



Abridged Report December 2006

**FOCUS**  
**ON**  
**CHILDREN**  
**UNDER**  
**SIX**



**Focus**

**On**

**Children**

**Under**

**Six**

**Abridged Report**

December 2006

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# Preface

This report is the outcome of a collective effort to bring children under six closer to the centre of attention in public debates and democratic politics. Many people have taken part in this long journey, in visible and less visible ways, and it is impossible to mention them all. A few milestones are mentioned below.

The report builds on a field survey of the Integrated Child Development Services (ICDS), conducted in May-June 2004 in six states: Chhattisgarh, Himachal Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. We shall refer to this survey as the "FOCUS Survey". Most of the field investigators were university students who worked without remuneration. We are grateful to all of them, not only for cheerfully facing the hardships of fieldwork in the torrid summer heat, but also for their help with the interpretation of the findings. The report draws on their personal observations as much as on the survey data. Among those who facilitated the survey, we would like

to thank Anuradha De, Claire Noronha, Kavita Srivastava, Meera Samson, Sudha Narayanan, and Swati Das, as well as the local organisations that hosted and helped the survey teams in the field.

Another important activity was the workshop on "Universalization with Quality: An Agenda for ICDS", held at the National Academy of Administration in Mussoorie in November 2004. The proceedings of this workshop were published in *Economic and Political Weekly* on 26 August 2006. We are grateful to the authors, as well as to other participants of the Mussoorie workshop, for their insightful contributions.

The report draws quite freely on earlier writings by various members of FOCUS' "extended family". We have done our best to mention the original sources, without burdening the text with frequent footnotes. We are also grateful to those who have contributed "boxes" on various topics to this report: A.K. Shiva Kumar, Anita Rampal, Anjali Alexander, Antu Saha,

Anuradha Khati Rajivan, Arun Gupta, Deeksha Sharma, Devika Singh, Enakshi Ganguly Thukral, Govinda Rath, Gurjeet, Indu Kaura, Joel Lee, Jon Rohde, Kiran Bhatta, Leela Visaria, M. Kumaran, Madhu Sarin, Mina Swaminathan, Mirai Chatterjee, Mridula Bajaj, Rolly Shivhare, S. Anandalakshmy, Sachin Kumar Jain, Samir Garg, Sandip Naik, Shalini Tai Moghe, Shantha Sinha, Shanti Ghosh, Shraddha Kapoor, Sudha Narayanan, Sudha Sundararaman, Sukhdeo Thorat, Surabhi Chopra, T. Sundararaman, Tara Gopaldas, Usha Rane, and Vimala Ramachandran. Special thanks are due to Anita Rampal for helping to write the section on early childhood education.

We would also like to thank those who sent material that could not be included in this abridged version of the report, for one reason or another. Every piece of evidence on the situation of children under six is valuable, and we have tried to make the best possible use of the material sent to us. However, not every contribution received could be included, whether it was to avoid duplication or due to constraints of space or readability.

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Aside from written material, the report builds on a long series of discussions, meetings, workshops and conventions held during the last few years. Special mention should be made of the "Convention on Children's Right to Food", held in Hyderabad on 7-9 April 2006 (for further details, see [www.righttofoodindia.org](http://www.righttofoodindia.org)). Like the branches of a banyan tree, each of these events had other offshoots, and a warm collective acknowledgement is due to all those who have helped to take this process forward – from keynote speakers to those who quietly helped with translation, logistics and other arrangements.

This report was put together by Citizens' Initiative for the Rights of Children Under Six (CIRCUS). As the acronym suggests, CIRCUS is an informal entity. It is a small work team, which effectively acts as a "bridge" between the office of the Commissioners of the Supreme Court and the secretariat of the Right to Food Campaign. CIRCUS has no fixed membership, but to give you an idea, those who actively contributed to

this report include Biraj Patnaik, C.P. Sujaya, Devika Singh, Dipa Sinha, Gurminder Singh, Harsh Mander, Jean Drèze, Navjyoti, Nandini Nayak, Reetika Khera, Shonali Sen, Spurthi Reddy, Vandana Bhatia, Vandana Prasad and Vivek S. Many of us actively participated in the FOCUS survey.

Aside from CIRCUS artists, some "real" artists lent their skills to the preparation and production of the report. Special thanks are due to Anuradha Madhusudhanan for cover design, Christian Oldiges for help with data analysis, and Sohail Akbar and Arudra Burra for editorial help.

This abridged report was prepared for "Bal Adhikar Samvad", a public meeting on the rights of children under six held in Delhi on 19 December 2006. It will be revised and expanded soon for wider circulation. If you have any comments or suggestions for improvement, please send us a line at the address below – we will be glad to hear from you.

**Citizens' Initiative for the Rights of Children Under Six**

**December 2006.**

## Important Clarification Relating to “NFHS-3” Data

The findings of the Third National Family Health Survey (“NFHS-3”, conducted in 2005-6) are in the process of being released as this report goes to print. Due to unexpected delay in the official release of the NFHS-3 results, particularly those related to all-India statistics, detailed presentations of NFHS-3 data were removed from this report at the last minute. However, we have retained NFHS-3 data available from the NFHS website

([www.nfhsindia.org](http://www.nfhsindia.org)), or obtained from early media reports and other informal sources. While state-specific NFHS-3 figures presented in this report are the “official” figures posted on the NFHS website, the occasional references to all-India figures (e.g. in Table 2.2) should not be considered as authoritative until the official release of the full NFHS-3 findings.

14 December 2006





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# Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
CDPO	Child Development Project Officer
DPEP	District Primary Education Programme
ECCE	Early Childhood Care and Education
FOCUS	Focus On Children Under Six
ICDS	Integrated Child Development Services
IYCF	Infant and Young Child Feeding
LHV	Lady Health Visitor
NHE	Nutrition and Health Education
NRHM	National Rural Health Mission
PDS	Public Distribution System
PHC	Primary Health Centre
PMGY	Pradhan Mantri Gramodaya Yojana
PUCL	People's Union for Civil Liberties
PSE	Pre-School Education
RTE	Ready-To-Eat
SNP	Supplementary Nutrition Programme
THR	Take-Home Rations
WFP	World Food Programme





# 1. Child Rights and Democracy



Arindam Saha

## 1.1. Introduction

Imagine what would happen if a gardener were to grow flowers by depriving them of sunshine and water for a few weeks, allowing anyone to trample on them, and then “catching up” with heavy doses of fertilizer. No doubt he or she would be considered singularly lacking in common sense. Something like this, however, is being done to Indian children. Most of them are left to their own devices until the age of six years,

when they are finally herded into school. Yet the first six years of life (and especially the first two years) have a decisive and lasting influence on a child’s health, well-being, aptitudes and opportunities.

The consequences are staring at us. About half of all Indian children are undernourished, more than half suffer from anaemia, and a similar proportion escapes full immunization. Few countries in the world have such poor indicators of child well-being.

For instance, according to the latest Human Development Report, India has the highest proportion of undernourished children in the world, along with Bangladesh, Ethiopia and Nepal. This humanitarian catastrophe is not just a loss for the children concerned and their families, and a violation of their fundamental rights, but also a tragedy for the nation as a whole. A wholesome society cannot be built on the ruins of hunger, malnutrition and ill health.

Against this background, there is an urgent need to reexamine what India is doing for the survival, well-being and rights of children under the age of six years (hereafter “children under six”). Broadly speaking, two types of intervention are needed. There is, first, a need to address the structural roots of child deprivation, including mass poverty, social discrimination, lack of education, and gender inequality. Second, there is a need for immediate protection of children under six, by

integrating them in an effective system of child development services that leaves no child behind. It is with this immediate task that this report is concerned.

This report is not just a “research” document. It does build, we hope, on sound research. But it is first and foremost an action-oriented report, aimed at facilitating public action for the rights of children under six. Every concerned citizen (including you, the reader) has something to con-

### Box 1.1. Infant Survival: A Political Challenge

In the Indian context, for the poor, the safe delivery of a healthy child and the survival of both mother and child cannot be taken for granted. A political regime that tolerates inequitable access to health and nutrition, and has little care for the respect and well-being of its infants and mothers, is not fully democratic. The process of ensuring that every child is taken care of as a matter of right involves societal pressure through public action, and democratization of all public institutions. It is a reflection of the country’s normative framework, its legal framework, its institutional framework, its power balances and priorities. In this sense, survival of the child and the mother is an indicator of the health of Indian democracy.

To ensure that every child is healthy, nourished and well taken care of is to unravel ideological positions, policy frameworks and structures of power operating at the family, community, state, national and global levels. These issues rarely come up for serious discussion and debate, and even political parties seldom think through the required interventions, or work out their intricacies. It is often not even considered important for electoral politics or for the functioning of democracy.

The fact is that taking care of infants or pregnant women is not just another sop or welfare programme, but central to the functioning of democracy. Public action that insists on universal access to institutions such as Primary Health Centres and ICDS exposes existing policy gaps and indifference in the system. This paves the way for compelling changes in the delivery of services, in favour of young children and women. It is in this struggle for the right to health that structures of domination and power unfold. These rest on values that are deeply entrenched in the system. As they unfold, it is evident that they are linked to the entire state apparatus and the structures that gain from the appalling health condition of infants and mothers. Such a process of public action would bring issues related to child health and nutrition centre stage in India’s democracy. It involves the deepening of democracy and emergence of leadership concerned with children and their rights.

In a true democracy, every child must be regarded as indispensable and the government must be held accountable for the deaths of children and mothers. Preventing infant mortality and ensuring child health require a policy framework based on this uncompromising norm. This would mean universal cov-

erage, professional services, investments without calculating costs, and sound institutional care and protection for all children, cutting across social and political hierarchies. Doing so is not easy as the poor have to compete with more powerful forces, whose priorities do not necessarily include the well-being of children.

Public action involving local institutions as well as larger support structures at the state and national levels, enabling the community to question and negotiate with authorities to deliver services, would pave the way for enhancing every child’s access to the ICDS and making it an institution for protecting the rights of children under six. This would involve participation of people in decision-making processes, and thus democratizing public spaces. ICDS too must be seen as a site for contestation of power.

Democracy is nurtured only when, through public action and pressure, the system begins to perceive violence and is compelled to bring about substantial change in favour of children’s right to health and well-being. Every malnourished child challenges the edifice of anti-democratic forces and alliances.

*Contributed by Shantha Sinha.*

tribute to this endeavour. Effective action, however, requires a sound understanding of the basic issues. It is in this spirit that we begin, in this chapter, by placing the rights of children under six in the larger context of democratic politics. This is a natural starting point, since the state of Indian children ultimately reflects a deep lack of political commitment to children's rights.

## 1.2. Children and Democratic Politics

India is often described as “the largest democracy in the world”. Largest it certainly is, but what about the quality of democracy? On this, different views are possible. If we focus on the health of democratic institutions, India does not look too bad in international perspective. It has a credible electoral system, a functioning parliament, an independent judiciary, a free press, vibrant social movements, a strong “argumentative” tradition, and so on. On the other hand, if we think of democracy as “government of the people, by the people and for the people”, there is still a long way to go. Indeed, most people have very limited opportunities to participate in these democratic institutions, due to poverty, lack of education, social discrimination, and other forms of disempowerment. Meanwhile, privileged sections of society (affluent classes, the corporate sector, the military establishment, and so on) have a powerful influence on demo-

cratic processes and public policy. This is why, sixty years after independence, so many people in India are still deprived of many essential facilities: health care, safe drinking water, quality education, social security, to cite a few.

In this lopsided democracy, where the concerns of poor people often count for very little, the well-being and rights of children count for even less. Indeed, poor children are twice removed from the centre of attention: not only do they belong to families that have little voice in the political system, they also have no voice within the family.

One symptom of the marginalization of children (especially young children) in Indian democracy is the low coverage of children's issues in the mainstream media. The point is illustrated in Table 1.1, which presents simple “counts” of articles on various topics published in *The Hindu*, one of India's leading national dailies. The elitist orientation of the mainstream media emerges clearly in several ways. First, the level of attention rises sharply as one moves to successively higher levels of the education system. For instance, “primary schools” receive more than twice as much attention as “anganwadis”\*, “secondary schools” six times as much, and “universities” nearly forty times! Similarly, “primary education” is mentioned twice as frequently as ICDS, “secondary education” three times, and “higher edu-

cation” twelve times. The “Nobel prize” alone received almost as much attention as ICDS during the last three years.

Looking beyond education-related articles, the elitist bias of the mainstream media emerges again in various ways. For instance, “nuclear weapons” are mentioned as frequently as “primary education”, and “foreign direct investment” receives almost as much attention as “child health”, “child rights” and “child development” combined. A separate count also shows that in 2006 the so-called “nuclear deal” between India and the United States hogged twice as much attention as ICDS. It is worth adding that *The Hindu* is a relatively progressive newspaper, which devotes more space than most other national dailies to social issues. The elitist bias of the mainstream media would probably be even starker if we were to look at other dailies, especially business papers.

A similar point can be made about the coverage of children's issues in parliamentary debates. According to a recent analysis of parliamentary proceedings by HAQ: Centre for Child Rights, only *three per cent* of the questions raised in Parliament during the last four years related to children. Even these questions were usually prompted by media reports, rather than by a sustained interest in children's issues. Further, among the child-related questions, less than 5 per cent were concerned with child

\* If you are not familiar with the terms “ICDS”, “anganwadi” and so on, please take a look at Section 3.1 and come back.

**Table 1.1. Children's Issues in the Media**

Keyword	Number of articles (published in <i>The Hindu</i> ) where the keyword appeared			Average number of articles per month, 2004-6
	2004	2005	2006 <sup>a</sup>	
<b>1. Institutions of learning</b>				
Anganwadi(s)	440	412	297	34
Primary schools(s)	896	976	800	79
Secondary school(s)	2006	2247	2031	185
University	13670	16030	13340	1266
IIT <sup>b</sup>	867	1079	950	85
<b>2. Education systems</b>				
ICDS <sup>b</sup>	147	182	115	13
Primary education	322	284	211	24
Secondary education	385	468	409	37
Higher education	1650	1750	1990	158
Nobel prize	121	124	88	10
<b>3. Other Issues</b>				
Child health <sup>c</sup>	183	201	140	15
Child rights <sup>d</sup>	186	193	173	16
Fashion show(s)	203	262	196	19
Shopping mall(s)	156	242	270	20
Child development	263	321	246	24
Nuclear weapon(s)	250	291	301	25
Nuclear power/energy	214	341	434	29
Special Economic Zone(s)	273	458	701	42
Foreign Direct Investment	617	799	499	49
Bollywood	851	1280	1160	97
Cricket	4040	3640	2930	312

<sup>a</sup> Up to 21 November.

<sup>b</sup> Including both "acronym" version and "full form" version.

<sup>c</sup> Including also "child's health", "children health", "children's health", etc. Note that the figures in this row are overestimates, because of overlap between these keywords (the same remark applies to "child rights", which includes "child's right(s)", "children's right(s)", etc.).

Source: Compiled from on-line archives of *The Hindu* (one of India's leading national dailies), available at [news.google.com/archivesearch](http://news.google.com/archivesearch). The figures indicate the number of articles in which a particular "keyword" appeared. For instance, the term "secondary education" appeared in 468 articles in 2005.

care and development in the age group of 0-6 years. Finally, “health and nutrition issues of children attract the least attention of the parliamentarians” (see Box 1.2). There is a sobering picture here not only of dismal neglect of children in parliamentary debates but also of virtual invisibility of children under six and their basic needs.

While children’s issues have received little attention so far in democratic politics and public policy, this

situation is not immutable. Indeed, in spite of its limitations, Indian democracy provides some space for disadvantaged groups to organize and defend their rights. In the case of children, this has to be done largely by others on their behalf, since children have no voice of their own in the system. As mentioned earlier, all concerned citizens can contribute to this process. That is why this report ends with a chapter on “What We Can Do”.

### 1.3. Child Care as a Social Responsibility

It is tempting to think that the care of young children is best left to the family. Parents are indeed best placed to look after young children, and generally do care for them. However, this does not obviate the need for social intervention, for at least four reasons (in addition to the possibility that some parents may simply “neglect” their children).

#### Box 1.2. Children’s Issues in Parliament

*Members of Parliament can collectively influence the Government to take more proactive measures to promote the welfare of children.*

(Shri Somnath Chatterjee, inaugural lecture on ‘Issues Pertaining to the Rights of Girl Child’, New Delhi, May 2006.)

The issues raised and discussed in Parliament are a good reflection of the priorities of elected representatives and the government. Children, of whom 16.4 crores are under the age of six years, constitute over 42 per cent of India’s population. And although they do not vote, they are citizens too, making those elected to the legislature as representative of them as of their adult counterparts. But do the elected representatives always take their role as representatives of young citizens seriously? Or do they tend to forget them, waking up intermittently when crisis strikes? Even more important, what are the issues that catch their attention and how are they identified?

A recent analysis of parliamentary proceedings (number of questions and nature of debates) by HAQ: Centre for Child Rights, reveals the following patterns.

- Only 3 per cent of the questions raised during the last four years related to children. Most of them related to an ongoing debate, discussion or coverage in the media.

- Health and nutrition issues of children attract the least attention of the parliamentarians. Only 11.4 per cent of the child-related questions raised in the last three years pertain to children’s health. This is despite the serious challenges confronting children’s health: today, one third of all malnourished children live in India and 30 percent of the global neo-natal deaths occur in India.
- It is clear that education draws maximum attention, with 58.9 per cent of the child-related questions devoted to it. And yet the Right to Education Bill remains to become a law.
- Only 4.6 per cent of the child-related questions raised in the last three years pertained to early childhood care and development - including questions related to crèches, day care services and ICDS, one of the ‘flagship programmes’ of the Government.
- The interest in ICDS fluctuates. In 2004, on average 2.7 per cent of all child-related

questions pertained to ICDS (3.4 per cent in the budget session and 1.9 per cent in the winter session). The questions relate to coverage, implementation of Supreme Court orders, and the situation of anganwadi workers. The proportion increased to 3.8 per cent in 2005, although the main concerns remained the same.

- About 20 per cent of the child-related questions focused on the protection of children against exploitation and abuse.

In recognition of the importance of paying attention to the young citizens of India, a ‘Parliamentary Forum on Children’ was launched on 2 March 2006, for the first time in India’s history. The forum aims to enhance awareness of children’s issues among parliamentarians, to ensure their rightful place in the development process. The children of India await the day when their elected representatives will truly represent them with the commitment and passion they deserve.

*Contributed by HAQ: Centre for Child Rights*

First, many parents are unable to take adequate care of their children due to poverty and powerlessness. This powerlessness, of course, also needs to be addressed through social intervention (e.g. land reforms, employment programmes and income redistribution). But children cannot afford to wait until these longer-term issues are resolved.

Second, what parents do for their children often depends on various forms of social intervention, such as the provision of public facilities. For instance, if health services of good quality are conveniently accessible, parents are more likely to look after their children's health. Similarly, while adequate breastfeeding (one of the major determinants of child nutrition) may not seem to require social support, it can actually be very difficult in the absence of provisions such as worksite crèches and maternity entitlements.

Third, many parents have limited knowledge of matters relating to child care and nutrition. To illustrate, in a recent study in Uttar Pradesh, half of the sample children were found to be undernourished, yet 94 per cent of the mothers described their child's nutritional status as "normal". On breastfeeding, too, folk wisdom can be quite limited and even plain wrong, in spite of thousands of years of experience. For instance, breastfeeding is often delayed for several days after birth based on the erroneous belief that a mother's first

breast milk ("colostrum") is harmful for the child. Feeding children is not as simple as it looks.

Fourth, social norms are very important in this field. For instance, the inclination of parents to immunize their children often depends on whether "other people" in their family, community or village do it. And food habits, of course, are mainly social rather than individual attributes. Here again, there is scope for social intervention, for instance in the form of awareness campaigns or just public debate.

For all these reasons, the care of young children cannot be left to the family alone. Social intervention is required, both in the form of enabling parents to take better care of their children at home, and in the form of direct provision of health, nutrition, pre-school education and related services. In short, child care is a social responsibility.

This responsibility should not be regarded as a burden. It is, in fact, an important means of social progress. This is "what our children taught us", as Mirai Chatterjee puts it based on many years of experience with SEWA's child care centres (see Box 1.3). As the author points out, public involvement with child care is not just about averting infant mortality or preparing children for school. It also serves many other goals: the wholesome growth of every child as a human being; the removal of poverty and

deprivation; the healthy socialisation of children; the realisation of the right to education and other fundamental rights; the elimination of social discrimination; the growth of collective solidarity; and so on. Socialised child care also contributes to the liberation of women in various ways: it reduces the burden of looking after young children, provides a potential source of remunerated employment for women, and gives them an opportunity to build women's organisations. It is in the light of these rich contributions of child care to social progress that the issue deserves far greater attention in public policy and democratic politics.

In practical terms, one important means of social intervention in this field is the Integrated Child Development Services (ICDS) – the only major national programme that addresses itself to the needs of children under six. There is a special focus on ICDS in this report, and also a vision for it: "universalization with quality". This is discussed at greater length in Chapter 3. The FOCUS survey, which is the cornerstone of this report from Chapter 4 onwards, also concentrates on ICDS.

Having said this, it is important not to lose sight of other necessary interventions that need to complement ICDS. These include crèches and maternity entitlements, which are also essential to the realisation of



### Box 1.3. What Our Children Taught Us

The Self-Employed Women's Association (SEWA) is a union of nearly 8 lakh women workers of the informal economy. It has promoted two cooperatives and three associations which provide child care for 10,000 young children. This experience has taught us a great deal about the different social roles of child care.

*One, child care facilitates poverty reduction.* Our members say, "with child care, we can work and earn and bring vegetables and dal for our children. Otherwise we eat rotla and marcha (roti and chillies)". We have repeatedly seen that when child care is available for the children of poor women workers, and during their hours of work, they are able to work and earn more. Studies in Kheda and Surendranagar districts report income increases of fifty per cent upwards for these mothers.

*Two, child care results in children's overall development.* We have had hundreds of sick and malnourished children who are completely changed individuals as a result of proper care. We have numerous examples of children who barely walked and talked because of physical or mental challenges. With love, care and encouragement they catch up with other children.

*Three, child care leads to women's development and overall well-being.* Child care reduces women's stress levels. Our members often say, "Since these centres started, I can work and earn in peace. I am no longer tense and worried about my child. And when I come home tired, I'm glad to see my child well-fed and happy."

*Four, child care encourages school-going.* In two 'melas' of our crèche 'graduates', child after child spoke about how important crèches were in encouraging school-going. The emphasis on equality of girls and boys has also (perhaps) encouraged girls to attend school, even high school, quite uncommon for poor families. Our crèches also release older siblings from child care responsibilities. In our

Kheda study, we found that 70 per cent of the children attended school for the first time after crèches were started in their villages. This, in and of itself, is a powerful case for starting crèches in every village and urban settlement.

*Five, child care breaks down caste, class and other social barriers.* Our children hail from all faiths and all sections of our multicultural, multilingual and ethnically diverse society. In our crèches, children of all castes and communities play and learn together. Needless to say, this is not an automatic or easy process. For instance, we were once given spacious rooms in the temple precincts for a crèche in a village. However we were told to vacate the premises once the temple authorities learnt that most of our children were from the Dalit community. In several villages, mothers also objected to one or the other crèche teacher because of her caste, or to children of all castes eating and playing together. In a couple of villages we were even forced to close down the centres in the face of strong opposition by the village community. But we held our ground. The firm stand has paid off and we now have the full backing and appreciation of the poorest of families and communities.

*Six, child care centres are a focal point for building women's organizations and community development.* Child care serves as an entry point for organization building and for promoting overall community development. At our crèche in Rasnol village of Kheda district, women defied the power of tobacco growers and factory owners through a mass sit-in - a first in the district's history. The 'dharna' went on for days and much of the struggle was led by women whose children had been or were in the village's crèche. The fact that the struggle was a success, resulting in payment of their dues, strengthened women's determination to organize as well as their commitment to crèches and SEWA.

*Seven, child care centres can be a focal point for disaster management.* Over the past five years our members, particularly in the poor-

est districts of Gujarat, have had to face repeated natural disasters. SEWA's crèches in these districts not only took care of the children but also acted as a point for the distribution of emergency relief materials - food, water, tents and medicines. This also helped to set up a chain of long-term rehabilitation activities.

*Eight, child care is an opportunity for wider capacity building.* SEWA has started a special training "school", Balanand Shala, for in-depth and on-going capacity-building of the child care teachers and teams. We experiment with new activities for the children and sharpen teachers' knowledge and skills on various issues - child development, health, social sciences, geography to mention a few.

Aside from running its own child care centres, SEWA has been involved in policy action to promote child care. Perhaps our earliest policy breakthrough was one involving ICDS. When the government offered ICDS to SEWA, it insisted that all the teachers had to be high school graduates. It took us two years to convince the authorities that higher education levels do not necessarily mean that a woman is a better child care worker.

Starting crèches for salt workers' children in Surendranagar district was another such breakthrough. Although funds were available in the salt workers welfare fund, no one thought of using it for 'children of the desert'. After protracted negotiations, the first crèches for salt workers' children were started.

Finally, after months of discussion, Gujarat has set up a special forum with government, people's organizations and NGOs to regularly discuss the needs of young children, monitor ongoing programmes and plan future ones. This was undertaken after SEWA wrote a letter to the state government suggesting the need to create a child care forum.

*Contributed by Mirai Chatterjee.*

children's right to food, survival and development (see Boxes 1.4 and 1.5). Adequate health services, of course, are equally critical. The special focus on ICDS in this report should not detract from this larger concern with the rights of children under six.

## 1.4. How Rights can Make a Difference

Earlier in this chapter we have noted that children's issues, especially the needs of young children, are deeply neglected areas of public policy in

India. We have also argued that child care is, ultimately, a social responsibility. Both issues call for much stronger affirmation of the fundamental rights of young children.

The value of a "rights approach" to social development has been well

### Box 1.4. What have Maternity Entitlements got to do with Children's Rights?

The rights of women and children are intertwined during the first six years of life and the health of children is intimately connected with the conditions in which their mothers work. Maternity entitlements (covering the provision of leave and benefits during maternity, nursing breaks and the facility of a crèche) are often viewed as a labour issue, a "woman as worker" issue. However, these entitlements intimately affect the primary conditions for the survival and growth of children including their rights to breast milk, safety, care and security; analogously treated as children's issues. This dichotomy in thinking has deeply affected the outcomes of public policy in this field.

Currently maternity entitlements as a right are available only to women employed in the organised sector - a mere 7 percent of all women workers. This leaves 93 percent of all women workers out in the cold or heat to manage the critical period of pregnancy, birth, breast feeding and infant care, as best they can. Understandably they have not been doing too well on that score.

Women manage work and childcare at great cost to their health and that of their children. With more women joining the unorganized workforce, they are out of the house for many hours of the day. They work in unprotected environments - in fields, forests, construction sites; as hawkers, domestic help, on piece-rate contract work and as cheap labour. They are open to exploitation, mostly lacking in family support systems, and entirely lacking in so-

cial security. It is not difficult to imagine what happens to infants and young children in such circumstances, which scarcely nurture survival and growth.

According to the Survival Series published in *The Lancet* in 2003, "breast feeding can prevent 13-16 percent of all child deaths". Breast milk is the first most important weapon in the fight against malnutrition and disease. However, the prime requirement to enable breastfeeding, is proximity of mother to child for the first six months, if not more. In the above conditions of women's work, and within the current framework of programmes designed for children, this is not a possibility. Maternity entitlements and crèches are the bonding glue that bring mother and child into proximity so that breastfeeding can take place. These entitlements are also necessary to ensure that an informed and caring adult is present and can provide the essential care required for survival, growth and development of the infant.

This link is well understood and accepted globally. The Convention on the Rights of the Child recognizes the child's right to breastfeeding and care. Article 11 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) clearly recognizes the period from pregnancy and birth to early childcare as special. It also calls for maternity protection and other essential measures to end discrimination and promote women's right to equality, as does the ILO Maternity Protection 2000.

Closer home, it is time we take a serious look at current gaps in thinking if the health

and well-being of women and children is to be ensured. This would mean, first and foremost, a closer examination of the maternity entitlements in place. Coverage, for one, is very limited. The Maternity Benefits Act and ESI Act for instance only cover women working in the organized sector. The National Maternity Benefit Scheme (NMBS) similarly only covers women identified as below poverty line (BPL). The total financial outlay for NMBS is also limited to a paltry Rs 500 per birth. While a handful of states have initiated schemes, the majority of them have still to do so. Tamil Nadu provides an outstanding example having recently announced an entitlement of Rs 1000 per month for six months. This will enable a woman to stay out of the workforce and breast feed and care for her infant—a luxury beyond the reach of most women.

What is needed is the following: First, maternity entitlements are due to all women, including adoptive mothers. There should be no discrimination on grounds of age, marital status, number of children or any other basis, though poverty may be the criterion for priority. Second, entitlements should start from two weeks before child birth and continue for six months after. Third, the amount must be prevailing wages for women who are employed and minimum wage for those working without wages. Finally, we need crèches at workplaces, in neighbourhoods and as part of the design of ICDS. Only then can the health and well-being of women and children be ensured and their rights be protected.

*Contributed by Devika Singh.*



demonstrated in recent years. Wider acknowledgement of elementary education as a fundamental right (recently expressed in the 86<sup>th</sup> constitutional amendment) has contributed to the rapid expansion of school

education in the nineties, evident in age-specific literacy data from the 1991 and 2001 Censuses. The Right to Information Act 2005 has lifted the veil of secrecy from government documents, a major step towards

restoring accountability in public life. Supreme Court orders on the right to food have forced the government to take major initiatives in this field, such as the provision of cooked mid-day meals in primary schools.

### Box 1.5. Creches: Are they Worth the Investment?

*“What do the children do?”*

*“The children? They play around, what else? We go for tussar reeling for 5-6 hours a day. The older children take care of them.”*

*“Yes, there are elders, they keep an eye on them, but feel they are too old to run around with young children. Leave your daughter at home, they say.”*

*“Yes, the young ones often get hurt... we worry a lot about the older children too... they learn bad habits from the men sitting around, swear and start playing cards and get into fights.”*

*“What about your sister-in-law, she has young children too?”*

*“Now we are all separate.. No one wants responsibility for other people’s children ... and then, she too has the cattle to feed and the bhunta to dry.”*

(Voices from a Jharkhand village)

Scientists say that 90 percent of the brain develops by the age of five. Economists tell us that prevention is more cost effective than cure. Child specialists know that the early years are foundational to development. And yet, we ignore the evidence and neglect our young. We continue to lose 6 percent of our newborns before their first birthday, 50 percent of our toddlers to malnutrition and a whole generation to poor health, low skills and poverty. Can we afford to ignore the role that crèches play in the survival, development and well-being of young children?

Of the 16 crore children under six, 40 percent belong to families on or below the poverty line. With more and more women

participating in the workforce and the breakdown of family support systems, crèche and childcare arrangements are no longer a peripheral issue but a necessity for 6 crore young children. These arrangements can no longer be viewed as a facility for the career oriented woman, who has a choice between motherhood and greater economic independence. Despite this only 22,038 crèches have been sanctioned under the Rajiv Gandhi Crèche Scheme, against a requirement of about 8 lakh crèches. Can we afford this gap?

A crèche essentially facilitates an aware adult to take on the small tasks involved in childcare for children under 3 years of age such as patient feeding of small *katoris* of soft food three-four times a day; a quick response to fever or diarrhoea to prevent illness from becoming life-threatening; someone to greet and comfort the child when she wakes up. A crèche is not just an enabling mechanism so mothers can work, but central to the battle against malnutrition, low birth weight and infant mortality.

We need crèches at workplaces to facilitate continued breast feeding and complementary feeding. We also need creches in neighbourhoods and as part of Anganwadis to provide safety, care, and address the learning needs of the under threes. We need crèches so that grandparents don’t ask for girls to stay back leaving them free to play, run and go to school. We need crèches so that women are treated as citizens with rights and receive the support they need during this time of motherhood and early childcare, thus enabling them to participate in work and life.

Despite the above, ICDS, the major national programme for the young child, does not include crèche as part of its design. This is a critical gap.

*“The Anganwadi? Yes, I have seen it. The didi comes for a little while to distribute food ...”*

*“What about a crèche?”*

*“What’s that?”*

*“A place where the children can be looked after by a didi- someone from your village, where the children can eat in time, be clean, and play”.*

*“Who will do this? We cannot even in our dreams think that our children will ever grow up in any other way.....”.*

Can the ICDS truly realize its goals without including the component of care and protection for young children, which crèches provide? How can food supplementation and immunization achieve their aims if the care giver is not present to ensure patient feeding and cleaning?

What will it take to make this change in ICDS? It will require hard decisions on minimum norms that must be strictly adhered to: adequate and safe space which most anganwadis lack; training, fair remuneration and support for woman who care for under three’s; longer working hours; simple equipment for cleaning and feeding, rest and play; mechanisms for more interaction with mothers. Does that mean higher cost? Yes. With better outcomes? Certainly.

*Contributed by Devika Singh.*

Similarly, the National Rural Employment Guarantee Act has empowered rural labourers and reversed the long-standing neglect of rural employment in public policy.

In the light of these experiences, there is a case for more active use of the rights approach in the context of children's issues, including the survival and well-being of children under six. Children's rights are not, of course, a new idea. The idea is conveyed in the Indian Constitution, notably Article 39(f), which directs the state to ensure that "children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity". For children under six, Article 39(f) is reinforced by the new version of Article 45, introduced with the 86<sup>th</sup> Constitutional Amendment: "The State shall endeavour to provide early childhood care and education for all children until they complete the age of six years". These Articles belong to the Directive Principles, and should be read along with Article 37, which states that these principles are "fundamental to the governance of the country", and that "it shall be the duty of the state to apply these principles in making laws". As Article 39(f) and 45 illustrate, the Directive Principles (largely due to Dr. Ambedkar) include a visionary emphasis on "positive freedoms". The government's formal commitment to child rights and positive freedoms was further affirmed in the international Convention on the Rights of the Child

(see Box 1.6). In practice, however, little has been done to protect and promote the positive freedoms of children as a matter of right.

The primary role of the rights approach is to change public perceptions of what is due to Indian children. In particular, the rights approach can help to put children's issues on the political agenda, and to forge new social norms on these issues. To illustrate, the recent recognition of elementary education as a fundamental right of every child has helped to dispel the resilient notion that education is "unnecessary" for some sections of society. A similar consensus needs to be built regarding the rights and entitlements of children under six.

Aside from its political value, the rights perspective has practical implications for public policy on child development services. First, this perspective is the main foundation of the demand for "universal" child development services. Indeed, one implication of the rights approach is that all children are entitled to certain "opportunities and facilities" (as the Constitution puts it) that do not have to be justified on a case-by-case basis, let alone submitted to cost-benefit tests. The main role of ICDS (and specifically, of the anganwadi) is to act as an institutional medium for the provision of these facilities: supplementary nutrition, immunization services, health care, and joyful learning, among others.

Second, the rights perspective points to the need for strong monitoring and redressal mechanisms, so that people are able to claim their entitlements. As discussed later in this report, there are few redressal mechanisms in the present scheme of things. In some states, for instance, nutrition programmes under ICDS have been interrupted for months at a time without any action being taken. One reason for this apathy is that these services are regarded as a form of state largesse, rather than as enforceable entitlements.

