perspective, accountability must accompany responsibility and authority. Officials are primarily accountable for: (a) their performance; and (b) their conduct. Accountability for performance implies: (i) that officials are required to, and will, give a full account of what and how they did whatever they did at work; and (ii) that they will bear the consequences, that is if they behave or perform poorly they would have to pay a price. It is not enough to follow the rules, because public officials can follow all of them and still not act effectively enough to achieve the desired policy outcomes. Therefore, individually accepting the responsibility for delivering the results agreed upon between manager and employee forms an important aspect of accountability. A basic premise of accountability for performance is that managers set priorities and objectives for individual workers whom they supervise. Effective managers set periodic objectives or targets that are based on the priorities of their organizations. Such objectives are clear and specific, time-

bound, measurable, and challenging yet realistic. As in the case of priorities, the objectives ought to be result-oriented, implying that the required results must be expressed in measurable quantities and qualities. If many, or most, managers do not insist on results, or if it is just not the norm in an organization for managers to insist on results, then the performance of the organization is likely to be modest, poor or approach failure. Accountability for conduct implies ensuring that officials obey the law and do not abuse their power. The most common types of abuse of power are: (i) corruption, which enriches public officials; (ii) clientelism, which channels public resources unfairly to specific groups; and (iii) capture, which provides rents to opportunistic economic actors.

Three requirements must be met in order to have accountability: (i) it should be clear to the officials what they are accountable for. In other words, their performance objectives must be spelt out very clearly and precisely; (ii) there must be good monitoring of their behavior and performance; and (iii) misbehavior and poor performance must be penalized.

Findings

While, in principle, a formal system of accountability for conduct and for performance exists in the Indian Public Service including the ICDS, in practice the tendency is to focus more on rules and less on performance. In addition, the predominant emphasis is on penalizing activities that breach the rules and result in poor performance and much less to reward rule-based behavior and good performance.

2.1. The framework for ‘accountability for performance’ is not very well developed in the ICDS and the related practices are weak. The exercise of performance-related accountability is dependent on two other management practices: (i) the setting of clear objectives and targets; and (ii) monitoring their achievement.

2.1.1 The practice of setting priorities or time-bound objectives or targets for individuals, teams and managers and monitoring them is not prevalent in the ICDS and NRHM. During the FGDs, some AWWs reported that no priorities were set for them by the CDPOs or supervisors and hence they had to set their own priorities, while several AWWs mentioned they were given priorities and objectives. However, these priorities were not consistent; they listed all ICDS objectives and activities, or were often very general, such as “we have nutrition-related priorities”. None of the AWWs described the objectives in terms of the results or outcomes to be achieved. Interestingly, different AWWs, supervisors, CDPOs and DPOs within the same districts reported these priorities in different order, clearly reflecting the lack of a guiding and binding order of priorities. In the case of health, all participants reported having priorities, which included everything that they were doing but had no common list of priorities and no common order among them. A large number of AWWs reported that they set their own targets for their centers, since their supervisors did not. As with priorities, the targets that the AWWs set for themselves were described in terms of activities. None of the targets were expressed in clear quantitative terms and were therefore not measurable. To the extent that they were quantitative, they related only to the number of beneficiaries that would receive services, the number of supervisory visits to be made, and not to the results of services received.

2.1.2 There is no focus on holding the functionaries accountable for achieving the outcomes. One of the most important requirements for improving nutrition is to hold all functionaries, and not just the AWWs, accountable for the outcomes that improve the

nutrition of children. Some of the most critical outcomes would be improvement in the feeding and caring behavior of mothers and, ultimately, a reduction in the number of children who are not growing well, whose nutrition status is not worsening, and an increase in the number of undernourished children whose nutrition status is improving. If supervisors focussed on these critical aspects, set objectives related to these and monitored the achievements of related results, that is held the level below them accountable for the outcomes and supported them in achieving these in the required ways, the focus would shift from just counting the numbers to whom services were extended to achieving these outcomes. For such a shift to occur, the ICDS' accountability for the performance framework must ensure a focus on results and not just processes.

2.2 The AWWs and the ANMs are generally held accountable for non-performance. The CDPOs, supervisors and AWWs, all acknowledge their collective responsibility for overall AWC performance, as is evident from the FGDs in Bihar and Tamil Nadu. However, in reality, the AWWs are alone held responsible for non-performance, and face disciplinary action. Supervisory visits by the officials are more authoritative than supportive, or guiding in nature. Hence, supervisors and CDPOs fail to provide the necessary support to improve AWWs and AWCs performance. Therefore, despite the acknowledgement of collective accountability, the AWWs do not receive support in implementing the program and the CDPOs and supervisors are not held accountable for their failure to provide the necessary support.

2.3 Accountability for performance at the managerial and leadership levels is particularly weak. While the overall accountability system for performance in the ICDS is weak, the chain of accountability is particularly feeble when it comes to holding managers and leaders accountable for their performance. Given that senior managers and leaders manage functional areas and organizational units at the national, state, district or even block level, their performance or non-performance is a matter of importance and can make large scale differences to the results. Since they play an important role in providing direction, managing the performance of hundreds of people whom they supervise, empower them, motivate them, build their skills through training, ensure sound work practices and procedures, and build organizational culture, it is indeed surprising that there are almost no demands of accountability on the managers. The bulk of those who seem to be punished for not following the rules or for poor performance are the AWWs at the AWC level. No questions are put to managers and, more importantly, no action is taken when training targets are not met, or when recruitments are inordinately delayed, or when supervision is inadequate and program quality poor, and so on. If any questions are asked, these might only concern the number of AWC visits made or not made by managers.

2.4 At the operational level, the aspect for which accountability is demanded is submission of MPRs in time. There is a systemic culture of focusing on numbers and AWWs, supervisors, CDPOs and DPOs all focus on activities that need to be reported in the monthly reports. Timely MPR submission is given the highest priority at the field level. For example, AWWs from Bihar reported that failure to submit monthly reports by the due date resulted in threats of deduction of salary, providing a written explanation for the delay (*spashtikaran*) or criticism in meetings which would be highly degrading or frustrating. As discussed in the section dealing with supervision (see point 1.2.3), the focus of supervision and monitoring is on filling up registers, collation of information and onward transmission, and submission of reports in time. Accountability for accuracy of data, service quality and meaningful results receives little emphasis.

2.4.1 There is little accountability for the data reported and the reliability of data generated is questionable. Many reports, including those from the NRHM, suggest that the ICDS reports on coverage, nutritional status and other parameters do not represent ground realities (Planning Commission, 2011). The data from Bihar shows the same number of beneficiaries for pre-school education (PSE) and supplementary nutrition (SNP) in three consecutive years, whereas these are likely to be the targets provided and reflect a 100 percent coverage (2009, 2011 and 2012). In this regard, the field data indicated that providing information that reflects, or may be interpreted as reflecting, implementation problems and issues are generally not viewed kindly by the senior officials, and those who report this run the risk of annoying them and being reprimanded. Therefore, instead of seeking support to improve the outputs and outcomes of work, the subordinate staff tries to avert the risk of being called to account by providing information that reflects positive numbers and progress that superiors like to see. Reporting of challenges and problems is not encouraged.

