Working across sectors: Exploring convergence between SNEHA, ICDS and MCGM

REPORT

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LIST OF ABREVIATIONS

SNEHA	Society for Nutrition, Education and Health Action
ICDS	Integrated Child Development Services
MCGM	Municipal Corporation of Greater Mumbai
NHM	National Health Mission
NUHM	National Urban Health Mission
THR	Take Home Ration
HCP	Healthy Cities Program
CMAM	Community Based management of Acute Malnutrition
ANC	Antenatal care
PNC	Postnatal care
AWW	*Anganwadi* worker
CDPO	Community Development Program Officer
CO	Community Organiser
PO	Program officer
PC	Program Coordinator
APD	Associate Program Director
CHV	Community Health Volunteer
SAM	Severe Acute Malnutrition
MAM	Moderate Acute Malnutrition
MO	Medical officer
ANM	Auxiliary nurse midwife
PHN	Public Health Nurse
DHO	District Health officer
UPHC	Urban Primary Health centre

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EXECUTIVE SUMMARY

As SNEHA ventures into building stronger connections with public systems such as the Integrated Child Development Services (ICDS) and Municipal Corporation of Greater Mumbai (MCGM), a question of interest has been- in what ways can ICDS, MCGM health posts and SNEHA work together towards maternal and child health? In this study, we try to get some insights on this question by capturing some of the perspectives and experiences of SNEHA program staff and two public systems these programs work with, the ICDS and the primary health system under MCGM. This qualitative study has been done in the field area of two SNEHA programs- the SNEHA Center (SC) program in Govandi and the Healthy City Project (HCP) in Malwani. The key findings of this study are summarised under two headings 1) Cross-sector work at the frontline between ICDS and MCGM health posts and 2) SNEHA's work with public health and nutrition systems.

Cross-sector work at the frontline between ICDS and MCGM health posts:

While country-level "written" policy documents advocate convergence between the public nutrition and health sectors, the policy push to operationalise these at the frontline appears to be low-key. Currently, interaction between these two sectors appears limited to check-ups done by doctors at Anganwadi centers, some referrals to health centers by AWWs; and the sporadic participation of AWWs in community-based immunization campaigns in certain geographical pockets. We found that efforts are being made by SNEHA to bring about joint activities (home visits, meetings) between frontline workers of both programs.

How is the concept of "*working together"* viewed by frontline and mid-level staff in ICDS and the health post? First, both sectors are thought of as having different vertical administrative structures- ICDS comes under the state government and the health posts under MCGM. Second, both ICDS and MCGM are thought of as having different sector-specific priorities. Frontline workers of both ICDS and health posts report having different work timings, seem to know little about each other's work and describe few instances of mutual interactions. Frontline workers of both sectors do not view "data-sharing" across the sectors as mutual help, but rather as shirking of work by the other party. Requests for data from the other sector is generally viewed with suspicion. Discomfort in data-sharing rises from the fact that frontline workers of both sectors look at this as a mechanism of monitoring. There is a worry that mismatched data/data discrepancies could lead to questions about their work and consequent punishments.

To exasperate matters ever more, both ICDS and MCGM appear to suffer from critical capacity gaps. In the case of ICDS, there is no dedicated outreach worker for nutrition and the Anganwadi teacher is expected to double up as one, even in her part-time, low-incentivised role; there are infrastructural challenges (lack of rented space, weighing machines and such); and poor quality ration who stocks are unpredictable are a reality. In the case of health posts, gaps in quality of service delivery at the health post has been pointed out as a big challenge during several discussions (the lack of drugs, trained human resource personnel to conduct family planning and poor experiences of people referred to health posts) ; in addition to this, the outreach team of health posts acknowledge not being able to contend with the large

coverage areas and increasing number of schemes and targets mandated from the top. All this makes frontline workers hesitant about participating in the "*other sector's*" work- even though the theoretical links between health and nutrition are generally acknowledged.

Has SNEHA been able to "glue" these two sectors in any way? SNEHA has been trying to bring both sectors together through the organization of joint meetings, workshops and other field-activities. But given the lack of policy-push from the two public sectors- as well as the above-described hesitancies at the frontline in doing cross-sector work, only few instances of joint work/ meetings get reported and only in certain geographical pockets. The most acknowledged role of SNEHA in the field seems to be as a data-messenger (conveying critical information from one sector to another) between ICDS and the health posts.

Findings on SNEHA's work with the public sectors- ICDS and MCGM health posts:

SNEHA does not see itself primarily as a "service-delivery" NGO that works on behalf of public systems. Rather, SNEHA staff perceive themselves as working for urban informal settlement communities in multiple ways; of which one strategy involves strengthening the public health and nutrition services and connecting these services to communities. SNEHA's relationships with public systems are informal (no formal partnerships) and at mid or frontline level. The NGO is generally accommodative of requests from the system; non-confrontational and is mindful of system constraints even while it appeals to public systems to provide better services. Box 1 highlights some roles of SNEHA while working with systems.

Box 1: Perceived roles of SNEHA in its work with public systems

Advocate to systems on behalf of community (System-level advocacy)	Engage with communities so they get services (Linkage)	Help in service delivery (Service aid)
Ask for more camps, more immunization, THR Compare lists with system staff to ensure people don't get missed out	Mobilize for camps, connect community people with appropriate people in systems, convince difficult people for immunization, convince for THR, convince for weighing	Anthropometry-technical assistance, new ideas for THR uptake, new ideas, learning with pamphlets, training of frontline workers, place for camps, weighing machine

It is interesting to examine the perceptions of public systems on the above roles of SNEHA. At mid-line and frontline, staff from both public sectors think well of SNEHA's commitment to the community- and look at the NGO as being supportive to the work of public systems even though at a small-scale. Public systems appear to value SNEHA's linkage roles (since SNEHA deepens local community outreach that helps systems with some of their targets) and its service delivery roles (through new learning, sharing of ideas and infrastructural help). However, discussion with staff in public systems also reveal that they are circumspect in their dealings with SNEHA. This is because of many reasons. For one, the organizational contexts within public systems is such that workers often focus on meeting immediate targets and reporting priorities- and doing little more. The presence of SNEHA puts pressure on them (though this pressure is gentle) and staff feel monitored. Some of SNEHA's linkage and service delivery roles of SNEHA are valued by public systems for meeting their targets, but other activities that do not have organizational value to the individual systems are either met with indifference or with some resentment (if these increase individual work burden). While frontline workers in public systems acknowledge learning from SNEHA's "good" frontline work, they express less intentions of changing their long-term practices. To add to all this, public systems views of SNEHA are generally coloured by a perception of all NGOs as "*watchdogs*" of the community that are capable of causing local dissent- and this also contributes to

underlying wariness. This wariness is aggravated by the lack of higher-level mandates to work with SNEHA; so mid-level staff are hesitant to take any blanket decisions on joint-work that might land them into trouble- and hence only small, discrete joint-activities get planned/executed.
Such perceptions within public systems pose an important challenge for SNEHA programs that have a high level of commitment to the community. SNEHA does not want to limit its role to being only a "system-helper"; but wants to play a transformational role in strengthening systems and link these to the community- but without being confrontational. But it is clear that the organizational culture/context that exists within public systems at the mid/frontline is currently not inclined to embrace such a transformational role easily. Overall, we found that SNEHA's capacity to rope-in public systems to be small-scale, limited to the front-line, limited to joint work on discrete activities, subject to constant negotiation and much dependent on personal relationships at mid-level.

What does all this mean for SNEHA's work with systems?

Our data shows that there have been three important contributions of SNEHA, through its work with public systems. One, it has filled urgent critical capacity gaps within systems. Second, SNEHA has demonstrated that "good" work can happen in the field. Public systems do appear to see value in the ideas, protocols and processes (the SNEHA models)- and acknowledge learning from SNEHA. However, it is the institutional context within which these systems function (mandates of public systems that lie elsewhere and are subject to constant changes, different priorities and incentives) that results in the limited uptake of these in routine practice. Third, SNEHA has not only taken the role of a gap-filler, but also acts as a data-messenger between two public systems like ICDS and the health posts, that otherwise do not get much chance to interact with each other, given their sector-specific priorities and work routines. By doing this, a critical gap in data-sharing between the two public sectors is currently being addressed.

Some of the things SNEHA might want to think more about are given below. One, programs constantly have to negotiate for joint-work with systems at frontline- but positive responses are a gamble. Higher level buy-in from systems (formal or informal) becomes important. What "higher-level" would be appropriate for SNEHA programs to function is an important question to ask. Secondly, SNEHA often practices appreciative inquiry while working at the frontline (motivating staff and appealing to them). While these efforts are valuable, our discussions showed that these were not sufficient in the long-run to bring about sustained systemic change in the motivation of public-sector frontline workers. Changes in the motivation of public sector staff seem to depend much on supportive changes (changes in incentive structure, hand-holding and monitoring mechanisms, infrastructural support, and such) within the organization they belong to. In the light of this, SNEHA programs might need to relook at the logic of achieving sustainable changes within public systems through only appreciative techniques.

Working across sectors:
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1: INTRODUCTION

The 1000 day approach and working across sectors:

It has been estimated that 250 million children (43%) of children from Lower and Middle Income Countries (LMIC) are at risk of not being able to reach their full development potential[i] . Globally, post the Lancet series on child development in 2008, the WHO and UNICEF promote the first 1000 day approach- as the main strategy for child development[ii]. The approach contends that the first 1000 days of life (the time spanning between conception and the second birthday of the child) is a critical window of opportunity for intervention- since this timespan lays the foundation for optimum health, growth and neurodevelopment of the child for its entire life span[iii].