Last but not least, the rights perspective highlights the possibility of putting in place legal safeguards for children's rights. Many Indian laws, of course, deal with children's rights in one way or another. But these legislative provisions tend to be of a "negative" kind, in the sense that they are aimed at protecting children from various evils (such as child labour or child marriage), rather than at guaranteeing the positive "opportunities and facilities" mentioned in Articles 39(f) and 45. The proposed Right to Education Bill, flawed as it may be, is an example of the sort of legislation required to guarantee positive freedoms to Indian children. More can be done in this respect, including similar legislation for children under the age of six years.

The rights approach, of course, can be extended beyond the realm of "child development services". Indeed, the protection of children's rights

### Box 1.6. Legal Safeguards for Children's Rights

The Convention on the Rights of the Child (CRC) aims to protect the civil, political, social, cultural and economic rights of the child. While India ratified the CRC in 1992, Indian law relating to the child is ad hoc, often inconsistent and does little to secure the rights of children. Indian laws relating to children view the child not as an individual bearer of rights, but as part of the family unit or as the responsibility of an adult. Consequently their rights, if any, derive from and are an adjunct to the rights of the family or the adult in question. Moreover many laws relating to children are implemented only partially if at all, leaving many aspects simply unaddressed by the Indian state. Some critical failures are highlighted here.

Who constitutes a child? One stark indicator of the scant legal protection they enjoy is the inconsistent definition of a child under Indian law. Different laws specify different ages up to which an individual is deemed to be a child. For instance although a child is a person below 14 years of age under the Child Labour (Prohibition and Regulation) Act 1966, the age of criminal responsibility for a child is a mere 7 years. Similarly under the Child Marriage Restraint Act 1929 a child is a girl (boy) under 18 (21) years of age, while the age of sexual consent is 16 years for an unmarried girl (but 15 years for a married girl!). While these inconsistencies were rightly acknowledged as problematic by the Department of Women and Child Development in its 1997 Country Report, a decade later there is still no unified definition of a child under Indian law.

A second failure relates to the inability of the state to guarantee early childhood care and education. The National Policy on Education identifies education for children un-

der six as a priority. However this policy initiative is not backed by hard-edged legal protection. Where early childhood care and development is concerned, although labour laws regulate the provision of childcare facilities in the organised sector, there is no comparable requirement in the informal one.

A related issue is the failure to deliver on the 86th Amendment of the Constitution of India 2002, which made education a fundamental right for all children aged 6 to 14 years. It also imposed a Fundamental Duty (51A) upon parents and guardians to provide a child in this age group with opportunities for education. But the state is still to fully acknowledged its legal responsibility for providing free, compulsory, effective and accessible education. The draft Right to Education Bill 2005, seeks to give effect to the 86th Amendment. The Bill provides, *inter alia*, that the state shall ensure: a school in every child's neighbourhood; that government schools provide free education; and that parents shall have greater control over such schools. The Bill also prohibits admissions tests and capitation fees, and establishes a National Commission for Elementary Education to monitor the delivery of primary education. We hope that the state will initiate an open debate about the content of the Bill, so that the consequent law is truly representative.

The failure to acknowledge the Right to Health is another important issue. This right is not protected as an individual right under the Constitution of India. However, the Directive Principles of State Policy charges the state with raising the level of nutrition and improving public health. Despite this, there is no legislation that comprehensively protects the child's right to adequate healthcare and nutrition. Some laws that affect child nutrition do exist. For example, the Infant Milk Substi-

tutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 (amended in June 2003), regulates the marketing and production of milk substitutes, feeding bottles and infant food, and prohibits any claims that these products are more beneficial than mother's milk. With similar objectives, the Food Adulteration Act bans the sale of non-iodised salt. But these are piecemeal measures while the Indian child's right to health and nutrition remains largely ignored by the law.

Yet another failure relates to sex selective abortion. Technology permits us to be highly efficient in discriminating against the girl child. The effects of sex selective abortion can be seen in the startling sex ratios of states such as Punjab (793 girls for every 1000 boys) and Himachal Pradesh (897 girls for every 1000 boys) (Census of India Provisional Population Figures 2001). The Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 prevents sex-selective abortion, but medical practitioners across the country continue to subvert the Act.

Finally, 'free' registration of births (compulsory under the registration of births and deaths act 1969) provided it is reported within 14-21 days is arguably too short a time frame. This is because one most parents lack awareness about such issues and two inaccessibility of birth registration facilities for many parents. This is important not least because a birth certificate is required to access key rights including the right to be enrolled in school, the right to be treated as a juvenile by the criminal justice system, and protections under laws against child labour.

*Contributed by Surabhi Chopra*

calls for far-reaching action in fields such as elementary education, gender relations and even property rights. And, as mentioned earlier, it

also involves maternity entitlements, the provision of crèches and related facilities. While the universalization of ICDS (more precisely, "uni-

versalization with quality and equity") receives special attention in this report, it must be seen in this larger context.

### Box 1.7. Child Care at the Work Place and the Employment Guarantee Act

A major factor affecting women and work are child care facilities, particularly at their workplace. If women are able to take their children to or close to their work place assured of reasonable child care it will make it a lot easier for them to access employment opportunities. In the case of children in the breast-feeding age group (0-2 years) the need for women to be able to have their babies closer at hand so that breast-feeding practices are not disrupted is even more important. Experience from around the world suggests that the difficulties (distance and time, paraphernalia to be carried etc.) in using child care facilities that are not at, or close to, their work place imply that women either do not use those facilities or opt not to work. However for poorer women the latter option (of not working) is often not available. In these cases children are either left at home with inadequate child care support (very young sibling or old family members) or carried to work and left in in-hospitable and unhygienic conditions. In both cases it is the small children that bear the brunt of the lack of social organization.

In India the logic of these arguments has been well received and recognized in legislature that mandates crèche facilities at work places. The Factories Act 1948, Plantation Labour Act 1951, Mines Act 1952, Beedi and Cigar Workers Act 1966, Contract Labour 1970, Inter-state Migrant Workers Act 1980, Building and Construction Workers 1996 and now the National Rural Employment Guarantee Act 2006 all require that employers provide for space and help to take care of children of the employed. However experience shows that these laws are rarely adhered to. According to one estimate there are a total of 15,000 creches in India (MS Swaminathan Research Foundation). The shortfall is clearly huge.

The recently enacted NREGA has cast the need for work-site facilities for children

in a new light. It is particularly important to insist on such a provision within the NREGA as it has the potential to make a decisive difference not just to women and livelihoods but also to the care of children.

A striking feature of the programme is the large-scale involvement of women and the corresponding impact on children. As I found in Dungarpur, Rajasthan during a mass social audit programme in April this year, site after site, had more than 80 per cent women workers. Since the men have migrated out and women are now at the work sites, children are simply left at home, alone. In several instances 5-6 year old siblings were looking after infant children all by themselves while their parents were away at work. Even breast-fed children were left at home in the care of young sibling. Their mothers feed them before leaving and then after they return. The only adults found at home were old people who seemed in need of care themselves. One can only imagine how the children fend for themselves and deal with untoward incidents that must occur with regularity. As one of the mothers at the site said: *"We have no idea how they are managing. Ooparwale ke bharose chhod kar aate hain, kya karen?"* (We leave them at God's mercy, what else can we do?).

In instances where there are no 'older' siblings, babies are brought to the work sites and left lying on the bare ground with no shade or covering, while the mother digs earth or breaks stones in the near vicinity. It is a pitiable sight to see an infant lying unprotected in such harsh conditions.

The National Rural Employment Guarantee Act states clearly that a woman should be deputed to look after young children at the work site whenever five children under the age of six are present. The NREGA Guidelines also call for the provision of crèche facilities at work sites and direct the state governments to ensure that the required resources are built into cost estimates. How-

ever, despite the dire need for crèche facilities, this aspect of the Act appears to be completely neglected.

The problem of childcare at work sites is actually more complex than it appears. The conditions at work are so harsh that bringing children there seems to be pointless. Permanent structures at the work site also do not seem to be an option, and makeshift arrangements may well be worse than leaving children at home. Some valuable suggestions have already been made and need to be explored further. One such is the possibility of employing a person under NREGA to look after a group of children, especially the infants, at one of the homes rather than at the work site. The children will have a caregiver and there will be no need to create an appropriate structure at the work site. Another suggestion is to set up mobile structures, such as tents, at the work sites that can be packed up at the end of the day and kept in a safe place till the next day. The latter has the advantage of providing a place for mothers to breast feed during the day when they are working. It will also probably give them greater peace of mind to have their children closer at hand.

There is no doubt that NREGA can provide a much-needed source of livelihood in rural areas, particularly for women. However, the impact on children calls for immediate attention. Here as in many other contexts, issues pertaining to children (especially those below the age of six) have been treated with indifference if not callousness. At the very least, effective childcare facilities should be arranged so that women are free to take up employment under NREGA without making their own children suffer. A recognition of the problem, and some creative thinking about how to deal with it, would go a long way in extending the benefits of the Act to a larger section of society.

*Contributed by Kiran Bhatta*



## 2. The State of India's Children



Anita Khemka

It has been suggested that the first question the Indian Prime Minister should ask his ministers is not “how is the economy growing?”, but rather “how are children growing?”. The ministers, however, would probably rather answer the former, for the state of Indian children is nothing short of a humanitarian emergency. Few countries, in fact, have worse indicators of child development. Progress in this field has also been very slow, with countries like

Bangladesh “overtaking” India during the last few years. This crisis casts a deep shadow on India’s progress in other fields.

### 2.1. Stumbling from the Start

The average Indian child gets a rather poor start in life. Even before birth, he or she is heading for disaster due to poor ante-natal care and maternal undernutrition. About one

\* The findings of the third National Family Health Survey (“NFHS-3”, conducted in 2005-6) are in the process of being released as this report comes to completion. Preliminary findings from NFHS-3 have been included in this chapter, but a fuller presentation awaits the next edition of the report. Where NFHS-3 results are not available, we have used the second National Family Health Survey (“NFHS-2”, conducted in 1998-9).

third of expectant mothers in India are deprived of tetanus vaccination, an important defence against infection at birth. Similarly, about one fourth of pregnant women do not have a single ante-natal check-up, and a majority of deliveries take place without the assistance of any health professional (Table 2.1). Worse, the average Indian mother is frail and anaemic. This is likely to result in low birth-weight, a major cause of child undernutrition.

After birth, life continues to be precarious. About one third of all newborn babies in India weigh less than the acceptable minimum of 2.5 kilograms. Undernutrition levels keep increasing during the first two years of life, largely due to poor breastfeeding and faulty weaning. About half of all children below three

years of age are undernourished, more than half are deprived of full immunization, and a large majority suffer from anaemia (Table 2.2). Illness is also widespread, with a fifth of all children suffering from diarrhoea and almost a third suffering from fever. A substantial proportion of Indian children (about one tenth) never reach the age of five.

As children grow up, poor nutrition and ill health affects their learning abilities and preparedness for schooling. In 1998-9, almost one third of all children in the 15-19 age group had failed to complete Class 5, and one half had not completed Class 8. So much for the “fundamental right to education”. By the time Indian children are supposed to complete upper-primary school, many of them have actually been pushed into the

labour force and are further ruining their health by working long hours in harsh conditions.

In short, millions of Indian children are condemned to stumble right from the start. During the first six years of life, and especially the first two, they sink in a dreadful trap of undernutrition, ill health and poor learning abilities. This burden is very difficult to overcome in later years.

## 2.2. Slow Progress

Another disturbing aspect of the situation of children in India is that the rate of improvement over time is very slow. Extreme forms of hunger and undernutrition, such as marasmus and kwashiorkor, have sharply declined over the years. But the general progress of nutrition indicators (such as the heights and

**Table 2.1. India: Maternal Health and Related Indicators**

	1998-99 (NFHS-2)	2005-6 (NFHS-3)
<b>Proportion (%) of mothers who had:<sup>a</sup></b>		
No tetanus immunization during pregnancy	33	n/a
No antenatal checkup	34	*
No iron or folic supplement	42	n/a
No assistance from health professional at delivery	58	*
<b>Proportion (%) of adult women with:</b>		
Anaemia	52	*
Body mass index (BMI) below 18.5	36	*

<sup>a</sup> Data pertain to births during three years preceding the survey.

Source: National Family Health Survey 1998-99 (“NFHS-2”) and National Family Health Survey 2005-6 (“NFHS-3”) data presented in International Institute for Population Sciences (2000, 2006); also available at [www.nfhsindia.org](http://www.nfhsindia.org). The figures apply to ever-married women in the age group of 15-49 years.

**Table 2.2. The State of India's Children**

	1998-99 (NFHS-2)	2005-06 (NFHS-3)
<b>Proportion (%) of young children with the following characteristics:</b>		
Low birth-weight	(about 30)	
Not breastfed within an hour of birth	84	*
Undernourished <sup>a</sup>	47	46
Stunted <sup>a</sup>	45	*
Wasted <sup>a</sup>	16	*
Not fully vaccinated <sup>b</sup>	58	56
Not vaccinated at all <sup>b</sup>	14	n/a
Birth was not preceded by any antenatal checkup	34	*
Suffer from anaemia	74	79
<b>Proportion (%) of young children who suffered from the following during the last two weeks:</b>		
Fever	30	n/a
Diarrhoea	19	n/a
Acute respiratory infection	19	n/a

<sup>a</sup> Based on standard anthropometric indicators: weight-for-age for "undernourished", height-for-age for "stunted", weight-for-height for "wasted".

<sup>b</sup> Age 12-23 months.

Source: National Family Health Survey (see Table 2.1). Unless stated otherwise, the reference group consists of children aged below 3 years (excluding children aged below 6 months if appropriate). For "low birth-weight", the estimate is from *Human Development Report 2006*.

weights of Indian children) is sluggish. The findings of the third National Family Health Survey ("NFHS-3"), released just a few days before the completion of this abridged report, are quite alarming in this regard. For instance, as Table 2.2 shows, the proportion of undernourished children, based on standard weight-for-age criteria, was virtually the same in 2005-6 as in 1998-9: in both years, nearly half of all Indian children were underweight. Even the decline of stunting in that period, from 45 per cent to 38 per cent, is far from impressive - about one percentage point per year. If the incidence of stunting continues to decline at this rate, it will take another twenty-five years or so to reach levels similar to those of China today.

Health-related indicators from the third National Family Health Survey are no less disturbing. For instance, they suggest that child immunization rates were much the same in 2005-6 as in 1998-9 (Table 2.2). The incidence of anaemia among children was also similar in both years; in fact, it was a little *higher* in 2005-6, according to the available NFHS-3 data. While some other indicators have improved, the general pace of change is excruciatingly slow - much slower, for instance, than in neighbouring Bangladesh (see below).

Similar concerns arise if we look at mortality indicators. In India as in most other countries, the infant mortality rate has steadily declined during the last fifty years or so: from about 150 per 1,000 live births in the

late 1950s to 60 per 1,000 or so today. However, the decline of infant mortality slowed down significantly in the nineties, compared with earlier decades. The rate of decline seems to have picked up again during the last few years, but nevertheless, the overall progress made since 1990 is quite limited in comparison with many other countries.

This slow progress in the field of child health and nutrition is all the more striking as the Indian economy is one of the fastest-growing in the world. During the last fifteen years, India's GDP has been growing at about 6 per cent per year on average, and per-capita income has more than doubled. Few countries have had it so good as far as economic growth is concerned. Yet the progress of child

development indicators has been much slower in India than in many countries with comparable or even much lower rates of economic growth.

## 2.3. India and South Asia

When India is compared with other countries, the comparison is usually made with “big” countries – say China or the United States. The focus also tends to be on relatively advanced countries, and on how India fares in comparison: whether, say, its army can withstand China’s, or whether democracy is more developed in India than in the United States. Except for the occasional comparison with

Pakistan, India’s immediate neighbours in South Asia are usually ignored. They do not seem to be considered worthy of comparison with India, perhaps because they are too small, or because they are assumed to be relatively backward. After all, isn’t India an emerging “superpower”?

Yet there is a great deal to learn from looking around us within South Asia, especially in matters of nutrition and health. Far from being “backward” in comparison with India, other South Asian countries are generally doing better than India in this field. The point is conveyed in Table 2.3. It may come as a shock to you to learn that India has the lowest child immunization rates in South Asia. For instance,

the proportion of children without BCG vaccine in India is twice as high as in Nepal, more than five times as high as in Bangladesh, and almost thirty times as high as in Sri Lanka! Turning to child undernutrition, India emerges in a poor light again, with only Nepal doing worse. And despite its sophisticated medical system and vast army of doctors, India has not been able to achieve higher rates of child survival than any of its neighbours except Pakistan. Almost any “summary index” of these child development indicators would place India at the bottom of this list of countries.

Some aspects of this picture are relatively well known. For instance, Sri Lanka’s outstanding achievements

**Table 2.3. Child Deprivation in India and South Asia, 2004**

	Bangladesh	Bhutan	India	Nepal	Pakistan	Sri Lanka
<b>Immunization</b> (% of children under 3 years who have <i>not</i> received the stated vaccine)						
BCG	5	8	<b>27</b>	15	20	1
DTP3	15	11	<b>36</b>	20	35	3
MCV	23	13	<b>44</b>	27	33	4
Pol3	15	10	30	20	<b>35</b>	3
<b>Child undernutrition</b> (% of children with the stated condition)						
Underweight	<b>48</b>	19	47	<b>48</b>	38	29
Stunting	43	40	46	<b>51</b>	37	14
Wasting	13	3	<b>16</b>	10	13	14
<b>Infant and child mortality</b> (per 1,000 live births)						
Infant mortality rate	56	67	62	59	<b>80</b>	12
Under-five mortality rate	77	80	85	76	<b>101</b>	14

Source: UNICEF (2006), *State of the World's Children*. In each row, the “worst” figure is highlighted.



in the field of child health have been widely noted. In spite of being almost as poor as India in terms of per-capita income, Sri Lanka has an infant mortality rate of only 12 per 1,000 – less than one fifth of India's (about 62 per 1,000). Similarly, child immunization is virtually universal in Sri Lanka, in sharp contrast with India where this is still a distant goal (Table 2.3). What is less well known is that Sri Lanka's success in this field is largely based on public intervention. Free and universal provision of essential services, especially in health and education, became an important feature of social policy in Sri Lanka at an early stage of development. For instance, most children in Sri Lanka have been integrated in a common schooling system of reasonable quality, under government auspices. In fact, private

schools have been banned since the 1960s, up to the secondary level. Indian readers may also be surprised to hear that in Sri Lanka “few people live more than 1.4 km away from the nearest health centre” (Oxfam International, 2006). The fact that Sri Lankan children are doing so well in comparison with their Indian siblings is no accident – it reflects highly divergent levels of public commitment to the well-being of children in these two countries.

No less interesting is the contrast between Bangladesh and India. In spite of being poorer (much poorer) than India, Bangladesh has better indicators of child development in many respects, as Tables 2.3 and 2.4 illustrate. The contrast in immunization rates is particularly sharp: the

proportion of children without vaccination is two to five times as high in India as in Bangladesh, depending on which vaccine one looks at. Similarly, infant and child mortality rates are significantly lower in Bangladesh than in India.

It is worth noting that this pattern is a relatively recent development: it is during the last fifteen years or so that Bangladesh has “overtaken” India in this field. While Bangladesh had a much higher infant mortality rate than India in 1990 (91 and 80 per 1,000 live births, respectively), today the positions are reversed: 56 per 1,000 in Bangladesh compared with 62 per 1,000 in India. India has been neatly leap-frogged, that too during a period when economic growth was much faster in India than in Bangladesh.

**Table 2.4. India and Bangladesh: Children's Well-being and Related Indicators, 2004**

	India	Bangladesh
<b>Infant mortality rate</b> (per 1,000 live births)	62	56
<b>Proportion (%) of one-year-olds immunized</b>		
BCG	73	95
Measles	56	77
<b>Proportion (%) of undernourished children, 1995-2003<sup>a</sup></b>		
Based on weight-for-age	49	48
Based on height-for-age	45	43
<b>Estimated maternal mortality rate, 2000</b> (per 100,000 live births)	540	380
<b>Net primary enrolment ratio (female)</b> (%)	87	95
<b>GDP per capita</b> (PPP US\$)	3,139	1,870

<sup>a</sup> Data refer to the most recent year for which estimates are available during this period.

Source: Human Development Report 2006. Unless stated otherwise, the reference year is 2004.

### Box 2.1. India Leap-frogged

In the context of the recent panic about the growth rate of the Muslim population in India, recent international data on “human development” in India and Bangladesh make interesting reading. Surely, India must be far ahead of Bangladesh in this respect? Indeed, Bangladesh is not only poorer (much poorer) than India, but also saddled with a large Muslim population. India, for its part, is now a “superpower”. One would, therefore, expect its citizens to be much healthier, better fed and better educated than their Bengali neighbours.

Let us examine the evidence. A good starting point is the infant mortality rate: 51 per 1,000 live births in Bangladesh compared with 67 per 1,000 in India, according to the latest Human Development Report. In other words, infant mortality is much lower in Bangladesh. This is all the more interesting as the positions were reversed not so long ago: in 1990, the infant mortality rate was estimated at 91 per 1,000 in Bangladesh, and 80 per 1,000 in India. India has been neatly leap-frogged, that too during a period when economic growth was much faster in India than in Bangladesh.

Other indicators relating to child health point in the same direction. According to the same Report, 95 per cent of infants in Bangladesh are vaccinated against tuberculosis, and 77 per cent are vaccinated against measles. The corresponding figures in India are only 81 per cent and 67 per cent, respectively. Similarly, 97 per cent of the population in Bangladesh have access to an “improved water source”,

compared with 84 per cent in India; and 48 per cent of Bangladeshis have access to “improved sanitation”, compared with 28 per cent of Indians. For good measure, the maternal mortality rate is much higher in India than in Bangladesh: 540 and 380 per 100,000 live births, respectively. Contraceptive prevalence, for its part, is higher in Bangladesh than in India – the “wrong” ranking again!

Perhaps all this has something to do with the fact that public expenditure on health as a proportion of GDP is almost twice as high in Bangladesh (1.6%) as in India (0.9%). The reverse applies to military expenditure, also known as “defence”: 2.3% of GDP in India compared with 1.1% in Bangladesh.

So much for health. But in education at least, India must be way ahead? Can Bangladesh boast a fraction of India’s Nobel prizes, famous writers, nuclear scientists, eminent scholars? Perhaps not, but Bangladesh appears to be closer to universal primary education than India: it has achieved a “net primary enrolment ratio” of 87 per cent, higher than India’s 83 per cent. What is more, Bangladesh has eliminated the gender bias in primary education, in sharp contrast with India where school participation rates continue to be much higher for boys than for girls. Other gender-related indicators also put Bangladesh in a relatively favourable light, compared with India: Bangladesh, for instance, has a higher female-male ratio and much higher rates of female labour force participation.

However, there is a consolation of sorts: the nutrition situation is no better in Bangladesh

than in India. In both countries, about half of all children are undernourished. No country in the world fares worse in this respect, but at least India is not alone in the back seat.

Some of these estimates may not be very accurate. Perhaps the ranking would be reversed, in some cases, if exact figures were available. But the general pattern, whereby Bangladesh is now doing better than India in terms of many aspects of social development, is unlikely to reflect measurement errors. This pattern is all the more striking as India used to fare better than Bangladesh in all these respects not so long ago – say in the early seventies, when Bangladesh became independent.

Bangladesh is no paradise of human development. Like India, it is still one of the most deprived countries in the world. However, social indicators in Bangladesh are improving quite rapidly. Whether one looks at infant mortality, or vaccination rates, or school participation, or child nutrition, or fertility rates, the message is similar: living conditions are rapidly improving, not just for a privileged elite but also for the population at large. In India, social progress is slower and less broad-based, despite much faster economic growth. This is one indication, among many others, that India’s development strategy is fundamentally distorted and lop-sided.

*Contributed by Jean Dréze (as published in The Hindu, 17 September 2004).*

It is also worth noting that the contrast between India and other South Asian countries would be even sharper if we were to focus on deprived regions or communities of each country, instead of national averages. This is because the internal inequalities are typically larger in

India. Other South Asian countries tend to be less “heterogeneous”, not only in terms of regional differences but also in terms of socio-economic inequalities. It is doubtful whether any country in South Asia (other than India) has substantial pockets where children live in such dreadful conditions as, say,

among the Musahars of Bihar or the Sahariyas of Madhya Pradesh. And it is worth remembering that Musahars alone represent a population of about 2.5 million – more than the entire population of Bhutan, or for that matter of 45 of the 177 countries listed in the latest Human Development Report.

## Box 2.2. Child Survival in Bangladesh

In 1990, the infant mortality rate in Bangladesh – 114 per 1,000 live births – was 21% higher than in India's 94. By 2004, the situation was reversed, with Bangladesh's infant mortality rate (56 per 1,000) being 10% lower than India's. In 1990, India's life expectancy at birth exceeded that of Bangladesh (52 years) by over 7 years. By 2004, the gap was negligible – 63.6 years in India and 63.3 years in Bangladesh. This is an impressive achievement given that in 2004, Bangladesh reported a per capita income of USD 406 – 58% lower than India's (USD 640); and between 1975-2004, GDP per capita grew annually twice as fast in India than in Bangladesh. Three factors, among many others, help to explain these dramatic improvements in child survival in Bangladesh.

*First*, economic empowerment of women through independent wage employment (e.g. in the garment industry) and self-employment (facilitated by huge microcredit programmes) have transformed the situation of women. It is a common sight to see groups of young Bangladeshi girls and women talking and marching in the mornings along Dhaka's roads to their worksites in garment factories. Studies indicate that more than 95 percent of women workers in the garment industry are migrants from rural areas. This unprecedented employment opportunity for young women has narrowed gender gaps in employment and income. At the same time, women have broken several traditional social taboos and become more self-assured. Society has come to value their financial contributions to family incomes and respect their participation in decision-making. These young women cherish their new-found freedoms and lifestyle choices and the opportunity to be part of a peer network. Postponement of the marriage and motherhood decision with its positive effects on child survival are direct consequences.

The spread of microcredit throughout rural Bangladesh has also contributed to better work opportunities. Grameen Bank

alone, as of May 2006, through 2259 branches covering more than 86 percent of all villages in Bangladesh, had disbursed Tk 290.03 billion (US\$ 5.72 billion) to 6.74 million borrowers, 97% of whom were women. BRAC has a comparable number of borrowers and credit advanced. According to recent estimates, these small loans have enabled over 50% of borrowers' families to cross the poverty line. New economic opportunities have also opened up as a result of easier access to microcredit. For instance, more than 250,000 Grameen borrowers operate mobile phones offering telecommunication services in nearly half the villages of Bangladesh where telephone services never existed before.

*Second*, social and political empowerment of women has occurred through regular meetings of women's groups organized by non-governmental organizations. For example, the Grameen system has familiarized borrowers with election processes as members elect every year their group chairmen and secretaries, centre-chiefs and deputy centre-chiefs. They also elect board members every three years responsible for governing Grameen Bank. This experience has prepared many women to run for public offices. In 2003, as many as 3,059 of the 7,442 Grameen members who contested won seats reserved for women in the local government (Union Parishad) elections. Substantial numbers of BRAC borrowers have won elections as well.

A recent analysis suggests much better knowledge about health among credit-forum participants than non-participants. The 55,000 BRAC women community health workers, themselves microcredit entrepreneurs, provide essential services such as family planning, care for tuberculosis and treatment of the most important childhood illnesses right in the home. Health messages are also an integral part of the school curriculum, and heard often on the radio as well.

*Third*, the participation of girls in formal education has dramatically increased, partly due to NGO efforts. For instance, BRAC's informal schools offer three years of primary

schooling to adolescents who have never attended school; retention is over 98%. After graduation, students can join Grade 5 in the formal schooling system which most of them do. Monthly reproductive health sessions are integrated into the regular school curriculum that includes topics such as adolescence, reproduction and menstruation, marriage and pregnancy, family planning and contraception, smoking and substance abuse, and gender issues. BRAC has now established over 35,000 informal schools with 1.5 million learners; each school provides free schooling for 30 students, at least 70% of whom are girls. The teacher is recruited and trained from the village where the school is established. Effort is made to involve parents and families through monthly parent meetings and influence community norms that encourage girls' delayed marriage. Today, enrollment of girls in schools exceeds boys, while 15 years ago girls were only 40% of school attendees.

Women's empowerment has gone hand-in-hand with significant improvements in health provisioning and health promotion measures. Over a decade, health workers went from house to house throughout the country, teaching women when and how to rehydrate their children suffering from diarrhoea. Today, Bangladesh has the highest use of oral rehydration in the world and diarrhoea no longer figures as the major killer of children. Almost 95% of children in Bangladesh are fully immunized against tuberculosis, as against only 73% in India.

Bangladesh's experience points to several critical elements that improve child survival: expansion of employment opportunities for women, improvements in their social status, increased political participation, social mobilization and community participation, effective dissemination of public health knowledge, and effective community-based essential health services.

*Contributed by Jon Rohde and A. K. Shiva Kumar*

### Box 2.3. Childhood among the Sahariyas

In May 2006, Dilli Dakha lost her first child, a girl aged one and a half years. After that she had a boy Sugreev who is now two. The couple then lost their twin daughters Ganga and Jamuna. According to Dakha, she was not able to feed them, as there was no milk. She says she eats one roti with onion once a day. Her family's diet does not include any pulses or vegetables, because they cannot afford it. Her husband earns around Rs.20 per day, on the few days he goes out to work. Subsequent to her third delivery she has started losing her sight, which is largely due to the deficiency of vitamin A. Deaths of children like Ganga and Jamuna are unfortunately not new to the district.

Dilli Dakha and her husband are Sahariya tribals. Sahariyas or the tribals who call themselves "Sehera or Sair", it is claimed are the first of all tribes in the country. For generations they depended on the forest for survival, living a subsistence life with limited needs. Agriculture, gathering forest products and hunting is their traditional means of earning a livelihood. Life has not been easy for the Sahariyas after their eviction from the forests.

Sahariya Children are the worst affected due to poverty, lack of livelihood resources and indifferent government policy. According to the regional medical research centre for tribals in Jabalpur, the Infant Mortality Rate of Sahariya is 88 (per 1000 lives births) and 93.5 percent of Sahariya children are severely malnourished. According to the same sources the average life span of a Sahariya is only 45 years, 74.3 percent of Sahariya children are underweight and 75.4 percent stunted. Data from the state governments Bal Sanjeevani Abhiyan (8<sup>th</sup> Report) indicates that 58 percent of the children in the age group 0-6

years in the district suffer from malnutrition. As far as children's are considered we don't see the Sahariya women in isolation. Nearly 86.5% Sahariya are anaemic because of non-availability of any proper and nutritious food. These indicators show that Sahariya's are one of the poorest and most deprived communities in the entire country.

The Sahariya of MP has been in the news a lot in recent years. One village Patalgarh of Karahal Block of Sheopur District of Madhya Pradesh has been in the news since February 2005 for the most distressing reason – the death of 13 innocent children. This village is situated at a distance of 70 kms from the district headquarters and 65 kms from the block headquarters. To reach the village one has to travel through thick forest and bumpy, muddy roads. The village situated in the interior does not have even the most basic infrastructure facilities. The nearest hospital for example is situated at a distance of 35 kms. This lack of accessibility is problematic not least of all because it affects the functioning of public services like anganwadi centers and provision of midday meals. Previously there was no anganwadi in Patalgarh village and the nearest one was in Hirapur village, 17 kms away. Mithilesh looks after the 'temporary' anganwadi in Patalgarh village to which 70 children have been enrolled. These children have not been given any food or supplementary nutrition from February 2006. There is a Multipurpose Health Worker for the village who is able to come only once a month, because he has to look after three panchayats. He has also been entrusted the duty of registration of births and deaths and in the given circumstances he leaves out many children. This is the main reason why the government has been denying the deaths. Most of the new born die within one month by which time neither their birth nor their death has been registered.

Recently the right to food campaign in MP demanded a joint commission of enquiry from the Commissioners of the Supreme Court. The state government also agreed and the enquiry commission has substantiated reports of malnutrition deaths in Sheopur and termed the predominantly Sahariya tribe as "one of the malnutrition hotspots in world". The JCE found that there is complete failure of governance, of the ignorance of the state to provide the very basic entitlements to Sahariya.

The right to food campaign in MP also filed an interim application in the ongoing case in the Supreme Court, hoping to make the state government more accountable for the children's deaths.

Subsequent to interventions from the Supreme Court the story of Patalgarh is totally different. The village now has a functioning Anganwadi, the ANM has been appointed and a "PDS tractor" brings grain from the nearby village once a month. Previous Supreme Court interventions also facilitated the distribution of temporary ration cards to enable people to access the PDS. Under NREGA a road construction work is also under-way and the workers are getting minimum wages of Rs. 61.37 per day.

Although Patalgarh is a priority for the government at the moment, little is done for other villages like Patalgarh, where indifference from the administration results in negligence and death of several innocent children. Every summer many Sahariya Children like Ganga and Jamuna die, but they don't always make the headlines of newspapers who are more concerned with the illness of Mahajans (pun intended) and Bachans.

*Contributed by Rolly Shivhare*

In short, we would do well to take more interest in our neighbours. South Asia is a useful “mirror” through which India can look at itself more realistically, tone down its superpower aspirations and acknowledge its awful treatment of children. There are also many positive lessons to learn from the recent achievements and initiatives of other South Asian countries. As India races for higher international status, catching up with Bangladesh in matters of child development would be a good start.

## 2.4. Regional Contrasts

National averages often hide major disparities between regions and socio-economic groups. This is particularly the case in a country like India, which is so large and so diverse. To illustrate, consider immunization rates, as reported in the second National Family Health Survey (1998-9). For a child born in Tamil Nadu, the chance of being fully immunized by age one is around 90 per cent (and even higher among privileged Tamil families). But the chance of being fully immunized is only 42 per cent for the average Indian child, and drops further to 26 per cent for the average “scheduled tribe” child and a shocking 11 per cent for the average Bihar child. When different sources of disadvantage (relating for instance to class, caste and gender) are combined, immunization rates dip to

abysmally low levels. For instance, among “scheduled tribe” children in Bihar, only 4 per cent are fully immunized, and 38 per cent have not been immunized at all. Startling disparities can also be observed in terms of other aspects of child development.

The regional disparities are further explored in Table 2.5, based on NFHS-2 data. The table focuses on four crucial aspects of the well-being of children: Survival, Immunization, Nutrition and Schooling (their SINS, if you like). For each of these, a standard indicator has been chosen (other indicators could have been used, but the choice does not matter much for our purposes). Each indicator is measured in percentage terms, and can be roughly interpreted as the “probability” that an average child in the relevant state achieves a particular goal: survival until age five, full immunization, adequate nourishment, and school participation, respectively. In the last column, we present a simple “summary index” of child development, based on these four indicators. This index is not very mysterious: it is just an average of the four indicators. To stress the vital importance of the achievements reflected in this index, we call it the “Achievements of Babies and Children” (ABC) index.