2.5 **Despite the system's focus on 'following the rules', accountability for conduct is generally poor.** Several reports refer to corrupt practices in the ICDS, related particularly to recruitment and the food meant for supplemental feeding (Planning Commission, 2011; Report on Gram Sabha for Social Audit of ICDS Programme, 2007 and Citizen's Initiative for the Rights of Children under Six, 2006). While this study was not designed to examine the issues of corruption, many references to corruption and irregularities were made by respondents at all levels in the FGDs and interviews. Whereas the following points are made in the context of the ICDS, the broader context of public accountability in India within which the ICDS operates is relevant. Some arguments state that though *de jure* policies might appear in place, yet in *de facto* implementation and delivery, there is rampant corruption, absenteeism, indifference, incompetence, inefficiency or outright failure (Posani and Aiyar, 2009), and that the Indian state, its institutions, and the rules that govern them are structured to avoid accountability altogether (Mehta, 2003 and Saxena, 2004).

2.5.1 Irregularities, corruption and rent seeking appear to be pervasive. Workers and officials at virtually every level stated corruption as a key constraint to recruiting the right kind of people, their motivation and commitment, and even in getting routine work accomplished. To quote one such statement, "Money is collected at every level – for appointments, transfers, even for cashing training vouchers at the treasury." In Bihar, where cash for purchase of food is sent to the AWCs, irregularities at all levels in the chain appeared to be common. The AWWs even mentioned rent-seeking by the Pradhan's of gram panchayats, whose signatures are required to withdraw cash. False or doctored certificates and mark sheets submitted by candidates at the time of application, bribes and political interference were constraints to appointing qualified and competent personnel, and many felt that an entrance test to test basic skills was necessary to ensure that the right persons got the jobs.

2.5.2 Several initiatives to check leakages and enhance accountability have been made by the MWCD and the states, particularly Bihar. Initiatives by some states to bring about transparency include online publication of lists of applicants, along with their CVs, and the results of the selection for the posts of supervisors, AWWs and helpers. A number of states including Bihar, Odisha and Andhra Pradesh have experimented with social audits to meet the prime objective of making the ICDS system and administration transparent and accountable. These audits have brought out the issues concerning leakages in food delivery, poor AWC infrastructure, unethical working by the functionaries, low awareness among the

beneficiaries, delayed payments and many more. In Bihar, to enforce basic rules, such as ensuring that AWCs open every day for the prescribed number of hours, and to curb leakages, the state government instituted a system of unannounced spot checks at AWCs, followed by severe action including suspension in the case of violations. As a result, a large number of AWWs, some supervisors and CDPOs were suspended. While this resulted in extensive improvements in ensuring that the AWCs opened daily and, as reported in an FGD by a senior official, 85 percent of the AWCs are now open, at every level from the district to the AWC, the officials appeared demotivated due to the environment of fear that had been generated.

2.6 The restructured ICDS focuses on ways to strengthen accountability. One of the goals of the ICDS Mission is to ensure good governance and accountability. The framework proposes three key ways of enhancing accountability in the ICDS: (i) community based monitoring and accreditation; (ii) internal monitoring; and (iii) concurrent external monitoring. Direct accountability of the ICDS mission system to the community and beneficiaries is envisioned through periodic public hearings and social audits. Besides, periodic external, household and facility surveys along with supervision, missions are proposed to track the effectiveness of ICDS activities and to monitor the outcomes. A grievance redressal mechanism including redressal arrangements at village, block, district, state and national level are broadly outlined and a web-enabled system is proposed to allow beneficiaries to register their grievances. Evolving a transparent appointment and selection policy is also proposed.

To sum up, despite the existence of a formal, largely punitive system on paper, there is in the public service, and within it in the ICDS, a very high tolerance for misbehaviour and ineffective performance. Corruption is pervasive and poor performance is widespread. Yet, relative to the magnitude of corruption and poor performance in the ICDS, few in it are held accountable. It is the worker at the bottom of the chain, the AWW who is usually held accountable and faces action for non-performance or misconduct. The chain of accountability at managerial levels is particularly weak. Poor accountability has led to a culture where non-performance and inappropriate conduct are perpetuated. The tolerance for the non-performance of managers has led to sub-optimal performance of the systems.

3 Work Practices and Procedures

In a large program such as the ICDS, where services are delivered through more than 1.3 million AWCs that serve as the service points, ensuring implementation of the program with minimal variation across locations and multiple points, and delivering services of a defined standard in an efficient and effective manner is both crucial and challenging. This requires building up an understanding among all involved in program execution about what is to be achieved and the manner of doing so. Therefore, it is critical that the ICDS defines and adopts carefully designed work practices, processes and procedures that promote the maximum possible efficiency and achievement of results.

The quality of the design of SOPs or work procedures can be indicators of capacity. Productive practices, processes and procedures are likely to result in appropriate quantity and quality of process outputs with given resources, thereby enhancing capacity, whereas poorly designed and defined work procedures can constrain capacity.

The literature on the analysis of the ICDS work practices and procedure is very scanty. This chapter bases its analysis on data collected through FGDs conducted for this study and draws heavily on the step-by-step analysis of work procedures in 2009-2010 by the CARE-USAID Integrated Nutrition and Health Project (INHP) in Chhattisgarh (CG) and Andhra Pradesh (AP), which was also updated in this study. The INHP undertook a work analysis related to five key processes impinging on nutrition, namely, fixed nutrition and health days, prioritized home contacts, structured sector meetings, supportive supervision and food commodity supply chain management (only in AP), after which SOPs were developed, documented and implemented on a pilot basis in selected districts of the two states. Andhra Pradesh subsequently expanded the effort across the state.

3. Work Practices and Procedures Analytical Framework

Practice is the way of doing something, or the way of performing a given task. A *process* is a set of related activities, actions and tasks directed towards a predetermined aim and carried out in sequence step-by-step to produce a specific product or service. *Procedure*, also referred to as SOP, is a prescribed or established process that is often written down for ensuring uniformity in implementation.

Processes contribute to capacity when they are structured and sequenced in the most efficient way, that is when they avoid waste of time and resources and use the least effort to produce the best possible results. Capacity is a product of productive work, practices and processes, and enhanced productivity leads to higher capacity. Procedures are descriptions of processes and it is necessary to document these descriptions in order to minimize variations in implementation across locations and thereby to enhance capacity across the program. Thus, the quality of work processes and documented work procedures are significant in their contribution to productivity, effectiveness and efficiency.

Findings

Work procedures in the ICDS are not satisfactorily designed and not compliant with good work procedures. As a result, there are large variations in how activities are conducted, particularly at the AWC and sector level, thereby affecting program quality and results. The lack of established and documented procedures further leads to non-efficient use of time and resources and a loss of productivity and capacity.