However, it has been seen that interventions during this time period are often fragmented; and thus, unable to address the multifactorial causes of child underdevelopment holistically [i]. To address fragmentation of early childhood interventions, two main strategies have been promoted in global circles-

1) through the delivery of bundled/integrated interventions

2) by working across sectors/bringing about convergence between individual sectors that can contribute to child development.

Both strategies are described below:

Bundled/Integrated interventions: The theory behind bundled/integrated interventions is that single components (for example, looking at only malnutrition in children) are not adequate, and a multi-component program may have synergistic effects on child development outcomes. However, the implementation of integrated interventions-despite the strong theoretical argument for these- has been challenging. Difficulties in multiskilling (training frontline workers on several issues at the same time), overloading community health workers and the community with messages, issues with supervision, and giving unequal importance to different program components have been reported[iv]. Integrated interventions also become extremely complex to evaluate; and in the absence of strong process documentations and logic models, it is not always easy to explain the impact (or lack) of programs.

Working across sectors/ bringing convergence between individual sectors: The other strategy is to work across different sectors to bring about joint action against malnutrition, ill-health and larger social

determinants of these issues. The need for intersectoral work is not a new concept but has been promoted in the field of primary health care since the Alma Ata declaration[v]. The recent Lancet series (2013) on child development further promotes the need for cross-sector work in this field- and argues that intensive coordination and monitoring of interventions across sectors is critical to child development [i, ii]. The adoption of the Sustainable Development Goals in 2018 further strengthened interest across the world in working across sectors. However, working across sectors has its own challenges- including dealing with differences in value systems and organizational culture; difficulties in establishing and maintaining implementation links; and in promoting shared understanding of goals and visions of partners and addressing confusion in roles and responsibilities[vi]. In the recent years, there has been interest in understanding how the need for intersectoral coordination has been understood; and what principles and preconditions can foster such efforts. It is with this perspective that this study has been undertaken.

Society for Nutrition, Education and Health Action (SNEHA): The 1000 day model and working in cross-sector partnerships

The Society for Nutrition, Education and Health Action (SNEHA) works in the urban informal settlements (slums) in Mumbai' to improve health and nutrition among women and children. This study is based on the work of two programs of SNEHA: the SNEHA Center program in Govandi and the Healthy City Projects in Malwani. Both programs work on a 1000 day approach to child development, delivering bundled interventions on different themes such as child health and nutrition, maternal health, reproductive health, and violence-and work with multiple partners- public and private.

Both programs have are pivoted on the work of community health workers who carry out the different activities of the programs including home visits, anthropometry, referrals to hospitals, and group meeting and events. Many of these activities are intended to be carried out in liaison with government community health workers who already work in informal settlements. The impact of the programs is to be measured through reduction in wasting in 0-2 years old children, increase in uptake of contraception and increase in early registration of pregnancies at health posts. More details of both programs have been documented (refer process documentation).

Aim of this study: The aim of the study has been to capture the perspectives and experiences of SNEHA program staff and their partners, namely ICDS and MCGM in their work together towards maternal and child health.

Presently, SNEHA as an organization has been exploring working in partnership modes with different public systems- and there is interest in understanding what manners of partnerships would best serve organizational as well as community needs. One important question of interest has been- should partnerships with systems be around direct interventions (aid better delivery of sector-wise interventions to

the community by home-visits, direct mobilization and other direct community activities) or indirect (strengthen systems for better delivery by motivating health workers and through advocacy- but not deliver any direct services)- or combinations of the above two? Some sub-questions of interest to programs in this regard have been

- What is the logic behind and the nature of our current "working with systems" idea (as perceived by our staff)?
- In what ways do our current manner of partnerships add value (or not) to different sectors and to the community?
- Are the ideologies, interests, organisational contexts (goals, visions, procedures), professional culture with different public systems conducive to working in partnerships of a certain kind rather than others?
- Can we bring different public systems to work together and how?
- What should be the nature of our partnerships with public systems (or how should we work with systems), moving forward?

This study does not claim to have all the answers to these questions, but it tries to put forward some of the perspectives of people from different sectors (SNEHA, ICDS and MCGM) and learnings so far from existing partnerships- so as to set into motion some thinking on the way forward with partnerships at SNEHA. Interpreting from the perspectives of different people, the research team of this study also offers some suggestions on the way forward.

Defining convergence: When we started this study, we did not have an exact definition for convergence. From initial discussions at organizational level and a brief overview of national documents on convergence (from the National Rural Health Mission website[vii]), we defined convergence at the beginning of this study as "*the delivery of seamless care to the community by bringing together interventions from different sectors".* SNEHA was to act as an NGO facilitator to bring interventions of different sectoral interventions together. In other words, SNEHA was to be a temporary "glue" between different sectors (in particular, the ICDS and the MCGM) and catalyse the convergence process.

But as we proceeded, we found that within SNEHA-except for a few higher level staff, the word convergence was not familiar. However, working with systems in different ways- and bringing them together for joint work was considered of importance- at all levels in the organization. Hence, we redefined convergence as working with the systems as *"partners*" in some way or other- and then bringing different systems together for certain interventions in the community. Hence in this study we look at

SNEHA's way of working with ICDS and with MCGM separately; as well as explore its glue role in bringing the two together.

2: METHODOLOGY

Study design and approach:

This is a qualitative study, has been conducted urban informal settlements of Govandi/Mankhurd and Malwani.[1]. Table 1 summarises the initial conceptual framework of the study, adapted from Garrett and Natalicchio, 2011. The framework is based on the premise that collaboration between sectors or convergence is not a natural state of affairs that happens but needs to be put in place deliberately. This framework focusses on the (a) internal context i.e. organizational characteristics that shapes the work outcomes/collaborations of the agency; (b) external factors i.e. macro level characteristics associated with the political, social, cultural and economic climate surrounding the partnerships; and (c) institutional links i.e. mechanisms through which the partner organizations can integrate and allow or encourage the different organizations to work together, with a level of effort that each partner judges to be acceptable (Garrett J, Bassett L, Levinson F J, 2011). [2] These three concepts further enable understanding of the (d) consequences i.e. what happens in the community/field as a result of the collaborative efforts between the three partners i.e. SNEHA, ICDS and MCGM. This framework is depicted in table 1.

Table 1: A framework for factors affecting collaboration between two sectors.

External context	Internal context	Institutional links
• Political environment in which the organisations operate • Development priorities • Economic considerations • Influential global stakeholders • Window of opportunity	• Leadership available to champion the cause, personal and professional values • Vision, goals, culture, prior experience with collaboration • Organizational structure including decision	• Shared understanding of framing of the problem • Defined roles and responsibilities including shared roles • Shared interests • Lines of accountability and supervision • Stakeholder participation

[1] Denzin N & Lincoln Y. 1994. Handbook of Qualitative Research. Sage Publication Inc.
[2] Working Multisectorally in Nutrition. Principles, Practices, and Case Studies. Edited by James Garrett and Marcela Natalicchio. 2011. International Food Policy Research Institute

for work on concerned issue	making structure • Incentive structure	in shared activities

Source: Adapted from Gareett and Marcela Natalicchio 2011

Sampling and study tools: The above mentioned framework provided reference for structuring the study tools designed to seek insight on perception of the three main respondent groups i.e. program staff of ICDS, MCGM and SNEHA. The primary data source has been in depth interviews and Focus Group Discussions (FGD). The study tools were pilot tested and modified. Formal permission for staff interaction with ICDS was obtained at SNEHA Centre Project and HCP. Interaction permission was received from MCGM HCP so the researchers were able to interact with the health post staff. However similar permission could not be obtained from SNEHA Centre project. Purposive sampling technique was used for sample selection.

Table 2: Data collection for this study

Respondent group	**SNEHA Centre Project, Govandi**	**HCP, Malwani**
SNEHA Staff	- 4 FGD with CO - 2 interviews with PO - 2 interviews with PC	- 4 FGD with CO - 2 interviews with PO - 2 interviews with PC
ICDS	- 13 interviews with ICDS field staff - 11 *Anganwadi* workers, 1 Supervisor & 1 CDPO from three coverage areas - Gautum Nagar, Dr. Zakhir Hussain Nagar and Janata Nagar.	- 13 interviews with ICDS staff – 11 *Anganwadi* workers, 1 Supervisor & 1 CDPO from coverage area - Centre 1, 2 & 3 from New Collector Compound (Plot 2-73).
MCGM	Nil	- 18 interviews with Health Post staff – 15 CHV, 1 ANM, 1 PHN, 1 MO from two coverage areas – Health Post 1 & 2

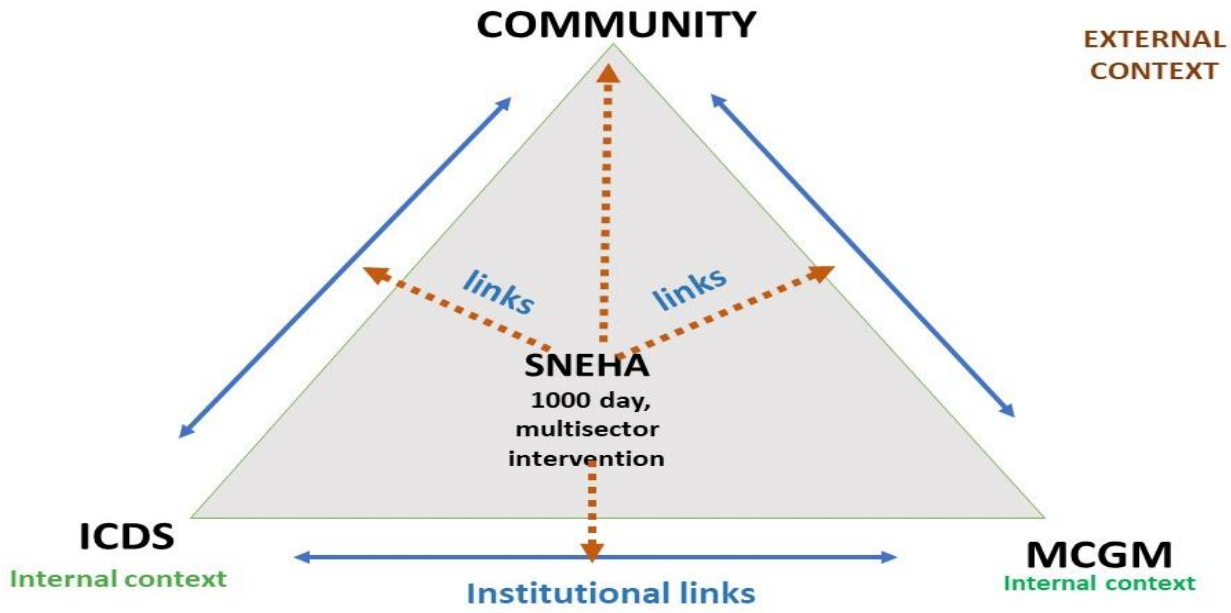
In SNEHA Centre which has 31 *Anganwadi* workers and HCP having 21 Anganwadi workers,

Data entry and analysis

The transcription of the respondent interactions was out-sourced and data entry was done by the researchers using NVIVO software. Data analysis was carried out simultaneously to track gaps in data collection and for reiteration of major themes emerging. Framework analysis and thematic write up were done with focus on the emerging themes and subthemes.