In interpreting this index, it is useful to remember that we are focusing here on very basic achievements of Indian children, as the acronym indicates. Ideally, we would like every

child (or almost every child – nothing is perfect) to survive until age five, be fully immunized, be well nourished, and go to school. In that case, the ABC index would be close to 100 per cent – full marks. As Table 2.5 shows, however, this ideal situation is nowhere near being realized in any Indian state, even Kerala – the trailblazer in this field. At the bottom of the scale, the ABC index is barely 50 per cent for the states formerly known (somewhat unkindly) as “BIMARU” states – Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Roughly speaking, this corresponds to a situation where the average child in these states achieves only half of the four elementary goals examined in Table 2.5.

Perhaps you will not be surprised to see Kerala at the top of this ranking, since Kerala is well known for its achievements in the fields of health and education, which have a long history. However, it is interesting to note that Kerala is no longer “way ahead” of all other states, as it used to be. Further, the states that are “catching up” with Kerala do not seem to be doing it on the basis of economic growth alone. If the achievements of babies and children were driven by economic success, we would expect Punjab and Haryana (India’s most prosperous states) to be ahead of other states. But in fact, Punjab and Haryana rank fourth and sixth, respectively, in terms of the ABC index. Both have been over-



taken by Tamil Nadu and Himachal Pradesh, which are now quite close to Kerala as far as child development is concerned.

There is an important pointer here to the role of public action in this field. Indeed, both Tamil Nadu and Himachal Pradesh have made serious efforts to ensure that all citizens have access to basic health, nutrition and education services. In Himachal Pradesh, for instance, a “schooling

revolution” of sorts has taken place during the last few decades. Widely considered as an educationally “backward” state not so long ago, Himachal Pradesh has rapidly caught up with Kerala, based on active state promotion of elementary education. In 1998-9, school attendance rates in the 6-14 age group were as high as 99 and 97 per cent for boys and girls, respectively, compared with 97 per cent in both cases for Kerala.

This schooling revolution, together with related social initiatives, has not only led to a dramatic increase in education levels but also (more recently) paved the way for rapid advances in other fields, including health and nutrition. Himachal Pradesh’s high ABC index is one manifestation of this general pattern of accelerated social progress based on public intervention.

**Table 2.5. Regional Contrasts in Child Development, 1998-99**

State	Selected Child Development Indicators <sup>a</sup>				“Achievements of Babies and Children” (ABC) index
	Survival (% of children who survive to age 5)	Immunization (% of children who are fully immunized)	Nutrition (% of children who are <i>not</i> underweight)	Schooling (% of children who attend school)	
Kerala	98.1	80	73	97	87.0
Tamil Nadu	93.7	89	63	92	84.4
Himachal P.	95.8	83	56	98	83.2
Punjab	92.8	72	71	91	81.7
Maharashtra	94.2	78	50	93	78.8
Haryana	92.3	63	65	89	77.3
Jammu & K.	92.0	57	66	84	74.8
Karnataka	93.0	60	56	80	72.3
Andhra P.	91.6	59	62	76	72.2
Gujarat	91.5	53	55	78	69.4
West Bengal	93.2	44	51	87	68.8
INDIA	90.5	42	53	79	66.1
Orissa	89.6	44	46	79	64.7
Assam	91.1	17	64	77	62.3
Uttar P. <sup>b</sup>	87.8	21	48	77	58.5
Rajasthan	88.5	17	49	76	57.6
Madhya P. <sup>b</sup>	86.2	22	45	76	57.3
Bihar <sup>b</sup>	89.5	11	46	63	52.4

<sup>a</sup> Age groups: “12-23 months” for immunization; “below 3 years” for nutrition; “6-14 years” for schooling.

<sup>b</sup> Undivided (e.g. including Jharkhand, in the case of “Bihar”).

Note: The “ABC Index” is an unweighted average of the four indicators (for further discussion, see text). States are ranked in descending order of this Index.

### Box 2.4. The Schooling Revolution in Himachal Pradesh

An abiding sight in the Himachal countryside is school children of all ages, girls and boys, walking on their way to or from school. Even a casual visitor cannot fail to notice the educational activity, especially deep in the mountains where one does not expect to find anything; and yet there are schools, and schools that function. Often housed in frugal buildings with few facilities, the sincerity with which teaching and learning appears to be taking place in these schools is inspiring. Tom mats and broken blackboards do not affect the order within the classroom or the efforts of both teachers and pupils to deal with the learning process. While far from perfect, it is nonetheless striking to find that the teachers have not abandoned their posts and have come to school on time, and that the children are seated in an orderly fashion with books or slates in hand, struggling to learn.

In 1951, the first post-Independence census showed Himachal's literacy rate to be 19 per cent. By 2001 it had gone up to 77 per cent, with male literacy at 86 per cent and female at 68 per cent. In the 15-19 age group, literacy rates were 95 per cent for females and 97 per cent for males, second only to Kerala, where the corresponding figures are 98 and 99 per cent respectively. Of all the states, school attendance rates in Himachal Pradesh (HP) in the 6-12 age group are the highest in the country. The distribution of educational performance in terms of gender and caste is also an impressive aspect of schooling in

Himachal. In the 7-15 age group not only are the aggregate levels of literacy very high, the gender gap (female literacy 94 per cent; male literacy 96 per cent) and caste disadvantage (SC female literacy 92 per cent; SC male literacy 95 per cent) have also greatly reduced.

My field work in Kullu district of HP had many memorable moments of interaction with the people. One that has remained with me and is perhaps most telling of the Himachali situation involves a remark by a person in Naggar town. When asked about the status of children in HP he said very matter-of-factly, "*bacche to sanjhe hote hain – voh humare tumhare nahin hote. Unki zimmedari hum sab hi ki hai*" (children are "communal" – not yours or mine. We are all collectively responsible for them)!

Looking at the record of HP with respect to children it does appear that this "notion" or philosophy has wide acceptance in Himachali society and has been imbibed by the state as well. This is reflected not only in the schooling performance of HP, but also in its health achievements. According to the NFHS-II, HP's infant mortality rate is 34.4; child mortality rate 8.3 and under-five mortality rate 42.4. All these figures are much lower than the All-India figures and second only to those of Kerala. Immunization records are similarly very impressive. While 83.4 per cent of all children aged 12-23 months have received all vaccinations (second to Tamil Nadu with 88.8 per cent) only 2.8 per cent have received none (close third after Tamil Nadu with 0.3 per cent and Kerala with 2.2 per cent).

The absence of disparities in HP, is particularly impressive. For instance, 82.9 per cent of non-SC children and 82.5 per cent of SC children, are fully immunized. What is even more noteworthy is that while 2.7 per cent of non-SC children have received no vaccinations only 1.8 per cent of SC children are in a similar position.

The schooling revolution in HP is an example of the complementarity between state action and social equality. On the one hand, the relatively egalitarian nature of social relations in Himachal Pradesh has, (a) facilitated the universalisation of elementary education by helping to make schooling, specially at primary level, a policy priority; (b) fostered the emergence of consensual social norms on schooling matters; (c) reduced the social distance between teachers and pupils; and (d) facilitated community participation in the schooling system.

On the other hand, the schooling revolution in HP has been fundamentally a state initiative. Its common schooling system, which contrasts so sharply with the segmented schooling found elsewhere in India, has played a key role in sustaining the egalitarian features of Himachali society. In particular it has virtually eliminated caste and gender discrimination in access to elementary education, guaranteeing basic opportunities that ultimately extend beyond the field of education to all citizens.

*Contributed by Kiran Bhatti*

Similar remarks apply to Tamil Nadu. Though Tamil Nadu has not been as successful as Himachal Pradesh in the field of elementary education, it has an outstanding record of active state involvement in the provision of health and nutrition services. For instance, it was the first state to intro-

duce cooked mid-day meals in primary schools, way back in 1982 – almost twenty years before the Supreme Court nudged other states in the same direction. As will be seen further in this report, Tamil Nadu also has an outstanding network of anganwadis. Here again, it is not an

accident that Tamil children are doing relatively well, and nor is it due primarily to economic growth. Rather, it reflects concerted efforts to provide children with the "opportunities and facilities" that are due to them under the Constitution. We shall return to this in Chapter 7.

At the other end of the scale, the dismal levels of child development in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh reflect a long history of public apathy towards the well-being of children in these states. In some of these states, or their “off-spring” (Chhattisgarh, Jharkhand and Uttaranchal), there have been positive signs of change in recent years. For instance, Chhattisgarh launched an innovative community health programme (the “Mitadin” programme) in 2001-2, and recent evidence suggests that this programme may be having a significant impact on child health (see Chapter 5). However, the general level of attention to children’s rights and well-being in these states remains abysmally low.



### 3. ICDS in a Rights Perspective



Nidhi Vij

Perhaps you have noticed, somewhere in your neighbourhood, a simple shelter or space where children under six gather every morning for a few hours. Depending on where you live, this “anganwadi” may be a dilapidated building with little sign of life (except for a brief rush when the “*dalia*” is served), or it may be a beautifully decorated space where children have a happy time playing games, singing songs, learning to count and enjoying some nutritious food. Quite likely, you have

not paid much attention to it, or asked yourself whether something can be done to make it work better. Yet a good anganwadi can make a world of difference to the well-being and future of young children. Indeed, just as schools can be used as a means of reaching out to children in the age group of 6 to 14 years (not just for the purpose of education but also for related activities such as sports and health check-ups), anganwadis can provide a crucial institutional medium to protect the

rights of children under six. From this it follows that the anganwadi itself should be seen as a basic entitlement of Indian children: every child should be within reach of a functioning anganwadi. Further, these entitlements should be legally enforceable. These are the basic principles of the “rights perspective” on ICDS.

### 3.1. ICDS: The Initial Vision

Integrated Child Development Services (ICDS) is the only major national programme that addresses the needs of children under the age of six years. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care and pre-school education. Because the health and nutrition needs of a child cannot be addressed in isolation from those of his or her mother, the programme also extends to adolescent girls, pregnant women and nursing mothers.

The motivation behind ICDS can be traced as early as the National Policy for Children 1974. This policy acknowledged that a majority of India’s children live in impoverished economic, social and environmental conditions, which impede their physical and mental development. The basis for focused intervention was further strengthened by evidence showing that general development programmes do not necessarily have much impact on the environment in which children live and grow. This

realisation called for special child-focused interventions, which would address the interrelated needs of young children. It is in this spirit that ICDS was launched by the Central Government in 1975. While the programme began on a small scale, in selected Blocks, the National Policy for Children 1974 did mention universal child development services as a longer-term commitment:

*“it shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth to ensure their full physical, mental and social development. The State shall progressively increase the scope of such services so that within a reasonable time all children in the country enjoy optimum conditions for their balanced growth.”*

ICDS services are provided through a vast network of ICDS centres, better known as “anganwadi centres” (AWC), or anganwadis for short. The anganwadi is operated by a modestly paid “anganwadi worker” (AWW), assisted by an “anganwadi helper” (AWH) or *sahayika*. Each anganwadi is supposed to cover a population of about 1000 persons (say 200 families). The local anganwadi is the cornerstone of the ICDS programme.

The basic services provided under ICDS fall under three broad headings: nutrition, health and pre-school education. Nutrition services include supplementary feeding, growth

monitoring, and nutrition and health counselling. Health services include immunization, basic health care, and referral services. Pre-school education (PSE) involves various stimulation and learning activities at the anganwadi. Further details are given in Box 3.1

ICDS is a complex programme with many actors. Though it is a “centrally-sponsored scheme”, the basic responsibility for implementing the programme rests with the state governments. At the ground level, the lead role is played by the anganwadi worker, who shoulders many responsibilities as the sole manager of the anganwadi. As we shall see, active anganwadi workers are true heroines. Their effectiveness depends on the support and cooperation of many other people: the anganwadi helper, the Auxiliary Nurse Midwife (ANM), the supervisor, the Child Development Project Officer (CDPO), among others, and of course the village community. Further details of different actors and their respective roles are given in Box 3.2.

The coverage of ICDS has steadily increased since its inception in 1975. Today, the programme is operational in almost every Block, and the country has more than 7 lakh anganwadis. However, the effective coverage of ICDS remains quite limited: barely one fourth of all children under six are covered under the supplementary nutrition component. Universalization remains a distant goal, let alone “universalization with quality”.

### Box 3.1. Basic ICDS Services

As its name indicates, the ICDS programme seeks to provide a package of “integrated services” focused on children under six. The main services are as follows:

#### A. Nutrition

**1. Supplementary Nutrition (SNP):** The nutrition component varies from state to state but usually consists of a hot meal cooked at the Anganwadi, based on a mix of pulses, cereals, oil, vegetable, sugar, iodised salt, etc. Sometimes “take-home rations” (THR) are provided for children under the age of three years.

**2. Growth Monitoring and Promotion:** Children under three are weighed once a month, to keep a check on their health and nutrition status. Elder children are weighed once a quarter. Growth charts are kept to detect growth faltering.

**3. Nutrition and Health Education (NHE):** The aim of NHE is to help women aged 15-45 years to look after their own

health and nutrition needs, as well as those of their children and families. NHE is imparted through counselling sessions, home visits and demonstrations. It covers issues such as infant feeding, family planning, sanitation, utilization of health services, etc.

#### B. Health

**4. Immunization:** Children under six are immunized against polio, DPT (diphtheria, pertussis, tetanus), measles, and tuberculosis, while pregnant women are immunized against tetanus. This is a joint responsibility of ICDS and the Health Department. The main role of the Anganwadi worker is to assist health staff (such as the ANM) to maintain records, motivate the parents, and organize immunization sessions.

**5. Health Services:** A range of health services are supposed to be provided through the Anganwadi Worker including health checkups of children under six, ante-na-

tal care of expectant mothers, post-natal care of nursing mothers, recording of weight, management of undernutrition, and treatment of minor ailments.

**6. Referral Services:** This service attempts to link sick or undernourished children, those with disabilities and other children requiring medical attention with the public health care system. Cases like these are referred by the Anganwadi worker to the medical officers of the Primary Health Centres (PHCs).

#### C. Pre-School Education

**7. Pre-School Education (PSE):** The aim of PSE is to provide a learning environment to children aged 3-6 years, and early care and stimulation for children under the age of three. PSE is imparted through the medium of “play” to promote the social, emotional, cognitive, physical and aesthetic development of the child as well as to prepare him or her for primary schooling.

There is also a need to revive the initial vision of ICDS as an integrated programme, based on the notion that children’s needs are indivisible and interrelated. As will be seen further on, the programme has been implemented in a lopsided manner, with the distribution of food supplements to children in the age group of 3-6 years “displacing” many other activities. Some services, such as nutrition counselling and pre-school education, have been deeply neglected and even virtually aban-

doned in some cases. There is an urgent need to reverse this “reductionist” approach.

## 3.2. Financial Allocations\*

As we saw in Chapter 1, the well-being and rights of Indian children tend to receive little attention in public policy and democratic politics. One indicator of this state of affairs is the fact that only a minuscule share of public expenditure is allocated to child-related programmes. According

to a recent estimate, out of every rupee spent by the Central Government, less than five paise go to child-related programmes (HAQ, 2006).

Further, only a small proportion of this tiny amount is allocated to children under six. As mentioned earlier, ICDS is the only major programme addressed specifically to this age group. The total allocation for ICDS by the Central Government in 2004-5 was a mere Rs 1,600 crores – less than *one tenth of one per cent* of India’s GDP. By contrast, in the

\* This section draws on the recent reports of the Commissioners of the Supreme Court, appointed to monitor the implementation of orders issued in the “right to food” case (*PUCL vs Union of India and Others*, Civil Writ Petition 196 of 2001). The reports are available at [www.righttofoodindia.org](http://www.righttofoodindia.org), along with a wealth of related material.

### Box 3.2. ICDS: The Main Actors

Many people are involved in the implementation of ICDS. The success of the programme depends on active cooperation between these different “actors”. The main actors are as follows:

**Anganwadi Worker (AWW):** She is the pillar of the programme. Her job is to run the Anganwadi: survey all the families in the neighbourhood, enrol eligible children, ensure that food is served on time every day, conduct the pre-school education activities, organise immunization sessions with the ANM, make home visits to pregnant mothers, and so on – the full list is very long!

**Anganwadi Helper (AWH):** The AWH is also central to the implementation of ICDS. She is supposed to assist the AWW in her tasks. Her main duties are to bring children to the Anganwadi, cook food for them, and help with the maintenance of the AWC.

**CDPO:** The ICDS programme is organised as a collection of “projects”. Normally, an ICDS project covers a population of around 100,000, and involves running about 100

Anganwadis. Each project is managed by a Child Development Project Officer (CDPO). The CDPO’s office is a sort of “headquarter” for the ICDS project.

**Supervisor:** The CDPO is assisted by “supervisors”, who make regular visits to the Anganwadis. The supervisors are supposed to check the registers, inspect the premises, advise the Anganwadi Worker, enquire about any problems she may have, and so on. Unfortunately, many supervisors do little more than checking the registers.

**Auxiliary Nurse Midwife (ANM):** The ANM acts as a crucial link between ICDS and the Health Department. Her main task in the context of ICDS is to organise immunization sessions, together with the Anganwadi worker. She also provides basic health care services at the Anganwadi.

**Accredited Social Health Activist (ASHA):** The National Rural Health Mission is set to create a cadre of women voluntary health workers (ASHA) at the village level, who are also expected to work with the ANM and AWW

to improve the nutrition and health of women and children.

**NGOs:** In some areas, NGOs play an active role in the implementation of ICDS. In fact, sometimes entire ICDS “projects” are managed by an NGO. Also, international organisations such as CARE and UNICEF often provide specific support to ICDS. For instance, CARE used to supply food for the supplementary nutrition programme, and UNICEF has been helping with the supply of medical kits.

**The Community:** Community participation is an important element in the design of ICDS. It can do a lot to help the effective functioning of Anganwadis. For instance, the community can be mobilised to provide the Anganwadis with better facilities (e.g. a ceiling fan), to ensure that they open on time every day, or to encourage mothers to participate in counseling sessions. Community participation can take place through Gram Panchayats, Mahila Mandals, Self-Help Groups, youth groups or just spontaneous cooperation. Unfortunately, community participation in ICDS is quite limited as things stand.

same year, the Central Government spent Rs.77,000 crores on “defence”!

Budget allocations for ICDS have steadily increased in recent years (see Box 3.3). Interestingly, there was an “acceleration” in this upward trend around 2002 – soon after Supreme Court hearings and the “right to food campaign” began. This is an encouraging sign that public action can make a difference. Having said this, public expenditure on ICDS is still very low, especially in relation to the goal of

“universalization with quality”. In the last Union Budget, for 2006-7, the allocation for ICDS was around Rs 4,000 crores - much less than one rupee per child per day.

Not only is the overall budget low, the item-wise breakdown also shows glaring inadequacies. For example, in 2004-5 each anganwadi in rural areas received a mere Rs 150 per month for “rent”. Getting proper space for an anganwadi within this budget is almost impossible. Similarly, few states have made reliable arrangements to provide angan-

wadis with medical kits or PSE kits. Recent reports submitted by state governments to the Commissioners of the Supreme Court suggest that only seven states have provided all their anganwadis with medical kits. In many other states (including Jharkhand, Rajasthan and West Bengal) not a single anganwadi has been provided with a medical kit.

Lack of funds has also affected the “supplementary nutrition programme” (SNP) under ICDS. Until December 2004, the Central Government used a very low norm of

“one rupee per person per day” on average for SNP, including the cost of food, fuel, condiments, transport and administration. This norm had not been revised since 1991. As Table 3.1 illustrates, many states actually allocated much less

than a rupee a day to SNP. In half of the twelve states for which data are available, the state government was spending less than 50 paise per child per day on SNP in 2002-3. In Bihar, the figure was as low as 15 paise per child per day.

Contrast this with the situation in Tamil Nadu, where the cost per meal varies between Rs 1.20 for children below 6 years to Rs. 2.08 for pregnant and nursing mothers (not including salaries, operating expenses and overheads).

### Box 3.3. Children Under Six and the Budget

Children in the 0-6 years of age need holistic attention. The interventions needed for this age group have come to be referred as Early Childhood Care and Education (ECCE) or Early Childhood Care and Development (ECCD). The Census 2001 estimates the population of children under six years at about 16.4 crore or 16 percent of the total population of India. Within the total child population, about 6 per cent are infants (children below one year), 12 per cent toddlers (those in the age group 1-2 years), 22 per cent preschoolers (between the ages 3 and 5) and the remaining 60 per cent in the age group of 6-14 years.

The Government in its 10<sup>th</sup> Five Year Plan document recognized the importance of giving special attention to the three age groups viz. infants, toddlers, and preschoolers, because of their age-specific needs. While this recognition is not new, the efforts to address these needs remain inadequate. This is reflected in the budgetary commitments devoted to the young child, despite the fact that devoting resources to ECCE is a highly profitable investment, bringing multiple benefits to society, the child and his or her family. UNESCO for instance estimates that every dollar spent on ECCE generates four dollars in benefits!

But is India investing adequately in this age group? Are current financial allocations and expenditure on the young child sufficient? An analysis by HAQ: Centre for Child

Rights suggests clearly not. For instance the average expenditure on government schemes for the young child was only Rs. 208 per child per year, for the period 2000-2005. Currently the government is implementing seven ‘schemes’ for children under six viz. ICDS, Early Childhood Education, Rajiv Gandhi National Crèche Scheme, National Nutrition Mission, Reproductive and Child Health, Strengthening of National Immunisation Programme and Polio Eradication and Child Adoption. The analysis shows that the cumulative expenditure of these seven programmes in 2000-01 was as low as Rs. 2476 crores or a meagre Rs. 151 per child. Although the last few years have seen an increase, the amounts still remain low. In 2004-05, the government spent around Rs. 4724 crore or only Rs. 288 per child, on these programmes.

The low priority given to the young child becomes even more evident when funds are analysed as a percentage of the union budget. In 2006-07, only 1.66 per cent of the total funds available in the Union Budget were allocated for children under six. In 2000-01 it was as low as 0.88 per cent. Expenditures are usually even lower. In 2004-05, only 0.95 per cent of the total union budget expenditure was spent on programmes relating to children under six.

The Integrated Child Development Services (ICDS) is the government’s flagship programme and is designed to address the comprehensive needs of children under six.

Allocations and spending on ICDS is therefore an important indicator of the government’s commitment towards the young child. Allocations for ICDS in the central budget have increased from Rs. 3315 crore in 2005-06 to Rs. 4543 crore in 2006-07 (see figure 3). Although this appears to be a huge increment; it is still not sufficient to cover the required cost of universal coverage of all children and settlements. As things stand ICDS services are provided to about 4 crore children through 7 lakh anganwadis. Compare this with the need to reach 16 crore children in 17 lakh settlements, required for universal coverage based on existing norms.

The status of the young child is inextricably linked with the mother. Without adequate support, the multiple roles played by women as workers, home makers and mothers, can lead to widespread neglect of the child during the critical years. This makes the rights of the young child closely connected to the rights of women to maternity benefits and child care provisions. Unfortunately however according to recent estimates only 23,834 crèches are sanctioned under the Rajiv Gandhi National Crèche Scheme, against the requirement of 8,00,000. Naturally then allocations too are highly inadequate. Although allocations under this programme increased from Rs. 41 crore in 2005-06 to Rs. 103 crore in 2006-07, the gap between requirement and availability still remains wide.

*Contributed by HAQ: Centre for Child Rights*



**TABLE 3.1. SNP Allocations by State, 2002-3**

	Total Allocation (Rs crores)	Allocation per person per day <sup>a</sup> (Rs.)
Andhra Pradesh	85	0.57
Haryana	9	0.22
Himachal Pradesh	10	0.48
Jharkhand	7	0.42
Karnataka	39	0.33
Madhya Pradesh	59	0.49
Maharashtra	45	0.35
Nagaland	6	0.87
Orissa	85	0.87
Tamil Nadu	152	1.69
Uttar Pradesh	85	0.51
West Bengal	56	0.98

<sup>a</sup> Mainly children but also including eligible women (e.g. pregnant and nursing mothers).

Source: Fifth Report of the Commissioners of the Supreme Court (available at [www.righttofoodindia.org](http://www.righttofoodindia.org)).

In response to Supreme Court orders, the SNP norm was doubled in December 2004. However, even the revised norm of “two rupees per child per day” is highly inadequate, and

source base of ICDS. Under-utilization of funds, especially Central Government assistance, has been a resilient problem. As Table 3.2 illustrates, utilization ratios are very low

makes it very difficult to provide nutritious food to children, including items like fresh vegetables. Further, this revised norm is yet to be implemented in many states. While low allocations are a major constraint, gross underutilization of funds further undermines the re-

in most states for which data are available: less than 50 per cent on average. Some states, notably Bihar and Jharkhand, have been extraordinarily slack in this regard. In Jharkhand, for instance, state authorities were unable to utilize a single paise out of Rs 37 crores allocated for supplementary nutrition under the Pradhan Mantri Gramodaya Yojana (PMGY) in 2003-4. After the withdrawal of CARE (formerly responsible for supplying nutrition to the entire state) in July 2002, it took more than a year to put alternative arrangements in place. As a result, no feeding took place in the anganwadis between May and December 2003 in the entire state. Bihar is not much better, with the state surrendering more than 24 crores in 2002-4. The state government even admitted that there is no feeding of children in the first few months of the financial year due to procedural delays.

**TABLE 3.2. Utilization of SNP Funds, 2003-4**

	Allocation (Rs crores)	Expenditure reported (Rs crores)	Utilization (expenditure as % of allocation)
Bihar	67	21	31
Jharkhand	55	3	5
Maharashtra	223	133	60
Uttaranchal	23	6	26
Tamil Nadu <sup>a</sup>	35	25	72
Total (5 states)	403	188	47

<sup>a</sup> Figures for Tamil Nadu do not include allocations and utilization under PMGY, as information was not available. For the other states, figures include allocation and utilization of both the state funds (non-plan) and PMGY (nutrition) funds.

Source: Fifth Report of the Commissioners of the Supreme Court (available at [www.righttofoodindia.org](http://www.righttofoodindia.org)). The states listed in the table are those that replied to enquiries from the Commissioners on these matters.

In short, aside from inadequate coverage, the reach of ICDS has been held up by meagre financial allocations, and even lower expenditure. Overcoming this hurdle is an essential step towards universalization with quality.

### 3.3. Supreme Court Orders

In April 2001, People's Union for Civil Liberties (PUCL, Rajasthan) submitted a writ petition to the Supreme Court of India seeking enforcement of the right to food. The basic argument is that the right to food is an aspect of the fundamental "right to life" enshrined in Article 21 of the Indian Constitution. Indeed, the Supreme Court has made it clear that the right to life should be interpreted as a right to "live with dignity", which includes the right to food and other basic necessities. For instance, in *Maneka Gandhi v. Union of India AIR 1978 SC 597*, the Supreme Court stated: "*Right to life enshrined in Article 21 means something more than animal instinct and includes the right to live with human dignity...*" Similarly, in *Shantistar Builders v. Narayan Khimalal Totame (1990) 1 SCC 520*, the Supreme Court stated: "*The right to life is guaranteed in any civilized society. That would take within its sweep the right to food...*"

The public interest litigation initiated by the PUCL petition is known as "PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001". The judgement is still awaited, but meanwhile, the Supreme Court has issued a series of "interim orders" aimed at safeguarding various aspects of the right to food. The first major order, dated 28 November 2001, directed the government to fully implement nine food-related schemes (including ICDS) as per official guidelines. In effect, this order converted the benefits of these schemes into legal entitlements.\* In the case of ICDS, the order actually went further than just converting existing benefits into legal entitlements: it also directed the government to "universalize" the programme. This means that every hamlet should have a functional Anganwadi, and that ICDS services should be extended to every child under six, every pregnant or nursing mother, and every adolescent girl.

The Court directives relating to ICDS, however, received very little attention for several years. Virtually nothing was done to implement them until April and October 2004, when several hearings on ICDS were held in the Supreme Court and further orders were issued. For instance, the Supreme Court explicitly directed the government to expand the number

of anganwadis from 6 lakhs to 14 lakhs, to ensure that every settlement is covered.

The Supreme Court orders of April and October 2004 gave a useful wake-up call to the government. The universalization of ICDS was included in the National Common Minimum Programme of the UPA government in May 2004. The National Advisory Council submitted detailed recommendations for achieving "universalization with quality" in October 2004, as well as follow-up recommendations in February 2005. The expenditure of the Central Government on ICDS was nearly doubled in the Union Budget 2005-6.

However, there has been relatively little progress in terms of the situation on the ground. The expansion of ICDS is quite slow, and in most states there is little evidence of substantial quality improvement. This reflects the fact that Supreme Court orders and budget allocations are not enough. Ultimately, what is required is a broad-based movement for the universalization of ICDS, involving not only the government but also the public at large. It is to support this movement, and your own involvement in it, that this report has been prepared.

\* The schemes are: the Public Distribution System (PDS); Antyodaya Anna Yojana (AAY); Sampoorna Grameen Rozgar Yojana (SGRY); the Mid-day Meal Scheme (MDMS); the Integrated Child Development Services (ICDS); Annapurna; the National Old Age Pension Scheme (NOAPS); the National Maternity Benefit Scheme (NMBS); and the National Family Benefit Scheme (NFBS). For further details of the Supreme Court orders, and of this public interest litigation, see *Supreme Court Orders on the Right to Food: A Tool for Action*, available from the secretariat of the Right to Food Campaign (and also at [www.righttofoodindia.org](http://www.righttofoodindia.org)).



### Box 3.4. Supreme Court Orders on ICDS

A significant amount of public attention has been drawn to the ICDS in recent years. This is partly due to interim orders passed by the Supreme Court in the 'right to food case', a writ petition currently pending before the Supreme Court of India (Civil Writ Petition 196/2001, People's Union for Civil Liberties v. Union of India and others). In this writ petition, the Supreme Court has taken the view that the denial of the 'right to food' amounts to the denial of the fundamental 'right to life and personal liberty' enshrined in Article 21 of the Constitution of India. The ICDS has since been recognised as central to safeguarding the 'right to food' of young children (up to six years of age), pregnant women, nursing mothers and adolescent girls. The noteworthy orders are highlighted here.

#### Order dated 28 November 2001

Each child up to 6 years of age is to get

- 300 calories and 8-10 gms of protein.
- Each adolescent girl to get 500 calories and 20-25 grams of protein.
- Each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein.

- Each malnourished child to get 600 calories and 16-20 grams of protein.
- Every settlement is to have a disbursement centre (Anganwadi).

#### Order dated 29 April 2004

- All 0-6 year old children, adolescent girls, pregnant women and nursing mothers shall receive supplementary nutrition for 300 days in the year.

#### Order dated 7 October 2004

- The number of Anganwadis shall be increased from 6 to 14 lakh.
- The minimum norm for the provision of supplementary nutrition should be increased to Rs. 2/- per child per day.
- All sanctioned Anganwadis shall be operationalized immediately.
- All SC/ST hamlets shall have Anganwadis as early as possible, and hamlets with high SC/ST populations should receive priority in the placement of new Anganwadis.
- All slums shall have Anganwadis.
- Contractors shall not be used for the supply of supplementary nutrition.

- Local women's Self-Help Groups and Mahila Mandals should be encouraged to supply the supplementary food distributed in Anganwadis. They can make purchases, prepare the food locally, and supervise the distribution.

- The Central Government and States/UTs shall ensure that all amounts allocated are sanctioned in time so that there is no disruption in the feeding of children.

- All State Governments/UTs shall put on their websites, full data for the ICDS programme including where AWCs are operational, the number of beneficiaries category-wise, the funds allocated and used, and related matters.

Several of these orders are yet to be implemented in full by the Central and State Governments. The most significant amongst these are orders to ensure that all children from 0-6 years, pregnant and nursing mothers and adolescent girls have access to ICDS services and further that all settlements, especially SC/ST settlements have access to an Anganwadi. For further details see Supreme Court Orders on the Right to Food: A Tool for Action, available from the secretariat of the right to food campaign.

*Contributed by Nandini Nayak*

## 3.4. Universalization with Quality

The value of a rights perspective on children's issues was discussed in Chapter 1. In this perspective, ICDS is not just a welfare scheme, but an essential entitlement of children under six. The anganwadi is a means of protecting their rights to nutrition, health, pre-school education and related opportunities – or at least of bringing these rights within

the realm of possibility. Following on this, the basic premise of this report is that all children under six should have access to ICDS (preferably as a matter of legal right), and also that the quality of ICDS services needs radical improvement. This overarching goal is expressed in the term "universalization with quality". A more complete expression would be "universalization with quality and equity". This stresses the need to give priority to underprivileged groups

(e.g. Dalit and Adivasi communities) in the process of universalization, as well as to eradicate social discrimination of any kind in the implementation of ICDS.

In concrete terms, what does "universalization with quality and equity" mean? It essentially implies the following: (1) every settlement should have a functional anganwadi; (2) ICDS services should be extended to all children under the age of six years (and all eligible women); (3) the scope

and quality of these services should be radically enhanced; and (4) priority should be given to disadvantaged groups in this entire process. In this report, the term “universalization with quality” is used as a short-term for these broad demands.

As discussed earlier, the basic premise of these demands is that the universalization of ICDS is an essential means of protecting the rights of children under six. There are at least four other arguments in favour of universalization: a legal argument, a political argument, an economic argument and an equity argument.

The legal argument is that the universalization of ICDS is mandatory under Supreme Court orders, as discussed in the preceding section. In fact, in an interim order issued on 7 October 2004, the Supreme Court directed the Central Government to specify the time frame within which it proposes to ensure that every settlement has a functional anganwadi. The government, however, is yet to make up its mind on this.

The political argument is that the universalization of ICDS is one of the core commitments of the Common Minimum Programme (CMP) of the UPA Government. The CMP clearly states: *“The UPA will also universalize the Integrated Child Development Services (ICDS) scheme to provide a functional anganwadi in every settlement and ensure full coverage for all children.”* Thus, aside from being important in its own right,

the universalization of ICDS can be seen as an aspect of the need to hold the government accountable to its promises. It is in this spirit that the National Advisory Council formulated detailed recommendations on ICDS, in line with the commitments of the CMP (National Advisory Council, 2004, 2005).

The economic argument is that providing health and nutrition services to children is a good “investment”, so to speak. Many recent studies indicate that the “returns” to child nutrition programmes are quite high, or at least, can be quite high. The methods underlying these estimates of economic returns have serious limitations, and the results are at best indicative. Further, one should guard against allowing economic criteria to become the arbiter of public policy in this field. Nevertheless, these studies strengthen the case for a major expansion of child development services in India.

Last but not least, there is an equity argument for universalization. Indeed, the universalization of ICDS would help to halt the inter-generational perpetuation of social inequality, by creating more equal opportunities for growth and development in early childhood. It would also foster social equity by creating a space where children eat, play and learn together irrespective of class, caste and gender. This socialisation role of ICDS is very important in a country where social divisions are so resilient.

Taken together, these arguments add up to a fairly strong case for the universalization of ICDS. Two counter-arguments should be briefly addressed. One is that ICDS does not and cannot work. It is easy to provide superficial support for this claim by citing horror stories of idle anganwadis or food poisoning. These horror stories, however, are a poor reflection of the general condition of ICDS. Indeed, recent evidence suggests that ICDS is performing crucial functions in many states, and that there is much scope for consolidating these achievements. This is one of the main messages of the FOCUS survey, discussed in the next chapter.