3.1 There is virtual absence in the ICDS of documented work processes and procedures detailing how each activity is to be conducted. The nature and scope of the activities that need to be conducted are not clearly determined, and if determined, are sub-optimally or poorly designed.

3.1.1 Operational manuals and work procedures for ICDS activities and their sequence, in which they need to be conducted, resources required, expected outputs and functionaries' responsibilities have either not been defined or contain inadequate details and are poorly designed. In the absence of defined work processes and procedures, AWWs and supervisors, are left largely to conduct the activities based on their own understanding of what is to be done, developed by reading official orders and guidelines, or through training programs, and training material:

- For instance, there is no step-by-step definition of what needs to be done, when and by whom during monthly sector meetings, meetings that take up considerable time of all AWWs and supervisors. At most sector meetings, a disproportionately large proportion of the time is devoted to the preparation, review, and revision of AWC MPRs. Some AWWs prepare and revise their individual reports with the help of the supervisor at the meeting, resulting in wastage of the time of all others. The disproportionately large time spent on MPRs also takes away from other important aspects of the sector meeting, such as discussion of issues and problems, sharing program updates and guidance on performance. As a result, the meeting does not accomplish its purpose. Had the procedure for conducting the sector meeting been clearly defined and communicated across the program, it would have contributed to greater efficiency and effectiveness in conducting sector meetings and increased productivity throughout more than 50,000 sectors in the ICDS.
- Home visits conducted by the AWW for nutrition and health counselling is yet another example where training material provides adequate information on prioritization of beneficiaries for home visit, whom to interact with during the home visit and counselling. This largely forms the basis upon which AWWs conduct home visits. However, there remain several areas that are not well designed and defined. For example, the practice is to record home visits in the AWW's diary. However, because this manner of recording the home visit does not allow for arranging pregnant women based on the expected date of delivery, it does not help the worker in determining which women are to be visited on priority, nor is it helpful in tracing the previous visit details, such as the counselling provided, and the areas for follow-up, thus leading to loss of efficiency and effectiveness. A well-designed work procedure would have taken these aspects into consideration and increased productivity and increased capacity. Taking cognizance of this, the ICDS while revising their MIS has included a home visit planner as one of the 11 essential registers and provided detailed instructions on how and when to fill it (MWCD, 2012).

3.1.2 Government orders and guidelines, formats, registers, checklists often provide the only definition of work procedures. Not being detailed enough, they are not the equivalent of well-designed work procedures. Official orders and guidelines invariably are policy directives and program guidelines that provide broad direction for the work or specify norms, such as the number of beneficiaries, number of supervision visits to be undertaken and so on. They do not holistically address: (i) the operational details and step-by-step description of how the activities in a procedure are to be conducted; (ii) the sequence in which they need to be conducted; (iii) the resources required; (iv) the expected outputs; and (v) the defined responsibilities and authorities for ensuring uniformity in operation. Similarly, the definition of work processes in most checklists and guideline formats is left to personal interpretation, and therefore there is no uniformity in implementation, effectiveness and efficiency of ICDS work processes across the program.

- An examination of how the VHND was conducted as part of the INHP work process analysis in AP and CG showed that AWWs and supervisors showed that functionaries undertook the various VHND activities based on their understanding of the VHND guidelines. AWWs and supervisors were aware that the main aim of the VHND was to ensure that beneficiaries who receive THR should also receive services, such as immunization, ANC, NHEd and growth monitoring. In actual fact, however, there was considerable variation and the VHND was being conducted in very many different ways. For example, many AWWs gave THR to the beneficiaries as the first service, after which many beneficiaries left the AWC without availing of the other services (food, being the most tangible, is often valued more than the other services, and once received many beneficiaries

left), thus defeating the very purpose of the VHND. In other cases, the AWWs gave THR only after immunization, ANC, NHED and growth monitoring had been conducted, thus ensuring that each service was delivered before the beneficiaries left the AWC. Many AWWs also reported that a VHND had been conducted, even in instances when no health functionary had attended the VHND and health services had not been delivered. In some places, the AWWs prepared 'due lists' to track all children who needed to be immunized at a particular VHND; in other instances, the AWWs relied only on their memory or the ANM's immunization register to track children who needed immunization on the VHND. In short, there is no established most efficient and effective way to conduct VHNDs and ensure that mothers and children receive the health and nutrition services that the ICDS and NRHM are supposed to provide. Even today, in most places, at VHNDs, the full set of health and nutrition services are not delivered and VHNDs are largely immunization and THR distribution days, despite some detailed guidelines from the NRHM, MoHFW (2007).

- One well-designed procedure is the set of guidelines (Government of Odisha, 2011) for the implementation of hot cooked meals and morning snacks for supplementary nutrition under the ICDS and hot cooked meal for emergency feeding program in eight KBK districts²⁶ of the state. Comprehensive operational details are provided for each activity for supplying hot cooked meals for supplementary nutrition under the ICDS scheme. The guidelines systematically include details related to feeding norms, weekly menus, ration sizes, quality parameters, procurement procedure, composition of procurement teams that decide upon the supplier and the price, checks on quality, the commodities provided under the central scheme (like rice) and the ones that need to be procured locally, quantities to be procured, recipes and their preparation, methods of funds provision, monitoring procedure, and formats for recording data and information. The functionaries responsible have been identified, including whom to contact in case of problems.

3.2 In the absence of documented SOPs for work processes, the implementation quality is varied, and effectiveness and efficiency are both compromised.

3.2.1 The virtual absence of defined work practices and the inadequacy of those that do exist, adversely affect the quality of service delivery at the AWCs. Hence, the functionaries adopt their own way of doing things and delivering services, based on their own understanding, skills, motivation and convenience. Data from the FGDs indicates that the ICDS has defined the norms for service delivery of the nutrition service in this program for ration size, type of food, number of home visits to be conducted by an AWW, frequency and number of visits to the AWCs to be carried out by supervisors and CDPOs, growth monitoring, and conducting VHND. However, the primary consideration is meeting the numbers without much regard for the quality of service provided. There is more or less very little attention to services where guidelines are minimal, such as referral services, identification of undernourished children or those who are not improving or becoming undernourished early, and the appropriate action needed. The variation reported by the AWWs in the number of monthly home visits conducted is extremely large, ranging from 5-50 in Bihar and from less than 50 to more than 150 in Tamil Nadu. If the procedure of a home visit was well defined and documented, and there was a benchmark of the time to be devoted to one home visit, it is possible that these variations would be minimized. It is therefore clear that the ICDS operations are affected by the immense variability in the execution of key activities, leading to ambiguity regarding which services are rendered and which are not, and how they are rendered, thereby affecting service quality.

²⁶ The KBK districts include: Kalahandi, Bolangir and Koraput

3.2.2 *The absence of adequately defined work procedures also affects supervision and monitoring.* Well-designed work procedures serve as benchmarks for what constitutes an acceptable way of accomplishing the procedure. These in turn are used by supervisors to judge or measure how activities are being performed, identify specific steps in which subordinates need support, based on which they are then able to provide that support rather than give general advice. In other words, work procedures can strengthen both oversight and support functions of supervision.