This framework was adapted for this study in an iterative manner- as the data evolved. The final iteration of the framework is shown in the figure 2.

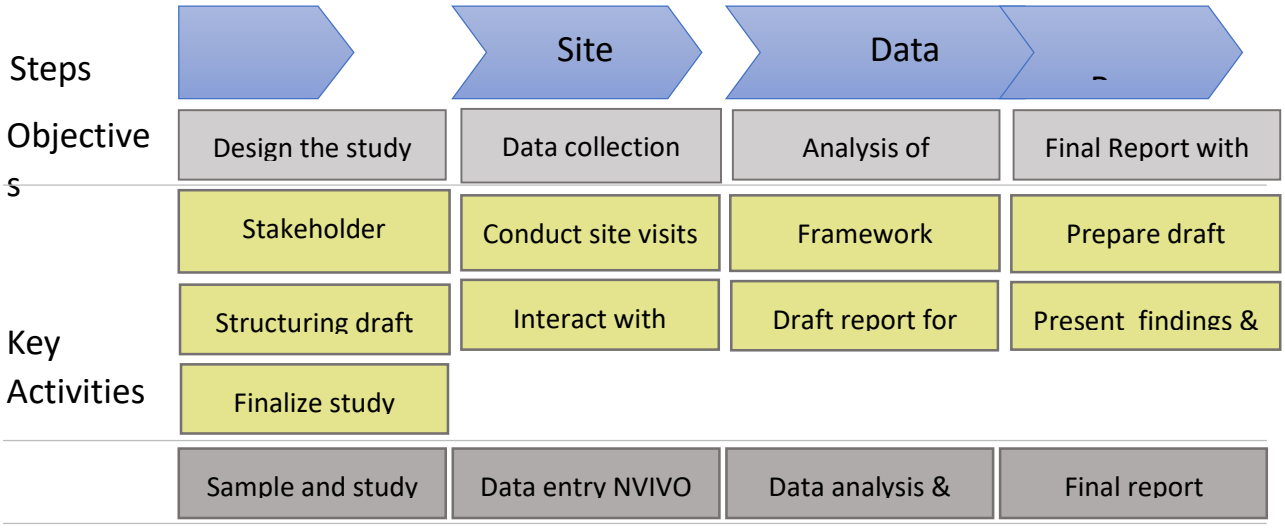
Figure 2. Framework for the study



In this figure, we depict SNEHA programs in the center, implementing interventions based on a 1000 day model across various themes such as malnutrition, family planning, violence and others. SNEHA works with ICDS and MCGM so as to link their activities to the community. SNEHA also works directly with the community in various ways- such as home visits, raising awareness and conducting group meetings and events. In this study we focus on SNEHAs partnerships with ICDS and MCGM- focussing on 1) the context within the different institutions that affect the partnership and 2) the manner of linkages that currently exist-as well as the nature of linkages that is potentially feasible given the contextual constraints described earlier.

Timeline: The various activities of the study conducted over a time period of one year can be grouped in to four phases as presented in figure 1.

Figure 1: Timeline for the study



4. FINDINGS: SNEHA and ICDS: WORKING TOGETHER

Manner of partnerships: We found that partnerships between SNEHA and ICDS are visible mainly at field-level (among frontline workers of both organizations) and at mid-level (at the level of supervisors of frontline staff, administrative level). Programs have put much efforts into building these partnerships and sustaining them.

The lack of higher-level (the level where policy decisions are made) linkages is perceived to pose limitations for joint work of SNEHA with ICDS. This is because SNEHA program staff often have to rely on personal relationships with ICDS staff at administrative levels for constant approvals of field-level joint work. Such an approach requires consistent, repeated permission-seeking at administrative levels of ICDS for different joint activities- which takes a lot of effort on the part of SNEHA programs and is time-consuming.

Even when mid-level permissions for joint work are in place, the attitudes and motivations of the field staff of ICDS, the Anganwadi workers (AWWs) strongly affects how the joint work of SNEHA-ICDS ultimately rolls out in the field. AWW perceive their main role as 'teachers' and do not perceive other outreach activities like home-visits and anthropometry of children as the main focus of their work. They see their work as a part-time, flexible commitment for a low salary rather than a well-paid job that demands stringent accountability[3]. Further, the lack of infrastructure (not having a permanent place to teach, not having a helper to distribute ration, not having regular stock of ration) makes AWWs feel

[3] It is important to mention here that the data from some AWWs shows a sense of evolution even within the ICDS programs. In many of the older AWWs, the motivations to be a teacher and not more than a part-time worker are strong. In some of the newer AWW, there are wishes to work in more formal roles; and supervisors also talk of intentions within the program to formalize AWW roles (have tabs to work with, have better monitoring systems and such.)

morally justified in delivering sub-optimal or incomplete work. With ICDS, there is very little routine monitoring of AWWs daily activities. AWWs thus tend to focus mainly on pre-school teaching- and do not feel accountable for the quality/completeness of other tasks such as anthropometry, home visits, mobilization for immunization and ration distribution. So, these activities are done in manners that AWWs, as individuals, consider as "adequate" given their personal motivations and organizational constraints; and attention is given mainly to what is perfunctorily required for reporting to their seniors. This same work ethic of AWWs is evident even during joint work with SNEHA (see Box 2).

ICDS perspectives on working with SNEHA: Does ICDS find any value in working with SNEHA? Overall, ICDS staff acknowledge that SNEHA does good work that is of much help to the community (see Box 2). ICDS supervisors as well as AWWs acknowledge what can be called as the "gap-filler" role of SNEHA- that is, SNEHA's help in filling gaps that exist in the work of ICDS. This includes the completion of anthropometry (and provision of equipment for this activity), mobilization of the community for immunization and events, doing home visits, generation of lists for ration, and sharing of complete data of the intervention area. AWWs also report learning from SNEHA frontline workers about how "good" home visits are conducted (they feel that SNEHA frontline staff share complete information during home visits, take time to build rapport with women, and use visual aids that are attractive). However, among AWWs, there is also an undertone of resentment towards SNEHA- for the presence of SNEHA implies not only support and sharing of workload for AWWs, but also appears to AWWs as an informal monitoring mechanism of their activities (for they can no longer get away with generating shorter lists of children or distribute less ration). AWWs, during our conversations, often feel the need to justify why they couldn't do the kind of "complete" work that SNEHA does- and attribute the better work of SNEHA's frontline workers to their superior incentive structures, trainings and having a full-time outreach work-role.

Box 2: Sample quotes from ICDS workers

On the ICDS context

"Our main work is to educate children."

"We get only mandhan (stipend). That also we do not get on time, delayed by two to three months...."

"I feel the payment should be increased. Then the quality of work will also improve."

"I will not lie. I wake up at 9 am. I take a bath and breakfast and I leave home for job at 10.30 and I reach here at 11 am. "

"On the new supervision system "It won't work, we already have refused it, new generation may handle it, but the old people like us not even know much English, we have eye problem, and we don't know how to handle it"

ICDS perspectives on SNEHA

We will face some difficulties later in doing work alone because there was lots of support from the SNEHA staff."

"SNEHA has shared many new ideas with us, for example, sometimes children do not eat, they shared the idea on how…."

"SNEHA's work is same like us, but SNEHA's field work is more than us. Our field work starts after 1.30. That is the difference in SNEHA and ICDS work. SNEHA do more field work than ICDS. ICDS do work of maintaining registers and do field work for that purpose. "

"We liked working together as we say ek se do do se tin -its good thing. Work get done fast. We used finish four days work in two days. (After SNEHA goes) we will spend six days for four days work alone. Slowly-Slowly according to age -also now 34 after two years 36, so improvement will less."

"When I come and go it should not matter to them as long as when anthro is going on, I am there. What I do, I know whether I am right or wrong. Instead of monitoring me, they should do their own monitoring. They should not put the burden on me……. it happens sometimes you get late."

SNEHA perspectives on working with ICDS: SNEHA programs, on the other hand, do not perceive themselves as getting many benefits from partnerships with ICDS (see Box 3). Some frontline workers mention that AWWs help SNEHA in convincing reluctant families to participate in certain interventions and also share updated knowledge on public sector schemes. However, SNEHA's main interest in working with ICDS comes mainly from a need to improve services provided by ICDS- and connect these services to the community. SNEHA programs perceive themselves as aiding ICDS in the following ways: in doing anthropometry and routinising this process in the community, in making complete lists of beneficiaries, in connecting ICDS with new families that shift into the intervention area, in the distribution of ration and its uptake, and in the organization of community events.