This is not to deny that the quality of ICDS services needs urgent improvement in many states. Indeed, that too is one of the core messages of the FOCUS survey. But recognising the need for quality improvements is not the same as dismissing ICDS as a non-functional programme. The FOCUS survey does not provide any justification for this defeatist outlook. On the contrary, it draws attention to the enormous potential of ICDS. This potential is well demonstrated in states such as Tamil Nadu (not to speak of Kerala), where ICDS is a political priority. The sensible way to go is to make better use of this potential, given that the foundations of ICDS are already in place throughout the country. To put it another way, opposing the universalization of ICDS on the grounds that there are

### Box 3.5. Child Development as an “Investment”

There is a perception that the scarce resources of a developing economy are best devoted to improving economic growth. The logic is that improvements in child nutrition and health are likely to follow robust income growth. Empirical studies, however, suggest that while this is true, it happens only at a modest rate (Haddad et al, 2002). This suggests that rather than relying solely on economic growth, nutritional and health concerns of children need to be addressed directly. In this context, recent studies by economists emphasize that devoting resources to child nutrition and health, far from being mere sectoral advocacy, is among the most economically justified uses of public resources (Alderman, 2004).

Children, they claim, are an investment. Committing resources today to reducing protein-energy malnutrition and micronutrient deficiencies in children would bring large economic returns in the long run. How does this happen? These gains are deemed to accrue through three broad channels. First, there are substantial *productivity gains* that work directly through the physical capacity to perform tasks (related to stunting), and indirectly through cognitive development and schooling attainments. Second, there might be significant *saving of resources* through cost reduction. These derive from lower infant mortality and lower costs of chronic diseases and healthcare for neonates, infants and children. Third, there may be *intergenerational benefits*, through subsequent generations being more productive through improved health.

It is not difficult to imagine that these gains exist; some even seem obvious. What is not obvious however is the magnitude of these gains. Needless to say, measuring these gains is a huge challenge. The exercise also hinges on assumptions that are often highly contested. Despite these difficulties and the many caveats, useful insights emerge from these studies.

Behrman, Alderman and Hoddinott (2004) calculate, for instance, that the total gains from averting each Low Birth-Weight (LBW) in a stylized low income country is around \$580. Of the total gain, an overwhelming 58% comes from increases in productivity, 18% from resources saved, 16% from gains through reduced infant mortality and the remaining 8% from intergenerational benefits.

Of the three channels, *productivity gains* seem to clearly dominate. It is this association between childhood nutrition and productivity that is now somewhat well established in empirical studies. For instance, a 1% lower adult height, as a consequence in part of poor nutrition in childhood, is associated with a 1.4% loss in productivity (Hunt 2005) and 2-2.4% reduced earnings as an adult, after controlling for competing explanations (Thomas and Strauss, 1997). The productivity impact via cognitive development and schooling is no less important. Poorly nourished children tend to start school later, make slower progress through school and have lower schooling attainments. Glewwe, Jacoby and King (2001) found that in the Philippines, children with better nutritional status started school earlier and repeated fewer grades. They also had higher school completion rates (Daniels and Adair, 2004). Further, school attainments appear to impact earnings. In Zambia, malnutrition tended to reduce lifetime earnings by 12%, because of an effect on schooling. Similar productivity impacts are evident on account of micronutrient deficiency. Altogether, a conservative estimate of productivity losses (from manual labor alone) in India due to stunting, iodine and iron deficiency in India is 2.95% of GNP! (Horton 1999)

Similar evidence on *resources saved* is scarce, and pertains largely to developed countries. For the US, the excess medical costs due to one LBW is put at \$5.5-6 billion dollars – 75% of which is costs of health care during infancy (Lewit et al, 1995). These estimates, based as they are on the cost of

healthcare, are highly context-sensitive and may not translate directly to similar costs for developing countries. Still, they are likely to be significant.

As for *intergenerational transmission*, since stature at age three is strongly associated with body size as an adult, malnourished girls, if they grow into women with small stature, are more likely to give birth to children with LBW; they also tend to have more complications during childbirth and face higher risk of child and maternal mortality (Ramakrishnan et al 1999). So the gains from addressing nutritional issues in one generation cumulate. To the extent that this disadvantage is not made up by compensatory investments in later years, intergenerational benefits could be substantial.

When the economic gains from spending on children are cast in terms of benefit-cost comparisons, productivity gains alone, in most cases, are enough to justify costs of nutrition interventions (Behrman, Alderman and Hoddinott, 2004). If we take into account the other gains as well – reduced mortality, reduced medical costs, intergenerational benefits – the value of benefits from most health and nutrition interventions exceed, by several times, the cost of such interventions. For instance, for integrated childcare programmes, the benefits are estimated to be 9-16 times the cost; for Vitamin A supplementation for children under 6, the benefits are anywhere between 4 and 43 times that of cost.

The empirical evidence is unequivocal and persuasive. Not only is there much to gain in absolute terms, the economic value of benefits from a class of health and nutrition interventions far outweighs the costs. Thus, not only are children investments, they might well be among the most “productive” available in developing countries.

*Contributed by Sudha Narayanan*

serious quality issues in some states would be like saying that primary schools should be closed because schools are not working very well in Bihar or Kalahandi.

Another counter-argument is that universalization is unnecessary and even wasteful: instead, public provision of child development services should be “targeted” to disadvantaged children. This advice is based on the familiar case for targeting social services: targeted interventions

are more “cost-effective” and also help to reduce inequality.

Whatever its merit in other contexts, this argument is easy to dismiss as far as ICDS is concerned, if only because there is no reliable way of “targeting” children who are vulnerable to malnutrition or ill health. Indeed, undernourished children are found in all socio-economic groups. Even among relatively privileged households, a substantial proportion of children are undernourished. To look

at this from another angle, the causes of malnutrition and ill-health are very diverse and these deprivations have no obvious, measurable “correlates” that could be used for targeting purposes. Thus, any targeted system is bound to leave large numbers of children exposed to malnutrition and ill health. It would effectively convert ICDS into a “hit and miss” programme. This is incompatible with the notion that nutrition, health and joyful learning are fundamental rights of all Indian children.



## 4. Ground Realities



Nidhi Vij

Integrated Child Development Services (ICDS) has set lofty goals for itself, and is based on fairly sound thinking. Here as with many other development programmes, however, there is a wide gap between theory and practice. This chapter turns to the “ground realities” of ICDS, based on a field survey conducted in May-June 2004 – the FOCUS survey.

### 4.1. The FOCUS Survey

The basic aim of the FOCUS survey was to find out how ICDS is doing on the ground. This was, of course, not the first study of its kind. In fact, hundreds of reports on ICDS have been written since the programme was initiated in 1975. Most of these re-



ports, unfortunately, are not very informative. Those that are based on government data have to be taken with a pinch of salt, since there are many biases in the official reporting system. For instance, it is well known that anganwadi workers have strong incentives to under-report severe malnutrition (say, “grade 3” or “grade 4”) among children enrolled in ICDS, to avoid being “blamed” for the problem. Independent surveys, on the other hand, also face serious problems in eliciting authentic information on the state of ICDS. For instance, when anganwadi workers are asked to describe the services they provide to the children, they often report what is supposed to be happening rather than what is actually happening. Mothers, for their part, often have limited awareness of what goes on at the anganwadi, especially in states with low levels of education. And children, of course, are too young to tell.

In the FOCUS survey, we tried to get around this problem in two complementary ways. First, similar questions were asked to different persons (anganwadi workers, anganwadi helpers, mothers, CDPOs, and so on), making it possible to “cross-check” their responses. Second, extensive use was made of direct observations by the field investigators, who were trained for this purpose. For instance, the field investigators were asked to write detailed notes about what was happening at the anganwadi when they arrived. Fur-

ther, they were instructed to reach the sample anganwadis during opening hours, without announcement. This helped to build an accurate picture of “everyday activities” at the anganwadi.

***“The anganwadi worker kept trying to give perfect answers. The register had been tampered with, as all kids were marked present though we only saw five. We also saw that all kids had healthy weight in the growth monitoring charts, which seemed very suspicious. The anganwadi would seem very efficient upon superfluous inspection, but on closer inspection we found that it was only functioning in name.”***

*(FOCUS investigators’ observations in Samra village, Chamba District, Himachal Pradesh.)*

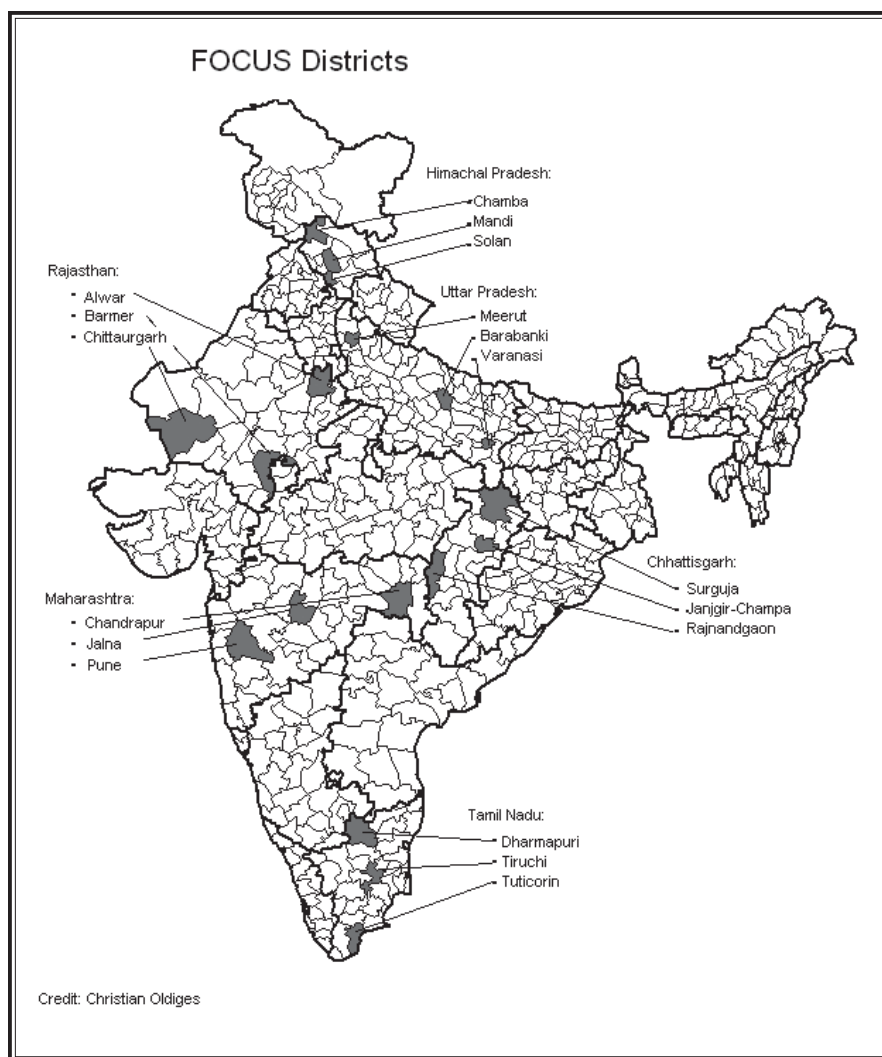
The FOCUS survey was conducted on a shoestring budget, with a modest grant from the Indian Council of Social Science Research (ICSSR). Since a national survey was beyond our means, we focused on six states (hereafter the “FOCUS states”): Chhattisgarh, Himachal Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. The states were informally selected, keeping in mind the need for balance between different regions and levels of socio-economic development. In each state, three districts were selected in a similar way, and then 12 villages (hereafter the “FOCUS villages”) were selected in each district through random sampling. Thus, the target

number of sample villages was 216 (thirty-six in each of the six sample states). Due to minor disruptions in the survey, however, the actual number of sample villages is a little lower – 203 to be precise. The number of “sample anganwadis” was the same, since a single anganwadi was surveyed in each sample village.

In each sample village, the survey began with an unannounced visit to the anganwadi, normally within the official opening hours though this was not always possible. Detailed interviews (both qualitative and quantitative) were conducted with the anganwadi worker and anganwadi helper. Similar interviews were conducted with a random sample of about 500 women who had at least one child below the age of six years, enrolled at the local anganwadi. We shall refer to them as the “sample mothers” and “sample children”, respectively. Aside from this, the field investigators took detailed notes based on their personal observations and team discussions. Interviews were also conducted with Child Development Project Officers (CDPOs) at the Block level.

In spite of the relatively small size of the sample, the FOCUS survey sheds some interesting light on various aspects of ICDS. The combination of survey data with direct observation is particularly useful in building an authentic picture of ICDS in different states. We turn, in the next section, to the survey findings.





## 4.2. How is ICDS Doing?

The short answer to this question (“how is ICDS doing?”) is “it depends”. It depends, first and foremost, on which state we are talking about. Indeed, the FOCUS survey points to startling contrasts in the effectiveness of ICDS between different states. At one end of the spectrum, Tamil Nadu is doing very well: anganwadis are open throughout the year, nutritious food is available there every day, regular health services are also

provided, and even the pre-school education programme is in good shape. At the other end, a day in the life of a typical anganwadi in Uttar Pradesh is little more than a brief ritual, involving the distribution of a bland, monotonous “ready-to-eat” mixture (called *panjiri*) to the children and some hasty filling – or fudging – of registers. There is rampant corruption from top to bottom, and no sign of any significant impact of ICDS on the well-being of children. Between these two extremes, there are many shades of achievement and failure in different states.

The important point to note is not just that these contrasts exist, but also that they reflect what has been done in different states to make ICDS work. Like children themselves, ICDS appears to thrive where it receives attention and care: adequate resources, regular training, proper facilities, close monitoring, imaginative planning, and responsible administration (e.g. regularity in food supply and salary payments), among other enabling factors. Where these enabling conditions are missing, anganwadis are not doing so well. But creating these conditions for the success of ICDS is largely a matter of choice – a choice within the realm of democratic politics.

The six FOCUS states can be divided into two broad groups. Three of them (Himachal Pradesh, Maharashtra and Tamil Nadu) have relatively active social policies, good indicators of social development, and effective public services. As it turns out, they have also made serious efforts to “make ICDS work”, and this is reflected in many indicators of the quality of ICDS services. We shall occasionally refer to these three states as the “active states”. By contrast, the other three states (Chhattisgarh, Rajasthan and Uttar Pradesh) have been relatively passive as far as ICDS is concerned. They have generally stuck to a “minimalist” implementation of the central guidelines, without investing significant financial, human or political resources in the programme. This inertia is reflected

### Box 4.1. An Anthropologist in FOCUS

As an anthropologist, there is a quest in me to venture into new field areas especially those which are remote and inundated with various social problems. The Integrated Child Development Service (ICDS) field surveys which were held in 2004 in three phases fulfilled this desire of mine to go for a long term field expedition. The incidents that I encountered in remote areas of Sirmaur of Himachal; Akaltara, Lundhra and Bhaithan of Chhattisgarh; Hastinapur and Barabanki of Uttar Pradesh as part of ICDS field surveys rank among my fondest memories.

Our main objectives of the field survey were to see, how the Anganwadi Centre in those areas were functioning and whether they were really doing what they ought to do for the welfare of the rural people. To find out the proper answers for these objectives, we were supposed to take personal interviews of targeted villagers. This was not an easy task for us, as in some places people did not respond properly because of their reluctance and ignorance. Nevertheless, people of the selected three states showed different attitude towards us (ICDS team).

I went to Sirmaur, Himachal Pradesh (bordering with Uttaranchal) in mid February 2006 as a part of three member field team which was supposed to conduct the ICDS pilot survey in one of the block as a sample block which was predefined. Villages were scattered and some of them were located in high altitude without any proper transport facilities. Climbing up hill was the only way to reach these villages. For a person like me who was born in a coastal region it was difficult to reach all these villages. While climbing up hill, I sometimes felt that I should jump off the hill because of the lack of stamina. But somehow I managed to undertake this daunting task. People were amicable and the villages were multi-caste. They secretly practice polyandry and inheritance is based on the system of the male primogeniture. Women somehow

exercise higher power in the decisions of the family though family structure is patriarchal in nature but this does not necessarily give them a higher status in the society. Hence being a male member of the team, I did not face any problem to interact with mothers and pregnant women who were the target group of our survey. During our assessment of the midday meal programme I observed that caste based differences played a major role as upper castes children generally brought their own utensils, although they sit together with lower caste children while eating food. The field work lasted for seven days with pleasant experiences in a high altitude area.

In the next trip the field team covered three blocks of tribal belt in Chhattisgarh. Our first block was Akaltara; everyday early in the morning we started our journey for the field, the weather was too hot because of the mid summer, during midday when the sun was unrelenting. In the mean time one of my colleagues fainted and required medical attention. Thus our team was reduced into three members from four. The work pressure increased due to this incident. However, finally we managed to complete our task in time. Our next block was Lundhra, the place which I loved the most. People were hospitable though transport facilities were practically nonexistent. We took shelter into a Reinbasaera (Guest House in Block Head quarter) which had no electricity or any proper sanitation facility. Thus, we managed our seven days in Lundhra with a single pair of clothes. As a male, I did not face any problem in taking bath near roadside tubewells, but for female members this was probably a nightmare. Since the people were so nice, we forgot all other obstacles that we were facing. People were mostly tribal and each village consisted of multi-tribal groups. Their eagerness to send their children into AWC and schools were amazing. They interacted with us intimately. Transportation was another factor, which curtailed our pleasure of doing a comfortable fieldwork. To cover one of the targeted vil-

lages we had to cycle almost 72 kms. There was a single bus which used to ply between our base camp and the selected village, but it was irregular in its timing. Only way to go there was either walking or cycling. Lundhra was one of the areas where Naxals were very active, as a result once Nidhi and I were asked by the people that if we subscribed to Naxalite ideology? The main reason behind asking such a question was that we were wearing black clothes. After, Lundhra, we moved to Bhaithan, it was similar to Lundhra. Targeted AWCs were in very remote places and lacked proper transportation. Walking was the only way to commute to these places. But presence of Ganga Da made our field work in Chhattisgarh a memorable one. Till date the memories of Chhattisgarh are deeply etched in my mind.

In the second phase of main survey, my early team had been reshuffled with introduction of a new colleague. We were supposed to cover two Districts of Uttar Pradesh. One was Meerut and the targeted block was Hastinapur while the other was Barabanki. Uttar Pradesh as a state despite all kinds of facilities being available which lacked in the other two states was not a pleasant trip. Caste and religious conflicts marked day to day life. People were extremely patriarchal in their thinking. Corruption and manipulation was clearly visible even at the level of ICDS project. Thakurs (Rajput), Brahmins and numerically dominant Yadavs manipulate the village social structure. They never allowed me as a male to interact with female respondents. People always kept on asking us about our own caste identities, whether we were eligible for sitting besides them or not. This caste consciousness is well marked in the case of upper castes. Many of the anganwadis were non functional and supply of midday meal was irregular. Recruitment process of AWC workers and assistances were also politically motivated.

*Contributed by Antu Saha*

in poor outcomes. To convey the fact that this inertia is not immutable, we shall refer to these three states as the “dormant states”.

While this dichotomy is often convenient for presentation purposes, and will be used from time to time, it should not be taken too literally. Indeed, there is much variation in the quality of ICDS services not only between the two groups but also within each group. Generally, Tamil Nadu had the best quality indicators, and Uttar Pradesh the worst, but there was much diversity between these two extremes. The picture also varies depending on which services one is looking at. For instance, judging from the FOCUS survey, child immunization services are as good (if not better) in Himachal Pradesh as in Tamil Nadu, but the “pre-school education” programme is much more advanced in Tamil Nadu. This diversity will have to be borne in mind as we go along.

The inter-state contrasts are illustrated in Table 4.1, which conveys the perceptions of ICDS among sample mothers. The last column presents the figures for the whole sample, covering all six FOCUS states. The first column presents the corresponding figures for Tamil Nadu, to give a sense of “what is possible” – how ICDS is doing in a state where it has received sustained attention. An important message emerges from the first two rows: anganwadis open regularly, and the “supplementary nutrition

programme” (SNP) is in place – not just in Tamil Nadu but also elsewhere. This is consistent with direct observation: nearly 80 per cent of the sample anganwadis were open at the time of the investigators’ unannounced visit. Similarly, in 90 per cent of the sample anganwadis, the investigators found that supplementary nutrition was being provided at the time of the survey. As we shall see in the next chapter, there are enormous variations in the quality of supplementary nutrition between different states. Nevertheless, it is encouraging to note that ICDS is a “functional” scheme – this is more than can be said of many other rural development programmes.

Looking further down Table 4.1, there are other signs of real achievement as well as major areas of concern. For instance, it is encouraging to find that a large majority (72 per cent) of mothers consider ICDS to be “important” for their child’s welfare. About two thirds of the sample mothers stated that their child attends regularly, and a similar proportion reported that their child is regularly weighed at the anganwadi. Regular weighing, in itself, is not necessarily a major achievement (depending on what is done with the measurements), as we shall see in the next chapter. But here again, the message is that some important activities are taking place at the anganwadi, with a strong potential for more as Tamil Nadu’s experience illustrates. On the

other hand, some ICDS services are in poor shape. Only half of the sample mothers, for instance, said that pre-school education (PSE) activities were taking place at the anganwadi. In some cases, this may reflect a lack of awareness on their part rather than the failure of the PSE programme. However, the observations of the field investigators confirm that pre-school activities were quite limited in most anganwadis, with the notable exception of Tamil Nadu.

Table 4.2 presents another set of summary indicators, capturing the perceptions of field investigators rather than sample mothers. In interpreting this table, it should be noted that the “standards” used by field investigators to rate the effectiveness of an anganwadi in a particular state are likely to be influenced by the general achievements and expectations in that state. For instance, an anganwadi rated as “poor” in Tamil Nadu may still work better than most anganwadis in Uttar Pradesh. This subjective element in many of the indicators presented in Table 4.2 has the effect of “diluting” the inter-state contrasts. Even then, the contrasts are remarkably sharp, and broadly consistent with what emerged in Table 4.1 based on the perceptions of sample mothers.

Even within states, there were major quality contrasts between different anganwadis. If one were to single out one factor that appears to drive

**Table 4.1. FOCUS Survey: Perceptions of ICDS among Sample Mothers**

	Tamil Nadu	“Active States” <sup>a</sup>	“Dormant States” <sup>a</sup>	Uttar Pradesh	Focus States <sup>a</sup>
<b>Proportion (%) of sample mothers who reported that:</b>					
The local anganwadi opens regularly	100	99	90	87	94
Supplementary nutrition is provided at the anganwadi	93	94	93	94	94
Their child attends regularly <sup>b</sup>	86	75	52	57	63
Their child is regularly weighed at the anganwadi	87	82	47	40	64
Immunization services are available at the anganwadi	63 <sup>c</sup>	72 <sup>c</sup>	49 <sup>c</sup>	44 <sup>c</sup>	60 <sup>c</sup>
Pre-school education activities are taking place at the anganwadi <sup>b</sup>	89	55	41	36	47
The anganwadi worker has a “kind attitude” towards the children	84	82	74	77	78
ICDS is “important” for their child’s welfare	95	88	57	59	72

<sup>a</sup> “Active states”: Himachal Pradesh, Maharashtra, Tamil Nadu. “Dormant states”: Chhattisgarh, Rajasthan, Uttar Pradesh. “FOCUS states” refers to the six states taken together.

<sup>b</sup> Among mothers with at least one child in the age group of 3-6 years (the reference group for this question).

<sup>c</sup> These figures are likely to underestimate the extent of immunization activities under ICDS, because immunization sessions often take place at the local health centre, with the help of the anganwadi worker.

Source: FOCUS Survey 2004. The figures are based on a random sample of women with at least one child under the age of six years, enrolled at the local Anganwadi.

**Table 4.2. FOCUS Survey: Observations of Field Investigators**

	Tamil Nadu	“Active States” <sup>a</sup>	“Dormant States” <sup>a</sup>	Uttar Pradesh	Focus States <sup>a</sup>
<b>Proportion (%) of anganwadis where:<sup>b</sup></b>					
Overall functioning is rated as “poor” or “very poor” by the survey team	13	28	41	42	35
Supplementary food was <i>not</i> being provided at the time of the survey	0	7	12	25	10
Effectiveness of child immunization is “low” or “very low”	12	6	41	44	25
<b>Proportion (%) of villages where:<sup>b</sup></b>					
The motivation of mothers to send their children to the AWC appears to be “high” or “very high”	60	51	27	23	39
Mothers look at the anganwadi worker as a person who can help them in the event of health or nutrition problems in the family	52	51	11	10	30

<sup>a</sup> “Active states”: Himachal Pradesh, Maharashtra, Tamil Nadu. “Dormant states”: Chhattisgarh, Rajasthan, Uttar Pradesh. “FOCUS states” refers to the six states taken together.

<sup>b</sup> Proportion of valid observations, i.e. of anganwadis/villages for which the relevant assessment could be made by the survey team.

Source: FOCUS Survey 2004. All figures are based on the overall assessment of the survey team, after an unannounced visit to the anganwadi and detailed interviews with mothers.

these contrasts, it would be the “human factor”, and in particular, the skills and motivation of the anganwadi worker. The human factor, of course, is not God-given. It depends on various enabling conditions such as the selection, training, supervision and work environment of anganwadi workers, and also the support they receive from the community. We shall take a closer look at these issues in Chapter 6.

### 4.3. Field Observations

In this section, we take a closer look at the regional contrasts mentioned earlier, with respect to different aspects of ICDS. This is an informal overview – most of the issues discussed below will be scrutinised again further on.

**Physical Infrastructure:** The basic infrastructure provided to run an anganwadi varied widely across states (Table 4.3). It ranged from an independent all-weather building with adequate space for play-way learning and separate spaces for storage and cooking in Tamil Nadu, to a one-room dingy and cramped structure in Uttar Pradesh. In Chhattisgarh and Uttar Pradesh, most of the anganwadis were located in the home of the anganwadi worker or helper. This is a highly unsatisfactory arrangement, which entails frequent disruptions in ICDS activity and restricted access for some communities of the village. In sharp

contrast to the north Indian states, most anganwadis in Maharashtra and Tamil Nadu had good buildings (though not necessarily “independent” buildings, in the case of Maharashtra), located near the primary school, with a source of clean drinking water and other essential facilities. Most of them were also well supplied with basic furniture, cooking utensils, storage containers, toys, charts and related equipment.

***The main difficulty we found was that the anganwadi did not have a place of its own. The anganwadi worker had to shift the anganwadi to the compound in the primary school, and felt it was problematic because teachers would not let them keep their things. Given a building of their own would help in giving the AWC place to store their equipments, SNP etc. It would also work in legitimizing their existence in the village.***

*(FOCUS investigators’ comment, Jafarpur village, Varanasi District, Uttar Pradesh.)*

**Human Resources:** The FOCUS survey pointed to a whole range of issues related to the selection, training, duties, supervision, remuneration, support and empowerment of anganwadi workers. The most helpless and ineffective anganwadi workers were found in Barmer district of Rajasthan. Most of them had never been to school and relied on their husband, brother or son to fill the ICDS registers. They were unable to maintain the children’s “growth

charts”, not to speak of imparting pre-school education to them. Also, there was much “political interference” in the appointment of anganwadi workers, and as a result, their motivation often left much to be desired. This picture, however, is not representative of the general situation of anganwadi workers. In all the sample states, many anganwadi workers came across as able women who could do a great deal to enhance the levels of nutrition and health in their community. With the necessary support and facilities, their work was highly effective. The main issue is to create the circumstances that enable this potential to flourish – more on this in Chapter 6.

**Supplementary Nutrition:** Regular provision of nutritious food is an essential precondition for the success of any anganwadi. If there is no food, or if the food is tasteless and monotonous, few children attend and no activity can take place. Unfortunately, many of the sample anganwadis failed this basic test of integrity, especially in the dormant states. In Uttar Pradesh, there are frequent interruptions in the supply of supplementary food. When food is available, it is just “panjiri”, a ready-to-eat mixture with a short shelf life which is often stale by the time it is distributed (several instances of children falling critically ill after consuming the local panjiri were reported in the sample villages). In Rajasthan, there is more regularity, but again no variety: children get the same



### Box 4.2. The Human Factor in ICDS

The “human factor” in ICDS can make a big difference, both positive and negative. This is one of the insights arising from a recent study of “positive deviance” in the ICDS programme, carried out in April 2004 in Banswara (Rajasthan) and Shahgarh (Uttar Pradesh) – some of the better-performing blocks in these two states.

Perhaps the most significant aspect of the human factor is the anganwadi worker – more specifically her education levels, caste and community affiliation, dynamism and leadership qualities, and whether she is a local resident. Half the battle, according to the state directorate in Rajasthan, is won with the selection of the right people.

While the educational level of the worker is important, we also found several anganwadi workers who were less educated and even illiterate but highly committed to their work. Training and motivation can also make a difference. But technique and system can do little if the workers themselves lack empathy. During the fieldwork, we came across influential anganwadi workers of the forward castes, with little interest in or commitment to their work. In Uttar Pradesh (UP), for example, where different communities compete for resources, access depends on the caste and community of the anganwadi worker. If the worker is from an OBC or forward caste, she makes little effort to reach out to the dalit children even when they live close by. They lacked empathy and accountability and were supremely confident that nobody could dislodge or transfer them from their present positions. This smugness was all pervasive. Unlike in Rajasthan where forward caste families normally shun public feeding programmes, the powerful in UP often corner benefits meant for the poor. In a related study, researchers were able to purchase the SNP meant for free distribution in anganwadis, at local shops!

The anganwadi helper is a crucial factor for good attendance of children. Daily wage workers and women who go for collection of forest produce or work in their fields were unable to escort their children to the anganwadi. Attendance then depends entirely on the ability and motivation of the anganwadi helper to fetch the children.

Finally the way in which the national objectives of the ICDS are understood and articulated by state officials can significantly affect programme outcomes. In Rajasthan, the state level leadership believed that the primary objective of ICDS is to promote better nutrition and health of children. As a result, the programme was geared for regular procurement and distribution of SNP. Discussions revealed that this was given “top priority”, followed by organising a monthly “health day”, to forge convergence with the health department.

This also held true for the state leadership’s belief that the primary beneficiaries of the programme are poor children. As a result, targeting was taken very seriously. Government orders issued in the last five years emphasised the importance of “proper selection” of anganwadi workers and “proper identification” of beneficiaries. The state guidelines specified that identification should be based on house-to-house surveys to weigh children in order to identify those malnourished and severely malnourished. These children were therefore enrolled on a “priority basis”.

The situation in UP was different. Discussions with state leadership revealed considerable ambiguity about the primary objectives of ICDS. While the officials interviewed agreed that nutrition and health were important, all of them gave precedence to pre-school education. This could also (perhaps)

be attributed to the overall administrative and political environment in the state. The political instability witnessed over the last few years has contributed to apprehensions to take decisions regarding awarding tenders for procurement and supplies. Consequently, ensuring quality and regular supply of the approved quantity has never been smooth.

Analogously the block and district level officials also proved to be a critical factor in the management of ICDS. The contrasting situation in the two states is revealing. One assistant CDPO in UP did not have a vehicle to undertake monitoring visits. Despite this she went on field visits and had already visited twenty-five anganwadis in her short tenure. Though she was motivated and committed, she was struggling in the cross currents of unmotivated supervisors.

The block and district officials are critical for creating a supportive environment and ensuring tight monitoring. This was perhaps central to the relatively high prevalence of good practices in Banswara district of Rajasthan. The CDPOs in this district were motivated and in close contact with the block office including supervisors. They had visited many anganwadis (except those in remote areas) and were fairly well informed about all aspects of the programme. They also attended the quarterly state level meetings on a rotation basis – thereby coming in direct contact with the state directorate. These quarterly meetings were used to communicate guidelines, provide training and get feedback on operational issues and problems.

The ‘human factor’ is clearly important. We found strong positive deviance in the anganwadis where these qualities converged.

*Contributed by Vimala Ramachandran*

**Table 4.3. Physical Infrastructure of Anganwadis**

	Own building	Kitchen	Storage facilities	Drinking water	Toilet
<b>Proportion (%) of sample anganwadis with:</b>					
Tamil Nadu	88	85	88	68	44
“Active states” <sup>a</sup>	44	48	57	65	20
“Dormant states” <sup>a</sup>	22	29	55	70	20
Uttar Pradesh	13	13	39	58	32
FOCUS States <sup>a</sup>	33	39	56	68	20

<sup>a</sup> “Active states”: Himachal Pradesh, Maharashtra, Tamil Nadu. “Dormant states”: Chhattisgarh, Rajasthan, Uttar Pradesh. “FOCUS states” refers to all six states. Source: FOCUS Survey 2004.

“murmura” every day. Many parents there viewed this lack of variety as a major reason for poor child attendance at the anganwadi. By contrast, there are three items on the menu in Himachal Pradesh (*khichri*, *dalia* and *chana*), served on different days of the week, and the supply is quite regular in spite of the difficult terrain. The diversity and nutritious content of the food are even higher in Tamil Nadu, where two types of food are provided at the anganwadi: (a) a fortified, pre-cooked “health powder” (to be mixed with boiling water or milk) for children below two years, and (b) a hot lunch of rice, dal and vegetables freshly cooked with oil, spices and condiments (with occasional variants such as a weekly egg) for children in the 3-6 age group. Further, the survey teams did not come across any disruption in the supply of food in Tamil Nadu, or for that matter Maharashtra.

**Immunization and Other Health Services:** Inter-state contrasts in the functioning of ICDS are particularly sharp when it comes to health-re-

lated services. In Maharashtra, immunization services were well integrated with ICDS, and only one of the sample children had not been immunized at all. Children enrolled at the local anganwadi were regularly weighed, their “growth charts” were well maintained, and children with low or faltering weight were often given food supplements. Close coordination with the primary health care system was also observed in Tamil Nadu. For instance, immunization sessions, health checkups and weight measurements are done each month on a pre-designated day in the joint presence of Health Department and ICDS staff. In Chhattisgarh, Rajasthan and Uttar Pradesh, by contrast, the growth charts were missing, fudged, poorly maintained or out of date in most cases, and even basic immunization services left much to be desired in many places. Having said this, some health services have been neglected in all the FOCUS states: referral services, home visits, and “nutrition and health education” (NHE) sessions,

among others. In some of the better anganwadis in Maharashtra and Tamil Nadu, NHE meetings were being held on the same pre-designated day as the health check-ups, but this appears to be the exception rather than the norm. In Rajasthan and Uttar Pradesh, most mothers had no inkling that such services were available and generally did not look at the anganwadi worker as someone who could help them in the event of health or nutrition problems in the family (see Table 4.2).

**Pre-school Education:** Among different ICDS services, pre-school education (PSE) is one of the most difficult to provide. The FOCUS survey suggests that pre-school education is in high demand, especially in areas where parents are relatively well educated. However, the development needs of young children are poorly understood by communities, and therefore the monitoring of PSE is limited. This leads to some casualness about pre-school education in many anganwadis. Lack of space, infrastructure and basic facilities is also



a common hurdle. Another problem is that many anganwadi workers are inadequately trained for this purpose. They also lack time for the planning of PSE and the development of aids and material for educational activities. For these and other reasons, the PSE component of ICDS is generally of low quality. Indeed, pre-school education activities were quite limited in most of the sample anganwadis, and virtually non-existent in large parts of Chhattisgarh and Rajasthan. The shining exception is Tamil Nadu, where most anganwadis have lively pre-school education activities every day (see also Chapter 7). Most children attending anganwadis in Tamil Nadu responded positively when asked to recite rhymes, sing songs, identify colours or perform simple exercises such as counting until ten. The pre-school education programme is well designed to suit the needs of young children, with teaching being done through a variety of creative games aimed at developing key skills such as language, recognition of objects, comparison skills, etc. New PSE kits are made available every year, and anganwadi workers are also well trained to prepare toys and games out of simple materials that are available locally.