3.2.3 *There are implications also for training.* Well-defined work procedures can also serve as guiding factors for the content of training programs that build skills. They help identify the knowledge and skills required for conducting each step of a work procedure and clearly indicate to trainers how each task is required to be accomplished, thus bringing more specificity to hands-on training, as also to joint trainings which are a tool to improve coordination.

3.2.4 *Efficiency and productivity losses result from a lack of well-designed and documented work procedures.* In the absence of well-designed and documented procedures, functionaries devise their own methodologies for carrying out assigned tasks based on their individual understanding, background, skills, capacities, perceptions and experiences, and even convenience. These methodologies may not be the most efficient, as in the case of sector meetings and home visits discussed earlier. Further, the absence of a defined and documented SOP for work processes is likely to be a major contributing factor for the observed variation in the quantum of time spent on conducting ICDS activities by AWWs, such as supplementary nutrition and home visits. For example, the range of time spent daily by the AWWs for: (i) preparing and distributing supplemental food is 24-51 minutes; (ii) pre-school education is 90-190 minutes; (iii) filling up records and registers is 12-99 minutes; and (iv) conducting home visits is 34-63 minutes. Similar variations are also found in the activities conducted by supervisors and CDPOs. These variations have a direct bearing on the quality of services and work efficiency. The immense variability in time spent by the AWWs, supervisors and CDPOs on different activities is discussed in detail in chapter 4, Availability, Competence and Management of Human Resources in the System.

Clearly, efficiencies vary and one activity gets assigned more time at the cost of another, perhaps more important one. In a program as large as the ICDS, there is simply no other way of assuring efficiency and quality but by conducting a productivity analysis and designing and defining appropriate work procedures, documenting and sharing them across functionaries, supervisors, training institutions and trainers. This will lead to a common understanding and operationalization of the 'how' aspect and enable working towards efficiency gains as well as effective delivery of services.

4. Summary of Management Capacity Constraints

This section draws upon the analyses from the earlier chapters and summarizes the management capacity issues in the ICDS. While the issues summarized here are examined in detail in the individual functional areas, a discussion on these is highly pertinent in the context of overall management.

The weak management capacity at all levels in the ICDS is one of the biggest constraints limiting the functioning of other operational areas. This finding is significant and contrary to the widely held view that the failure in the ICDS is at the level of the AWC and due to the poor capacity of the AWW.

4.1. **Lack of adequate human resource management structures have constrained the ICDS capacity to deliver its services adequately and efficiently.** There is shortage of staff with required knowledge, skills and motivation; vacancies continue for prolonged periods at the ICDS departments in the states and at the ICDS division in the MWCD. The recruitment criteria that ICDS currently has are generic and are not suited to recruit people with right kind of skill mix. The prime focus is to appoint trainable people whose skills and competencies could build through on-the-job training.

4.2. **Weak management structures for training at all levels have hindered the ICDS system in building the knowledge, skills and competencies of its workforce.** At the national level, the management structure and thus the functions are split between the training division at the MWCD and NIPCCD but it is unclear as to who is ultimately responsible for planning, periodic reviews, monitoring and evaluation and follow-up actions. There is a shortage of human resources for training management and the personnel are not clear of what is expected of them in terms of training management. Further, there is a lack of conceptual framework and vision, inadequate strategic planning and resource mobilization which constrain the commensurate expansion and capacity building of the training system.

4.3. **The data collected under ICDS MIS is neither analysed nor fully aligned with the data needed for better operational decisions or to review progress towards achieving the ICDS objectives.** There is neither a dedicated leader nor dedicated functional home for M&E and as a result, the ICDS MIS lacks an adequate conceptual framework for M&E functions, data crucial to track the progress of nutrition activities and outcomes is not gathered and there are issues regarding reliability of data and its minimal use.

4.4. **Lack of other GMPs like setting of objectives, priority setting and empowerment further constrain the ICDS to attain its ambitious mandate.** Underlying all of these management constraints are the key GMPs outlined in the framework besides the three discussed, the others namely the setting of objectives, operational planning, empowering and coordination are also key to contributing to the poor management capacity.

4.4.1. *The practice of setting priorities or specific time bound objectives for individuals, teams and managers is not prevalent in the ICDS.* While some reported that no priorities were set for them by their managers or supervisors and that they set their own priorities, several mentioned that these were set. However, the priorities described were not consistent and were described either in terms of priority groups to be served or in terms of activities to be delivered. The setting of targets, while reported by some is however not a universal practice followed by all managers in the ICDS and the NRHM. At each level of management, while some functionaries did note that they/their managers do set objectives and targets, there were respondents who reported that no targets were set for them by their own managers. There is no focus on results, targets are not expressed in clear quantitative terms and are therefore not measurable. To the extent that they are quantitative, they relate only to the number of beneficiaries to receive services, the number of supervisory visits to be made and so on, and not to the results of services received.

4.4.2. *Operational planning is not undertaken at all levels and by all managers.* Planning is an essential part of management, and all managers at the operational level need to undertake plans for the operational unit they manage. ICDS has been a centrally driven program with all plans developed at the national level and there is little operational planning. Planning related

to organization of work, formation of teams, allocation and division of work are generally defined centrally. Work planning, assignment and redistribution are undertaken to manage the workload when vacancies exist or arise.

4.4.3. *In public sector programs including the ICDS, authority is highly centralized and there is virtually very little devolution of authority.* Even if the senior managers want, they cannot delegate authority, since rules do not permit it. Furthermore, seniors often do not regard it important to give employees much information or share with them much analysis. Subordinates, in turn, do not think they should solve problems. They push all problems upward and expect their supervisors and managers to resolve them. Ability is constrained because resources with people at every level to achieve their objectives are limited. Further, the sheer volume of work and their time constraints (see chapter 4, Availability, Competence and Management of Human Resources in the System) do not permit them the necessary time to devote to support, mentor and coach those whom they supervise. Therefore, the majority of the functionaries feel disempowered – neither do they have adequate opportunity nor the ability. At each level, managers feel disempowered to motivate their staff, to manage performance, to take initiative or to solve problems.

4.4.4. *The management reforms proposed under the restructured ICDS include a focus on decentralization.* Recognizing the need to move away from the centralized nature of the program, the shift towards decentralizes planning and management in the restructured ICDS is indeed a very positive trend and presents a real opportunity to make this a key component of the management reform. This, however, will need bold changes to the organizational culture, including decentralization of decision making authority to local levels. Top leaders must ensure that managers, especially at the district levels and below are required to develop operational plans and held accountable for their implementation, provided the requisite skills to do so, are empowered to make operational decisions and resolve problems. Not only will this improve management of the program, it will also contribute to improving motivation, empowerment, and accountability.