Box 3: SNEHA perspectives on working with ICDS: Sample Quotes

If they don't get salary for months, then that frustration is taken out in work. They may come late or they just give snacks to children and leave. There is a feeling that why should I do activities such as immunization, ANC registration.... I have done with my work and am leaving."

"My AWW is around 60 year old, very weak also. So, I don't take her for visits when we have to climb stairs."

"Some Anganwadi workers are there, who give their time for the activities, talk and stay also till 2.30-3.00 pm, like in my area."

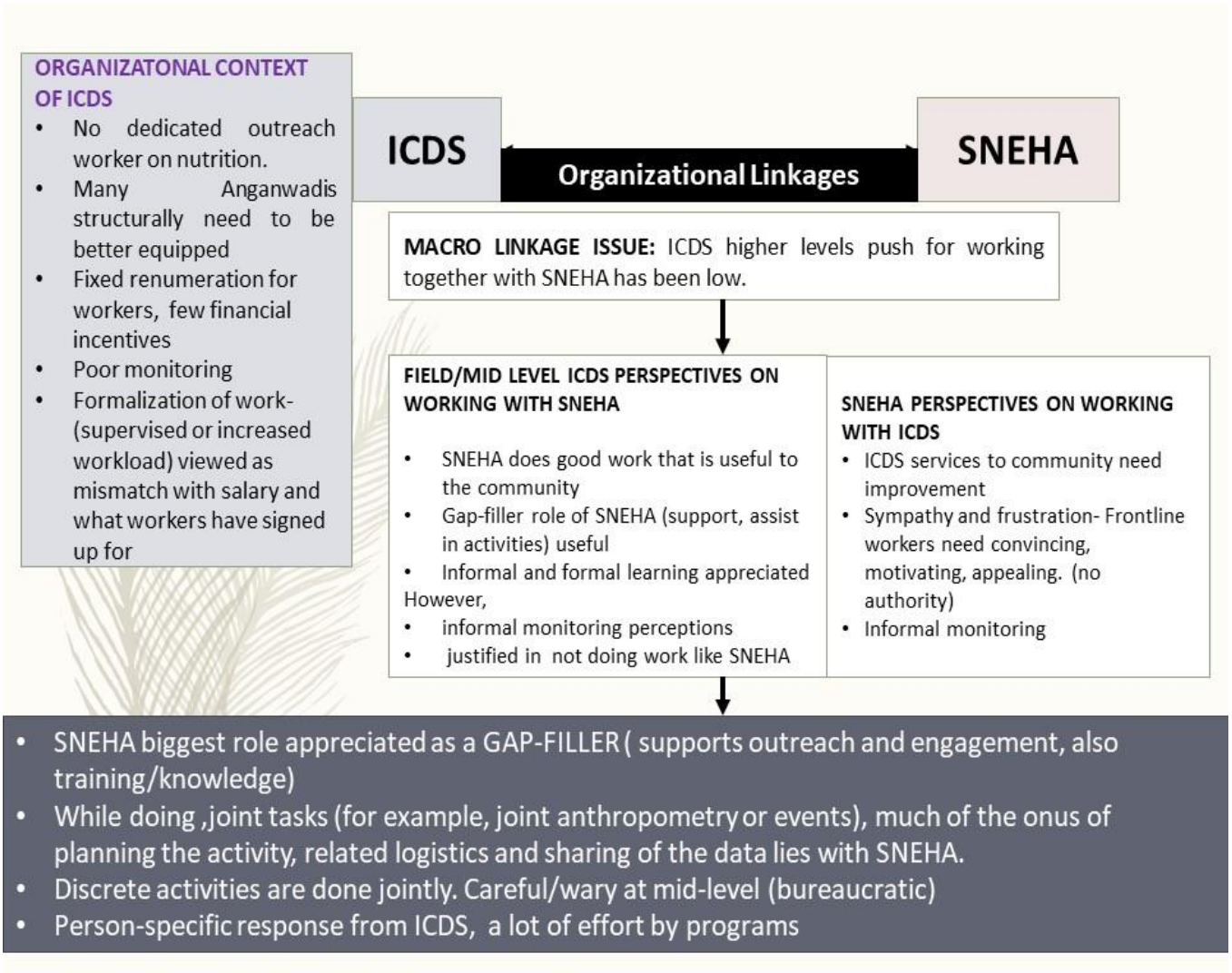
"We just tap them...the AWW saying 'didn't you go for the mobilization?' That's what we do from which they also come to know that we are observing them."

""We are able to reach to the CDPO level at ICDS…It is very important to have a push from the higher levels. If we really believe in convergence, then we should do it from the top level and not mid-level."

Working with ICDS has not been without challenges for SNEHA; and much effort has been put by SNEHA program staff to cultivate this relationship. It has been mentioned by staff that it is harder to "work together" with AWWs (for example, fixing a joint date with AWWs for anthropometry in the community) than doing work alone. Some SNEHA staff also mention being uncomfortable with promoting the uptake of ration provided by ICDS in the community- since the ration was often of poor quality. Importantly, SNEHA does not have direct authority on AWWs to be able to force them to participate in tasks such as anthropometry or mobilization. Hence, for most, SNEHA treads carefully, is sympathetic to the concerns of AWWs (and particularly so, since the AWWs' lack of training and monetary benefits starkly contrasts with that of SNEHAs frontline workers) and tries to motivate them to join in the completion of all these tasks. In working jointly with AWWs, the main tactics that are used by SNEHA are that of convincing, motivating, appealing, listening to their woes- and in the absence of cooperation despite all this effort- going ahead with the supposedly "joint" activities without their support, and yet acknowledging AWWs and sharing all data with them. Thus, when doing joint tasks (for example, joint anthropometry or events), much of the onus of planning the activity, related logistics and sharing of the data lies with SNEHA.

Figure 3 summarises the main findings about linkages between ICDS and SNEHA

Figure 3: Working together: ICDS-SNEHA



5. SNEHA AND MCGM: WORKING TOGETHER

Manner of partnership: We found that partnerships between SNEHA and the public health system under MCGM are visible mainly at the level of health posts and its linked outreach teams. Permissions for joint work are obtained at the level of the MoH (ward office) and higher, policy-level linkages are weak. The absence of higher level linkages, similar to that of partnerships with ICDS, makes much of working

together with health posts depends on local cooperation from the MoH and the health posts (also see footnote[4]).

The nature of the partnership between SNEHA-MCGM at field-level is slightly different from that of SNEHA-ICDS. For one, the emphasis of ICDS field partnership is mainly on "*joint work*" (joint activities with the AWWs, building their capacity and motivating them to work). However, the emphasis of the partnership with health posts is on "*complementary*" work. That is, health posts have a set of dedicated frontline workers called Community Health Volunteers (CHVs) intended to carry out outreach activities of the health post and engage with the community. The frontline workers of SNEHA tend to complement the work of these CHVs and serve as additional outreach workers for the health post and help in doing mobilization, referrals and collection of data. Thus, the SNEHA-MCGM field partnership is less about doing activities together in physical terms (like doing joint home visits) and more in terms of helping the system attain better coverage of its services. In fact, CHVs often do not cover SNEHA's intervention areas and deliberately focus on other geographies.

This sort of "complementary" gap-filling partnership has evolved probably because of the current need of MCGM- which SNEHA programs have tried their best to address. Senior staff from the health department share that increasing slum populations as well as increasing number of programs/ schemes at health posts have resulted in the over-burdening of CHVs, whose numbers are not adequate to do justice to the current scale of outreach work mandated at the health posts. CHVs are contractual workers, who are monitored closely by the health posts they are attached to and cover 6-7 plots. Interactions with CHVs reveal that majority of them had joined the system with the intention of taking up a part-time job and perceive themselves as the "roaming" people of the health post. CHVs share that large areas they are mandated to cover in short time periods, and a top-down, non-participatory approach to their work routines limits the depth of community engagement they are able to do. This, along with pressure from the health post to complete certain targets, leads to a tendency of CHVs to focus only on the "low-hanging" fruit (people who can be convinced easily to uptake services) and overlook challenging cases. Given these conditions at the health post, a set of complementary extension workers offered by SNEHA- who are well trained and willing to mobilise (even if it's a small area) is considered useful by health post staff for meeting required targets. For instance, during an immunization camp, CHVs are often allotted areas that are not within SNEHA intervention- for it is assumed that SNEHA frontline workers would take care of their area.

[4] From the findings, one can interpret that the lack of higher level linkages with MCGM has a strong influence on the working of programs. Several of SNEHA program indicators -even in the case of a direct intervention program- are highly dependent on services provided by health posts- like the provision of vaccines, condoms, multivitamin and iron tablets, deworming tablets, ANC check-ups and conduction of operations. Constraints on these services often arise due to decisions at levels above the health post (like stock outs or lack of personnel or training); and SNEHA's has limited influence at higher levels to address these constraints.

Health post staff perspectives on SNEHA: Health post staff, in general, acknowledge the usefulness of SNEHA in improving reach of its services, in mobilising the community and in the collection of data. Health post staff feel that SNEHA frontline workers are especially good at working with "refusals" from the community and consider them as having superior training/ways of community engagement. In addition, health post staff point out that SNEHA staff never show "attitude" (even if they have superior skills), are always polite and hence easy to approach for help (see box 4).