**Community Support:** The ICDS programme is generally quite popular with the community in Tamil Nadu and Maharashtra. Attendance of children at the anganwadis was quite high, especially in comparison with

the other sample states. In many villages, the community also helped in various ways to make the anganwadi a more lively and attractive place for children. For instance, financial support was often provided for painting the walls or buying additional equipment such as basic furniture, toys for children or even electric fans. In the other states, there was little evidence or feeling of community support, except for stray cases of panchayats making premises available to run the anganwadi.

We hope that this brief tour of critical issues gives a sense of what emerged from the FOCUS survey. More detailed findings are presented in the following chapters. In a nutshell, these findings are perhaps best read as a “wake-up call for ICDS”. The programme clearly has a strong potential, and has much to contribute to the well-being and rights of children under six. At the same time, it is clear that this potential has often been wasted, mainly due to sheer neglect (itself reflecting the fact that children have no “voice” in the system, as discussed in Chapter 1). The condition of ICDS in the dormant states is particularly alarming. On a more cheerful note, there have been significant developments related to ICDS in several states since the FOCUS survey was completed, partly due to the new momentum generated by Supreme Court orders. We shall return to this in Chapter 8.

## 4.4. Social Exclusion and Special Needs

Social barriers of various kinds often prevent children from participating in ICDS. For instance, many Dalit children are unable to attend the anganwadi because it is located in the upper-caste hamlet, far away from their houses. Children with disabilities are often made to feel unwelcome, aside from the physical hurdles they may face in joining other children at the local anganwadi (and the frequent lack of skills required to include them). And children of migrant families, or of women employed in the informal sector, may have no access at all to ICDS, in the absence of special provisions to include them. There are many other examples of this problem of “social exclusion”, and of the related issue of “special needs”.

Social exclusion may be of two kinds: active exclusion and hidden exclusion. “Active exclusion” refers to cases of deliberate discrimination against, say, Dalit or Adivasi children. “Hidden exclusion” refers to more subtle ways in which marginalized children may be prevented or discouraged from participating in ICDS at par with other children. Taunting disabled children is a common example of hidden exclusion. Sometimes, of course, there is a thin line between active and hidden exclusion, but the distinction is useful in so far as it reminds us of the need to consider both aspects of the problem.

### Box 4.3. “Victim Blaming” as a Form of Hidden Exclusion

A large part of the ICDS apparatus blames poor people for being malnourished and for not being able to access the services government so kindly provides. The blaming gets severe when the ICDS staff deal with poor women, especially from tribal or dalit families. They are told that the government is trying so hard to help them, and that they are undeserving and ungrateful. Further they are blamed for being lazy, unclean and superstitious, and thus responsible for the bad condition of children. This is a strategy consciously or unconsciously adopted by most of the staff. It has become so ingrained in the function-

ing of the programme that even a freshly recruited staff member from a poor tribal family picks up this attitude within a few months of joining the service.

In a tribal setting, this has extremely damaging results. Tribal people feel offended and get discouraged from approaching ICDS services. The other impact is in terms of reducing the effectiveness of messages around changing feeding practices for children. Blaming the recipients puts them in a defensive position, and the impact of counselling gets lost. In 23 out of the 29 villages where an initial survey was done in Manendragarh

block (Koriya District, Chhattisgarh), people reported having experienced discouraging attitudes from the ICDS staff. For example, they were told to keep clean. This really made the tribal people feel hurt because they keep their houses, clothes and bodies very clean anyway. Victim blaming behaviour by the staff has been a major reason for the non-acceptance of promotional and preventive messages in child nutrition. It has also reduced the popularity of ICDS services.

*Extracted from “Grassroots Mobilisation for Children’s Nutrition Rights in Chhattisgarh”, EPW, 26 August 2006, by Samir Garg.*

Active exclusion ought to be a relic of the past, but instances of it did come up in the FOCUS survey. To illustrate, in some anganwadis Dalit children were made to sit separately from other children while eating, or served with different, demarcated utensils. One example was Marhada village in Mandi District (Himachal Pradesh), where Dalit children were served in bowls and the rest in plates. Similarly, we found cases where upper-caste parents objected to a Dalit helper cooking for their children, or even giving them water. Most of the villages where active caste discrimination was observed were located in

the northern states (including Himachal Pradesh), but some instances were also found in Maharashtra and Tamil Nadu.

On the face of it, active exclusion in ICDS has a limited reach. In the FOCUS survey, instances of active exclusion were relatively few, and parents - including Dalit parents - rarely mentioned them (Table 4.4). To illustrate, in answer to the question “did your child ever face any kind of discrimination at the anganwadi because of his/her caste”, a vast majority (98 per cent) of Dalit mothers replied in the negative. However, many respondents may hesitate to acknowledge

incidents of caste discrimination. Some may not even perceive these incidents as “discrimination”, if they have become part of the accepted social order.

What seems clear, however, is that the main problem is hidden exclusion rather than active exclusion. Observations from the field investigators suggest that hidden exclusion is indeed quite common (see Table 4.4 and Chart 4.1). Unfortunately, it is often hard to tell how social exclusion works, or even whether it is involved at all. For instance, if one asks an anganwadi worker why she often “skips” Dalit hamlets during her home visits, she may say that it is because these hamlets are comparatively remote and hard to reach, even if the real reason lies in caste prejudice. Similarly, a village sarpanch may be able to give many coherent reasons why the anganwadi is located in the “main” hamlet (which happens

**Table 4.4. Perceptions of Social Exclusion**

Proportion (%) of mothers who objected to children of different castes using the anganwadi	2
Proportion (%) of SC/ST mothers who felt that their child had faced caste discrimination at the anganwadi	1
Proportion (%) of villages where the field investigators observed any evidence of caste discrimination in ICDS	16

Source: FOCUS Survey 2004.

to be an upper-caste hamlet), rather than in the Dalit hamlet.

Ordinary survey data are of limited use in understanding hidden exclusion. To illustrate, consider the location of anganwadis. In Table 4.5, the hamlets located in the FOCUS vil-

lages have been divided into six categories, depending on the identity of the numerically dominant community (SC, ST, Muslim, etc.). For each category, the table presents (in the relevant row) the percentage distribution of hamlets in terms of dis-

tance from the nearest anganwadi. It shows, for instance, that only 25 per cent of SC-dominated hamlets have an anganwadi within the hamlet, compared with 34 per cent of hamlets dominated by “general caste” households. As it happens,

#### Chart 4.1. Caste Discrimination in ICDS: Observations of Field Investigators

*“The anganwadi worker does not enroll children from the Harijan Basti.”*

(Kotwa Village, Barabanki District, Uttar Pradesh)

*“Even though this is a Muslim dominated village, not a single child from that community has been enrolled at the anganwadi.”*

(Suwara Village, Barmer District, Rajasthan)

*“The anganwadi worker is a Brahmin and does not make home visits to the Maurya (Scheduled Caste) Basti.”*

(Koyeripur Village, Varanasi District, Uttar Pradesh)

*Mothers of the children going to the anganwadi complained that the anganwadi worker discriminates on the basis of caste while distributing SNP.”*

(Waleedpur Village, Meerut District, Uttar Pradesh)

*“Most of the Muslim households were non users (eligible families with not a single child enrolled at the AWC). The AWW seldom goes there and talks to them or convinces them to get their children enrolled.”*

(Parsa Ka Baas Village, Alwar District, Rajasthan)

*Caste based discrimination is still prevalent. The Sarpanch is from a “general” category and is not in favor of Scheduled Castes availing the anganwadi services.*

(Ganishpur Village, Meerut District, Uttar Pradesh)

*Since the anganwadi worker is a Harijan, villagers from higher caste do not send their children to the anganwadi, and even the Pradhan interferes with its functioning.*

(Nandapur Village, Meerut District, Uttar Pradesh)

**Table 4.5. Physical Accessibility of Anganwadis for Different Social Groups**

Hamlet category (identity of largest population group)	Percentage distribution of hamlets (within each category), by distance from the nearest anganwadi <sup>a</sup>				
	0 <sup>b</sup>	1-100 metres	101-300 metres	301-999 metres	1 km or more
“General” <sup>c</sup>	34	6	6	22	32
OBC	28	19	14	19	20
SC	25	14	18	26	17
ST	20	10	10	32	28
Muslim	25	0	13	50	12
Other	30	10	10	10	40
All hamlets	27	13	12	24	24

<sup>a</sup> Entries add up to 100 in each row.

<sup>b</sup> There is an anganwadi within the hamlet.

<sup>c</sup> Hindu but not OBC/SC/ST.

Source: FOCUS Survey 2004. Each entry in the table indicates the proportion of hamlets (in a given category) located at a specified distance from the nearest anganwadi. For instance, among SC-dominated hamlets 25 per cent have an anganwadi within the hamlet and 17 per cent are more than 1 km away from the nearest anganwadi.

however, the “general caste” hamlets are also more likely to be further than one kilometre away from the nearest anganwadi than any other hamlet category. Looking at the table as a whole, no striking pattern emerges: the distribution of hamlets in terms of distance from the nearest anganwadi is not very different for different social groups. However, this information has to be read in the light of the fact that disadvantaged communities such as Scheduled Castes, Scheduled Tribes and Muslims are supposed to be the “priority groups” of the ICDS programme. Table 4.5 suggests that, in practice, these communities are not receiving priority, at least not in terms of the placement of anganwadis. This failure to implement the priority guidelines may well reflect various forms of active or hidden exclusion. In fact, it can be regarded as a form of social exclusion per se, no matter how this failure came about.

Similar issues arise when we look at the social composition of children enrolled in ICDS. As Table 4.6 indicates, the share of SC/STs among

children enrolled in the sample anganwadis is about 40 per cent – much higher than their share (27 per cent) in the population of the sample districts. But again, this finding is not inconsistent with pervasive “exclusion”, since SC/ST children are supposed to be the priority groups.

The difficulty of eliciting authentic information on caste discrimination is well illustrated by recent studies of this issue in the context of mid-day meals in primary schools. In a general survey of mid-day meals conducted in 2003, based on standard interview methods, little evidence of caste discrimination (or at least of active discrimination) emerged, with the major exception of upper-caste resistance to the appointment of Dalit cooks (Drèze and Goyal, 2003). But a later survey, based on participatory methods with the active involvement of Dalit field investigators, revealed that caste discrimination in mid-day meals – active as well as hidden – was actually quite common (see Box 4.5).

Something similar may be happening in the context of ICDS. The FO-

CUS survey findings on caste discrimination are somewhat ambiguous: they suggest that active exclusion is relatively uncommon, and do not throw much light on the extent or nature of hidden exclusion. On the other hand, a more recent survey, focusing specifically on social exclusion, suggests that hidden exclusion is quite pervasive. For instance, this study (based on a detailed survey of 14 villages in Andhra Pradesh, Chhattisgarh, Jharkhand and Uttar Pradesh) found that “in none of the surveyed mixed-caste villages was the ICDS centre located in the dalit hamlet”. The study also found extensive evidence of “everyday caste discrimination” at the anganwadi. To illustrate:

*... differential attitudes of the AWW [anganwadi worker] and AWH [anganwadi helper] to children of different castes and economic backgrounds played a major role in discouraging the participation of children from disadvantaged castes. The helper would not collect children from the low caste hamlets, and often these children and their guardians were terrified about how they would be treated by the ICDS staff if they defecated or were naughty, although children from more advantaged backgrounds did not harbour such fears.*

(Harsh Mander and M. Kumaran, “Social Exclusion in ICDS”, 2006)

The authors also uncovered other forms of active or hidden exclusion.

**Table 4.6. Participation of SC/ST Children in ICDS**

Age group	Proportion (%) of SC/ST children among all children enrolled in the sample anganwadis <sup>a</sup>	
	Girls	Boys
0-3 years	43	42
3-6 years	44	44

<sup>a</sup> Based on enrolment registers at the anganwadis.

Source: FOCUS survey 2004. The share of SC/ST in the population of the sample districts is 27 percent.

### Box 4.4. India's Forgotten Forest Children

In July 2004, with distressing regularity, 11 Adivasi children were reported to have died of starvation in Dongriguda (Nabrangpur district) in Orissa. Dongriguda is a forest settlement located inside the Temera Reserve Forest bordering Chhattisgarh. In contrast to the typical official response of denial, the Secretary of the state's Women and Child Development department ordered an immediate enquiry. This revealed that the Forest Department had refused to open an anganwadi in the hamlet close to where the children lived. This was due to fears that it would be considered illegal - an 'encroachment' on forest land.

Newspaper reports suggest that Dongriguda is one of 200 such 'forest encroachments', where Adivasi's are denied access to any welfare measures. The number of Adivasi's so affected, is quite sizeable. According to the Ministry of Environment and Forests, 13.43 lakh hectares of forest land is allegedly forest encroachments. At a conservative estimate of one hectare per family, this suggests a combined population of 15 lakh forest dwelling families or 75 lakh people including children. Infact the official figures of forest 'encroachments' are likely to be a gross underestimate of the people actually living in such settlements, especially in states like Orissa. It is relevant to note that this estimate accounts for the eviction of alleged encroachers, between May 2002 and March 2004, from 1.52 lakh hectares of forest land. The fact that a majority of people living on ancestral lands have been wrongly labelled as 'encroachers', is an added misfortune. This happened due to sweeping notifications which declared Schedule V Adivasi areas as State For-

ests, without any survey or settlement of rights, as required by law. The origins of the Recognition of Forest Rights Bill currently with Parliament lie in this historic injustice done to the country's pre-dominantly Adivasi forest dwelling communities.

The Dongriguda tragedy and the enquiry findings, prompted the then Secretary - Women and Child Development, to catch the bull by the horns. After discussions with the Principal Secretary, Forest & Environment, he issued a radical order which stated:

*"I would like to clarify in clear terms that children and pregnant / lactating mothers residing in any hamlet within the geographical boundary of the ICDS project will be enumerated for the purpose of the project and will be included under vital ICDS services including Supplementary Nutrition Programme, if eligible otherwise. Whether the hamlet is part of a revenue village or not, whether it is formally part of a forest village or whether it is an encroachment on forest land either pre-1980 or post-1980, is of no consequence as far as the ICDS scheme is concerned."*

The Principal Secretary, Forest & Environment, also instructed the departments field functionaries to allow anganwadi workers and ANMs access to encroached settlements to discharge ICDS duties. This was followed by orders from the Chief Secretary to the Collectors of all KBK districts, to strengthen government programmes related to supplementary nutrition, food security and health in their districts

Although these orders are a welcome change, they remain at best a partial remedy to reach out to India's forest children. Infact

even the residents of official 'forest villages' created by the forest department themselves, cannot get domicile certificates. These can be issued only by the Revenue Department which has no jurisdiction on 'forest' land. Consequently, they are unable to get SC/ST certificates necessary for accessing reservation and other benefits.

Despite government orders to the contrary, 'encroachments' on forest land continue being deprived access to other basic welfare services and livelihood rights. For instance, the Forest Department did not permit the District Collector to even install a tube well for drinking water in Dongriguda, because the settlement is considered a forest 'encroachment'. Moreover no department other than the forest department can undertake any construction activity on forest land. Many forest settlements as a result, lack basic school, anganwadi and primary health infrastructure, unless the forest department undertakes the responsibility of building them. Residents also cannot benefit from the Indira Awas Yojana, as they have no title deeds to the land on which they live. Loss of crop and livestock due to wildlife or drought, is also not compensated.

The situation is particularly dire in settlements (both legal and allegedly illegal) inside wildlife sanctuaries and national parks, where the Wildlife Protection Act effectively deprives residents of the fundamental rights guaranteed by the Constitution. Malnutrition, sending children away for work, distress migration and starvation deaths will remain the order of the day in such areas unless the resource rights of such forest dwellers are recognised.

*Contributed by Madhu Sarin*



### Box 4.5. Caste Discrimination in Mid-day Meals

In 2003, a survey was conducted among Dalit communities in 306 villages across the states of Rajasthan, Andhra Pradesh and Tamil Nadu. The purpose was to obtain a ground-level view of how, where, and to what degree caste discrimination operates in the Midday Meal Scheme (MMS) in government schools. This was done by measuring various indicators of Dalits' access to and participatory empowerment in the MMS.

The first set of indicators used related to physical access to MMS. This was measured in three ways. One by examining the proportion of villages implementing the MMS. Over 98 percent of the villages surveyed had a functioning MMS. It seems therefore that state governments have achieved the initial step of facilitating access in these states.

Two the proportion of villages in which the MMS was held in a physical setting accessible to Dalit children say in the school building as opposed to a (Dalit-exclusive) temple. Of the villages having a functioning MMS, 93 percent appropriately serve it in the school building itself. The remaining hold it in other 'public' buildings, with the notable exception of two villages in Tamil Nadu where it is served in Hindu temples, spaces that conventionally exclude Dalits.

Three the proportion of villages which situated the MMS in a non-threatening locality say a Dalit colony as opposed to a dominant caste one. If the physical setting of the MMS is important, the locality in which that space is situated is equally if not more significant. In terms of caste geography, the majority of midday meals in TN and Rajasthan are held in dominant caste localities. The MMS was served in a dalit locality in only 19 and 12 percent of the villages surveyed in these states respectively. In notable contrast, the corresponding proportion was 47 percent in Andhra Pradesh. This seems to go a long way towards ensuring Dalit access, and might even help erode dominant caste prejudices

against entering Dalit localities. In Rajasthan and Tamil Nadu, then, the vast majority of Dalit children must enter an area of heightened vulnerability, tension and threat, in order to avail themselves of the midday meal or its dry grain equivalent.

The second set of indicators deals with Dalits' participatory empowerment in, and ownership of the MMS. This was measured by examining the proportion of villages in which Dalits are employed as 'cooks' and 'organisers' in the MMS. In hiring practices, Rajasthan is the least likely to employ Dalits. Only 8 percent of villages surveyed had a Dalit cook, and not a single village had a Dalit organizer. While Tamil Nadu hires proportionally more Dalits, they still remain firmly in the minority; 31 percent had employed Dalit cooks and 27 percent Dalit organizers. Andhra Pradesh clearly leads the three states in this regard. Close to half had employed dalits: 49 and 45 percent as cooks and organizers, respectively.

The third indicator used was the Dalit community-level access to the MMS. The analysis suggests that caste-based exclusion and discrimination in one form or another does in fact exist in a significant percentage of cases. More than one third or 37 percent of the villages surveyed in these three states reported "having a problem of caste discrimination in the MMS". The individual; state figures are 52, 24 and 36 percent for Rajasthan, Andhra Pradesh, and Tamil Nadu respectively.

This aggregate data includes cases of both exclusion and discrimination, defined as 'inclusion with inequitable treatment'. Cases of outright exclusion in the survey are few but startling. In six villages, Dalit children are totally barred from participation in the MMS by dominant castes. In the remaining discrimination manifested itself in the following ways. In the villages that specified the nature of caste discrimination, close to half report a problem of dominant caste opposition to Dalit cooks. The second most common issue at 31 percent is segregated

seating. A more intensified practice of segregation, in which Dalits and dominant caste children are served separate meals altogether, was reported in 9.2 percent cases. The same percentage said that teachers discriminate among students by giving inferior or insufficient food to Dalit children.

There are lessons to be learnt here. In addition to relocating or newly locating MMS centers in Dalit colonies or other accessible caste-neutral localities, state governments can begin tackling the problem of exclusion and discrimination by seeking partnerships with Dalit women's groups and other NGOs to jointly implement and monitor such programmes. Overall, Andhra Pradesh (Rajasthan) has the highest (lowest) percentage of Dalit cooks, organizers, and MMS served in Dalit localities. These states simultaneously also have the lowest (highest) percentage of reported caste discrimination with Tamil Nadu somewhere midway in these respects. While direct causality is difficult to prove, it appears that increased Dalit access and participatory empowerment corresponds with a decreased incidence of exclusion and caste based discrimination. The relative success of the Andhra Pradesh government in these matters could then be a result of its engagement with local women's groups in the execution of government programs. For instance implementation of MMS through DWACRA groups, as opposed to the usual government machinery, increases the scope for Dalit women to make empowered, effective and participatory interventions. This ensures their children's equal access to the Right to Food and Education, as well as their own Right to Employment (as cooks, organizers, or teachers). By fostering Dalit empowerment in this way, the government can decrease the incidence of discrimination, improve access, and begin to make the Right to Food a reality for Dalits at par with other communities.

*Contributed by Sukhadeo Thorat and Joel Lee.*



### Box 4.6. Disabled Children and ICDS

An intensive field study covering 14 villages in 4 states of Andhra Pradesh, Chhattisgarh, Jharkhand and Uttar Pradesh, was recently undertaken to examine “social exclusion” in ICDS. The most striking finding of the study was the fact that in none of the surveyed villages did they find any registered disabled children.

In Dhaba and Gundardehi villages in Chhattisgarh, the researchers came across three children with disability (seemingly six years above) who had never availed of any anganwadi services. There was only one case in which an adolescent girl Subala from Barhi village in Jharkhand, was recently registered at the anganwadi. Subala is 18 years old and speech impaired since birth. Her parents have passed away and she lives with her maternal uncle. Initially she was going to school but she faced a lot of humiliation from other students and teachers as well. After not being able to do her homework one day, the teacher struck Subala’s name from the rolls, saying she could not read and write properly. She has subsequently enrolled in the anganwadi and talks to the others through sign language. She has also enrolled in the sewing centre and has become one of the fast learners. Although her uncle wanted to give her an education, this was impossible due to the unavailability of special schools. The only government scheme from which she benefits is the ICDS.

In villages Dhabha, Gundardehi and Saranda, the team was not able to interact with any disabled children aged under six. But discussions with older children suffering from disability and their par-

ents confirmed that they were never sent to the anganwadi. Infact parents in Hathkongra village were convinced that their disabled children were simply not eligible to receive ICDS services. The parents of mentally challenged children, in particular, did not send their children outside the home, fearing harassment from other children and adults. In Billa village in Jharkhand, two disabled children were found to have been excluded from any ICDS service, largely because their parents as daily wage earners did not have the time to take them to the anganwadi. Moreover in all the villages, the parents of disabled children stated that the anganwadi was not a best place for their children, although they all aspired for them to eat dalia (porridge) and mingle with other children.

The story in Hardoi village in Uttar Pradesh was the same - disabled children were completely excluded from anganwadi services. Here too the families believed that the programme did not have any provisions for disabled children.

Priyanshu aged five years unable to walk on his own, has never seen an anganwadi. His mother, however, is aware of ICDS services but thinks that she cannot send him there because God has made him differently. “*What will they do at the centre?*” asks a mother whose abled child receives supplementary nutrition (panjiri) from the anganwadi. But Priyanshu’s mother wishes he could go – to make friends, to eat panjiri and to learn poems.

It was striking that disability was stigmatised, even when members of the dominant caste suffered from them. For instance, the only advantage a mentally challenged daughter of the tribal sarpanch had, was that she could roam freely in the village. Accompanying the team throughout its visit, she was

constantly taunted and made fun of. This often resulted in unpleasant situations with the girl protesting in abusive language, which she could afford to do probably due to her father’s power.

In most villages the excluded caste group reside in distant settlements consisting of households with disabled parents and children. Their vulnerability increases due to caste, powerlessness, distance, pressure of wage work etc. One particular family is a good example of the multiple vulnerability faced by families with a disabled care-giver. Shakur Minya used to pull a rickshaw at nearby Daltonganj. After a prolonged illness resulting in a bad leg, he could not go back to rickshaw pulling. In order to support his family, he had to start begging in Daltonganj itself and return to his village in the evening. Despite their destitute condition, neither does his 18 month old son receive food from the anganwadi nor did his disabled wife receive any ICDS services while pregnant and nursing. They now live in the outskirts of the village.

Another such case is that of Sarphudin Ansari and his wife Meymun Bibi from Pokhrakhurd village in Jharkhand. Both are differently abled. Sarphudin cannot walk without support and Meymun cannot see. They have a two year old daughter who has never received any food from the anganwadi. Meymun was also not assisted during her pregnancy. Sarphudin is working in a tailoring shop and earns Rs.20-25 per day. They live outside the border of the village. They have no information about ICDS services and are totally excluded from them.

*Contributed by Kumaran and Harsh Mander*

### Box 4.7. Children in Families of Migrant and Daily Wage Workers

Researchers in a study of 14 villages in four states of Andhra Pradesh, Chhattisgarh, Jharkhand and Uttar Pradesh noted that exclusion from ICDS services was very high among landless workers and small farmers, because they have to migrate for long periods. In four surveyed villages in Chhattisgarh, for instance, tribal people dependent upon rain-fed agriculture often migrate during lean seasons. In Andhra Pradesh similarly a number of them go to work in brick kilns. The children of such 'migrant' families do not receive ICDS services for the period they are away, even though they may be enrolled at the local anganwadi.

In the surveyed villages in Jharkhand and Uttar Pradesh, distress migration was the main coping strategy in off-seasons, when work as agricultural labour is not forthcoming. The landless Dalit families at Rejo village in Jharkhand are engaged in agricultural labour, rickshaw pulling and *hajamat* (the barber's trade). The daily wages they earn is not more than Rs 20 and 10 per day, for men and women respectively. It thus becomes imperative for them to migrate to Bihar or Uttar Pradesh for work, as many also have to pay back their debts to the dominant caste Yadav's in the village. In Rejo village, the anganwadi worker herself admits that these families are very poor. She also gives them the supplementary food from the anganwadi when there is no food in the family, even if the children are not enrolled. This however was one of the few examples of positive response from the ICDS staff towards children from socio-economically vulnerable segments.

Most migrant households in Rejo village were similarly excluded from ICDS services. Kameshwar Ram's son Ashok is landless and has migrated to Punjab to work as a daily wage earner. His two year old child is not enrolled to receive supplementary nutrition from the anganwadi. They are not informed about take home rations, immunization or health services and are not visited at home for counselling by the anganwadi worker. The family also do not make demands on the anganwadi worker. They have no access to any government food or livelihood schemes and barely survive from their daily wage earnings. When asked about their 'exclusion', they say it is their fate.

Even where alternative livelihoods exist within or near the village, like in the stone quarries in Dhaba village (Chhattisgarh) or *bidi* making in Hathkongra village (Chhattisgarh), children may still be excluded from ICDS services because of the cruel logic of grinding poverty. In such cases, parents do not perceive ICDS services to be beneficial enough to justify the loss of wage employment either of parents or older working siblings who would need to take the young child to the anganwadi. In cases where both parents work as daily wage labourers, the older children are required to take care of the younger ones at home, rather than go to anganwadi even though they may be eligible. The timings of the anganwadi are also unsuitable to families in which all the care givers are daily wage earners. Respondents from excluded families in all four surveyed villages in Chhattisgarh said the nature of their work made it difficult to come and avail ICDS services between 9 am to 1 pm, the opening hours of the anganwadi.

Kallu and his four children reside at Purwara tola in Jharkhand. He earns his bread from rickshaw pulling at the Bihar-Uttar Pradesh border. Kallu is a perennial migrant and comes to his village on a monthly or fortnightly basis. He is completely excluded from government services and does not have even a ration card. In his family, Amrita Devi is nursing but is unfortunately not enrolled at the anganwadi to receive services and has never been visited by the worker to her house. Kallu says he has no time to discuss these matters with the anganwadi worker.

In Billa Village in Jharkhand, landless labourers migrate for a month or two at a stretch in search of wage employment. We found two migrant families with children eligible to receive services but not enrolled at the anganwadi. As migrants they are most vulnerable but also the ones who get routinely and automatically excluded from government programmes run in the villages.

Imtiaz Ansari is a rickshaw puller at Daltonganj town. He has a three year old daughter who has never received supplementary nutrition from the anganwadi but she has been immunised with the help of the anganwadi worker. Dilip Kumar Mahato is another landless daily wage labourer in the same village. He has four children under the age of 6 years. Neither his wife Sushila Devi nor his children receive any food from the anganwadi. They stay at quite a distance from the anganwadi and are too busy in any case to find time to visit the centre everyday. They too, like so many others, remain excluded from ICDS and other government services.

*Contributed by Harsh Mander and Kumaran*

These include: selective neglect of Dalit children by anganwadi workers or helpers; favouritism in the appointment of anganwadi workers; giving preference to children from certain privileged groups in the provision of specific services; and purposely withholding information from marginalised groups about their entitlements under ICDS.

On a more positive note, ICDS is also a means of *fighting* caste discrimination and other traditional patterns of social exclusion. Indeed, in comparison with many other spheres of social life in Indian villages, the anganwadi is a site of relative social equality. It is a space where children of different social backgrounds learn to sit, play and eat together. As we saw in Chapter 1, this early interaction across the tradi-

tional barriers of caste, class and gender is an important aspect of the “socialisation role” of ICDS.

***“Though caste discrimination exists in the village at large, it does not affect the working of the anganwadi. Even children from upper caste households come and eat, in spite of the anganwadi worker being a Harijan.”***

*(FOCUS investigators’ observations, Sanarli Village, Mandi District, Himachal Pradesh.)*

At the end of the day, the main equity issue in ICDS is perhaps not so much the perpetuation of traditional patterns of social exclusion as the failure to make good use of the programme as a means of fostering social equality. This can be done in many ways, from ensuring genu-

ine priority to marginalized communities to reinforcing the socialization role of ICDS. As discussed in Chapter 1, the ultimate goal is not just “universalization with quality” but “universalization with quality and equity”.

In this section, we have discussed the issue of social exclusion mainly with reference to caste. It is important to remember, however, that social exclusion comes in various garbs and has many victims: not only Dalit or Adivasi children but also street children, migrant children and others. The problem of social exclusion also has to be linked with the issue of “special needs”, related for instance to disability. We have tried to give a voice to some of these marginalized children in the Boxes presented in this section.

## 5. Around the Anganwadi



Nidhi Vij

In this chapter, we continue our examination of the “ground realities” of ICDS with a closer look at specific services. We begin, in sections 5.1 and 5.2, with nutrition-related interventions, followed by health-related interventions in sections 5.3 and 5.4. The last section looks at pre-school education, or rather, “early childhood education”. As discussed in Chapter 3, these different services should not be seen in isolation. They complement each other, and their smooth

“integration” is one of the chief goals of ICDS. Nevertheless, each area of intervention raises specific issues and requires focused attention.

### 5.1. The Supplementary Nutrition Programme

According to Pierre Mac Orlan, artist and writer, “humanity is first and foremost a stomach”. Though one may disagree with this statement, it cer-

tainly applies to children, and especially to young children. In fact, the statement is based on Mac Orlan's personal experience of hunger during his childhood in France. No doubt many Indian children feel much the same. Protecting children from hunger is the first step towards the realization of their fundamental rights.

### Home Food and Supplementary Nutrition\*

Adequate food is the most important requisite for the healthy growth of a child. While this applies throughout early childhood, adequate food is particularly crucial during the first two years, when rapid growth occurs and the child is entirely dependent on her mother and family for food. Insufficient food not only results in undernutrition in terms of low weight, but also hinders growth. It also makes the child more vulnerable to infection and illness.

The most basic food requirement of a child pertains to energy, usually measured in calories. Energy is needed for activity and growth, and also for catch-up growth following infections. In spite of their small size, young children have voracious needs for energy, because of their rapid growth. A baby needs about 120 calories per kg of body weight per day. Thus, on an average, a baby of one to two years needs 1,000 calories daily. This is about half of what the mother eats! To achieve this high

calorie intake, a child needs frequent and appropriate feeding. Many children remain underfed because their energy needs are underestimated or difficult to meet with the kind of food they are given.

Aside from calories, the nutritional needs of children include adequate proteins, fats, minerals and vitamins. These nutrients are found in very different proportions in various types of food, and some are found in specific foods only. For instance, green leafy vegetables tend to be rich in iron and Vitamin A but not in Vitamin C, while oranges contain Vitamin C but no calcium. Thus, a balanced diet, with adequate intake of different types of nutrients, is also important for good nutrition and healthy growth. Aside from calorie deficiency, Indian diets are characterized by massive deficiencies of various nutrients. For instance, in the age group of 4-6 years, the ratio of average intake to "recommended daily allowance" (as defined by the Indian Council of Medical Research) is only 16 per cent for Vitamin A, 35 per cent for iron and 45 per cent for calcium.

One of the main components of ICDS is the "supplementary nutrition programme" (SNP). The need for supplementary nutrition arises from the fact that many children are unlikely to be well fed at home. This may be due to poverty, lack of time, inadequate awareness of children's

nutritional needs, misguided food habits, or even (in some cases) parental negligence. The required supplementation is both quantitative and qualitative: the former essentially involves raising energy intake, and the latter improving the quality and diversity of the child's diet. Quantitative supplementation alone, without attention to quality, is likely to be ineffective if not counter-productive. In some anganwadis of Uttar Pradesh, for instance, it was found that children ate stale *panjiri* day after day. If this kills their appetite, and reduces their intake of richer food at home, it may do more harm than good. Poor food supplements also send a wrong message to the parents: "children can eat anything" and their nutritional needs do not require special attention.

Supplementary feeding should never be treated as a substitute for effective feeding practices at home. Parents, and especially mothers, are clearly best placed to look after the nutritional needs of their children. Most of them are also keen to ensure that their child is healthy and well nourished. Empowering them to do so is, ultimately, the best way of protecting children from undernutrition. Indeed, the nutritional needs of a child can generally be met from local foods ordinarily available in most Indian villages. Adequate

\* Parts of this section draw on Shanti Ghosh (2004), a very readable introduction to nutrition and child care – highly recommended.



purchasing power, and a good understanding of child nutrition, can go a long way in averting child malnutrition. As long as these conditions are not met, the supplementary nutrition programme under ICDS has a crucial role to play, but this should not make us lose sight

of the importance of promoting better child feeding at home.

### Supplementary Feeding Under ICDS

The Supplementary Nutrition Programme (SNP) under ICDS serves at least four purposes: a nutrition

purpose, an incentive purpose, a well-being purpose and a socialization purpose. The nutrition purpose, already discussed in the preceding section, is to ensure that every child has an adequate, balanced diet. At a more basic level, the SNP is a useful means of protecting children from

#### Box 5.1. Preventing Malnutrition through Better Feeding at Home

Breast milk is a child's right. Every child should be exclusively breastfed for six months, starting almost immediately after birth, preferably even before the placenta is expelled and mother cleaned up. Even though all mothers notionally breastfeed, the percentage of children *exclusively* breastfed drops steadily from 72 percent for children under one month of age to about 20 percent at six months, the period during which exclusive breastfeeding is recommended by WHO. A large number of mothers also squeeze out the first milk (colostrum), considering it to be dirty.

While the situation regarding breastfeeding is clearly unsatisfactory, the situation regarding introduction of semi solid food (complementary feeding) from six months onwards, is even worse. Child malnutrition sets in very early in life, with nearly 12 percent of children aged six months and under being underweight. It increases rapidly and by 24 months, more than half the children are underweight. Obviously then, the crucial period to prevent malnutrition is the period from birth to two years. Prevention and management of malnutrition therefore must take place at the household level. These efforts should also be supported by trained health and ICDS personnel and by experienced older women in the community, who have successfully nurtured their children.