Recommendations

Many weaknesses in the implementation of the ICDS are due to the poor management practices in the program. If not addressed, they will continue to severely constrain program implementation, efficiency, productivity and quality of services. This is especially critical given that in the restructured ICDS, a large number of managers will be recruited. Hence, it is important that the quality of the overall program management system and culture, which is dependent on GMPs, is transformed and upgraded. Keeping this in mind, the following recommendations are worth considering by the ICDS:

1. A management development program for all senior and mid-level managers at the national level and state ICDS departments, and at the district level should be introduced. The content should include all the key management skills, such as how to set result-based objectives, how to develop operational plans, as well as the use of important techniques, such as workload analysis, feasibility analysis, costing analysis and work process analysis.
2. The ICDS leadership should ensure decentralization of management and require that managers at all levels set annual objectives based on outputs and results as well as develop operational plans for their areas. Leaders should assign responsibilities to higher level managers to monitor and ensure that this is done, appraise lower level managers and their

subordinates, based on these objectives, and then implement this performance management system right through the ICDS. This will enhance accountability for performance in a cost-effective manner.

It is critical to design and implement a program aimed at improving supervision over the next few years. The program should include: (i) appointment of a high-level program manager to oversee and manage the entire program for the period; (ii) development of a conceptual framework for the nature, role and scope of supervision, which will include the right kind of data needed to carry out such supervision and will specify the skills and competencies needed for supervisions and, thus, the kind of training that supervisors would need to get; (iii) development of, if necessary through a series of pilots, a sound procedure for supervision that must be followed by all supervisors; (iv) an analysis of the efficiency gains in making supervisory visits by provision of transport facilities to supervisors and assessment of relative costs appointing large numbers additional supervisors and provision of transport; (v) identification of the most important data required to be collected during supervision, development of the data collection system for this and the individual reports to be produced by each supervisor; (vi) development of district, state and national summary supervision reports that focus on key national trends and are provided periodically to top management at each of these levels; and (vii) training of all supervisors and then launching the system.

3. Although the restructured ICDS has defined a framework to enhance accountability, it still has a long way to go. A change of culture that values accountability and embraces good management practices to enhance accountability is required. Building accountability that relies on civic engagement in which ordinary citizens and civil society organizations participate directly or indirectly in extracting accountability from the government is the key.

One example of a social accountability mechanism which is grounded in a positive-sum, rewards-based view of accountability is the Citizen Report Card. The use of this instrument is on the rise throughout the world. In recent years, the system of report cards has been supported by the World Bank in Uganda, Albania, the Philippines, and Peru. This system has also been adopted by municipal presidents in the Ukraine and numerous cities in India. The experience that began this energetic innovation is the scorecard organized by the Public Affairs Center (PAC) in Bengaluru in 1994, and then repeated in 1999 and 2003. Steps in planning and organizing a report card are described in (India: Public Affairs Center, 2005) and include strengthening leaders at the local level and strengthening Panchayati Raj Institutions (PRI) to make the system more effective, transparent and accountable for delivery of services, so that workers can be held responsible for their actions or for non-performance.

4. In order to ensure efficiency in program implementation and enhance the quality and effectiveness of service delivery and the predictability of results across the program, it is imperative that the ICDS embark on a productivity improvement campaign. This will involve getting specialists to analyse all processes and procedures and improve or totally re-design them if necessary, taking into account all financial and other constraints, and document them as SOPs. The SOPs will not only inform the functionaries as to what is expected from the process, but also serve as ready reckoners for them in conducting their activities effectively and efficiently, and as benchmarks for supervision. A beginning in this direction has been made by the ICDS in AP and CG, and can be further built upon. The ICDS should adopt this strategy of defining and documenting the work and management processes across the program, while allowing for local flexibility. It will also be important to periodically review the documented SOPs for their applicability, appropriateness and adequacy, and develop and

update these when changes or new activities are introduced or when a better way of doing the same thing is found. However, to avoid confusion, all updating must ensure that at any point of time only one SOP exists.

5. Given the huge scale of its operations, the ICDS should consider introducing an audit program as a tool for monitoring and verifying the effective implementation of policies and documented SOPs. Audit conducted by trained and competent personnel is a systematic, independent and documented process for obtaining verifiable audit evidence relevant to the set of policies, SOPs and evaluating it objectively to determine the extent to which they have been fulfilled. Establishing such a system will require assigning the responsibility for managing audit programs, establishing audit program objectives, coordinating auditing activities and providing sufficient audit team resources.

As mentioned in the GMP framework, most of the GMPs are inter-related and aim at bringing about significant changes required in the management of the ICDS. Simultaneous work on all these GMPs is necessary. The organizational culture will remain a critical underlying part of the improvement in the GMPs.

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Annex 1: Detailed capacity assessment analytical framework

Capacity area: Division of Labor

From a management point of view full functional clarity as to the nature and scope of each role, function and task is essential to achieving results, enhancing productivity and efficiency. This means that all functions must be identified, developed, grouped appropriately and assigned to units or individuals, in a way that ensures that there are no functional splits, gaps or overlaps as these result in poor performance.

The design of work and its division among organizations, or organizational units ought to follow certain rules and the extent to which they are followed impacts capacity. The extent to which certain rules of DoL are being met are indicators of DoL constraints.

- **Functional gaps** exist when an important role/function/task is not being carried out and/or led and managed by any agency or organizational unit. They constrain capacity just like the lack of an organizational home. Functional gaps become capacity constraints because there is no unitary command and it is difficult to retain overall accountability for the function. Unclear division of work leads to misinterpretation of the responsibilities of others, or conscious decisions to let others take action resulting in frequent functional overlaps, gaps and conflicts.

- **Functional splits or fragmentation** occur when tasks or functions that belong together into one role and placed in one organization are divided among several roles and placed in several organizations/units. Because it is difficult to get an overall picture of the function due to its fragmentation, it often becomes difficult to coordinate it due to the large number of 'fragments'. In some instances, fragmentation is technically not feasible, such as when the volume of additional work or coordination effort required to produce the output outweighs the benefit of splitting the task/function, fragmentation is best avoided. In others, fragmentation is unavoidable or may even be necessary, in which case any constraints to capacity can be overcome by excellent coordination ensured by putting in place all the mechanisms and work practices required to do so.

- **Functional overlaps** exist when several agencies or organizational units carry out the same role/function/task and serve the same clients or group of clients. They constrain capacity since they result in role conflicts, duplication of effort, under-utilization of resources, wastage and higher costs.

Functional overlaps are acceptable, and not considered a constraint when a country is divided into geographical regions and the delivery of services is based on it, or in decentralized systems when there are many field agencies/offices with identical functions, but they serve different groups or geographically separate populations, and there is no duplication of effort. On the contrary, they can improve capacity if, and only if (a) they have identical norms and standards, and resources based on identical (or justifiably different) norms and (b) they are well coordinated and well monitored from a central/national agency/office.

- **Coordination** within and among organizations is necessary. It becomes a capacity constraint when coordination is difficult or is lacking as a result of which significant inefficiencies and wastage occur, for which it is not possible to hold any organization, organizational unit, or individual staff members accountable.