It is generally accepted that when SNEHA mobilises the community, the demand for Ante Natal Care (ANC) check- ups, iron tablets, immunizations, family planning services increases- which, in turn, means additional work for the health post. This additional burden on the health post is not always appreciated- since the health post does not always appear to have the resources to contend with it. However, in the case of immunizations, the political push for completion of targets is very high- and hence, health posts are willing to make some efforts to accommodate the increase in demand. In the case of family planning, incentives given to CHVs for completing tubectomy targets aids their cooperation. Fortunately, much of the additional burden of work generated due to SNEHA's presence happens to match the pressure on the health post from the top- and also sometimes resonates with CHV's interests and financial incentives. Hence, the additional work does not seem to be resented [5].

Box 4: Sample quotes from staff in the health system

The health post context

The health post set- up we have -it was the same 15 years before and now- but the slums have grown. So the health post set up is not able to cope." Senior staff

"We have lot of administrative work…from above, they want report – in this format… CHV have to do survey of 60 people every day, they write in their book, and tell their supervisor. We compile all data together – fever, for malaria. Then we send to specific department." Senior staff

CHVs- on their work

"Earlier each plot had about 60 families…now they are three times that…covering everyone becomes very difficult…CHVs have increased…but not that much….now there is too much work…and lot to do alone…earlier it was not like that…earlier we used to have more time to help each other." CHV

"*We don't have personal targets, but the HP has a target to complete and is divided among the CHVs*"

"*First we come here and then they tell us what work is to be done; depending we do all that. Like we have to look for an ANC or PNC. Or a camp, you go there, they say. Or they tell us to do some survey. We have to come back here and report.*"

[5] When SNEHA brings additional work to health posts that does not match with the political priorities of the health posts (for instance-fungal infections), SNEHA program staff share that they have not been able to make much head-way in pushing for these.

Health posts' perspectives on SNEHA

SNEHA really helps us cover all the population...and for immunization, sometimes there are 70-80children and we can't do all." ANM

"We can't stay in one place for a lot of time since we have a lot of plots to cover; so we do joint visits only sometimes- but we decide who will go where. That is very helpful- since we can cover plots better." CHV

"I can learn from Sneha people, they give information to mothers about how to give them food, they have pamphlets and all." CHV

"*They never leave any work undone…even if the work goes on till 2 or 3, and their lunch time gets missed, they sit and work with us missing their lunch time also…" CHV*
"The thing is they have small areas to cover, so they really know those areas better than us. They know exactly which child is where and who is where, and because of this, their work happens much better than ours. Also, they don't have to keep switching from one work together" CHV

Slums have grown and program components kept on getting added vertically. All the vertical programs have increased, but the staff on the ground has been the same. So, the need of the hour is that NGOs like SNEHA must complement the health post set up" Senior staff

"*When I find something that is overpowering, I definitely call SNEHA and tell them to help…like I leave certain pockets to Sneha…and we must have these clearly defined with clarity on paper to prevent duplication" Senior staff*

"Malvani has population of one lakh, seventy thousand population, so not enough staff. In this situation, SNEHA is very good for us, in convincing people – they help in converting in FP and immunization." *Senior staff*

"Our staff are not trained to handle strong refusals. But strong refusals, SNEHA are able to tell them. They really help us. they talk very nicely your method is different." Senior staff

SNEHA perspectives on MCGM: Does SNEHA find benefits in partnering with MCGM? Even in the relatively "direct" program model that has been currently adopted in the two SNEHA programs- several of SNEHA's program achievements are dependent on services provided by health posts- like the provision of vaccines, condoms, multivitamin and iron tablets, deworming tablets, ANC check-ups and conduction of operations. Constraints on these services pose limits on program activities and directly affect program indicators. Hence, working with the system in a "gap-filler" role, complementing their outreach

mechanisms and linking the community to services provided at health posts is considered to be in the best interests of SNEHA programs (see Box 5).

Within SNEHA, while AWWs are often viewed as demotivated personnel who don't do optimal work (with exceptions)-and at the same time, sympathized with for the lack of support and incentives they receive, CHVs are looked at a little differently. CHVs are regarded as over-worked, having a "thin" existence and not known to many in the community due to their spread-out outreach areas. They are regarded as not having the bandwidth within their work-routines to do in-depth community engagement work or joint work with SNEHA. CHVs are not usually viewed as useful for SNEHA's community engagement work (for SNEHA frontline workers mostly perceive themselves as having a better rapport with the community than CHVs). CHVs are viewed as useful only in certain cases where technical knowledge on medicines or a hospital procedure is needed. CHVs are called for joint home visits only when joint pressure by the team of frontline workers is perceived as having potential to increase uptake of certain services. SNEHA staff also involve CHVs in joint home-visits if a referral (for example, a tubectomy) involves an incentive for CHVs. In other cases, SNEHA frontline staff directly refer/ accompany people to the health post. In general, SNEHA staff, in their work with MCGM, talk more in terms of difficulties faced due to poor quality services at the health post (like non-availability of drugs and vaccines or the poor treatment of women during delivery); and give less importance to challenges in joint community outreach work. SNEHA staff feel that they are not able to make much headway to improve the quality of services provided at the health post.

Box 5: SNEHA perspectives on the health post

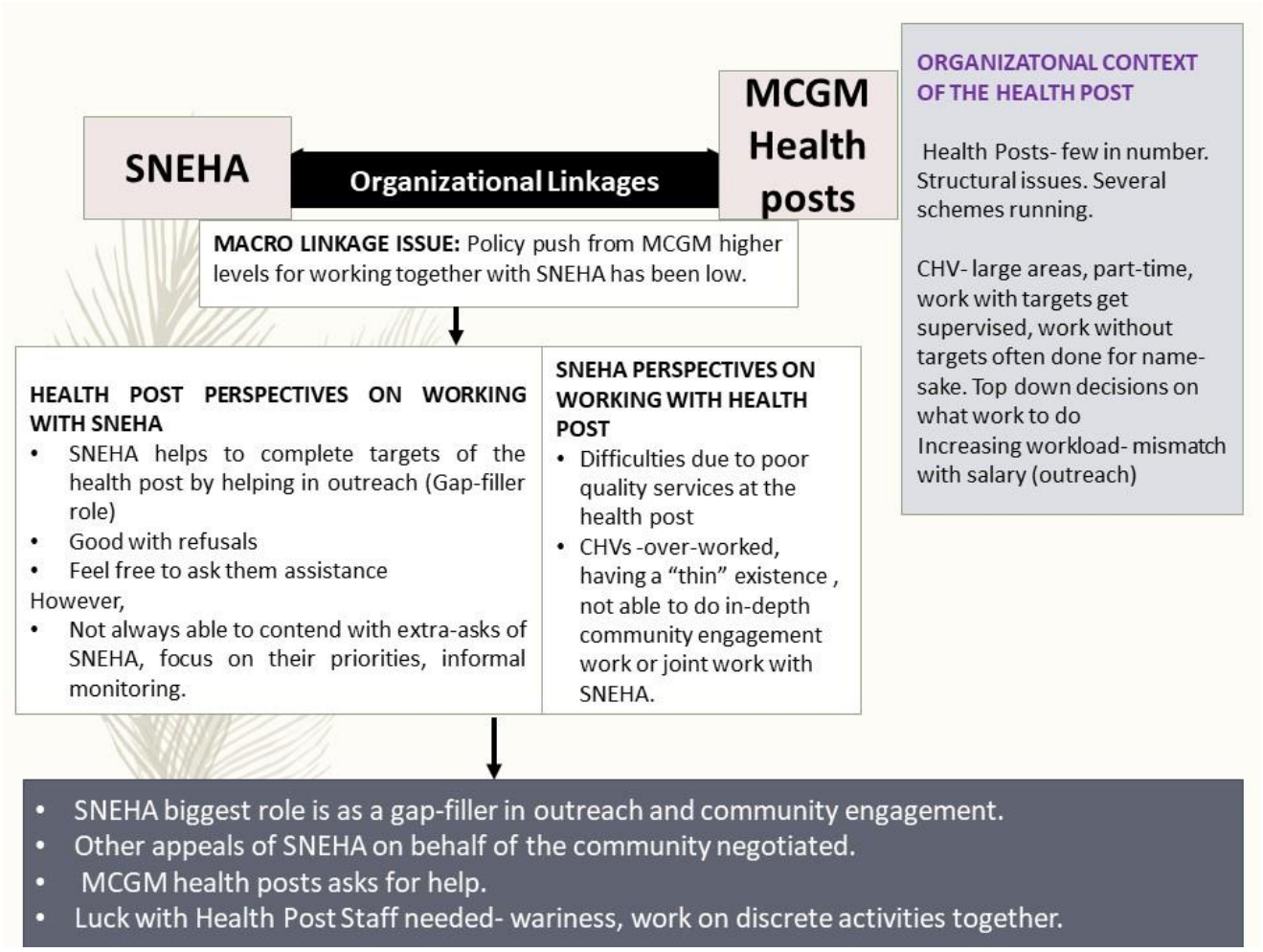
CHV has very thin existence in field, CHV has more workload, TB survey, children survey, they are always occupied with survey work, paperwork they have more so they are not able to meet people more.
"for CHV she has target, so to make her happy as she gets incentive or promotion for it so we handover the case (tubectomy) to her to take so she gets benefited, for us it does not matter"

"We have very good rapport with them, CHV, PHN or doctor, we are having very good relations with them, luckily PHN and doctor there are very good"

"I work with CHV in two places. I have seen the difference in communication. In one place the CHV will only to do her work, we have to call her. In the other area the CHV herself calls our CO."

Figure 3 summarises the main findings about linkages between MCGM health posts and SNEHA

Figure 3: Working together: MCGM health posts-SNEHA



6. SUMMARY FINDINGS: SNEHA's work with systems

Persistence and effort put into building relationships with public systems observed in both programs:

SNEHA has been running programs on maternal and child health in the community for several years- with a strong focus on community engagement strategies and with some involvement of the public nutrition and health sectors. Recently, the political environment within SNEHA advocates a shift towards building stronger partnerships with different public sector systems and with the community.