The diet pattern in India consists of a mixture of cereals and pulses like khichri and missi roti or dal, chawal in the north and idli, upma and dosa in the south. This combination enhances their food value. The be-

lief regarding "cold" and "hot" foods should not be condemned outright for there are innumerable foods to choose from. The belief that cereals are bad for the liver or that banana produces cough and phlegm can however be got over with tact and patience.

For the first six months, breast milk is the sole source of energy for the baby. Between 6 and 12 months of age, complementary foods are needed to fill the energy gap and also provide minerals including iron, zinc, and vitamin. Good 'weaning food' should meet certain criterion: it should be rich in energy and nutrients; clean and safe; soft and easy to eat and easy to cook.

When food is first introduced, a small amount equal to 2-3 spoons should be given. This should be gradually increased in quantity and frequency, so that by the age of one the child is eating 4-5 times a day and breastfeeding as well. As far as possible regular family food (without spices) should be given to the child after softening and mashing, rather than cooking special food. The food should be soft but not watery. It should also be noted that the foods recommended below are everyday foods, that others in the family also eat. So cost should not be a problem.

At 6 months of age the child should be given mashed banana or some cereal like suji, ground rice, ragi, etc. Seasonal fruits such as chikoo or papaya may also be given though apple or pear will need some cooking. Mashed rice with dal, vegetables or a roti softened in dal or some gravy, can be gradually introduced. At this stage babies should be fed 3-4 times a day.

When the child is between 9 to 12 months a variety of household foods can be given, 4-5 times a day. These include dal, roti, khichri, dalia, curd etc. and upma, idli, dosa, curd rice etc in the south. Egg can also be given either boiled or scrambled.

After the age of one year, the child can eat the food prepared for other members of the family. Among non-vegetarian families, minced meat, chicken or fish can also be introduced at this age.

In the absence of the mother, any family member including grandparents, aunts or a friendly and obliging neighbour can take over the role of feeding the child. The adolescent girl should be in school and only help out when she is at home. The child should now have her own plate, so that the amount of food the child has eaten can be clearly gauged. Needless to say, the child's and the caretaker's hands should be washed before feeding and food should be kept clear of flies. The food given to a child should not have spices and should be comfortably warm, neither too hot nor too cold. The child should set the pace and not the mother. Do not insist on making child eat more, if the child is not inclined to do so. Scolding or threatening should also never be resorted to.

Meal times should be a happy time, both for the child and the caretaker. Some children like to be told a story, hear a song or look at a picture book while eating. All this can make feeding a pleasant experience, which it should be.

*Contributed by Shanti Ghosh*



### Box 5.2. Hidden Hunger and Possible Interventions

'Hidden Hunger' is one of two types of hunger. The first is overt (or raw) hunger, or the need to fill the belly every few hours. Overt hunger definitely has to be addressed in our chronically underfed child. It is his or her primordial cry for food, or the "macronutrients" (calories and proteins) which provide energy.

The second type of hunger is "hidden hunger" for micronutrients (e.g., vitamins, minerals like iron, iodine, zinc and calcium) that are required in tiny amounts. Hidden hunger is not felt, recognized or voiced by the child or her parents. The reason for this is that micronutrient deficiencies do not translate into pangs of hunger, but into subtle changes in the way the child behaves. For instance, if the child is deficient in Vitamin A, he/she will not be able to see properly at dusk ("night blindness"), and respiratory ailments may also occur. In severe Vitamin A deficiency, the child may go totally blind. Iron Deficiency Anaemia (IDA) is India's huge problem. In such cases, the child will slow down both mentally and physically, perform poorly in school and experience chronic tiredness. In the case of iodine deficiency, there will be mental retardation. In its severe form, a goitrous lump may grow at the base of the neck. Zinc deficiency results in short stature. The terrible public health problems of scurvy (Vitamin C deficiency), pellagra (deficiency of niacin, a Vitamin B deficiency), or night blindness caused by Vitamin A deficiency, have been virtually wiped out. Yet, we cannot afford to be complacent as "hidden hunger" remains very widespread in India.

Several national programmes for Iron, Vitamin A and Iodine deficiency have been launched to address different forms of hidden hunger. Overall however they have not done well with respect to either the young child (through ICDS) or the older school-going child (via the mid day meal programme).

Children in the one to six age group need minuscule amounts of vitamins and minerals everyday to keep them in good health. One possible approach is to design low-cost micronutrient packages. With a weight of just about 2 grams and approximate cost of Rs. 2 per sachet, it would be the most feasible, affordable, and appropriate proposition for the low-income-group. The 'instant-fortificant' can be added to the child's gruel or 'kanji' or a mashed roti. Addition of just 1 gram of good quality barley-malt to the sachet, could liquefy and homogenize almost solid cereal-cooked foods and ensure complete consumption of vitamins and minerals. It could be sold at anganwadi centres, chemists, 'pan-masala' shops and even super-market stores. It is easy to transport, has a long shelf-life and is affordable. The regular distribution of such micronutrient packages could well be undertaken in the context of the universalisation of ICDS

Several other micronutrient interventions in the context of the universalisation of ICDS could also be undertaken. Some suggestions on the way forward follow. First fortify and multi-micronutrient supplement complementary foods like milk and cereal flours, for children under two years of age. Although the cost of fortification between 1-4 percent

of the finished product is minuscule, yet fortified packaged foods are expensive. For example, iodized salt at the fortification stage costs only Re 1 per kg; but by the time it comes to your kitchen it costs Rs 7 - 10 per kg. This is why central and state government should encourage and subsidize such ventures.

Second adopt the four-in-one package of "deworming, Vitamin A, iron tablets and iodized salt" in schools. This package has already been extended successfully to more than 30 million school-going children: 3.5 million in Gujarat, 11 million in Karnataka, 10 million in Tamil Nadu and 7.5 million in Andhra Pradesh. Such initiatives could be easily integrated with mid-day meal programmes. As things stand, mid-day meals address the "raw hunger" problem, but fail to address "hidden hunger" in most states. This package can also be adopted in other institutions where there is a captive population: anganwadis, hostels, hospitals, office, factories, plantations, etc.

Third give impetus to the double-fortified salt programme.

Finally conduct counselling and practical information-education-communication campaigns for doctors, media and the common man, with repeated demonstrations at the household level. Modern communication media such as television and radio could also be used for domiciliary counselling.

*Contributed by Tara Gopaldas*

hunger, especially among communities (such as the Musahars or Sahariyas) that are vulnerable to food insecurity.

The incentive purpose refers to the role of the SNP in attracting children to the anganwadi. You, the reader, may feel that children ought to

come to the anganwadi of their own free will, without being "bribed" by the smell of hot food. But it would be naïve to expect a child (or even her parents) to grasp the full importance of going to the anganwadi every day. Good food can therefore be of great help in motivating chil-

dren to attend the anganwadi on a regular basis. Indeed, the magnetic power of free food has been well demonstrated in diverse contexts, in India and elsewhere. For instance, many studies show that attendance levels in India's primary schools shot up after cooked mid-

day meals were introduced (Khera, 2006).

The well-being purpose is simply to make children feel good for its own sake - not just to attract them to the anganwadi. Giving them some good food is a way of making the anganwadi environment more friendly and welcoming. When villagers arrange for some "special food" to be served to the children on a particular occasion, it is not to boost their calorie intake or attendance charts. It is just a means of making them happy - that is what the well-being purpose is about.

Finally, the socialization purpose is to overcome the barriers of caste and class among Indian children. Restriction

on the sharing of food play an important role in the perpetuation of caste prejudices, and breaking these restrictions at an early age can help to foster a sense of social equality. Young children do not have much consciousness of caste, and if they get used to sharing food with other children, there is a chance that they will continue doing so as they grow older. The fact that, in relatively conservative social settings, upper-caste parents often resist or resent "inter-dining" at the local anganwadi (see Chapter 4) is an indication that this practice threatens traditional power structures.

Needless to say, the extent to which the SNP achieves these goals de-

pends on the timeliness and quality of feeding arrangements. In this respect, the situation varies a great deal between different FOCUS states, as we saw in the preceding chapter. These contrasts are further scrutinised in Table 5.1. In the "active states" (Himachal Pradesh, Maharashtra and Tamil Nadu), an overwhelming majority of sample mothers were satisfied with the quality and quantity of SNP food. In the other states, however, complaints were common on both counts. In Uttar Pradesh, the "basket case" as far as SNP (or for that matter other ICDS services) is concerned, more than half of the sample mothers were dissatisfied with the quality of

**Table 5.1. Quality Variations in ICDS: Supplementary Nutrition Programme (SNP)**

	Tamil Nadu	"Active States" <sup>a</sup>	"Dormant States" <sup>a</sup>	Uttar Pradesh	FOCUS States <sup>a</sup>
<b>Proportion (%) of mothers who report that:</b>					
SNP is provided at the local anganwadi	93	94	93	94	94
Food distribution is "regular" <sup>b</sup>	100	95	72	54	83
Children get a "full meal" at the anganwadi <sup>b</sup>	100	87	48	32	68
<b>Proportion (%) of respondents who feel that the quality of food is poor:</b>					
Mothers <sup>b</sup>	7	15	35	55	26
Anganwadi workers	0	2	20	35	11
<b>Proportion (%) of respondents who feel that the quantity of food is inadequate:</b>					
Mothers <sup>b</sup>	2	13	54	69	33
Anganwadi workers	3	12	28	33	20

<sup>a</sup> "Active states": Himachal Pradesh, Maharashtra, Tamil Nadu. "Dormant states": Chhattisgarh, Rajasthan, Uttar Pradesh. "FOCUS states" refers to the six states taken together.

<sup>b</sup> Base: Mothers who reported that SNP was provided at the local anganwadi.

Source: FOCUS Survey 2004.

SNP food, and more than two thirds said that the quantity was inadequate. The perceptions of anganwadi workers were broadly similar to those of sample mothers, though satisfaction levels were generally higher among anganwadi workers, as one might expect.

### The Case for Cooked Food

SNP arrangements under ICDS are generally different for children above and below the age of three years. Children in the age group of 3-6 years are generally fed “on site”

at the anganwadi. For younger children, however, on-site feeding is not very practical as it requires mothers to come with their children to the anganwadi every day, something they may not be able – or willing – to do. Also, this arrangement is not suited to the needs of young children, who require frequent feeding in small quantities over the day rather than a hearty mid-day meal. This is the main reason for “take-home ration” (THR) arrangements.

Leaving young children aside for now, there are two broad types of

on-site feeding arrangements for children in the 3-6 age group: cooked food and “ready-to-eat” items such as *panjiri* or *murmura* (see Table 5.2). The FOCUS survey suggests that cooked food is, generally, a preferable arrangement. To start with, children seem to like cooked food much better than ready-to-eat items. Mothers, too, were generally much happier with the supplementary nutrition programme when it took the form of cooked food. In fact, most of the serious complaints (stale food, stomach aches, and so on) came up in the context of ready-to-eat items.

This preference is reflected in the fact that child attendance at the anganwadi seems to be much higher when cooked food is provided than when ready-to-eat items are distributed. In the FOCUS survey, sample mothers were asked whether their child attends regularly. Statistical analysis of the responses indicates that the chance of an affirmative answer (“yes, the child attends regularly”) is higher by almost 50 percentage points when cooked food is provided at the local anganwadi. The details are presented in Table 5.3, for those who are familiar with statistical analysis. As the table indicates, we found that the probability of regular attendance depends over-

**Table 5.2. Type of SNP Food given to Children under ICDS**

	Age Group	
	6 to 35 months	3-6 years
<b>Uttar Pradesh</b>	<b>Take-home Supplements:</b> 'Panjiri/Weaning Food' (wheat, soya and rice flour, sugar).	<b>Ready-to-Eat:</b> 'AREF/ Panjiri/ Murmura' (wheat flour, soya flour, malt ragi flour, sugar, vitamin and proteins pre-mix).
<b>Rajasthan</b>	<b>Take-home Supplements:</b> 'Baby Mix' (wheat, soya, sugar, edible oil, rice, vitamin and minerals pre-mix).	<b>Ready-to-Eat:</b> 'Murmura' (wheat flour, soya flour, edible oil, vitamin and minerals pre-mix) sweet or salty in alternate months.
<b>Maharashtra</b>	<b>Take-home Supplements:</b> <sup>a</sup> 'Sanjeevani Powder' (soyabean powder, wheat, soya milk).	<b>Cooked meal:</b> Khichdi/ dalia/ chana on alternate days.
<b>Chhattisgarh</b>	<b>Take-home Rations:</b> Wheat dalia, salt, oil, gur.	<b>Cooked meal:</b> Dalia (wheat soya blend); puris or halwa on special occasions.
<b>Himachal Pradesh</b>	<b>Take-home Rations:</b> Rice, moong dal and ghee for khichdi; chana, whole milk powder, sugar and dalia.	<b>Cooked meal:</b> Khichdi/ dalia/ chana (or sprouted grams) on alternate days. Kheer on special occasions.
<b>Tamil Nadu</b>	<b>Take-home Rations:</b> <sup>b</sup> 'Sattu' (fortified health powder containing ragi, wheat, jaggery, bengal gram and groundnut).	<b>Cooked meal:</b> Rice with dal and vegetables every day, and an egg once a week.

<sup>a</sup> For children aged six months to one year.

<sup>b</sup> For children aged six months to two years. Does not include the food supplied by donor agencies such as CARE and the World Food Programme.

Source: FOCUS Survey 2004; also state-specific ICDS Guidelines. This table presents the state-specific SNP “norms”. In practice there are variations around these norms between different anganwadis in some states.

**Table 5.3. Effects of Cooked Food and Anganwadi Location on Child Attendance**

Probit analysis of child attendance [Dependent variable: Dummy for “regular attendance” (1 = regular, 0 = not regular), as reported by the child’s mother.]	
Independent variables	Marginal effects
Anganwadi provides cooked food	0.47 (3.41)**
Anganwadi is located in the same hamlet as the child’s house	0.35 (5.16)**
State dummies:	
Himachal Pradesh	-0.10 (0.63)
Maharashtra	-0.40 (2.91)**
Rajasthan	0.07 (0.43)
Uttar Pradesh	0.12 (0.75)
Chhattisgarh	-0.47 (3.13)**
Number of observations	323

\*\* Significant at 1% (z statistics in parentheses).

Notes: (1) This analysis focuses on children aged 3-6 years. (2) Tamil Nadu is the “default” state (no dummy). (3) Socio-economic variables such as education, SC/ST, owning a “pacca” house or having an APL card are not significant.

Source: FOCUS survey 2004. The coefficient of the “cooked food” variable (first row) suggests that the probability of regular attendance rises by 47 percentage points when cooked food is provided at the local anganwadi.

whelmingly on two variables: provision of cooked food, and location of the anganwadi. When cooked food is provided, and the anganwadi is located in the same hamlet as the child’s house, the probability of regular attendance is around 80 per cent, irrespective of the socio-economic characteristics of his or her family. This is yet another confirmation of the magnetic power of nutritious food.

Further, cooked food is less likely to be “shared” with other family members than ready-to-eat items. For instance, in Rajasthan it was often

found that *murmura* was freely going around the house and even the village, where it had become a common snack. This defeats the purpose of providing “supplementary nutrition” to vulnerable children. To some extent, the same can happen with cooked food, if SNP substitutes for home meals. But if cooked meals served at the anganwadi are of good quality (as in Himachal Pradesh, Maharashtra and Tamil Nadu), children would benefit from “qualitative supplementation” from cooked food even if there is some substitution for

home meals. With ready-to-eat items, the supplementation effect is likely to be much lower, to the extent that the food is shared. Cooked food also allows for greater flexibility and easier adaptation to local tastes.

There is another consideration of great importance, which is often overlooked in “technical” analyses that pay no attention to the politics of this issue. Ready-to-eat items tend to be pushed by commercial lobbies that are often hard to resist or regulate. In many states, the supply of ready-to-eat items has enriched private contractors who have little regard for the well-being of children, and miss no opportunity to cut costs by compromising with the quality of the food. Uttar Pradesh is one of the worst offenders in this respect: state-wide SNP contracts worth hundreds of crores of rupees have been doled out to a few private contractors, without any transparency. According to a senior official in the Ministry of Women and Child Development, some of this money finds its way back to the politicians who pull the strings, and are used to “buy votes” at the time of elections. Meanwhile, the SNP programme in Uttar Pradesh has become a health hazard, with stories of food poisoning appearing at regular intervals in the local media.

Before concluding on this, it is worth noting that cooked food is not necessarily more expensive than ready-to-eat items. Indeed, the food is typically cooked by the anganwadi

helper, who is already on the ICDS payroll (and her remuneration is very small in any case). Decentralised

food purchases could even lower the cost of providing a nutritious meal at the anganwadi. For instance, SNP

allocations are lower in Himachal Pradesh than in Rajasthan or Uttar Pradesh, but the quality of the food

### Box 5.3. Right to Food vs. Right to Loot: The Long Shadow of Contractors in ICDS

The ICDS programme over the past two decades has been the site for 'public-private partnership', much before the notion gained the popularity it enjoys today. In virtually every Indian state, the supplementary nutrition programme (SNP) of the ICDS, has been provided by contractors.

Till recently, the costs of the SNP were met entirely from state government funds, while all other costs of infrastructure, salaries etc, were financed with funds given by the centre. It was therefore the state governments prerogative to administer these contracts. The fact that the size of these contracts are often sizeable - ranging between 25 crores (in smaller states) to over 250 crores (in larger ones) - makes it the prone to corruption and diversion of funds. Over time the tenders for these contracts have been drawn to favour key players and irregularities remain the norm rather than the exception. In Chhattisgarh, for instance, the last contract was renewed despite the presence of a "no renewal" clause in it. Complaints about the quality of SNP and irregularity in delivery to the anganwadis were also conveniently overlooked by pliant officers.

Besides compromising on quality and nutritive value, the contractor system proved disadvantageous in other ways as well. First, 'dalia' became the norm for all children, even though it might be culturally inappropriate and often unpalatable and irrespective of age specific needs. Thus the need for calorie-dense food, other than weaning foods, required for older children, pregnant and nursing mothers and adolescent girls was also overlooked along the way. This is largely to do with the fact that dalia can be prepared easily - just by adding boiling water to the contractor provided mix.

Second, it did not allow for monitoring to be decentralised, or for the community or panchayats to exercise any control what-

soever on the nature and quality of food given at the anganwadi, or even whether it reached the centre at all.

It was a combination of all these factors which led the Supreme Court of India to ban contractors in a landmark interim order dated 7 October 2004 (in the case PUCL vs. UoI and Others, CWP 196/2001). The court directed that "*contractors shall not be used for supply of nutrition in anganwadis and preferably ICDS funds shall be spent by making use of village communities, self-help groups and Mahila Mandals for buying of grains and preparation of meals*". By doing so the Supreme Court provided some hope that young children, mothers and adolescent girls might now get a diverse menu of culturally appropriate and nutritious food, as was originally envisaged.

The battle to dislodge contractors from the ICDS system however was far from over. The Office of the Commissioners of the Supreme Court, responsible for monitoring compliance of orders, have been able to rid SNP of contractors in barely half a dozen states. This too with enormous difficulty.

At the end of two years since the Supreme Court passed their interim order banning contractors, a number of large states like Uttar Pradesh and Assam have still not removed contractors. In other states, the contractor-politician-bureaucrat nexus has tried innovative ways to repeatedly circumvent the Courts orders. The deep-rootedness of this nexus can be gauged from the responses of a few states. In Chhattisgarh, for instance, the State Government wrote to the Commissioners clarifying that they were not contravening court orders since they were procuring from "manufacturers" and not contractors. This arbitrary distinction was raised by a number of state governments. In other places where government orders to eliminate contractors were issued, subtle clauses to ensure their continuance also crept in.

This happened for one in Maharashtra where orders to remove contractors and hand over SNP to Mahila Mandals and Self Help Groups, was accompanied with a clause allowing the 'Co-operative Federation' to supply those areas where such organisations were not present. Since the Federation essentially sources all the supplies through private contractors, this allowed them a back door (re) entry into the ICDS system. This matter is presently sub-judice in the Supreme Court.

The contractor lobby have also tried to place hurdles in implementation in those states which are determined to comply with court orders. Delhi is a case in point. A recent decision by the Government of Delhi to hand over the SNP to NGOs, led many contractors to apply under the revised scheme after registering themselves as NGOs. However since the Delhi Government had framed the scheme in consultation with the Commissioners, a clause requiring the NGO to be registered for at least three years had been included as a criteria for eligibility. This clause was subsequently challenged and turned down after a long drawn-out legal battle, much to the contractors dismay.

The silver lining comes from states like Bihar, Jharkhand and Chhattisgarh, who have put in place alternative decentralised mechanisms. Many other state governments are feeling the pressure, especially from the Commissioners and the Supreme Court, to follow suit.

What this entire saga does prove is the similarity of the relationship between corruption and society to that of the human body with a virus. The virus mutates and finds new forms, each time it is attacked. Perhaps, with persistence, the right to food will prevail over the right to loot.

*Contributed by Biraj Patnaik*



is much higher in Himachal Pradesh. And even where cooked food raises SNP expenditure, it does so by generating employment for poor rural women on a substantial scale at relatively little cost. This is a valuable role for ICDS, aside from the other arguments for cooked food.

## 5.2. Feeding of Infants and Young Children

The early years of life, say the first two to three years, are the most critical period in the development of the child. This is when his or her “capabilities” (health, nutrition, learning abilities, etc) are largely determined. For instance, about 90 per cent of the development of the brain takes place before a child reaches the age of two years.

This is also the period when the nutritional status of Indian children deteriorates in an irreversible way. For instance, according to the National Family Health Survey 1998-9, the proportion of underweight children rises from 16 per cent to more than 60 per cent between the ages of six months and two years. If we are serious about preventing malnutrition, a sharp focus on this age group is essential.

While this was part of the “initial vision” of ICDS (see Chapter 3), in practice the main focus of the programme has been on children in the age group of three to six years. Younger children

have been comparatively neglected, if not excluded. Child feeding practices are virtually absent from the training of anganwadi workers as well as other ICDS staff. Infant feeding, care of young children and ability to counsel mothers effectively were some of the main topics on which anganwadi workers interviewed in the FOCUS survey wanted additional training. These matters are also conspicuous by their absence (at least in any meaningful way) from the activities of supervisors, CDPOs and even ANMs.

“Infant and young child feeding” (IYCF) has received considerable scientific scrutiny in recent years. It is well established, for instance, that breast milk is the best food for a young child from many points of view – nutrition, survival, protection from infection, and wholesome growth, among others. As the National Guidelines on Infant and Young Child Feeding 2006 put it:

*Modern science and technology has not been able to produce a better food for young infants than mother’s milk. Breastfeeding is the best way to satisfy the nutritional and psychological needs of the baby.*

(Government of India, 2006, p. 7)

Going beyond this general observation, there are now widely-accepted norms relating to infant and young child feeding. These are reflected, for instance, in the Global Strategy for Infant and Young Child Feeding

(WHO/UNICEF, 2003), and also in the above-mentioned National Guidelines. The current recommendations, sometimes described as “optimal” infant and young child feeding, include:

- initiation of breastfeeding within an hour of birth;
- exclusive breastfeeding for six months; and
- continued breastfeeding for two years or beyond, along with appropriate complementary feeding (e.g. semi-solid mushy foods) beginning after six months.

One means of promoting these practices is nutrition counselling, and specifically, IYCF counselling. This involves, for instance, advising a nursing mother about breastfeeding, right from the time of birth, and helping her with any difficulties she may have. The effectiveness of this approach has already been established in various contexts, including a recent experiment conducted by the Breastfeeding Promotion Network of India (BPNI) in Gujarat. It is important to note that this experiment was conducted within the ICDS system, through anganwadi workers.

Unfortunately, nutrition counselling (and more generally, home visits) is yet to be developed as an active component of ICDS. In many states, anganwadi workers rarely visit pregnant or nursing women at home, or counsel them in other ways (such as the prescribed “nutrition and health education” sessions). This lacuna is



### Box 5.4. Infant and Young Child Feeding

Infant and Young Child Feeding (IYCF) has much to contribute to child nutrition, survival & development. According to a series on child survival published in *Lancet* (2003), breastfeeding is the most effective means of preventing childhood death. Breastfeeding can prevent thirteen to sixteen per cent of child deaths, while adequate complementary feeding between the ages of six to 24 months could prevent a further six per cent. Another study of over 10,000 babies in rural Ghana estimated that 22 per cent of all neonatal deaths could be avoided by beginning breastfeeding within one hour of birth in all women.

According to the WHO, optimal infant and young child feeding constitutes beginning breastfeeding within one hour, exclusive breastfeeding for the first six months and beginning complementary feeding after six months along with continued breastfeeding for 2 years or beyond.

The optimal feeding of infants and young children is critical, not only for survival, but also for early child and long-term human development, since most brain growth occurs during this very vulnerable period. *Undernutrition* impairs cognitive development, intelligence, strength, energy and productivity of a nation, as it disturbs the very foundation of life and development.

The status of IYCF in India is quite dismal. Only sixteen per cent of infants are breastfed within an hour of birth. Since institutional deliveries account for almost 34 per cent of all deliveries, this figure also shows that breastfeeding is not a widespread institutional practice. According to NFHS-II (1998-99), the practice of exclusive breastfeeding falls rapidly: while 72% of children are exclusively breastfed in the first month, only 20% of children under six months of age are exclusively breastfed. Only 35.9% of children in the six-nine months age group receive any solid or mushy foods in addition to breastmilk. Thus

the promotion of early and exclusive breastfeeding for the first six months and appropriate complementary feeding thereafter are major challenges.

There are two possible reasons of inappropriate feeding practices. First is lack of information and social support. Breastfeeding mothers are given inadequate social support, largely because the practice of breastfeeding is no longer valued in society, and there is little understanding of women's needs in this regard. The lack of adequate information and awareness also contributes to inappropriate feeding practices. Thus a mother in Himachal said that she did not exclusively breastfeed because she did not have enough breastmilk for her baby – a misconception that repeats across the country, from rural Bihar to urban Delhi. Health workers offer milk supplements to treat this perception rather than building their confidence and skills. Meanwhile, information on the feeding of infants and young children available in newspaper articles and other media is often misleading, a fact that causes further confusion.

Second is lack of skilled support from health workers in hospitals and nutrition workers in the field. Most health and nutrition workers in hospitals (especially those working in pediatric and maternity areas), don't have the knowledge or the skills to help women establish and maintain the practice of exclusive breastfeeding. Because of this, they overlook the importance of counseling on optimum infant feeding practices. The experience of one expectant mother is telling. When she informed her gynecologist of her intention to exclusively breastfeed for six months, she was told that it was only appropriate to do so for the first four months! Commercial pressures also lead to inappropriate practices. An employee of an international organization related her experience with a pediatrician to whom she went for a

post-partum check-up. Though she told the doctor that she had no problems feeding her baby, she was prescribed an infant milk substitute!

'Skill training' is the key factor in promoting good breastfeeding practices such as early initiation and the elimination of prelacteal feeding. To extend the duration of exclusive breastfeeding, women must be reached and supported early during the prenatal period, at the time of birth, and during the first few weeks and months of the post-partum period (this is when breastfeeding problems occur and women are likely to shift from exclusive to partial breastfeeding). Since improper complementary feeding is mostly due to lack of knowledge about nutrition and child care, interventions addressing this should focus on education of women that should start when the baby is around five to six months of age, continuing throughout the period of early childhood. Improving breastfeeding practices requires behaviour change, something that doesn't happen spontaneously, and requires the encouragement and support at the family and community level.

When women are empowered they are better able to take care of themselves and their babies. Take the recent case of an employee of an international NGO in Orissa, who was advised by the pediatrician in a nursing home to feed her newborn with tinned food for the first two days. She did not follow the advice; the doctor was counseled, presented with a copy of the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 (IMS Act) as amended in 2003, and given other literature on breastfeeding. Efforts to make optimal infant feeding a success will require further empowerment of this sort.

*Contributed by Deeksha Sharma and Arun Gupta*

### Box 5.5. First Hour Magic

In India, about 16 lakh babies die before reaching their first birthday. Of these, more than 11 lakh babies die before they are a month old. This amounts to the death of three babies every minute. The primary causes of these deaths are: Neonatal infections (52 percent) Asphyxia (20 percent); and low birth weight (17 percent). Most of the deaths by neonatal infections happen from diarrhoea and pneumonia, for which breastfeeding is the most effective intervention. One in every four is born with low birth weight and is at greater risk of death.

A recent study from rural Ghana (based on 10,947 breastfed singleton infants) has shown that initiation of breastfeeding within the first hour of birth reduced an infants' risk of death. There was also a marked

increase in risk with an increase in delay in the initiation of breastfeeding. Overall late initiation (after day 1) was associated with a more than a two fold increase in risk. Giving pre-lacteal feeds also increased the risk of neonatal mortality. The study concluded that if all women initiated breastfeeding within an hour of birth, 22 percent of all neonatal deaths could be prevented. In the Indian context, this would amount to 2.5 lakh neonates annually; all of whom could potentially be saved from death by just one act – initiation of breastfeeding within one hour of birth. However, only about 16% women practice this. (NFHS-2)

Timely initiation of breastfeeding is beneficial for both the baby and the mother for several reasons. First, colostrum provides the baby

with nourishment and also acts as its first immunization. Second, it helps the production of enough milk for the next feed. Third, it provides skin-to-skin contact and warmth that baby's, particularly premature and babies with low birth weight, need. Fourth, it makes use of the baby's sucking reflex (only present during the first hour) to establish proper latching. Finally it also helps prevent blood loss in the mother, a major cause of maternal morbidity and mortality.

Initiation of breastfeeding within the first hour of birth is therefore the first and most important step towards reducing infant mortality, since it is vital for reducing neonatal mortality, and indeed works as a magic !.

*Contributed by Arun Gupta.*

**Table 5.4. Advice on Infant Feeding**

Did you receive any advice on infant feeding from the anganwadi worker? <sup>a</sup>			
	Yes	No	Proportion (%) who said "yes"
Himachal Pradesh	5	7	42
Tamil Nadu	6	9	40
Maharashtra	5	10	33
Chhattisgarh	2	10	17
Uttar Pradesh	3	19	14
Rajasthan	0	14	0
FOCUS States	21	69	22

<sup>a</sup> Responses from 90 sample mothers who delivered a baby during the 12 months preceding the survey (another six did not answer the question).

Source: FOCUS Survey 2004.

reflected in the FOCUS survey. To illustrate, among women who had delivered a baby in the 12 months preceding the survey, barely one fifth said that they had received any advice on infant feeding from the anganwadi worker. It is worth noting, however, that here again there are sharp variations between states. Judging from Table 5.4, the practice

of nutrition counselling does seem to be gaining ground in some states, notably Himachal Pradesh and Tamil Nadu where almost half of the respondents had received advice. However, some caution is required here since the number of respondents was quite small.

Nutrition counselling is required not just for breastfeeding but also for

other aspects of infant and young child feeding. For instance, faulty weaning is a common cause of child malnutrition: we are all used to the sight of a young child pathetically chewing on a thick, dry *roti*, hard to digest and unequal to the child's nutritional needs. Healthy weaning requires adequate and appropriate complementary feeding, such as frequent feeding of semi-solid mushy foods. Often, major improvements in child nutrition are possible at that stage, even within the limited resources available to the household, through better knowledge and understanding of nutritional matters. For instance, dipping that thick *roti* in a little milk can make it much more palatable and digestible for the young child. Similarly, children need to be protected from various misconceptions about young child feeding that can be quite harmful, such

as the notion (prevalent in some of the FOCUS villages in Chhattisgarh) that *mahua* liquor is a good remedy for diarrhoea.

Having said this, nutrition counselling is not the only sort of intervention required to protect young children from undernutrition. Some families are just too poor to give their children healthy food. Even if they are not, they may have other priorities. This is where direct feeding of children under ICDS, or direct provision of foods that facilitate healthy feeding at home, can help. In the age group of three to six years, this takes the form of feeding at the *anganwadi* – we have discussed that in the preceding section. As we saw, however, this arrangement is inappropriate for younger children.

An alternative is the so-called “take-home rations” (THR) system, whereby mothers are given weekly rations of appropriate food for their young children. In Maharashtra, for instance, we found that mothers of young children received regular rations of a nutritious powder (popularly known as “*sukhad*” in some areas) to be mixed with hot water or milk. A similar arrangement (involving the distribution of laddoos or “*sattu mavu*”) was in place in Tamil Nadu. In both states, this was supposed to be combined with nutrition counselling, though this was not happening everywhere.

These experiences suggest that well-designed, appropriate THR systems

can work relatively well. There have been other encouraging initiatives along these lines in various states in recent years. Having said this, there are some pitfalls to avoid in this context. One problem is that THRs intended for children may end up being shared among all family members. This may be due to a shortage of food at the household level, or to a lack of understanding of the special needs of the child. In Maharashtra and Tamil Nadu, it seems that this is largely avoided by ensuring that THRs are clearly seen as “baby food”, and by combining THRs with some nutrition education. By contrast, in states like Rajasthan and Uttar Pradesh, children under three often get the same *panjiri* or *murmura* as older children, if they get anything at all. These items are readily shared in the family, since there is little to indicate that young children would particularly benefit from them. As mentioned earlier, these inappropriate THRs also send a wrong message to the parents – that young children can eat anything.

Another common problem, already mentioned in the previous section, is the pernicious influence of food “contractors”. Like ready-to-eat items, take-home rations are often supplied in bulk by private contractors, who have incentives to cut costs by compromising on quality, or to over-charge. Greedy politicians or bureaucrats are often not far behind, manipulating the allocation of

contracts and taking their “cut”. This whole game can have a disastrous effect on the quality and effectiveness of the THR system. One answer is tighter regulation and greater transparency in the allocation of contracts. Another is to avoid contractors altogether. Indeed, THRs can, in principle, be prepared at the *anganwadi* based on local foods, rather than supplied by private contractors. In Tamil Nadu, for instance, *anganwadi* helpers prepare nutritious “laddoos” for young children (and in some villages, even the raw material for the laddoos is prepared locally by women’s self-help groups). This is an issue on which further learning is required.

We end on this topic with three further remarks. First, the nutritional and other needs of young children cannot be effectively addressed under ICDS unless a second *anganwadi* worker is posted in each *anganwadi*. A single worker cannot be expected to take care of feeding children in the 3-6 age group, imparting pre-school education to them, making home visits, organising THR distributions, and so on. As we shall see in Chapter 7, one of the distinguishing features of ICDS in Tamil Nadu is a pioneering experiment with the “two workers” *anganwadi* model, which has made it possible to reach out to children under three. There is an important lesson here for other states.

Second, the wake-up call for children under three should not be read as

an argument for discontinuing feeding programmes for older children, or for “rationalising” (read downsizing) other ICDS services. Nor should the extension of ICDS to children under three come at the expense of timely universalisation. Rather, it needs to be seen as an integral part of the task of “universalisation with quality”.

Finally, nutrition counselling, take-home rations and related nutrition services under ICDS can only go so far in protecting young children from malnutrition. Other interventions, outside the realm of ICDS, are also required. For instance, if mothers who work outside the household (so-called “working mothers” – as if others were not working) are to be able to follow the recommended breastfeeding practices, they must have adequate maternity entitlements as well as enabling facilities at the workplace. As discussed in Chapter 1, the rights of children under six cannot be protected through ICDS alone.