- **Functional differentiation:** It is important for a function to have an organizational home or unit and clear leadership. When a function has an organizational home and leadership, there is a better chance that the leader will: formulate a conceptual framework, a vision/mission, and a strategy for it; develop plans for its implementation; apply standards and norms to it; guide, monitor and control its execution; and enforce accountability for it.
- **Functional overload** happens when too many functions are placed in one organizational unit. People who are carrying out other functions in this unit can also carry out these functions efficiently, but they fail to do so because of time constraints.
- **Functional fog** refers to cases where the roles/ functions/ tasks are not defined and worded well enough, letting managers interpret the role/ function/ tasks of their organization/ unit themselves, the way they see it and/or want it to be.

Capacity area: Leadership

The five key tasks of leadership are: (i) provide direction to the sector or organization and define its future in terms of desired outputs; (ii) develop strategies for achieving the desired outputs, ensuring that these are followed by careful planning; (iii) mobilize people and other resources for the implementation of the strategies and plans; (iv) continually articulate and communicate the direction, strategies and plans; and (v) ensure unity of effort and keep organizations in the sector, and people in the organizations on track, pursuing the direction given.

The extent to which each of these tasks is carried out can serve as an indicator of leadership capacity.

The tools that leaders use to provide direction are conceptual frameworks, vision, mission and strategies. The existence of effective written statements of vision, mission and strategy are also indicators of the strength of leadership (see Box 3.1 for definition of effective vision, mission and strategy statements). Awareness of the importance of these tools, and the ability to formulate and use them are therefore necessary.

Effective leaders develop comprehensive conceptual frameworks for the sector or each important function or problem that needs to be resolved. These articulate the working hypotheses of dealing with a complex phenomenon – a system, process, function or behavior. The working hypotheses describe, in particular, the structure of the phenomenon, *its building blocks, the relationships in the building blocks, and the manner in which they work individually and collectively.*

Vision, mission and objectives are not mere statements, but critical assertions of what any organization aspires to achieve, and these define for each person within the agency the purpose of their work, as well as the role each has to play in helping the organization achieve its mission. Therefore, communication of the vision, mission and strategy are important and effective leaders continually communicate the direction that they want the organization to follow, explaining the strategies behind their plans, the visions behind their strategies and the conceptual frameworks behind their visions. They incorporate messages of direction in daily briefings, utilizing every opportunity to link the specifics of a situation with the bigger picture. Not only do effective leaders talk about the direction, they also demonstrate their

commitment to it by personal example and resource allocation. This helps bridge the gap between organizational strategy and the objectives of the average employee, often referred to as the strategy-performance gap. Research indicates that less than 10 percent of strategies are effectively executed, one of the reasons for the gap being insufficient communication and articulation of strategy (Kaplan and Norton, 1996).

Capacity area: Human Resources in the System

The combined effect of three key factors, namely the size of the workforce, its knowledge and skills and level of motivation, enables or constrains an agency's ability to function effectively and achieve its mandate. These are described below.

1. Size of workforce

An optimum number of people must be available to accomplish the volume of work necessary for achieving an agency's mandate. While too few will lead to compromises in the quantity and quality of work, too many will lead to inefficiencies. The number of persons required to carry out the functions and tasks necessary to fulfil the organization's goals is determined by two factors, namely workload and efficiency. Workload is the amount of work that an individual worker, a group of people, or an organization must carry out in a given time, to fulfill the expectations set out in the vision, mission, strategies and plans of the organization. Efficiency refers to the extent to which time, effort and resources are used well, that is without wastage. Therefore, staff planning and specifying norms for the number and ratio of staff at each level is an important HR management function. Effective management of this function requires that the number of staff be fully aligned with workloads and be based on systematic and objective analysis of workloads at each level or unit.

2. Knowledge and skills

Adequate knowledge and the right mix of skills are required to carry out each function or task effectively. Though these terms are often used interchangeably, 'knowledge' refers to the information possessed, while 'skill' refers to the ability of using knowledge and applying it in a given context. Effective management involves selecting people with the right mix of knowledge and skills and developing their knowledge and skills to the desired level to enable them to carry out the tasks effectively and efficiently. Therefore, specifications of knowledge and skills for each category of workers and managers must be identified and then used to guide recruitment norms and criteria, and to inform training programs. In the ICDS context, where recruitment criteria are quite generic and the program relies heavily on the training system to impart the requisite knowledge and build the necessary skills of its workforce. Therefore, given the critical importance of training, it is dealt with in a separate chapter as a sub-system of HR.

3. Motivation

People must be motivated to achieve their goals. Motivation is the drive, internal or external, that leads individuals towards their goals (Singh and Tiwari, 2011). Motivation is goal-directed, and therefore cannot remain outside the goals of any organization whether public, private, or non-profit (Olajide, 2000). Clarity of roles and objectives, access to knowledge and resources, remuneration, physical conditions at work and organizational culture are some of the factors that affect a worker's motivational levels. Organizational culture plays an important role in enhancing the motivational levels of individuals. A culture that provides to individual workers objectives and priorities that are seen as important and challenging,

provides a sense of forward momentum for progress, promotes trust, respect and communication between managers and subordinates and encourages constructive feedback can contribute significantly to enhancing motivation. Lack of motivation can be a capacity constraint since it leads to under-utilization of human talent and resources and unutilized capacity.

Capacity area: The Training Sub-System

Training forms a very important component of human resource development, performance and motivation. Three elements are critical for effective training, namely: the availability of training that is timely and adequate in quantity, is relevant, and of high quality. This chapter analyses each of these elements in detail to examine the constraints that limit the capacity of the ICDS training system.

Availability of adequate training essentially includes two aspects to meet the needs of trainees: (i) timely initial training; and (ii) periodic training provided subsequently.

Training is considered adequate when the initial training, referred to as orientation and on-job training, is provided in a timely manner to newly recruited personnel, and thereafter provided periodically at specified intervals or to meet special training needs to enhance skills and competencies and build new skills and knowledge. Provision of initial training in time is important because, if delayed, the personnel will work inefficiently and acquire sub-optimal or dysfunctional work habits and practices that may have to be undone, thereby making subsequent training much more difficult.

The relevance of training depends on the extent to which its content matches the skill gaps of the trainees. This requires a job analysis to understand the knowledge, skills and competencies required for each job category, and an assessment of entry level skill gaps of trainees. The curriculum and content of training should be based on this analysis.

Quality is the extent to which relevant content is taught and actually learnt by the trainees and the extent to which training helps them in skill development. Teaching and learning are two different dynamic processes and teaching does not automatically lead to learning (Vermont and Verloop, 1999). While the former essentially aims to transmit knowledge from an external source to the learner, the latter is an active, constructive, and self-directed process in which learners build up internal knowledge or personal interpretations of their learning experiences (Bednar et al, 1991). The ability of instructors to transmit knowledge and the readiness of the functionaries to imbibe, retain, and use this knowledge is therefore vital for high-quality and effective training.