We observed that both programs have worked extremely hard and left no stone unturned to work with both public systems. At program level, much effort has gone into building and maintaining personal relationships within staff who work in public systems. It must be noted that gaining the trust of public systems- and cultivating professional relationships- has involved much persistence, time and effort- by SNEHA program staff. Hence, these efforts deserve much appreciation.

Direct and indirect ways of working:

What manner of support should SNEHA provide to systems? What will SNEHA programs gain by working with systems? These have been questions of interest to the organization.

Within SNEHA, the terms “direct” and “indirect” interventions have been coined for two different ways of work. “Direct” intervention programs are geared towards direct delivery of services by services through SNEHA frontline workers, in addition to working in conjunction with public systems to limited extents. However, there is some concern within the organization that running programs only in a direct manner- for it is believed that such program models result in communities becoming dependent on SNEHA’s interventions; and are hence left without alternatives on SNEHA’s exit. So, it has been suggested that programs within SNEHA must gradually phase into more “indirect” modes of work before exit. The more “indirect” intervention program models are intended to work mainly through public sector systems and strengthen the capacity of these systems; at the same time, these models are intended to build community capacity to demand services from these systems. The end goal of this phasing out- from direct to indirect intervention models- is the complete handing over of the responsibility for maternal and child health to existing public systems and the community-on SNEHA’s exit. Both HCP and Sneha Center programs are generally considered as “direct” intervention models currently, but the researchers in this study feel that this distinction between “direct” and “indirect” is not black and white. The two programs of this study lie somewhere in this spectrum between being “indirect” and “direct”- with some activities within the programs being more strongly linked to partners (“indirect”) than others.

Box 6: SNEHAs work with systems

Acknowledgement of SNEHAs role as temporary

SNEHA is here for four to five years, but they-ICDS and MCGM are permanent. So, we tell the community that we don't stay here indefinitely, whatever you need, you need to ask them." (Frontline worker, SNEHA)

"After we go from here, ICDS, MCGM and the community… all three will be here. SNEHA's work is to make the foundation… like a tree has a foundation..." (Frontline worker, SNEHA)

Frustration with poor quality work in systems

"We have to make ourselves relax for the woman's sake (in the community) but we do get angry a lot (relating a family planning episode that got cancelled) (Frontline worker, SNEHA)

"During Anthropometry sometimes the Anganwadi worker is not able to come ..then she sends helper. If helper is also not there...we do it ourselves because we have to do it regardless of whether they come or not" (Frontline worker, SNEHA)

"They also don't put much effort to convince women and if a woman is not ready for immunization then they will add the name in the refusal list. No one take responsibility and it does not affect their appraisal." (Frontline worker, SNEHA)

"…but even today we have to plead with them to get work them – why is it so! What I feel bad about is that even today, SNEHA is not at the brand / policy level. ((Program Coordinator, SNEHA)

Sympathetic and accommodative

They don't get salary on time. Like we get it on time, we get it on first of every month. But they don't get it then how will they be interested in doing their work. (Frontline worker, SNEHA)

CHV has 1000 houses and our CO has 200 houses...So we can bring them but how can CHV bring children from 1000 houses by accompanying with them?" (Program Officer, SNEHA)

Motivating appealing, negotiating

Our limitation is that we cannot force much...we have to work with love, love...and slowly." (Program Coordinator, SNEHA)

We have been told to put sugar in the mouth and ice on the head and then work (Frontline worker, SNEHA)

Characteristics of SNEHA's work with public sectors:

SNEHA does not see itself primarily as a helper to systems or a "service-delivery" NGO that works on behalf of public systems. Rather, SNEHA staff perceive themselves as working for the community in several ways- including connecting the community to the public health and nutrition systems. Thus, some of the characteristics of SNEHA's role in systems is as follows (also see Box 6):

1) SNEHA's relationships with public systems are informal and at mid or frontline level.
2) SNEHA is accommodative of systems requests and understanding of the constraints that systems face. In the frontline specially, SNEHA staff acknowledges that public-sector frontline workers do not always do "complete" jobs- and often express frustration over it. At the same time, SNEHA frontline workers are sympathetic to the constraints that public sector frontline workers face.
3) Although SNEHA is accommodative and non-confrontational in its relationships with systems, it does negotiate with systems for better services on behalf of the community. It often negotiates by provided support in service delivery for any additional services SNEHA demands.
4) With frontline workers, SNEHA does not have any direct authority; thus, it uses appreciative inquiry techniques (appealing, motivating, handholding, refocussing on strengths and the good work of people rather than their weaknesses)

Conceptualising SNEHA's activities in relation to system

SNEHA can be conceptualized as working with systems in three ways- 1) by acting as an advocate to systems on behalf of the community 2) by engaging better with communities so that communities get outreach and other services they are entitled to from the public systems and 3) by helping systems deliver better and providing aid in services. Box 7 summarises these three roles.

Box 7: Perceived roles of SNEHA in its work with public systems

Advocate to systems on behalf of community (System-level advocacy)	Engage with communities so they get services (Linkage)	Help in service delivery (Service aid)
Ask for more camps, more immunization, THR Compare lists with system staff to ensure people don't get missed out	Mobilize for camps, connect community people with appropriate people in systems, convince difficult people for immunization, convince for THR, convince for weighing	Anthropometry-technical assistance, new ideas for THR uptake, new ideas, learning with pamphlets, training of frontline workers, place for camps, weighing machine

How are these roles of SNEHA interpreted within public systems?

At mid-line and frontline, staff from both public sectors think well of SNEHA's commitment to the community- and look at the NGO as being supportive to the work of public systems even though at a small-scale. Public systems appear to value SNEHA's linkage roles (since SNEHA deepens local community outreach that helps systems with some of their targets) and its service delivery roles (through new learning, sharing of ideas and infrastructural help). However, discussion with staff in public systems also reveal that they are circumspect in their dealings with SNEHA. This is because of many reasons. For one, the organizational contexts within public systems is such that workers often focus on meeting immediate targets and reporting priorities- and doing little more. The presence of SNEHA puts pressure on them (though this pressure is gentle) and staff feel monitored. Some of SNEHA's linkage and service delivery roles of SNEHA are valued by public systems for meeting their targets, but other activities that do not have organizational value to the individual systems are either met with indifference or with some resentment (if these increase individual work burden). While frontline workers in public systems acknowledge learning from SNEHA's "good" frontline work, they express less intentions of changing their long-term practices. To add to all this, public systems views of SNEHA are generally coloured by a perception of all NGOs as "*watchdogs*" of the community that are capable of causing local dissent- and this also contributes to underlying wariness. This wariness is aggravated by the lack of higher-level mandates to work with SNEHA; so mid-level staff are hesitant to take any blanket decisions on joint-work that might land them into trouble- and hence only small, discrete joint-activities get planned/executed.

Such perceptions within public systems pose an important challenge for SNEHA programs that have a high level of commitment to the community. SNEHA does not want to limit its role to being only a "system-helper"; but wants to play a transformational role in strengthening systems and link these to the community- but without being confrontational. But it is clear that the organizational culture/context that exists within public systems at the mid/frontline is currently not inclined to embrace such a transformational role easily. Overall, we found that SNEHA's capacity to rope-in public systems to be small-scale, limited to the front-line, limited to joint work on discrete activities, subject to constant negotiation and much dependent on personal relationships at mid-level.

7. ICDS and MCGM: Convergence of activities and SNEHA as a glue

Current status of convergence: While country-level "written" policy documents advocate convergence between the public nutrition and health sectors, the general policy push to operationalise these has been low. SNEHA too has not been able to facilitate or engender such a policy level push [6]. In terms of administration, ICDS comes under the state government and the health posts under MCGM; thus, both have distinct, vertical administrative structures. Both ICDS and MCGM have different sector-specific priorities that leave little room for the practice/implementation of joint work. The frontline workers of both ICDS and health post know little about each other's work. They have had very less opportunity to meet and interact (see Box 7). Currently, interaction between the two sectors appears limited to check-ups done by doctors at Anganwadi centers, referrals to health centers by AWWs; and the sporadic participation of AWWs in community-based immunization campaigns. Efforts are currently being made by SNEHA for joint meetings/data sharing/joint home visits by the frontline workers of both programs.

Box 7: Barriers to convergence between the ICDS and MCGM-Sample quotes

Intersection of health and nutrition – little operational overlap

"There are no malnourished children in our area" CHV

"Anganwadi Sevika's work is different... they have to sit at one place. We have to wander here and there and meet people "CHV

"We do not have that much focus on health, the whole outlook is different, the system itself is different." AWW

Not comfortable/trained on the other sectors' work

"The health department cannot do much about nutrition because we can only give advice, we can give medicine and tonics…but can't give food...so, no direct effect." (CHV 1)

"CHVs are seen with the doctor, like during vaccination camps... they are with the doctors while giving polio etc. So, we can also give information but when they do, people would accept more readily." AWW

Not used to sharing across sectors

"*If we go there and ask for some information about the children. we are told that their madam has told them not to give..." CHV*

"Once it happened that they...CHV wanted a list that we had put together personally, of the children of our area. They needed that. But our madam told that we need not give...when we are doing the work, why should we give the list to them." AWW

Timings do not allow for working together

"We have different timings and hardly even meet, so I don't want to say anything bad about others... like 9,30 we go to the field, they come by 11.30 or 12." CHV

"*Their...CHV and our timing are different, so we cannot go for visit together. Their time is 10 am to 1 pm, ours is 10.30 am to 3.30 pm." AWW*

[6] A policy level MoU had been signed between SNEHA, ICDS and MCGM in 2015- but with the change of personnel within the public systems, this MoU has not been operationalized.

SNEHA as a catalyst: Some success in plastering gaps sector-wise and being a good data-messenger.