### 5.3. Health Services

Illness was rife among children living in the FOCUS villages. The point is illustrated in Table 5.5, which presents data on morbidity among the sample children (these are children below the age of six years enrolled at the local anganwadi). As the last two rows indicate, every other child in the sample had at least one of the

symptoms listed in the table during the two weeks preceding the survey. About one third had fever, 21 per cent had diarrhoea, and 17 per cent had a persistent cough. These figures are in the same range as the corresponding all-India figures from the second National Family Health Survey (see Table 2.2 in Chapter 2). Only 55 per cent of the sample children were free of these three ailments.

These alarming statistics underline the urgent need for better child health services in rural India. These are typically provided by the Health Department through health centres such as the Primary Health Centre or sub-Centre. Some health services, however, are meant to be “integrated” with ICDS in one way or another. For instance, immunization sessions and health checkups are often conducted at the anganwadi, or with the help of the anganwadi worker under ICDS. Similar remarks apply to antenatal care and maternal health – we shall return to these in the next section.

As with the supplementary nutrition

programme, health services under ICDS display some basic functionality, but quality indicators reveal major deficiencies. For instance, in nearly 70 per cent of the anganwadis, it was found that the Auxiliary Nurse Midwife (or “Lady Health Visitor”, in the case of Tamil Nadu) had visited three times or more during the preceding three months, in line with the current norms. Immunization routines were also in place in most anganwadis, whether they involved on-site immunization sessions conducted by the ANM (as in Maharashtra) or visits to the local health centre under the supervision of the anganwadi worker (as in Himachal Pradesh). However, the reach and quality of health services was, on the whole, quite poor in the FOCUS states, as Table 5.6 illustrates.

Here again, there were major variations between different states. Tamil Nadu and Maharashtra, which

**Table 5.5. Child Morbidity in the FOCUS Villages**

Proportion (%) of sample children who had the following symptoms during the two weeks preceding the survey	
Fever	32
Diarrhoea	21
Persistent Cough	17
Extreme Weakness	11
Skin Rashes	5
Eye Infection	2
<b>None of the Above</b>	50
<b>Any of the Above</b>	50

Source: FOCUS Survey 2004.

**Table 5.6. Health-related Services under ICDS**

	Tamil Nadu	“Active States”	“Dormant States”	Uttar Pradesh	FOCUS States
<b>Proportion (%) of sample mothers who reported that:</b>					
They had been visited at home by the anganwadi worker	58	42	19	23	30
Their child was weighed regularly at the anganwadi	87	82	47	40	64
Their child’s growth chart had been discussed with them <sup>a</sup>	50	44	24	15	36
Health checkups were available at the anganwadi <sup>b</sup>	57	58	21	21	38
<b>Proportion (%) of sample children who were:</b>					
Fully immunized	71	62	29	37	46
Not immunized at all	4	2	20	15	11
<b>Proportion of villages where the FOCUS investigators felt that:</b>					
The effectiveness of immunization services was “low” or “very low”	12	6	41	44	25
Mothers look at the anganwadi worker as a person who can help them in the event of health or nutrition problems in the family	52	51	11	10	30
<b>Proportion of anganwadi workers who reported that the following services had been provided during the preceding 12 months:</b>					
Deworming	74	67	48	46	58
Referral services	83	59	45	33	54

<sup>a</sup> Among mothers who said that their child was weighed regularly.

<sup>b</sup> These figures are likely to be underestimates, as they are based on an open-ended question about the activities that take place at the anganwadi.

Source: FOCUS Survey 2004.

have relatively good health services in general, have also made substantial progress towards the effective provision of basic health services under ICDS. In the typical anganwadi in both states, growth charts were well maintained, immunization services were fairly regular, health checkups took place from time to time, and so on. Himachal Pradesh is also moving rapidly in the

same direction. In fact, in some respects Himachal Pradesh was doing even better than Maharashtra or Tamil Nadu. For instance, 84 per cent of the sample children in Himachal Pradesh had a vaccination card, and 76 per cent were fully immunized – higher figures than in any other FOCUS state. The investigators’ observations provided further evidence of the effectiveness of

immunization services in Himachal Pradesh.

In many cases, the limitations of health services under ICDS are just another reflection of the general problems that have plagued ICDS as well as health services in India. For instance, the shortages of funds, staff, infrastructure, supervision and political interest discussed earlier apply here too. The fact that a ma-



jority of anganwadis in the FOCUS survey did not have a medical kit is a telling indication of the low priority attached to health services in the ICDS system. Similarly, health services under ICDS have been affected by the general lack of financial support for public health services. As is well known, India has one of the lowest levels of public expenditure on health in the world, as a proportion of GDP (barely one per cent), and this is bound to restrict what can be achieved.

Having said this, health services under ICDS also raise special problems, notably those associated with the smooth “integration” of activities involving not only the ICDS staff but also the Health Department. Joint activities are only as strong as their weakest link, and this imparts a particular fragility to health-related ICDS services. For instance, immunization sessions typically require the presence of the ANM as well as of the anganwadi worker. If one of the two is missing, the activity breaks down. This simple example conveys the critical importance of smooth collaboration for the success of health services under ICDS.

Another matter on which closer cooperation between ICDS and the Health Department is urgently required is the rehabilitation of severely

malnourished children. This issue has come into sharper focus in recent years, with regular reports of “hunger deaths” in different parts of the country. Children suffering from severe undernutrition (say “grade 3” or “grade 4”) often live in families where they have little chance to recover. Their mother may not have the resources, knowledge, time, energy or power required to provide intensive and effective care to a severely malnourished child. In such circumstances, the child needs intensive care under medical supervision, combined with some social support for the mother during and after the rehabilitation period. The anganwadi worker has an important role to play in identifying such children and motivating their parents to take action, but the provision of rehabilitation facilities is the responsibility of the Health Department. There have been useful initiatives to facilitate this process in recent years, such as the Bal Shakti Yojana scheme in Madhya Pradesh – see Box 5.6.

The scope for better coordination can be illustrated with reference to

the regularity of health workers’ visits to the anganwadi - the first step towards any major health activity under ICDS. In some of the sample anganwadis, the visits of health workers (mainly the ANM) were scheduled on fixed, pre-specified days, such as the “second Tuesday” or “third Friday” of each month. In other cases, the visiting days were not pre-specified, and sometimes not even announced in advance (the health workers just “dropped by”). As it turns out, the practice of “fixed-day visits” seems to have a remarkable impact on the regularity of the health workers’ visits. As shown in Table 5.7, the proportion of anganwadi workers who stated that the health worker “rarely” or “never” paid regular visits to the anganwadi was as high as 40 per cent in cases where visiting days were not pre-fixed, compared with only 5 per cent when they were pre-fixed.

The system of “fixed-day visits” seems to be gaining ground, and is now practiced or prescribed in several states. Going one step further, some states have introduced a

**Table 5.7. Health Workers’ Visits: Regularity and Predictability**

Does the health worker make regular visits to the anganwadi? <sup>a</sup>	Where health workers’ visits take place on “pre-fixed days”	Where health workers’ visits are not pre-fixed
“Always”	56	28
“Usually”	40	32
“Rarely”	4	20
“Never”	0	20

<sup>a</sup> Percentage distribution of anganwadi workers’ responses. Source: FOCUS Survey 2004.



### Box 5.6. Bal Shakti Yojana: An Innovative Initiative to tackle Malnutrition in Madhya Pradesh

Madhya Pradesh (MP) has some of the worst indicators of child mortality and malnutrition. The need to provide 'intensive intervention' to its severely malnourished children (SMC) led to the Bal Shakti Yojana (BSY) - a package of services for SMC provided through the department of health.

The BSY, launched in October 2005 in Guna district, essentially involves setting up a Nutrition Rehabilitation Centre (NRC), to intensively manage children with severe malnutrition, as well as provide nutrition training and counselling to their care takers. Identification, referral and follow-up is the responsibility of the anganwadi worker, in close collaboration with the department of health. What makes this programme different is 'convergence' *in actual practice* between the ICDS and health systems, only otherwise seen (if at all) in the immunization programme. It also a welcome (if late) demonstration of the fact that malnutrition is not just the concern of the ICDS but also the health system. Currently only implemented in two districts of Guna and Shivpuri (both notorious for deaths amongst Sahariya children), it is due for replication throughout the state.

The NRC are well located, accessible, sign posted and adjoining the district hospitals from which they derive all medical support. They are clean, spacious and airy with adequate toilets and spotless kitchens. The staff includes one paediatrician or doctor, a nutrition educator and feeding demonstrator, a cook, a cleaner and three nurses. Daily OPDs are held for referred children by the paediatricians who also attend as and when called. There seems to be a good and responsive relationship between the hospital ward and the NRC, though a difference in attitude between the two persists. Children are dropped to the centre regularly by government transport, after planning with the anganwadi worker and as per the availability of beds in Shivpuri, for there is no such arrangement in Guna.

Children and mothers move freely in and out of the ward. There is a distinct 'good attitude' towards the child and her family, and a welcoming, positive energy in trying to solve any problems that arise, but are not 'schemed for'. Thus, for example, accompanying older children in Shivpuri are sent for the bridge course in non formal education by the Sarva Shiksha Abhiyan for the duration they are there. Similarly accompanying men are provided opportunity to work at a nearby construction site.

Children are admitted and kept for fourteen days with the threefold intention to stabilise them with complete medical management, demonstrate weight gain, and train care givers for feeding at home. All children are initially seen by the paediatrician and the sick ones admitted to the paediatric ward at the district hospital. A standard treatment guideline is followed. A budget of Rs 15 per day is allocated for food for the child who is fed every two hours, about eight times through the day. Standardized and well worked out recipes are used by the cook under supervision of the nutrition educator. Daily training sessions are also held with mothers.

Follow-up is the responsibility of the ICDS programme. Each child is sent home with a discharge paper and growth card. They are also given iron and vitamin supplements and are supposed to be seen at least four times in six months by the anganwadi or health worker and brought back to the NRC if necessary. In Shivpuri, follow up camps are organized every two to three months, in which doctors examine the children discharged from the NRC. These camps also function as catchments for new admissions.

The staff are highly motivated by the level of interest and support shown by the collectors, chief medical officers, doctors and consultants, as well as by the early results of the programme. The programme also enjoys the close support of UNICEF, voluntary agencies, individuals, the Rotary Club and Sewa Bharti. Thus, there is a considerable

element of community participation in the programme. The official coordination mechanism is the monthly District Health Committee (Zilla Swasthya Samiti), but much informal interaction happens on a daily basis by phone and rounds of concerned departments.

The main accomplishments and potential gains of the programme are a renewed focus on the issue of malnutrition, convergence between the health care and ICDS system; a better, caring, non-judgemental attitude to poor women and children at a government facility and flexibility and convergence amongst different programmes and funding sources. But some gaps remain including weak follow up by both ICDS and health systems at the village level; weak linkage for full management and follow up of important diseases like TB, again at the community level; and shortage of paediatric drugs for TB and formulations for iron supplementation.

The first NRC was started in a relatively informal way. Early successes however have surprised and enthused both the community and the health-care providers involved. Although it is too early to estimate impact of the BSY initial results are quite hopeful. In Guna of a total of 400 admissions, only 1 death has occurred. For Shivpuri the figures are 1069 and 7 respectively. This amounts to a mortality of less than 1 percent, remarkable when compared to expected mortalities of about 20 percent in cases of SMC. Anecdotal evidence also suggests that many children continue to do well in the community, for at least some months after discharge. Case studies and photographs tell their own tale of visible improvements in children's condition. However this needs to be studied more systematically over a longer period of time.

*Contributed by Dr Vandana Prasad as adapted from 'Accelerating Child Survival', Book 3, PHRN Course.*

monthly, pre-fixed “health day” in each anganwadi. Possible activities to be taken up on health day include immunization, weighing of small children, distribution of take-home rations and nutrition counselling. This practice is to be further extended soon under the National Rural Health Mission (NRHM). It is a useful example of the sort of initiative that would facilitate a better integration of health services with ICDS. Another example is the practice of joint trainings between ICDS and Health Department staff, already in place in Tamil Nadu (see Chapter 8).

The recent initiative to post an Accredited Social and Health Activist (ASHA) in every settlement of 1,000 persons in 18 major states, under the National Rural Health Mission, is an opportunity for further “convergence” of ICDS and health services. Indeed, according to the NRHM guidelines, the responsibilities of the ASHA include various tasks related to children under six, such as:

- Creating better public awareness of health issues and health services.
- Counselling related to pregnancy, breastfeeding, immunization, nutrition and care of the young child.
- Mobilising the community and facilitating the utilization of health services.

- Accompanying pregnant women and sick children to health centres.
- Providing “first contact care” for minor ailments such as diarrhoea and fever.

There is, thus, a natural complementarity between ICDS and the ASHA programme, and making good use of it is essential to the success of both. The ASHA initiative is an opportunity to extend the reach and quality of health-related ICDS services. Conversely, ICDS can provide a vital link, at the village level, between the ASHA and the health system, and also help to create an effective support system for the ASHA.

ASHA-type “community health volunteer” programmes have a chequered history, and it would be naïve to expect this one to succeed in a hurry, or even to lead to rapid changes in health outcomes. The flaws of public health services in India are too deep to be adequately addressed in this manner. Nevertheless, recent experience points to the possibility of achieving major health improvements based on this approach. The experience of the Mitanin (“health friend”) programme in Chhattisgarh, initiated in 2001-2, is particularly interesting in this respect. Indeed, as Table 5.8 illustrates, the progress of health indicators in recent years has been much faster in Chhattisgarh than in India as a

whole. The contrast is particularly sharp for indicators of antenatal care, child immunization, birth assistance, treatment of diarrhoea, and child nutrition, all of which are related in one way or another to the Mitanin programme. These findings should not be taken as conclusive evidence that the Mitanin programme is working, but nevertheless, they point to a possible “take-off” in the health situation in Chhattisgarh, which deserves to be closely watched. This development is all the more significant as it is happening in one of the “dormant states”.

## 5.4. Antenatal Care and Maternal Health\*

Women are the bearers and main care-givers of all children, male or female. After a child reaches the age of six months, the mother need not be the main care-giver, but she usually is. Thus, it is self-evident that the health women maintain, the power they wield, the decisions they are able to take, the support they receive as child care-givers while balancing onerous roles as workers and home makers, their self-esteem and values, all impact all children. The impact on the girl child is even greater because patriarchy is transmitted from woman to woman and social conditioning created at the earliest of ages. Whether it is the deafening silence that surrounds the birth of the

\* Parts of this section draw on the booklet Campaign Issues in Child Health, prepared by Jan Swasthya Abhiyan (2006).

### Box 5.7. ICDS and Community Health Volunteers

Though child mortality rates have declined considerably, the rate of decline is still far short of what had been planned for or anticipated. Thus the National Commission on Macroeconomics and Health predicts that at the current rate of decline, the all-India IMR will fall from 61 (as 2003) to 42 in 2016, whereas the goal was a two-thirds reduction from 63 to about 21. Only Kerala - which has *already* crossed this threshold - will reach this level of reduction by the year 2016.

The thrust of past state policy to address child mortality has been the ICDS programme and the ANM's services. The ICDS center contributes through growth monitoring and the reduction of child malnutrition through supplementary feeding. But supplementary feeding does not reach most children below two to three years of age, which is the most vulnerable period and where most children slip into malnutrition. A number of other problems of access and design and exclusion reduce its effectiveness in increasing child survival.

The ANMs time is largely used up in reaching immunisation and antenatal care. But immunisation cannot contribute more than a 1 to 3% decline. Her availability in every habitation on every day for providing prompt and appropriate care to the newborn and to the sick child or for providing skilled assistance at birth is very limited. Her space to promote appropriate child care practices like prompt initiation and exclusive breastfeeding has been limited. Yet it is precisely these simple interventions that save the most lives.

NGOs have tried to address child survival issues through community health worker programmes. Most such programmes have been able to demonstrate a dramatic decline in infant mortality over three to five years. The most well known of these are

the Jamkhed and Ghadchiroli programmes, but there are many more examples.

Unfortunately government efforts to scale up such programmes have not in the past met with similar success. The Mitanin Programme of Chhattisgarh state has been relatively more successful in scaling up community health worker programmes. The Mitanin is envisioned as a community representative who informs the community and its families of the changes in child care practices and the access to child health services required to improve child survival. She is also to provide prompt and appropriate care to sick children - a role captured in the slogan "Pratham din, pratham upchaar".

This programme builds synergy with the anganwadi system and the ANM's work. The Mitanin attends the immunisation day at the hamlet level, where all three services converge. One of the Mitanin's key roles is to facilitate access to ICDS services, and to identify and address social exclusion of vulnerable families, to ensure that arrangements are made to reach outlying hamlets and to ensure that the quality of services delivered is as per the norms.

But the programme goes beyond providing assistance to the anganwadi worker to put in place a set of essential interventions that she undertakes herself. Most of these are interventions which overlap with and supplement the ICDS programme in precisely those areas where ICDS has a weak performance. Thus Mitanins counsel the whole family at their homes on prevention and management of malnutrition, whereas anganwadis are more often limited to meeting the mother in the center. Mitanins also focus on the first two years of life and on management of sick children in this age group. Another key indicator of the Mitanin programme, is her visiting every family with a newborn child on the very first day to promote six essential prac-

tices: breastfeeding the baby within the first hour, feeding the mother adequately, keeping the baby warm, weighing the new born, and referrals for those with very low birth weights, and immunisation. These are simple, do-able things for a very moderately trained (often barely literate) volunteer, but which have a considerable impact on child survival. As the programme proceeds past the first three years, training and support continues to build her capacity. The major social mobilization that accompanies this community health volunteer training effort, not only supports the Mitanin in her work but can independently contribute to improving outcomes.

Early results have been encouraging. From 87 per 1000 in 2002, rural IMR fell to between 77 (SRS) and 75 (NFHS) in 2003, and to 61 in 2004. Process indicators like early breastfeeding have also improved: in 2002, only 27% of children were breastfed within the first day, now it 88% (UNICEF survey). However there is considerable work ahead to ensure that these early and fragile outcomes stabilize, and are extended to other parameters without compromising the process characteristics of the programme.

The National Rural Health Mission has launched a major community health volunteer initiative, the ASHA programme. The ASHA could become a mobiliser of the community to ensure access of the poor and marginalized to essential public services. This activism could combine with the provision of simple but life saving "first contact care" for the sick child and with promotion of appropriate child care practices. If this were to happen, then as the Mitanin programme shows, there is considerable potential to accelerate child survival and improve child health in the nation.

*Contributed by T.Sundaraman*

**Table 5.8. Progress of Health Indicators: Chhattisgarh and India**

	Chhattisgarh			India		
	1998-99	2005-06	Change <sup>a</sup>	1998-99	2005-06	Change <sup>a</sup>
<b>Positive Indicators</b>						
Proportion (%) of mothers who had at least 3 ante-natal care visits for their last birth	33	55	+22	44	*	+7
Proportion (%) of births assisted by health personnel	32	44	+12	42	*	+6
Proportion (%) of children below 3 years who were breastfed within an hour of birth	14	25	+11	16	*	+7
Proportion (%) of children aged 12-23 months who are fully immunized	22	49	+27	42	*	+2
Proportion (%) of children with diarrhoea in last 2 weeks who received ORS	30	42	+12	27	*	-1
<b>Negative Indicators</b>						
Proportion (%) of children below 3 years who are underweight	61	52	-9	47	*	-1
Infant mortality rate <sup>b</sup> (per 1,000 live births)	81 (79)	71 (60)	-10 (-19)	68 (68)	* (58)	-11 (-10)

<sup>a</sup> Percentage points.

<sup>b</sup> In brackets, the Sample Registration System (SRS) estimates for 2000 and 2004-5, respectively (the 2004-5 is an unweighed average of the 2004 and 2005 estimates). The state of Chhattisgarh was formed in 2000, and SRS estimates for earlier years are not available.

Source: National Family Health Survey (International Institute for Population Sciences, 2000, 2006).

girl child, the delays in getting to health care services, the discrimination in feeding, the early induction into housework and care of younger siblings or the curtailment of education, the girl child is disempowered in these early years and prepared to be a "woman" in a "man's" world.

Being the main care-giver for children, the woman's own health and well-being pertain directly to the health of the newborn as well as her ability to give care in the vital initial years of life. The "care-giver" role is so steeped in invisibility, so poorly understood and so much taken for granted that interventions to provide support are largely missing even as huge bodies of research

show the relationships of women's work, time, energy and power to the health of children. It is this combination of disempowering factors that gives rise to the so-called "South Asian enigma": exceptionally high levels of child malnutrition, even in comparison with countries that have similar levels of per-capita income.

Antenatal care, maternal health and related services are, thus, important for at least three reasons. First, they have a crucial bearing on the well-being of children under six, since the well-being of a child is intimately related to that of his or her mother. For instance, as we noted in Chapter 2, nearly one third of Indian babies

are born with a low birth-weight ("born undernourished", so to speak), with serious consequences for their nutrition and health achievements not only in childhood but also later on. Second, good antenatal care and maternal health are essential to break the inter-generational perpetuation of malnutrition and ill health. Undernourished mothers tend to have undernourished children, and undernourished girls become undernourished mothers themselves later on. If pregnant women and nursing mothers do not receive adequate care, this vicious circle is bound to continue. Third, antenatal and maternal health care are important from the point of

view of the well-being and rights of women themselves, aside from those of the child. Even if the health of a child had nothing to do with that of his or her mother, she would still be entitled to these facilities for her own sake.

As with other health services, maternal care is supposed to be largely provided through the health system, but some services are linked with ICDS in one way or another. For instance, every anganwadi is supposed to “register” pregnant women and to provide various services to them or at least facilitate their provision: nutrition supplements, antenatal checkups, tetanus immunization, and nutrition counselling, among others. In practice, these services are very patchy, as Table 5.9 illustrates. In the “active” FOCUS states (Himachal Pradesh, Maharashtra and Tamil Nadu), es-

sential maternal care is relatively well integrated in the ICDS routine, and women increasingly regard these services as their basic entitlements. In Tamil Nadu, for instance, it is now rare for a pregnant woman not to receive the standard support services (nutrition supplements, antenatal checkups, tetanus immunization, iron tablets, and so on), even among disadvantaged sections of the population. In the “dormant” states, however, these services are often lacking. In Uttar Pradesh, about half of the sample mothers did not have a single antenatal checkup during their last pregnancy (among those who had delivered a baby during the 12 months preceding the survey). This is a shocking indictment of the state of health services in Uttar Pradesh. No less shocking is the fact that nearly 80 per cent of these women re-

ported “serious complications” during their last pregnancy – see Table 5.9. If we set aside these extreme cases and look at maternal health indicators for the six FOCUS states together, the picture is similar to what we found earlier with respect to other health services: the rudiments of the system are in place, but there are major gaps and lapses. Also, here again, there is little evidence of an active rapport between the anganwadi worker and the concerned women, going beyond routine services. For instance, only 28 per cent of the sample mothers answered “yes” to the following question: “During your last pregnancy, did the anganwadi worker or health worker ever advise you to take any special precautions or to change your diet and habits in any way?” In Tamil Nadu, the corresponding figure was 67 per cent,

**Table 5.9. Ante-Natal Care and Maternal Health under ICDS**

	Tamil Nadu	“Active States” <sup>a</sup>	“Dormant States” <sup>a</sup>	Uttar Pradesh	FOCUS States <sup>a</sup>
<b>Proportion (%) of recent pregnancies preceded by:</b>					
Provision of nutrition supplements	88	81	51	29	66
At least one ante-natal checkup	100	93	50	50	72
TT immunization (at least two doses)	94	74	37	41	48
Provision of iron and folic acid tablets	94	95	57	52	75
Any pregnancy-related advice from the anganwadi worker or health worker	67	45	13	14	28
Home visits by health staff arranged by anganwadi worker	50	47	16	10	31
<b>Proportion (%) of recent pregnancies involving “serious complications”</b>	25	30	54	77	43

<sup>a</sup> “Active states”: Himachal Pradesh, Maharashtra, Tamil Nadu. “Dormant states”: Chhattisgarh, Rajasthan, Uttar Pradesh. “FOCUS states” refers to the six states taken together.

Source: FOCUS Survey 2004. This is based on a sub-sample of 96 mothers who delivered a baby during the preceding 12 months. The figures for specific states are based on very small samples and should be treated as indicative.



which is reasonably high and suggests once again that “change is possible”.

While antenatal care is very important, many women are already so disempowered when they start having children that it is essential to intervene much earlier. For instance, it is well established that women’s education has a major influence on child health, whether through better understanding of health and nutrition issues, giving women more voice in the family and society, or enabling them to use health facilities more effectively. It is partly in recognition of this need for early intervention that adolescent girls have recently been brought within the ambit of ICDS. However, ICDS services for adolescent girls are still very limited. The main intervention, Kishori Shakti Yojana, is restricted to a small number of adolescent girls in selected Blocks, and often boils down, in practice, to the distribution of food supplements. It is hard to see how this could significantly alter the circumstances that lead to the disempowerment of women as mothers and care-givers.

The links between women’s empowerment and child health clearly emerged in the FOCUS survey, in many different ways. It is perhaps no accident that the three states with relatively well-functioning ICDS services and better indicators of child well-being (Himachal Pradesh,

Maharashtra and Tamil Nadu) are also those with less oppressive gender relations and a relatively active participation of women in the economy and society. In these states, women had much higher levels of awareness of nutrition and health issues, and more articulate demands, than in the other FOCUS states. For instance, they often knew the names of different vaccines and checked their children’s immunization cards. In Chhattisgarh, Rajasthan and Uttar Pradesh, by contrast, the sample mothers were often in the dark with respect to the simplest aspects of child care. When they were asked why their children were not vaccinated, some of them replied, “nobody came to tell us”, or “we didn’t think about it”.

Their disempowerment is well illustrated by the story of Sushila in Vishala village of Barmer District. Sushila lives with her husband and two children in a small mud hut on the outskirts of the village. Her husband is a cobbler and the family is very poor. Sushila, who has never been to school, was unable to answer most of our questions, and simply continued with her beautiful embroidery work during the discussion. *“I have never gone out of the house since I got married,”* she said with a tinge of sadness, *“except when I am ill and my husband takes me to the hospital in Barmer.”* Her children have never been vacci-

nated. *“I have no idea about vaccination,”* Sushila said, *“no-one informed me, so what do I do?”* Some of her neighbours’ children are enrolled at the anganwadi and she is interested in sending her own children there, but she does not know how to go about it. In fact, she does not even know where the anganwadi is.

Thus, maternal and child health have to be linked with larger issues of gender equality and women’s empowerment. The role of ASHAs as potential agents of change in rural India, briefly discussed in the preceding section, has to be seen in this light.

## 5.5. Early Childhood Education

It is during the first few years of life, even before she enters primary school, that a child develops her mind and skills. During these early years she will learn to socialize with others; to recognise and respond to different emotions; to make moral judgements (about right or wrong, “villain or hero”); to work carefully with her hands and fingers and manipulate her muscles to respond to her wishes; to ask what may feel to us like “a hundred questions a minute”; to look for some answers herself; to explore, make hypotheses and construct intuitive theories; to draw imaginative figures (creating an equally ex-



### Box 5.8. Play Is Serious Business

#### Take 1:

*Outside, sounds of children playing on the 'phisalpatti' (slide). Inside, small groups of children sitting on the floor around 'chowkis' (low, rectangular tables). One of these has stone-pebbles which are being deftly picked up and placed on the outline of a tree ... another one has children painting with their fingers on printed paper torn from magazines. On yet another chowki is a large bowl with colourful beads that children are stringing with full concentration. Two other groups are engrossed in different corners of the room: in one, a space cordoned off with a dupatta serves as place for running a home, with make-believe cooking, chopping, making tea; others are playing with plastic glasses, sieves and bowls in a sand pit. A didi is hovering in the background, moving between the groups, providing an encouraging remark here and an appreciative pat there, always observant, alert and ready to provide support if required.*

The pre-school years are marked by great advances in the child's ability to explore, understand relationships and develop a self identity. The ability to reason is at a very elementary level. Thus children learn best through concrete objects and first hand experiences. They enjoy music, rhythm, repetition, have a short attention span of 7-15 minutes and want their individual space and attention. The child is an active participant rather than a passive recipient in the process.

#### Take 2:

*A short distance away, sounds of children reciting in a chorus - 'A' for apple, 'B' for boy, 'C' for cat, ... The children are dressed in maroon and grey, sitting in neat little rows with their bulky school bags lying next to them. The teacher is standing next to a black-board with a cane in her hand pointing to small pictures on a chart hung from a nail on the wall. A familiar sight in most Government schools. But wait a minute, aren't these children too young to go to school? Is this pre-school or school starting a little early?*

The key to a good programme lies in the planning of the curriculum and the daily activities. The skill and training of the teacher becomes critical in these transactions. A day in the life of a pre-school child should include activities to address the physical, cognitive, socio-emotional and creative needs of the child. This requires a balance of active and quiet periods, larger and small group activities with an element of fun and enjoyment.

#### Take 3:

*Children squealing and playing, sacks on their backs, their nimble fingers rummaging through filth and household garbage. It will fetch them a few rupees from the local 'kabadiwala'. They have always been doing this, their older brothers and sisters have done this. School is certainly not an option: the 'Masterjee' beats us and the other children tease us ...*

Research has shown that 80% of a person's brain is developed by the age of six. The development of neural pathways is determined by the opportunities that a child gets to interface with external stimuli. Developmental milestones are achieved through a complex process governed by inherent abilities, interests and experiences. Because of this, the provision of a developmentally rich learning environment is very important.

The lack of such an environment leads to:

- Delayed milestones and readiness skills
- Poor performance in school
- High dropout rates
- Poor adjustment in life
- Low self image

It is possible to provide a no-frills, conducive environment where children get the opportunity to explore, manipulate and learn at their own pace; where there is no pressure to perform and achieve, and outcomes are evaluated not in terms of increase in "knowledge" but in terms of increase in the "capacity to learn". These experiences inform the child's worldview at the most formative stage and help lay the foundations for a healthy, well integrated and productive individual.

*Contributed by Mridula Bajaj*

pressive language of drawings); to narrate stories, often with complex characters; to take decisions and put forth her arguments; to understand the mother tongue and much, much more. Play-way learning is thus "serious business", as Mridula Bajaj aptly puts it (see Box 5.8).

As noted earlier, early childhood education (also called "pre-school edu-

cation" elsewhere in this report) is yet to receive the attention it deserves as a component of ICDS. The FOCUS survey suggests that, where early childhood education is provided at the anganwadi, such activity is sporadic and limited. Tamil Nadu and Himachal Pradesh were the only states with a fairly active educational component in ICDS. As table 5.10

shows, 86 per cent of the mothers in Tamil Nadu, and 74 per cent in Himachal Pradesh, said that educational activities were taking place at the Anganwadi. In the sample as a whole, however, the corresponding proportion was only 47 per cent.

This lack of attention to early childhood education (ECE) in ICDS is all the more unfortunate because it has

**Table 5.10. Early Childhood Education at the Anganwadi: Perceptions of Sample Mothers**

	Tamil Nadu	“Active States” <sup>a</sup>	“Dormant States” <sup>a</sup>	Uttar Pradesh	FOCUS States
<b>To your knowledge, are any playing or learning activities organized at the anganwadi?</b>					
Yes	86	54	41	36	47
No	5	20	26	26	23
Not Aware	9	26	33	38	30
<b>Do you think that these playing or learning activities benefit your child?<sup>b</sup></b>					
Yes	90	81	57	56	70
No	0	4	14	7	8
Cannot say	10	15	29	37	22

<sup>a</sup> “Active states”: Himachal Pradesh, Maharashtra, Tamil Nadu. “Dormant states”: Chhattisgarh, Rajasthan, Uttar Pradesh.

<sup>b</sup> Base: Mothers who answered “yes” to the previous question.

Source: FOCUS Survey 2004. The respondents are mothers with at least one child aged 3-6 years enrolled at the local anganwadi.

much potential as a “selling point”, so to speak. This point emerged in discussions with a separate sample of parents whose children were *not* enrolled at the local anganwadi for one reason or another. More than 70 per cent of the respondents stated that they would like their child to be enrolled. Further, among the reasons why they wanted their child to go to the anganwadi, education came first (it was mentioned by more than half of the respondents).

Mothers with a child enrolled (called “sample mothers” in this report) frequently expressed a strong desire to see their child learn something at the anganwadi, and also socialize with other children. They conveyed this in simple words, such as “*Uthna baithna aur doosre bacchon se ghulna milna seekh jayenge*”. Where such activity does take place, mothers generally considered it beneficial for their children (Table 5.10). Many also said

that it would help children prepare for school and make admissions easier. As one mother put it, her son was becoming smart by going to the anganwadi rather than staying idle at home - “*Hoshiaar banta hai, phokat ghar me rahega to kya karega*”. One mother even said that education must not be limited to reading or writing - children must learn many things, including cycling.

With increasing educational aspirations of poor parents, there is even greater responsibility on ECE to provide a more stimulating environment for children, and to compensate for the disadvantages they may face in deprived homes. This includes a need for rethinking the conceptual foundations of Early Childhood Education, beyond what passes for “preschool education” in many anganwadis today. Learning requires active construction of knowledge by children, with support from

adults and collaboration with their peers. What happens in most “preschools” and also urban “nursery” schools in the name of “teaching” is quite contrary to the natural process of development of a child. Not only are most preschools oblivious of the processes of learning that do take place in young children, and how they can be supported, but what they offer is outdated if not damaging. For instance, there is enough research to show that the development of the “number concept” requires the child to make correlations with concrete objects, to look for patterns, to see sequences, to understand relationships between bigger and smaller or cardinal and ordinal numbers. Mechanically repeating the names of “numbers” or *ginti* does not help. In one anganwadi in Varanasi, the survey investigators found children were being taught multiplication! This is what happens

### Box 5.9. Learning Wonders

Learning language, particularly her mother tongue, is a critical area of the child's development especially during early childhood. It also remains however the most misunderstood. It is now well accepted for instance that only 'repeating' names does not help a child develop her vocabulary. She must in fact be encouraged to construct her language by observing the world, interacting with people and making 'meaning' through familiar contexts. The following extract shows how a one and half year old child begins to categorise animals and construct her own vocabulary, without being 'taught' to recite their names.

Naima at eighteen months is fast acquiring language – not just to communicate, as is usually assumed, but to actively engage with her environment, to observe it closely and understand it better. She looks at a peacock flying and excitedly calls out "kaka" - the Malayalam word for 'bird'. However,

as soon as the peacock lands on the ground and starts walking, she points and says "bhow-bhow". She sees no contradiction in calling it by another name - the 'name' is just the category she places new things in, to see how it fits in with the things she is familiar with. Her spoken vocabulary at this stage comprises of barely a couple of words, but she understands many more, and also constructs associations to use the same words as broad categories, or rather as concepts.

Why is the peacock a "bhow-bhow" as it walked on the ground? Clearly, her brain sees more similarities in that position between the peacock and the dog than with a bird, the dominant feature of which is to fly. Similarly, she looks at a lizard high on a wall and confidently calls it 'kaka' (bird), again using her own observation to arrive at the 'concept' of a bird, among the things she found off the ground. These names are 'constructed' by her, not 'taught' or suggested by any one,

and she uses them during a short period of a few months when she has begun to name things. Interestingly, as her vocabulary develops further, as part of her daily interactions with her family, she forgets about the words she had previously coined - looking annoyingly surprised if we call a lizard a 'kaka'. "Palli" she says indignantly, (using the Malayalam word for lizard), wondering how we could make such absurd errors of observation!