Capacity area: Monitoring, Evaluation, and the Management of Information in the Nutrition System

The KM function encompasses capturing, analysing, developing, sharing, and effectively using organizational knowledge. The purpose of KM is to provide direction that is to formulate the conceptual framework, vision, mission, policies, and strategies, in order to obtain and allocate financial and other resources, for the development and implementation of plans or programs, to exercise accountability or for research. The information may also be used to validate the need for change.

Monitoring is a generic management process for exercising control in organizations and to ensure that activities are implemented according to the operational objectives, design and plan, and are 'on track'. Therefore, a prerequisite for effective monitoring is that at the operational level, there should be clear objectives and plans against which progress can be compared. Monitoring in the absence of these is meaningless.

Monitoring takes place at multiple levels of management. Supervisors are expected to monitor the workers and the activities under them; mid-level managers are supposed to monitor the supervisors, senior managers have to monitor the mid-level and top-level managers, who are the leaders in their organizations, are required to monitor the organization and its operations as a whole. Nevertheless, the focus differs at each level. Usually, at the lower and mid-level, the focus of monitoring is mainly on exercising control, whereas at the higher levels, the focus is on assessing what changes might be required.

Evaluation is used to draw conclusions, its purpose being to improve operations or change course. Evaluation provides the basis for adaptation and change in strategy either to improve operations or, where the original objectives, design and plan are not achieving the desired outcomes, to identify the changes needed for achieving them.

Management of information refers to the gathering of data required for monitoring and evaluation, and its organization, processing, and analysis for monitoring and course correction if needed.

Monitoring and evaluation are inter-related. There can be no evaluation without monitoring, whereas there can be monitoring without evaluation. The key points pertaining to the differences and inter-relationship between monitoring and evaluation are:

- The data required for evaluation does not fully overlap with the data required for monitoring, because the questions the two seek to answer are different. Usually, many of the evaluation questions focus on outputs and outcomes while almost all questions in monitoring focus on inputs, process, and action. Monitoring must focus also on results that can be measured over the short term as these are early warning signals that can lead to corrective action, but not to changes in vision, policy, and strategy.
- Much of the data collected for monitoring can be used to explain the conclusions reached in evaluation. However, there is invariably a need for additional, less frequently collected data that must focus on the intended medium to long-term results, or outcomes, the cost at which these are achieved and the unintended results.
- For monitoring, where the objective is to control operations, the data needs to be collected and analysed on a monthly, quarterly, or yearly basis. On the other hand, for the evaluation of outcomes, policies and strategies to see whether the vision is being attained, the data needs to be collected and analysed much less frequently, since it takes a long time to produce and observe a change in outcomes. The methods and techniques for data collection and analysis differ for monitoring and evaluation.

It is thus paramount that the monitoring and evaluation framework differentiates between: (i) the information and data to be monitored for control of activities and for evaluating results; (ii) the frequency at which it is to be collected, analysed, and used; (iii) the users of the information ; and (iv) what information will be analysed by whom and used in which manner.

Clear targets for both short-term objectives and long-term goals that provide the interface between the overall strategy and policy need to be set. The objectives of the organization should be clearly articulated and made known to all functionaries responsible for performing activities and to those monitoring the performance.

Monitoring has a cost: both a financial cost and an opportunity cost. The financial cost refers to the money spent on collecting, collating, storing and analysing the data, writing and disseminating the reports; the opportunity cost refers to the time spent by all the people doing this work, as well as all the recipients of the reports, who have to spend time reading the reports, perhaps at the cost of doing more productive work. This is particularly true when data is collected and little or nothing is done with it. Monitoring without follow-up, that is taking corrective action is useless. The cost is determined, among other factors, by the scope and quantity of data gathered, the frequency of its collection, the extent of analysis and its distribution. The cost may become very high if too much data is collected, if the data is collected too frequently, and if it is disseminated too widely, both horizontally and vertically. Frequently collected operational data, aimed at controlling operations, is needed at the operational levels of an organization and not at policy and strategy levels.

Capacity area: General Management Practices

(1) *The setting of objectives:* At the individual worker or manager level, this is part of the system of accountability for performance and is hence discussed in detail in the accountability section. It differs from the setting of objectives at the organizational level, which is part of the leadership discussion.

(2) *Operational planning:* Operational plans are based on a clear definition of the mission, specifying quantitative and qualitative targets, as well as timelines. These entail a step by step analysis, description and timing of all key steps leading to the fulfilment of targets.

(3) *Empowering:* For the managers and workers to achieve these objectives, it is important to develop people, (i.e., to train, mentor and coach them) and to give them the opportunity and the ability to achieve certain objectives. Giving them the opportunity means giving them the responsibility and authority to do certain things (responsibility is often given, but not authority). Giving them the ability means giving them the necessary resources – financial, physical and human – needed to achieve the objectives, and to develop them to achieve personal mastery.

(4) *Coordination:* This essentially involves establishing clearly who does what and who is dependent on whom for what actions and then ensuring that each dependent and interdependent action is taken. Coordination is discussed in detail in the Chapter 2, The Nutrition Service Delivery System and Division of Labor within the System.

(5) *Supervision:* The supervision of managers and workers combines two main elements, namely oversight and support. Oversight refers to the activity of watching the performance of subordinates when they carry out operations, for the purpose of control. Support refers to the activity of providing subordinate staff with guidance, and coaching, mentoring and motivating them. Most of the time, support is given as an integral part of oversight (see section on supervision for a more detailed framework).

(6) Accountability: This refers to the practice of requiring officials to take responsibility for their actions. Officials are primarily accountable for: (i) their conduct; and (ii) their performance (see section on accountability for a more detailed framework).

(7) Sound work processes and procedures: This is essential to achieve results with maximum efficiency. Practice is the way of doing something, that is, what we do, when we perform a given task and how we do it. Process is a set of actions and tasks directed towards a predetermined aim and carried out in sequence, step by step. Procedure is a prescribed or established process, also referred to as establishing SOPs (see section on work practices and procedures for a more detailed framework).

The management practices in these seven categories are highly interdependent; while analytically distinct, in practice they are interwoven. This means not only do they influence each other but are often also practised together. To illustrate this point, empowerment improves the capacity to deliver services not only directly, but also indirectly since it motivates people to perform better. The setting of clear, measurable objectives improves the capacity to deliver services not only by providing clear direction for action, but also by making it possible to hold workers and managers accountable.