The challenges faced by SNEHA programs in bringing ICDS and health posts to work together at the frontline must not be under-estimated. For one, the policy push from higher levels for working together has been low. This poses limits on the extent to which field-level efforts at convergence can be authoritatively executed. Secondly, our evidence in the previous sections suggests that- even if a top-down policy push is present- the present organizational context and work-routines of both frontline workers may not be conducive to convergence. While frontline workers of both programs were able to discuss several conceptual links between health and nutrition, they shared that both sectors- health and nutrition- have different work focus and priorities. Most health staff did not even consider malnutrition as an issue in their areas. Some AWWs report technical unfamiliarity with issues like family planning and felt that they were unaware of the potential side effects of certain vaccines. Hence, they share that it could be risky to advocate these services in the community. Also, the timings of both frontline workers and their work routines rarely match; so, they don't meet each other in the field. All this makes the operationalization of the convergence idea very difficult.

SNEHA has been putting much effort to routinise data-sharing between ICDS and health post staff. SNEHA programs believe that it is important for all frontline workers across programs to be on the same page about happenings in the community- for instance, about the number of children who are not immunized; and about new migrants to the area. Sharing data across ICDS and MCGM is also intended to benefit complicated cases that needed holistic attention from both sectors. But bringing about this data-sharing has not been easy. This is because frontline workers are often scared that they might be scolded for sharing sector-specific data with others without formal permissions. AWWs as well as CHVs do not view data-sharing as mutual help, but rather as shirking of work by the other party. Requests for data from the other sector is generally viewed with suspicion. Discomfort in data-sharing also rises from the fact that frontline workers of both sectors look at it as a mechanism of monitoring. There is a worry that mismatched data/data discrepancies could lead to questions about their work and consequent punitive actions.

These issues- a lack of policy-level push, differences in ideologies and work routines at the frontline, an organizational culture unsupportive and unused to sharing data- exasperated by critical capacity gaps within each sector- make it extremely challenging for SNEHA to bring all its partners to the same table. Thus, SNEHA's intentions to act as a glue between its two partners, ICDS and MCGM, does not appear to have translated into strong action so far. Much of SNEHA's current efforts have been directed towards filling gaps in both sectors individually than in bringing them together. In other words, SNEHA has been a gap-filler, *"plastering*" gaps to facilitate the better delivery of sector-specific services- rather than a cross-sector glue. SNEHA has also made attempts to act as a data-messenger between ICDS and health posts.

For example, routine SNEHA-ICDS and SNEHA-MCGM meetings are conducted- and relevant key messages are shared across sectors. Figure 4 summarises convergence between ICDS and MCGM.

WORKING TOGETHER IN THE FRONTLINE: HEALTH AND ICDS

Organizational Context

ICDS: STRUCTURAL LIMITATIONS

- There is no provision for an outreach worker on nutrition. AWW intended to do some amount of outreach.
- Anganwadi structurally poorly equipped- rented buildings, small space
- Workers don't get salaries on time, and are paid few incentives. Training and supervision lacking.

WORK ROUTINES AND SECTOR-SPECIFIC PRACTICES ARE NOT SUPPORTIVE OF CROSS-SECTOR WORK

- Resistance to formalization of work- supervised or increased workload viewed as mismatch with salary and what the frontline workers had signed up for. AWW signed up for a part-time, "easy" job.
- Fixed renumeration and little financial incentive for convergence
- Field level monitoring is poor.

Community context

- Increasing slum population- in both sectors, there is lack of capacity to deal with increasing population and migrants
- Migrant population- tracking and following up is a challenge; language and cultural differences between frontline workers and the community
- Perception that the population requires motivation, intensive mobilization.

ICDS ⟷ **HEALTH**

Organizational Linkages

MACRO LINKAGE ISSUE: HEALTH AND ICDS AS TWO VERTICAL PROGRAMS:
ICDS comes under the state government, and the health sector under MCGM. While conceptual linkages between health and nutrition are acknowledged, different priorities leave little room for the practice/implementation of joint work.
Policy push from higher levels for working together has been low. All this leads to:

BELIEF THAT BOTH WORKERS HAVE A DIFFERENT FOCUS OF WORK.

- AWW perceived themselves and are perceived by others as teachers. Their main work is giving food and teaching the children; working against malnutrition.
- Whereas the CHV is perceived as a outreach health worker- who mobilizes (motivates) the community for health related services, and does health related surveys.

NOT COMFORTABLE/TRAINED ON THE OTHER SECTOR'S WORK

- While some frontline workers have conceptual understanding of the links between health and nutrition, they have little awareness/knowledge of working in the other sector
- Many CHVs not even aware of malnutrition in their areas
- AWW that have reported instances of participation in immunization report that working in the health sector is a "Risk" (if something happens, they don't have support).
- AWW also report technical unfamiliarity with issues such as family planning or side effects of immunization.

NOT USED TO SHARING ACROSS SECTORS

- Attitudes of sharing not inculcated in the system
- Lack of bonding and communication within health workers- makes requests for data suspicious
- Don't view data sharing as mutual help, but as shirking of work by the other party
- View/discomfort that non matching data can lead to questions and punitive action

TIMINGS DO NOT ALLOW FOR WORKING TOGETHER

- Mismatch of timings for activities such as home visits or joint mobilization

Organizational Context

HEALTH SECTOR:STRUCTURAL LIMITATIONS

- Health Posts- few in number
- Outreach worker present, but covers large areas.
- Outreach workers paid salary plus incentive, but feel it is low compared to the work burden. Present only part-time in the community.

WORK ROUTINES AND SECTOR-SPECIFIC PRACTICES ARE NOT SUPPORTIVE OF CROSS-SECTOR WORK

- CHVs have multiple tasks to complete and report having no time to work on other topics (even if compelled to, work will be namesake)
- Only work with targets get supervised; work without targets often done for name-sake. Pressure to complete targets on frontline workers
- Top down decisions taken based on immediate health system priorities. Frontline work gets decided at the last minute which makes it difficult to work with partners
- Resistance to formalization of work- increasing workload viewed as mismatch with salary and what the frontline workers had originally signed up for.

Working across sectors: Current status

- The frontline workers of both sectors know little about each others work.
- They have had very less opportunity to meet and interact; any interaction is informal. Right now, interaction between the two sectors is limited to check ups done by the doctor at the AW, referrals to health centers by AWW; and sporadic participation of AWW in community based immunization campaigns. Exceptions have been reported.

(Some efforts made by SNEHA for joint meetings/data sharing/joint home visits by the frontline workers of both programs- occasional joint home visits happening; and data sharing happens in separate ICDS-SNEHA and MCGM-SNEHA meetings.)

7. What do the above findings imply for future directions of SNEHAs work with public sectors?

In this section, we have tried to summarise some thoughts on how SNEHA can work with and across public systems- deriving from the findings of this study.

The need for higher level partnerships

We found that there are deliberate intentions within SNEHA programs to move into stronger partnership modes and do more "joint work" with ICDS and MCGM. However, in the absence of policy-level buy-in on convergence, field-level joint work becomes both a challenge and a gamble for programs. To move towards stronger partnerships, higher-level engagement of SNEHA with public systems is a must. Also, the current strengths of program staff in SNEHA lies in strong community engagement and in working locally with administrative/field-levels rather than policy levels of the system. To institute higher-level partnerships, SNEHA might need to add on organizational human resources with a different skill-set.

The "gap-filler" role of SNEHA- that addresses critical capacity gaps in public sectors- as an important strategy

It is evident that both ICDS and health posts currently suffer from critical capacity gaps. In the case of ICDS, there is no community outreach worker for nutrition and the teacher is expected to double up as one, even in her part-time, low-incentivised role; there are infrastructural challenges (lack of rented space, weighing machines and such); and poor quality ration who stocks are unpredictable are a reality. SNEHA is able to compensate for some of these gaps by providing a set of well-trained frontline workers who do much of the field-level screening for malnutrition, raise awareness, aid in the distribution of ration, and provide some infrastructural relief. In the case of health posts, gaps in quality of service delivery at the health post has been pointed out as a big challenge during several discussions (the lack of drugs, trained human resource personnel to conduct family planning and poor experiences of people referred to health posts) ; in addition to this, the outreach team of health posts acknowledge not being able to contend with the large coverage areas and increasing number of schemes and targets mandated from the top. Here, SNEHA programs feel that they are not able to do much to improve services at the health post itself; but they are able to complement the work of the health post outreach team due to the strong community engagement abilities of the programs' frontline staff. Thus, in work with both ICDS and MCGM, SNEHA appears to act as a *"gap-filler*". It tries to make up for some of the gaps, especially in outreach and community engagement, within these systems.

We feel that SNEHA's role as a "gap-filler" might need to continue as an important partnership strategy- until critical capacity gaps within ICDS and MCGM can be bettered. The gap-filler role, especially at the

frontline need not only be about joint work (targeted at physical togetherness of activities between workers- like doing joint home-visits in the community). Rather, SNEHA can focus on complementing the work of public systems, thereby making up for deficiencies in outreach and community engagement within these.

SNEHA's presence is not ways viewed as "help" by public systems: Some implications of this viewpoint

We found that both ICDS and health post staff acknowledge SNEHA's role as a "gap" filler to be useful for the community. However, it is also evident at field-level that both, ICDS and health post staff, do have some reservations against SNEHA's involvement in their work. This seems to be because SNEHA's presence not only implies support and sharing of burden but also tends to get perceived, to some extent, as an informal monitoring mechanism of work within these public systems. Further, in some cases, SNEHA's support to systems tends to increase their work rather than decrease it (for example, due to SNEHA's strong community engagement, more people turn up for immunization or more people demand ration from the Anganwadi-resulting in more work for the public systems involved). Also, general perceptions of SNEHA's good quality frontline work, viewed as a product of a well-trained, well-supported and well-incentivised team, starkly contrasts with perceptions about the frontline work of ICDS and MCGM- and such comparisons naturally tend to engender some resentment.