None of the management practices included in the seven categories can alone greatly enhance or constrain capacity. It is the cumulative effect of many or all of them together that results in significantly enhanced or constrained capacity. The setting of clear and measurable objectives has little effect on capacity without empowerment, and empowerment has little effect without motivation. Likewise, motivation has little effect without empowerment and monitoring has little effect without accountability. Hence, management practices are a bundle of interconnected, often inseparable, ways of managing. They are the “small forces that can together result in dramatic change.”²⁷

²⁷ Malcolm Gladwell, “The Tipping Point: How Little Things Can Make a Big Difference”

Annex 2: New approved staffing pattern under ICDS Mission

STAFFING AT EACH LEVEL				
Level	Sub Level	POSTS PER UNIT		Additional staff at each level
		Regular	Contractual	
National	Mission Directorate	-	15	Program Manager: 5; Prog. Associate:5; Data Entry Operator: 5
	National ICDS Mission Resource Centre (NIMRC)	-	34	Advisor: 8; Sr. Consultant: 10; Consultant: 10; Data Analyst: 2; Data Entry Operator: 4
	Training Resource Cell ; TRC (5 centers)	-	4	Training Officer: 1; Training Associate: 1; Trg. Methodology Specialist: 1; Curriculum Development Specialist: 1
State	State (Large states - 17)	21	26	Program Manager: 4; Sr. Consultant: 10; Consultant: 10; Data Entry Operator: 2
	State (Small states - 11)		15	Program Manager: 3; Sr. Consultant: 5; Consultant: 5; Data Entry Operator: 2
	UTs		3	Program Manager: 1; Sr. Consultant: 1; Consultant: 1
District	District Team	-	6	District Coordinator: 5; Data Entry Operator: 1
Project	Project ICDS Committee	-	3	M&E and Nutrition Surveillance Coordinator: 1; Nutrition Health Mobilizer: 1; ECCE Coordinator: 1
	Block ICDS Resource Centre (BIRC)#	-	3	Counsellor: 1; Para Counsellor: 1; Outreach worker cum Helpline operator: 1
Cluster	Supervisors (based on number of AWCs)	-	-	
<p><i>NOTE: Supervisor post (not included) will continue as per the existing norms</i></p> <p><i>*Total number of regular positions at state level</i></p> <p><i>#Only in 10% projects primarily located in 200 High Burden Districts</i></p>				

Source: ICDS Mission: Broad Framework for Implementation, MWCD (2012).

Annex 3: Nutrition conceptual framework, vision, mission, and strategies in some states

HARYANA	<p>Haryana has a two-fold nutrition strategy, planned and implemented in January 2003:</p> <p>(i): improving the nutritional status of moderately and severely malnourished children (0-6 years), by continuous monitoring of the weights of children, targeting severely malnourished children for SNP and NHed.</p> <p>(ii): community participation in growth monitoring and nutrition awareness camps at the village level, also including incentivising the mothers and VLCs to help in GMP.</p> <p>Financial commitment not mentioned.</p>
GUJARAT	<p>The Gujarat State Nutrition Mission concept is to provide an enabling mechanism to different departments to converge for concerted efforts that address and improve the nutritional status of the targeted population, including adolescents, those in nine months of pregnancy till two years of age and children up to six years. The strategy is to educate people about nutrition related issues, strengthen service delivery for improving the health and nutrition status of the target population, build the capacities of service providers, reduce severe and moderate malnutrition among children up to six years by improving IYCF practices, improving micronutrient status of all children up to six years, addressing PEM, carry out periodic nutrition surveys, and screen women and children on VHND or Mamta Diwas.</p> <p>Financial commitment: expenditure for the Gujarat State Nutrition Mission shall be incurred under the following budgetary provisions: (i) approved budget for the Gujarat State Nutrition Mission from State budget; (ii) concerned departments' budget lines; and (iii) NRHM budget lines.</p>
KARNATAKA	<p>Karnataka's Comprehensive Nutrition Mission started in 2011, targeting children up to six years, with special emphasis on children up to two years in view of the significance of this period in their process of development. Adolescent girls between 10-18 years and pregnant and lactating mothers would also be targeted.</p> <p>Specific Objectives of the Comprehensive Nutrition Mission:</p> <p>(i) reduce underweight and undernutrition conditions in children, low body mass index among adolescent girls and women in the project areas in the shortest possible time, by following the inter-generational, life-cycle approach;</p> <p>(ii) eliminate wasting in children and severe malnutrition in children;</p> <p>(iii) reduce incidence of low birth babies, infant mortality, child mortality, maternal mortality, anemia and other micronutrient deficiencies among children, adolescent girls and women; and</p> <p>(iv) spread information and awareness to the communities to enable behavioral change regarding proper child care, care of the girl child throughout her life cycle, of pregnant and nursing mothers, and proper dietary practices within existing family budgets.</p> <p>Financial commitment: no details of funding. The paper only mentions that the government will provide Rs. 50 million for the pilot project.</p>
MADHYA PRADESH	<p>Atal Baal Aarogya Evam Poshan Mission or Child Health and Nutrition Missions work in an integrated and coordinated manner to improve the nutrition and health status of children in Madhya Pradesh and address the problem of child malnutrition. The goals of the mission are:</p> <ul style="list-style-type: none"> • reducing the mortality rate for children under five years (U5MR) from 94.2 to 60 per one thousand live births; • reducing the percentage of underweight children in the same age group from 60 percent to 40 percent by 2015 and, further, from 40 percent to 20 percent by 2020; and • reducing the prevalence of severe acute malnutrition (SAM) in children below five years from 12.6 percent to 5 percent by 2015 and to a negligible level by 2020. <p>Financial commitment: the state government will provide the financial, administrative and other support necessary to meet the goals and objectives of the Atal Baal Aarogya Evam Poshan Mission and its components listed in the document and also provide resources for institutional and administrative arrangements to facilitate its smooth functioning.</p>
MAHARASHTRA	<p>The RajmataJijau Mother-Child Health & Nutrition Mission was constituted by government resolution dated March 11, 2005 with the primary objective to reduce grade-III and grade-IV malnutrition in children up to six years in the state. Its complementary</p>

	<p>objectives include:</p> <ul style="list-style-type: none"> • ensuring provision of neo-natal care to pregnant women, new-born care and special focus on health, nutrition and complete immunization of children in the 0-3 age group (in effect, focus on the entire period from the stage of conception to the time the child is three years old); • reduction of grade-I and grade-II malnutrition in the state; • assisting the public health department in providing training for implementation of the IMNCI and home-based new-born care programs on a pilot basis in selected PHCs; • focus on education of adolescent girls to reduce the incidence of child marriages and promote spacing between children; and • making efforts to bring about social transformation through participation of the community so that responsibility for nutrition management is transferred from the government to civil society. <p>Financial commitment: funded by UNICEF.</p>
TAMIL NADU	<p>Malnutrition Free Tamil Nadu: with this new vision and approach, the state government announced in 2002 its intention to make Tamil Nadu 'malnutrition free.' The policy for a 'Malnutrition Free Tamil Nadu' will guide the state's long-term multi-sectoral response to malnutrition from 2003 to 2020.</p> <p>The objectives for 2020 are to reduce human malnutrition of all types, including sub-clinical deficiencies, to the levels of the best performing countries in the world, namely:</p> <ul style="list-style-type: none"> • low birth weight to 10 percent; • underweight and stunting among 0-3 year children to 15 percent; • anemia in adolescent girls to 20 percent; • anemia among 0-3 year children to 20 percent; and • anemia in pregnant women to 30 percent.
UTTAR PRADESH	<p>The state is expected to initiate the state nutrition mission in 41 high focus districts (news in TOI April 9, 2013).</p>