All this means that SNEHA's well-intentioned efforts to help public systems are not always viewed as "help" by people in the system. Discussions with SNEHA program staff show that they have already sensed these issues, and hence tend to proceed with caution in their public-sector relationships. Program staff adjust to several demands made by public systems and try hard to work around staff routines in public systems. Working like this is not easy for programs. Both programs, HCP and SC, deserve to be highly appreciated for their careful handling of all relationships with public systems (One frontline worker told us that they always work "*with ice on our heads and sugar on our tongues*"- while working with personnel from public systems). Staff at SNEHA also share that methods like Appreciative Inquiry have been useful in trying to change work-attitudes within the system, but we did not assess these methods in this study. But our findings do imply that changing viewpoints within systems about SNEHA's presence, clarifying the roles the organization intends to play and gaining the trust of public systems- are indispensable steps towards working in partnership. These are issues that both SNEHA programs we studied have already recognised, are working on, and would probably need to continue long-term.

Moving out of "gap-filler" roles into more indirect strengthening roles within systems: Are we ready? Are the systems ready?

In a "gap-filler" role, SNEHA appears to fill some gaps within public systems, especially in relation to outreach and community engagement. While this role can be thought of as necessary - much of the systems-related interventions that SNEHA does in this "gap-filler" role are not sustainable after the exit of

its programs. One important question for programs is whether these can move out of "gap-filler" roles to more "indirect" ways of working with public systems that are potentially more sustainable.

Two "indirect" strategies that are being considered within SNEHA include 1) building the capacity of frontline workers in public systems and 2) motivating them to deliver better services. Both these strategies are intended to strengthen the outreach work of public systems like ICDS and MCGM. These strategies are to be complemented by strategies at community-level such as setting up of community action groups.

Is the strategy of capacity-building of frontline workers in public systems likely to work? Our data shows that frontline workers of other sectors- ICDS and MCGM- acknowledge learning much from SNEHA- in formal as well as informal ways. CHVs and AWWs cite instances where they have learnt from SNEHA workers about the conduction of better home visits and about building rapport in the community. However, even while these workers acknowledge learning from SNEHA on better ways to work, intentions to better these services are not evident in discussions with them. In case of AWWs, the lack of such intentions is rooted in the perception of their roles as teachers, poor infrastructural and incentive support, exasperated by the fact that the performance of tasks such as home visits or anthropometry are not monitored for completeness or quality by the seniors. In case of CHVs, this lack is rooted in their perceptions of having large coverage areas and top-own targets that hinder deep community engagement. Due to such attitudes of AWWs and CHVs, there is bound to be a "know-do" gap on the exit of SNEHA (for even though we might have trained the AWW and CHVs to "know" better, they may not "do" better work).

Can we motivate frontline workers of public systems to work better? Our data suggests that AWWs would be willing to work with SNEHA as long as SNEHA does not demand them to change their working patterns or increase their scope of work dramatically. Our discussions highlight that the lack of motivation of AWWs needs much more than a mere change in their current mind-sets- and has deeper roots in the kind of incentive structure they are offered, in perceptions of their work-roles, and in the historical organizational culture within ICDS that allows justification of sub-optimal work [7]. Indirect methods of working with MCGM health posts and outreach teams could be even more challenging- for there seems to be little in the scope of work of CHVs that is amenable to modification given their current work routines- unless their numbers, allotted coverage areas, and targets can be changed drastically.

Hence, a complete shift of SNEHA to "indirect" support strategies could be challenging, given the current capacity gaps that ICDS and health posts face. Importantly, many factors that motivate frontline personnel in these systems appear to lie outside the purview of SNEHA programs. It could be difficult to bring about sustainable changes in the values/perceptions/work of frontline workers in public systems based only on

motivational or capacity building efforts by SNEHA programs- if other aspects of their respective organizational contexts remain unchanged.

On bringing about convergence between ICDS and MCGM activities: SNEHA as a messenger

Bringing about convergence between ICDS and MCGM has been challenging for SNEHA due to the lack of policy-level push, differences in ideologies and work routines at the frontline, an organizational culture unsupportive and unused to sharing- and all this is exasperated by critical capacity gaps present within each sector. In such a situation, much of SNEHA's current efforts have been directed towards filling gaps in both sectors individually rather than in bringing them together. Our discussions suggest that while SNEHA staff feel that that they have not been able to glue both sectors-ICDS and MCGM-together- as well as intended, they have been able to act as data-messengers between the two sectors. Hence, SNEHA appears to be able to facilitate the sharing of critical information between ICDS and health posts; thus, filling a gap in field-level convergence, albeit temporary.

A recognition that working with systems can slow down program activities/outcomes: Need for a different lens to evaluate programs?

One important issue to note is that there is a recognition within both programs that working with public systems could slow down and restrict SNEHA's program work. The slowing down/restriction of SNEHA's has been partly attributed to the fact that there are gaps and constraints within public systems that SNEHA is not able to address (for SNEHA's efforts to be a gap-filler are directed mainly at outreach and community engagement- and the other gaps remain). Constraints within public system thus tend to constrain program activities too- and more so, when joint activities are designed in manners where SNEHA programs has less direct control. Despite this, it also very strongly believed within SNEHA programs that if working with systems would result in more "permanent" solutions in the community, then this slowing down might be a worthy trade-off. Nevertheless, despite the recognition of challenges of working with public systems, it is difficult for programs, in reality, to accept this slowing down or potential dilution of program processes when working through partners. This is because the programs within SNEHA strongly feel accountable for the better delivery of maternal and child services and for the achievement of better indicators in the community- even when these are dependent on the work of several partners. Given these sentiments, there is a need to look at how SNEHA programs that work with partners must be evaluated.

Concluding thoughts: In conclusion, the two programs we studied have undertaken a very courageous journey of working in partnerships with different public systems. The following aspects of partnerships in HCP and SNEHA center deserve much appreciation:

First, both programs, at field level, have worked extremely hard and left no stone unturned to work with both ICDS and MCGM. Much effort has gone into building and maintaining personal relationships within staff who work in public systems. It must be noted that gaining the trust of public systems- and cultivating professional relationships- has involved much persistence and investment of time and effort- by SNEHA program staff. Hence, these efforts truly deserve to be applauded.

Second, programs have also put much efforts to fill gaps within the public systems they work in. This role of SNEHA plays out very strongly in the data. Hence, the "gap-filler" role of SNEHA is likely to contribute to improving some field-level processes within public systems in intervention areas- especially pertaining to outreach and community engagement. Efforts made by SNEHA in improving outreach and community engagement have been acknowledged by all partners.

Third, SNEHA, through its work with public systems has demonstrated that "good" work can happen in the field. Public systems do see value in the ideas, protocols and processes (the SNEHA models)- and acknowledge learning from SNEHA. However, the institutional context within which these systems function (mandates of public systems that keep changing and lie elsewhere, different priorities and low incentives) results in limited uptake of these.

Third, SNEHA has not only taken the role of a gap-filler, but also acts as a data-messenger between two public systems like ICDS and the health posts, that otherwise do not get much chance to interact with each other, given their sector-specific priorities and work routines. By doing this, a critical gap in data-sharing between the two public sectors is currently being addressed.

Future directions: As an organization, SNEHA is now on the brink of making some choices on the manner of partnerships with public systems. We do not have one right answer on how programs can proceed with these partnerships, but this study highlights the following.

- SNEHA programs find it challenging to work with field/administrative levels of public systems without higher-level buy-in.
- There are critical capacity gaps within the public systems that SNEHA works with. SNEHA programs are seen by the systems as having value in addressing some of these gaps- especially those pertaining to outreach and community engagement. It was felt that a listing of these gaps-and SNEHA's supportive role- must be discussed with public systems- during early stages of program design.
- At the same time, SNEHA may not be able to address all constraints within public systems. Since it cannot address all constraints within systems, SNEHA must endeavour not to allow constraints of public systems to become constraints for its programs.
- SNEHA can take on the role of being a data-messenger between two public systems like ICDS and MCGM.

- SNEHA can build capacities of frontline workers in public systems- in both formal and informal ways. However, the attitudes and motivations of these workers are not easy to change- without supportive changes in the broader organizational context they belong to.
- Programs express a need to balance quick accomplishment of program goals with more sustainable, but long-term solutions. The more dependent SNEHA programs are on partners, the achievement of program goals is a gamble- since the program loses direct control over interventions. Given this, a combination of activities that are "direct" and "indirect" might be a way forward; but getting to a good combination strategy may involve some experimentation.

Limitations of this study

Within the scope of this study, we did not include perspectives of the beneficiary community. However, we have other studies that give insights on this aspect. Also, when we began this study, community groups were just being formed by the programs and hence we felt it was too early to study these groups.

We also focussed only on the frontline work of the systems. We have defined frontline workers loosely as those who interact directly with the beneficiary community. We also did not focus on external context much and it would have been interesting to study how this external context affects convergence.

Also, we saw several dynamic changes taking place in the public systems even as we embarked on this study. In general, frontline worker roles are getting more formalised. When we begun the study, ICDS was giving fortified food, but very recently, it switched to the provision of raw ration (wheat, rice, and pulses) whose demand in the community is great. A mandate has been issued that these rations can be given only to families where children have been completely immunized. These changes might aid better convergence between ICDS and MCGM with regard to immunization in future.

Lastly, we studied only two informal settlements with regard to convergence. In other places in Mumbai, the scenario could be different. But from what we have seen in literature within India and in countries with similar contexts [viii,ix]. there is reason to believe that implementation challenges do exist with regard to cross-sector action.

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