No one had 'taught' Naima to begin learning in the mother tongue or to learn names – to call a peacock a 'bhow bhow'. And no one certainly asked her to list 'five similarities between a bird and a lizard'! If she had been given such a list of 'names' to recite, her brain will not function this way - to observe, conjecture, compare, contrast and classify and even confidently coin terms to engage with what is happening around her.

*Contributed by Anita Rampal*

in preschools (and even primary schools) in the name of early maths, which later leads to deep maths anxiety and a fear of numbers.

Current theories of learning do not consider children to be empty vessels which can be filled with "good" information. And yet, that is how things continue to happen in most preschools. Even in anganwadis with an active education programme, we often found that children were only made to identify and ritualistically repeat "names" of objects – "names" of alphabets, of numbers, of vegetables or fruits shown on badly printed charts. Sadly, such "parroting" in chorus is what usually happens in most anganwadis, with the exception of Tamil Nadu where

more thoughtful education activities are often planned (see Chapter 7).

The following is a fairly typical account of what the field investigators wrote after observing ECE sessions at the anganwadi:

*"The anganwadi worker played/taught the children. The eight children initially did not respond but later when she explained that the observers were just 'teachers of a school' they became responsive. She talked about colours, shapes, animals, sounds made by different animals. For dog she just asked how it barks and children immediately responded 'bhow'."*

This account, from Chamba District in Himachal Pradesh, supports the larger point just made. Children at the age of four to five years might

be amused to shout "bhow" when asked to emulate how a dog barks, but their education cannot be limited to such sporadic and even trivial exercises of so-called "joyful learning". Children can learn much more as part of their development process, but need proper stimulation and support. To give "early childhood education" a holistic chance of taking place, it would be important to look at it as a foundation for the development of the child, rather than through the narrow lens of "pre-school education". This requires a system where ECE is not geared to fit children in the present limited mould of primary school or determined by "preparation for admission" to primary school.

Early childhood education must include all children, including those

### Box 5.10. The Shishuvachan Programme in Pune

#### Pre-school education and learning achievements

It is a known fact that in ICDS classes the main focus is on health and nutrition, though pre-primary education accounts for about 40% of the training of anganwadi teachers. Generally, educational activities at the anganwadi are very limited. Pratham therefore decided to strengthen the foundations of learning by introducing the Shishuvachan programme in Pune, for children just below the age of five years. Children in this age group are admitted to primary school in the following academic year.

The Annual Status of Education Report (ASER) 2005 brought out the fact that if children do not acquire basic learning skills at the initial stage of their schooling, it is very difficult for them to acquire such skills later on. Table I below gives comparative data for Std. 1 children of three states: Kerala, Madhya Pradesh and Maharashtra.

The above table is self explanatory. The ASER 2005 survey was conducted in the months of October and November 2005. Even in a progressive state like Maharashtra, it was found that around 67% of the children were in the “nothing” or “letter only” categories in terms of reading abilities. Pratham intervention through Shishuvachan was started in the 2003-04.

#### Shishuvachan in anganwadis in Pune city (2004-05)

The programme was piloted in 300 anganwadis located in slums of Pune city in 2004-05. Pratham had trained members of the slum communities to teach basic skills of reading and number recognition to children in the age group of 4.5 to 5 years. Pratham Shishuvachan teacher used to teach children for one hour at the local anganwadi. The parents of the children welcomed the intervention. No balwadis were run in these communities other than ICDS classes. Around 4,400 children participated in the Shishuvachan programme. Pratham provided teaching-learning material to each anganwadi. It was observed that children’s attendance increased significantly. Parents formed their own committee to oversee the programme.

The Table II below indicates that most children achieved reading and number recognition skills in just six months:

The above data reveal that there were no children in the “nothing” category. Children had acquired reading and number recognition skills before they were admitted to Std. 1. Though this programme was launched collaboratively, Pratham was unable to convince ICDS officials to take it up in the following academic year. Therefore

Shishuvachan had to be started in the slum communities. But around 60% of Pratham’s Shishuvachan teachers were absorbed as anganwadi teachers in newly opened anganwadis.

#### Shishuvachan in slum communities of 11 cities of Maharashtra (2005-06)

Based on the Pune experience, Pratham decided to expand the Shishuvachan programme in 11 cities of Maharashtra where Pratham’s other programmes were already in place. The objective was to reach to every child in the relevant age group in the selected slum communities. The classes were started with nominal fees of ten rupees per month. Around 70% of the parents were paying fees. No child was turned back for non-payment of fees.

Table III indicates the same trend as in Table II above. Expansion of this programme confirmed that people in the poor communities want quality education for their children.

#### What is Shishuvachan programme?

Shishuvachan programme aims at introducing the children to formal education through informal means. This programme also ensures that every child can acquire basic learning skills. Children in the age

Table I.

ASER 2005									
Std.	Children who can read					Children who can do			
	Nothing	Letter	Word	Para Level I	Story Level II	Nothing	Number Recognition	Subtraction	Division
<b>Kerala</b>									
I	10.0	18.5	39.9	8.2	23.4	16.8	64.1	10.8	8.3
<b>Madhya Pradesh</b>									
I	57.1	20.9	9.4	4.7	7.9	64.3	26.4	4.7	4.6
<b>Maharashtra</b>									
I	29.4	38.2	21.9	5.3	5.2	53.4	40.9	4.5	1.2

Contd...

Contd...

age group of 4.5 to 5 years and children in Std. 1 are covered. The duration of Shishuvachan is 9 months, which comes to around 120 working days. Typically, around 15 to 20 children are enrolled in a class. This programme is conducted in 4 phases of 30 working days each.

Children of this age group are like blotting paper - highly enthusiastic, curious and imaginative - ready to get absorbed in diverse activities and want to experience whatever is possible. The Shishuvachan programme tries to understand this aspect of their energy and provides them constructive activities that enable them to learn reading and number recognition without stress. This programme prevents children from lagging behind and helps in strengthening the foundations of learning basic skills. The method used is child friendly and not strenuous.

**Table II. Shishuvachan in anganwadis 2004-05 (Pune city)**

Children who could read				
	Nothing	Letter	Word	Simple sentence
Pre test (4420)	96%	4%	0%	0%
Post test (4298)	0%	2%	5%	93%
Children who could				
	Count objects	Read numbers up to 20	Do additions up to 10	Do subtractions up to 10
Pre test (4420)	15%	11%	12%	6%
Post test (4298)	99%	99%	100%	99%

Numbers in brackets indicate how many children who participated.

**Table III.**

Children who could read					
	Nothing	Letter	Word	Simple sentence	
Pre test (8818)	53.5	33.5	11.0	2.0	
Post test (9283)	5.2	25.4	37.1	32.3	
Children who could do/recognize					
	Nothing	1 to 20	21 to 100	Addition	Subtractions
Pre test (8881)	49.6	39.2	9.9	0.9	0.5
Post test (9782)	4.2	35.0	40.4	12.2	8.2

Contributed by Usha Rane.

who are "differently abled". Parents need to be involved and must be shown what children are learning, so that they can encourage children and keep up the motivation. What happens at the anganwadi must be discussed in panchayat meetings, and parents and community members need to be invited to come and observe the progress of children. Public display of drawings and oral presentations, not just of just some so-called 'good' students but of all children (observed in Maharashtra), helps parents appreciate that learning is a natural part of the development of every child.

Needless to say, effective ECE requires adequate facilities, infrastructure and equipment. For instance, anganwadis need adequate space (indoor and outdoor), including space for work in small groups, in pairs and also in a circle. While children take up activities in groups, the teacher should be able to move around and interact with them, and give individual attention to some. Unfortunately, many of the sample anganwadis lacked the basic infrastructure needed for such activity. While 82 per cent of the sample anganwadis in Tamil Nadu had space for indoor activity, in Uttar Pradesh it was about half. Many

anganwadis also lacked basic play equipment like counting frames, building blocks, toys etc. that could make the centre more attractive to children. About one fourth of the sample anganwadis did not have any "PSE kits". In anganwadis where kits were available, they sometimes lay unused in a locked trunk as workers said they would be hauled up if things went missing or broke.

Portfolios of children's learning, a record of what they have drawn or made, helps teachers assess children on a continuous basis in a non-threatening manner, which in turn leads to a better sense of self-worth



**Box 5.11. The Joy of Learning**

From the point of view of human development, early childhood is the most critical period of life. It is also the period of fastest learning. Within a year of birth, the newborn child, has started acquiring two critical skills - walking and talking – after starting from scratch!. Can you imagine any adult, at any other stage of life, learning a comparable amount in one year?

Early Childhood Care and Education (ECCE) stimulates and guides this development, helping children to grow in many different dimensions - physical and mental, social and emotional, personal and aesthetic. Of course, all this must rest on a solid foundation of health, built up from adequate and appropriate nutrition, a clean and safe environment, good habits, and protection from communicable disease. Children cannot flourish unless these basic conditions are in place.

How does the child learn and develop? The natural mode of learning - play activity – is also the best. By “play” we mean

activity or experience which the child freely chooses and is wholly engaged in. Everyone knows that children can concentrate for hours on things which they enjoy. But the skilled guidance of a teacher is needed for children to get the most learning out of play. Teachers can contextualize the learning and place it within a larger framework ;and help the child move on when it is necessary to do so. Children need challenge and opportunity, as well as help, to gain mastery - which in turn breeds the “joy of learning” that leads spontaneously to the next step. Children see no difference between play and work: but because many people nowadays think that play is something different from learning, it may be better to call play-based learning “activity-based”. Such ECCE does not need elaborate and expensive equipment, but it does need a skilled and trained teacher.

In a way, the description above captures the spirit of the ICDS programme, because it is integrated and activity-based, though not always well implemented. But importantly, the

ICDS does not support the harmful practices seen so often in private nursery schools, – forcing children to sit still for long hours, memorizing and repeating things which they don’t understand, or writing with pencils held in little fingers. These activities are educationally unsound at this stage of life, unhelpful and can even be a waste of time as they take away precious time that children should be using to master more appropriate skills.,Such activities can even be damaging or dangerous. For instance, children can develop vision problems when they have to focus on small letters in trying to read, or orthopaedic problems in shoulder, elbow or wrist if made to write before they can hold a pencil properly.

ICDS, of all the programmes in our country, has the greatest potential to develop as a holistic programme of ECCE, but there are many obstacles to be overcome and many miles to go before that dream comes true.

*Contributed by Mina Swaminathan*

and also deeper learning. No quantitative assessment or use of standardized tests should be done at an early stage and children should not be subjected to interviews to help them pass pre-school tests or gain entrance in primary school. Children from disadvantaged backgrounds need much more attention and support and a ‘culture of success’ needs to be established right at start, to

ensure that all children develop their full potential. The responsibility of the system must be recognised for children’s learning and development, and the onus must not be placed on parents or on the children themselves for what is today taken to be their ‘failure’ or ‘weakness’.

The most challenging task, however, is to design creative training programmes for nursery teachers

and anganwadi workers. As Mina Swaminthan aptly puts it (Box 5.11), effective ECE “*does not need elaborate and expensive equipment, but it does need a skilled and trained teacher*”. The theoretical bases of many of the current courses are however weak and little emphasis is given on reflective practice of teachers, with close observation of children and their processes of learning.

**Table 5.11. The Distance Factor: Anganwadis and Primary Schools**

Percentage distribution of hamlets in terms of distance from the nearest anganwadi and primary school						
	0	1-100 metres	101-300 metres	301-999 metres	1 km or more	Total
<b>Anganwadi</b>	27	13	12	24	24	100
<b>Primary school</b>	22	14	12	22	30	100

Source: FOCUS Survey 2004. These figures pertain to all hamlets in the FOCUS villages for which data were available.



This applies even in the more active states. For instance, SCERT Kerala has recently designed a curriculum for the training of pre-school teachers, but its format remains limited and tied to the traditional mode of “information giving” about distinctly adult categories, such as “insects”, “health”, “transport”, “public institutions” or “communication”, which are not natural to the way children think. The possibility of developing more creative, appropriate and stimulating training curricula is well established from the work of organisations such as SEWA (see Chapter 6) and Mobile Crèches (see Chapter 8).

Another lesson from these organisations’ work is that locating the anganwadi in or near the school premises is a useful way of facilitating its educational purpose. As Mirai Chatterji observes, based on SEWA’s experience:

*“Whenever we have had crèches in the school premises, it has benefited all. The young children come in with their older siblings, they get used to the idea of school and their older siblings come in and play with the little ones during the school breaks. There is a general atmo-*

*sphere of learning and education, with the young children quickly learning from the older ones already at school.”*

(Mirai Chatterji, “What Our Children Taught Us”, 2006)

The fact that schools are generally located in “neutral” spaces reinforces the case for locating anganwadis in or near school premises, as this would facilitate access for disadvantaged communities such as Dalits and Adivasis. This arrangement would also foster accountability and help to ensure that the anganwadi opens regularly. However, there are also various pitfalls to avoid in this approach, such as anganwadis becoming deserted during school holidays, or the anganwadi being neglected because the helper is diverted to clean school premises. More importantly, relocating an anganwadi near the school premises would be counter-productive if the school is far away from the children’s houses. In the FOCUS villages, the distribution of hamlets in terms of distance from the nearest primary school is similar to their distribution by distance from the nearest anganwadi (Table 5.11). Thus, relocating all anganwadis near pri-

mary schools would not have much overall effect on their accessibility in terms of distance. However, “blanket relocation” of this type, as has happened recently in Uttar Pradesh, does create a distance problem for hamlets that happen to be relatively cut off from the nearest school. What is needed is a discriminating approach, whereby relocation near school premises takes place only if the school is relatively close to children’s homes.

Of course, reviving educational activities in ICDS requires more than just relocating the anganwadis. As we saw, it also requires adequate facilities, more effective monitoring, better training programmes for Anganwadi workers, and even some basic conceptual rethinking. The first step, however, is to recognise the problem and to learn from states that already have lively educational programmes, such as Kerala and Tamil Nadu. “Universalization with quality” is not just about expanding the coverage of ICDS, or quality improvements. It also means extending the scope of ICDS services, and in particular, reinstating health care and early childhood education at the centre of the programme.

## 6. The World of Anganwadi Workers



Arindam Saha

Perhaps it has not occurred to you that the work of an anganwadi worker is, in many ways, much harder than that of (say) a primary-school teacher, or for that matter a university professor. For an anganwadi worker every child counts and his or her needs are both complex and different from those of other children. Great skill and patience is required at every step, whether it is to feed or teach the child, or even just to attract the child to the

anganwadi. Even for an educated, skilled and trained woman, the work of an anganwadi worker is very challenging. For a poorly trained and under-equipped woman, it may border on the impossible. Most anganwadi workers face these challenges with little support, and are often undervalued or even unnoticed. This is why anganwadi workers have been called "India's unsung heroines". In this chapter, we lend our ear to their voices and concerns.

## 6.1. India's Unsung Heroines

The anganwadi worker is the moving spirit of ICDS at the village level, and the success of the programme depends a great deal on her skills and motivation. Those, in turn, depend on a variety of factors: how anganwadi workers are selected, how they are trained, their work environment, the extent of community support, and so on. In this as in other respects, the FOCUS survey pointed to major variations, both between

and within the sample states. We met some very able anganwadi workers who took pride in their work and gave it their best, as well as others who had been appointed for political reasons and did the minimum. As mentioned in Chapter 4, this “human factor” can make a world of difference.

As Table 6.1 illustrates, there is much diversity in the personal and social backgrounds of anganwadi workers. No striking pattern emerges here, at least in the FOCUS areas. Generally,

the education levels of anganwadi workers are somewhat above average, compared with other adult women in the sample districts. The representation of different communities (e.g. scheduled castes, scheduled tribes, Muslims) appears to be roughly in line with their share of the population, though Muslim women are under-represented – only 3 per cent of anganwadi workers in the FOCUS sample were Muslim. Anganwadi helpers, for their part, come from relatively underprivileged backgrounds. A large propor-

### Box 6.1. What's in a Name?

She is thirty-two years old, and you can see her anywhere in India. But she has no name of her own yet. She is still called the “anganwadi worker” (AWW), after the name of the place where she works.

And do you know how the anganwadi got its name? The first child education centres in India were called Bal Vatika, or Bal Mandir, an Indian equivalent of the Children's Garden (Kindergarten in German). In the fifties, this expression became popular as “balwadi” (“wadi” being the Marathi equivalent of vatika) and the child care worker/teacher was christened Bal Sevika. The great Anutai Wagh, who introduced early childhood education to children of the poor tribals of Western Maharashtra, coined the expression “anganwadi” to describe the simple, low-cost balwadis that she ran right in the courtyards of huts in tribal hamlets. And when ICDS was started, this expression was picked up.

But alas, no one remembered to give a name to the worker. After all, she is the most important person in the programme, the one who provides the care, the education, and all the other components of child care. No building or angan can do that - only a hu-

man being can. Yet, she does not have the dignity of a name of her own, a name that will recognize her worth, her skills and her contribution.

To do this work, a person has to be skilled. Many people, from humble parents (the famous “common man” or “common woman”) to high officials, assume that such a worker has no skills, and no need for skills. “What does she do, after all, except minding children for a few hours?” is how many rural parents put it. In a different language, this view implies that the job is simply an extension of a woman's maternal role, that should come “naturally” to every woman, and that requires no special training. But think again. If it is difficult to manage two or three under-sixes in a family, how much more difficult it would be to manage twenty five or thirty in a small space? Is she not the child's first teacher? In fact, we all know that she does much more than just teach.

From this ostrich-like attitude springs another one – a refusal to recognize that as a worker she requires a regular wage. So after thirty-two years, our nameless worker, who does countless jobs during the day is still called a “volunteer”, gets a pittance as an “hono-

rium” which is graciously raised by a few rupees every few years as a token of appreciation. While she gets all the pitfalls of government jobs, like transfers and disciplinary action she enjoys none of the benefits, like a regular grade or social security. No wonder Saraswati Amma, an anganwadi worker of twenty-five years standing, said, on hearing about a scheme to give Rs.50,000 to the family of an anganwadi worker if she died of an accident or illness while in service, “We are more useful to our families dead than alive!”

Another result of this attitude is that there is still no regular recognized training or certification for awws. All they get is an “on-the-job” orientation when they join (down from the original three months to one month now) and occasional “refresher” courses of a few days duration. So if a skilled and experienced worker wants to leave and look for another job, or set herself up in self-employment, she does not even have a certificate of training to do so. When will we give this person an identity and a life, with a dignified name, an adequate training and a fair wage?

*Contributed by Mina Swaminathan*

### Box 6.2. Unsung Heroines: Tarabai Modak and Anutai Wagh

Tarabai Modak and Anutai Wagh, her student, disciple and later co-worker, were two wonderful women. For the first time they demonstrated how to meet the needs for the welfare, education and development of children under six, so that they could grow up to become healthy and prosperous citizens of this country. Anutai, a child widow, got her education at Seva Sadan, and later joined Nutan Bal Shikshan Sangh, an organisation working in Maharashtra and Gujarat, as a preschool teacher. Here she met Tarabai Modak, already a teacher and growing leader, and the two began to work together.

Dissatisfied with her achievements in the cities, Tarabai Modak wanted to work with children and women struggling in poverty, in rural and tribal areas. She selected Kosbad, in Thane District, Maharashtra, which was populated largely by Warli tribals for this purpose. In need of a partner who could help her to fulfil her dreams, she invited Anutai Wagh to come along who eagerly agreed. Thus began a lifelong journey of partnership.

The area where they started their work was a difficult one. It did not even have primary school, let alone a pre-primary school. In

order to take education to the children who spent their days grazing animals in the forest, Tarabai started a “mobile” primary school, where the teachers went to the children and taught them wherever they were. This was the origin of what is known as “non-formal education” today and has been beautifully documented in Tarabai’s own words in the slim publication, “The Meadow School” (1961).

Not content, they soon launched into the next venture – starting pre-primary education for the little ones, for which Anutai took charge. They called it Balwadi, (‘wadi’ being the colloquial term for garden, or vatika in formal Hindi). The poor working women used to leave their children in the Balwadi and Anutai would clean and feed them with some daliya and engage them in play activities with simple local materials. The community and the families used to contribute what they could. Initially people did not trust them but after a lot of advocacy and proven work they won the confidence of the local people.

Both of them were also involved in teacher training and set up a training institute at Kosbad Hill as part of the Gram Balak Shiksha Sangh. They also brought out a newsletter with their limited resources, called *Shikshan Patrika*, mainly for teachers. After some time,

the Government of Maharashtra began to help them with some funds. By now, both of them had become well known as the leaders of the nascent movement for pre-school education. But they always remained rooted to the grassroots, working with communities, children and teachers.

In due course, Tarabai and Anutai were able to convince the Govt. of India, with the support of the late J.P. Naik, to draw on their experience to develop a preschool education model for the Fourth Five Year Plan, when the ICDS was launched. This was also when the word “anganwadi” came into use, because they were able to show that a good pre-school could be run with low-cost local materials in rural areas, even when located in an “angan” or courtyard.

After Tarabai’s death in the late seventies, Anutai carried on with the work till the end, in the mid-nineties. Today, when we see an “anganwadi” or “balwadi”, we salute the memory of these two women, whose devotion and hard work brought these words into common use. We can never forget their contribution.

*Contributed by Sandip Naik (based on an interview with Shalinitai Moghe, a close associate of the two), with inputs from Mina Swaminathan.*

tion of helpers (37 per cent) have no formal education at all, and 43 per cent belong to a scheduled caste or scheduled tribe.

The FOCUS survey included detailed discussions with anganwadi workers. These discussions brought to light a range of important concerns. Some of them were perhaps a little exaggerated, but many of them were actually consistent with the survey data. For instance, anganwadi workers often complained of poor infrastruc-

tural facilities, from inadequate space to lack of basic equipment. As we saw in Chapter 4, basic facilities are indeed lacking in a large proportion of anganwadis.

Similarly, many anganwadi workers complained about the burden of maintaining numerous registers. The registers were directly inspected by the FOCUS investigators and we found that, on average, an anganwadi worker had to maintain as many as twelve registers. It was not un-

common for them to look after more than twenty registers, and one (in Tamil Nadu) was struggling with a full 33 registers. Filling registers took 6 hours of the anganwadi worker’s time every week, on average. This means a full day of work, for which no allowance is made either in terms of time use planning or in terms of remuneration.

While the problem of excess registers is relatively easy to address, anganwadi workers have other,

more fundamental concerns. Their main concerns, as perceived by the field investigators on the basis of their discussions with anganwadi workers, include the following: inadequate infrastructure; lack of training; low and irregular salaries; excessive work overload; lack of community support; and intimidation or extortion from the supervisors. Table 6.2 presents survey-based information on these and other demotivating aspects of the work environment of anganwadi workers. The combined effect of these hurdles is to demotivate and disempower many anganwadi workers, and this debilitating work environment is bound to affect the quality of their work. In the next section, we take a closer look at some of these concerns.

## 6.2. Concerns of Anganwadi Workers

### Work overload

Many anganwadi workers complained of an excessive work burden. In some cases, this was due to staff vacancies, which increased the work load for appointed workers. For instance, in Chandauli Block of Varanasi District (Uttar Pradesh), only 43 of the 167 posts of anganwadi workers had been filled at the time of the survey. Many of the appointed workers had been asked to manage more than one centre. Needless to say, this is next to impossible.

***This anganwadi doesn't have an anganwadi worker appointed for***

**Table 6.1. Social Background of Anganwadi Workers and Helpers**

	Anganwadi Workers	Anganwadi Helpers
<b>Percentage distribution of anganwadi workers/helpers in terms of selected characteristics:</b>		
<b>Age</b>		
18-30 years	27	29
31-45 years	56	46
Above 45 years	17	25
<b>Caste/community</b>		
General (Hindu)	31	19
OBC	34	33
SC <sup>a</sup> (17)	22	31
ST <sup>a</sup> (10)	10	12
Muslim <sup>a</sup> (9)	3	3
Other	1	2
<b>Education (level attained)</b>		
Uneducated	5	37
Class 1 to 4	2	18
Class 5 to 7	12	25
Class 8 to 10	53	20
Above class 10	28	1
<b>Marital status</b>		
Unmarried	2	1
Married	84	72
Widowed	7	20
Divorced, separated or deserted	7	7
Other	0.5	0
<b>Residence</b>		
Within the village	80	88
Outside the village	20	12
<b>Main occupation of the household</b>		
Casual labour	18	35
Cultivation	28	25
Self-employment (other than cultivation)	23	12
Salaried employment	25	13
Other	6	15

<sup>a</sup> In brackets, the corresponding population shares in the sample districts (from the 2001 Census).

Source: FOCUS Survey 2004.

***the last one year. The worker from the neighbouring anganwadi has been given additional charge of this centre, but she only maintains the registers. The anganwadi exists only in name but almost no services are available.***

*(Investigators' observations, Hastinapur Block, Meerut District, Uttar Pradesh.)*

Another source of work overload is the burden of "non-ICDS duties":

tasks that anganwadi workers are asked to perform over and above their ordinary ICDS work. In rural areas, the anganwadi worker is often the only woman who can be conveniently "mobilised" for special duties at the village level. As a result she is often asked to assist with various government programmes, especially those relating to women and children. In Rajasthan, for example, the



### Box 6.3. Uphill Battle in Narkanda

Everyone we asked, including the receptionist at the government hotel, seemed to know the location of the nearest AWC. The AWC was, however, not prominently located. When we reached there at about 11 am (it opened from 10 am to 1 pm), nine children were sitting on a strip of *dari* in the verandah of an extremely dilapidated building. The children were playing with toys (abacus, building blocks, soft toys) and reciting numbers. The AWW was present and teaching them. She welcomed us without hesitation or even much surprise and readily agreed to talk with us though she was eager to explain why there were only nine children present. She seemed bright and interested and quite familiar with her job. Her name indicated that she belonged to the upper caste. While we were there she received a phone call on her cell phone telling her some people were looking for the anganwadi.

Seven of the children were 'nepali' and the two others were described as 'local'. They looked quite comfortable and recited 'the fish' song (*macchli jal ki rani hai* etc) for us complete with actions though none knew what a fish looked like. One of the children was about eight years old. She had brought two younger siblings as well as a baby cousin who was the youngest present, (so four of the nine children were from the same family). We asked why she wasn't in school.

The family had migrated a year ago and she had not yet acquired the affidavit she required for entry into school.

The AWC has been given one room by the Nagar Panchayat. The room was in shambles and the roof looked as if it might collapse any moment (in fact it was broken in one corner). The AWW said it was not safe to put children in the room, which was why they sat on the verandah even when it was snowing. She felt that was one reason that children don't attend. In any case, the small room was being used as a store and was choc-a-bloc with supplies and things. We were told the entire building was due for demolition but no alternate space had yet been designated for the AWC as far as the AWW knew. There was no toilet or facilities for running water.

No helper was in evidence. When asked, the AWW said she hadn't had one for a year ever since the existing helper got married and went away. The problem seemed to be that the CDPO had delegated the task of appointing the helper to the Panchayat, and interviews had not been held for one reason or the other, even though, as she kept saying, she was finding it very difficult to run the centre without one.

The ANM did not attend the centre itself for immunisations. Children were instructed to go to the nearby PHC on immunisation days

instead. A doctor came from the PHC every couple of months to do health checks. The AWW claimed all the children were fully immunised. The AWC had no children in the Grade II, III or IV category.

The AWW said there was no problem with food supplies or quality. She was supposed to cook *dalia* and *khichhri* and supplement it with peanuts or *gud-patti* for children over three. "People might have complained to you about the food because they don't like peanuts and *gud-patti* being given in summer since it is 'hot food'", she said, though no one had complained to us. 'Hyderabad Mix' is given only for Grade IV kids and no other ready to eat food was being used. Pregnant and lactating women and children under 3 were being given dry rations every 15 days.

The AWW had been with the ICDS for over 5 years. She said she enjoyed her job but things had become very difficult in the last year or so with a marked increase in her tasks what with home visits and the maintenance of records. She said she was keen to run a good centre and felt the most important requirement for her was to have decent infrastructure where people would want to send their children.

*Contributed by Dr Vandana Prasad*

anganwadi worker still gets "family planning targets", despite recent directives from the central government proscribing this practice. Similarly, in Himachal Pradesh the task of cooking mid-day meals in primary schools was initially assigned to anganwadi workers. It is only after the Commissioners of the Supreme Court intervened that alternative arrangements were made.

These are perhaps extreme examples of objectionable diversion of

anganwadi workers for non-ICDS purposes. But even other common demands made on their time raise important questions. For instance, in many states anganwadi workers have been asked to help with the formation or management of "self-help groups" (SHGs). This is an inappropriate demand, since responsible management of a self-help group requires skills and attention of a kind that anganwadi workers are unlikely

to be able to provide without prejudice to their ICDS work. Similarly, it is not clear why anganwadi workers should be mobilised for election duties, conducting censuses or meeting DPEP targets – to mention a few examples of non-ICDS duties that were observed in the FOCUS survey. Aside from adding to the work overload, these non-ICDS duties divert attention from ICDS in various ways. In the worst cases, they create a situ-



**Table 6.2. Demotivating Aspects of the Work Environment of Anganwadi Workers**

Proportion (%) of anganwadi workers who:	
Have been mobilised for non-ICDS duties during last six months	79
Feel that the money received to run the AWC is "inadequate"	71
Face problems in procuring AWC equipment on time	64
Feel that the AWC equipment is "inadequate"	61
Did not receive salary during last 30 days	60
Have to use personal money to ensure smooth functioning of AWC	52
Have to maintain more than 12 registers	39
Feel that their training is "inadequate"	34
Did not receive any pre-service training	25

AWC = Anganwadi centre.

Source: FOCUS Survey 2004.

ation where the anganwadi worker is under pressure to "perform" in terms of these additional duties, which are given more importance than her core responsibilities.

***"Since the inception of the self-help group (SHG) scheme and other such national schemes, the workload of the anganwadi worker has increased to quite an extent."***

(CDPO, Karsog Block, Mandi District, Himachal Pradesh.)

The answer to this problem is to insist that anganwadi workers should not be recruited for non-ICDS duties, and that their official job description should be adhered to. This does not preclude revising their job description from time to time. For instance, it has been suggested that anganwadi workers could help to halt the alarming decline of the (female to male) "sex ratio" in the 0-6 age group, which is largely due to the spread of sex-selective abortion.

This role could conceivably be integrated in the anganwadi workers' routine, since it relates closely to other ICDS activities such as home visits and counselling of pregnant

mothers. What needs to be avoided is arbitrary mobilisation of anganwadi workers outside their official job description.

### Low remuneration

Another major complaint of anganwadi workers (not to speak of anganwadi helpers) is their low remuneration. This remuneration is called "honorarium", reflecting the initial vision of the anganwadi worker as a semi-voluntary community worker. The Central Government contributes Rs 1,000 per month per worker, and any further remuneration has to be paid from the state government's coffers. Of the six FOCUS states, only three had set aside additional funds to raise anganwadi

**Table 6.3. The Burden of Non-ICDS Duties**

Percentage distribution of anganwadi workers by number of days spent in non-ICDS duties during the six months preceding the survey:	
Zero	35
1 to 5 days	41
6 to 10 days	15
11 to 15 days	2
16 to 20 days	1
more than 20 days	6
Proportion (%) of anganwadi workers who were mobilised for the following duties: <sup>a</sup>	
Pulse polio	93
Leprosy programme	15
Election work	4
Self-help groups	5
Family planning	3
Census	1
Other work	46
Proportion (%) of non-ICDS duties imposed by different departments:	
Department of Health and Family Welfare	93
Department of Women and Child Development	5
Other departments	2

<sup>a</sup> 147 anganwadi workers report being mobilized for non-ICDS duties; some reported being mobilized for more than one non-ICDS duty, which is why the total is more than 100.

Source: FOCUS Survey 2004. The figures are based on responses from anganwadi workers.

### Box 6.4. Demands of Anganwadi Workers' Unions

ICDS has completed more than 30 years of existence, yet its services do not till today extend to even one third of all children under six. The moves to universalise the programme are therefore welcome. In the context of universalisation however there is an urgent need to recognise the serious constraints that the programme faces and work out ways to address them.

One of the central reasons for the poor effectiveness of ICDS is the failure to consider the needs of the massive anganwadi workforce that has been deployed for this purpose. Characterising them as voluntary workers on the one hand and shifting a large burden of social services on their shoulders on the other, is at the heart of many of the poor outcomes of the programme. Explaining their demands in a memorandum to the Government, the All India Federation of Anganwadi Workers and Helpers (AIFAWH) Union stated:

*"Because of the close relationship of the anganwadi employees with the people, their services are being utilised for the implementation of various other schemes and programmes of the Government under the health, education, revenue, Panchayat Raj departments. Some of the jobs in which the anganwadi workers and helpers are involved are related to the Health department like creating awareness on ORS, Upper Respiratory Infections, Directly Observed Treatment System (DOTS) for Tuberculosis, AIDS awareness, motivation and education on birth control methods etc. They are also involved in jobs related to the Education department like Total Literacy Programmes, Sarva Siksha Abhiyan, DPEP, and Non Formal Education etc. In some States they are even involved in the promotion of small savings, group insurance, in forming Self Help Groups, in conducting surveys to identify*

*BPL families, Leprosy survey, Filariasis survey, cattle census etc.*

*Most of the basic information about the people in the village - births, deaths, number of handicapped persons, BPL population, etc is invariably available at the anganwadi centres. The anganwadi workers in several states are also asked to actively involve themselves in stopping child marriages and other such practices. In short, over the years, anganwadi centres have developed into multiple service delivery centres for the benefit of children and women, at the grass root level. Their services are generally welcomed and appreciated by the people.*

*Though as per the ICDS scheme, they are supposed to work for only four and half hours in a day, in practice, they have to work for more than 6-7 hours in a day to fulfil all these responsibilities entrusted to them.*

*But unfortunately, even after around 30 years, the ICDS continues only as a Scheme and the anganwadi workers and helpers are not even recognised as employees by the Government. They are paid only a meagre honorarium. They do not have any job security or social security. After decades of service they do not have anything to fall back upon in their old age and are forced to starve. They do not have any promotional avenues."*

It is curious how a central and regular public service of this nature continues to be declared a voluntary arrangement. This is partly because an anganwadi workers duties are perceived to be an extension of domestic child care and women's work, both of which are often invisible and unpaid. A similar logic extends to the public sphere, making her work voluntary and honorarium based. This is one reason why anganwadi workers demand to be called teachers, in the belief that this would alter the perception of their work and recognise it as an essential public institution.

In efforts to universalise a good quality early childhood care programme, the anganwadi worker is the first and most dependable ally. Widely regarded as an 'agent for social change', she also represents one of India's largest and most poorly paid workforce. Unfortunately local public perception puts much of the blame for a weak programme on her shoulders, and she is often perceived to be part of the problem. This, so called non performance, helps justify the poor terms of service she has. It also justifies the notion that fairer terms of employment would result in diminished levels of accountability.

In practice however most anganwadi workers have a good relationship with the people they serve. However problems like irregular supply of supplementary nutrition or its poor quality, can lead to considerable friction between her and the community. Widespread bureaucratic and political corruption further erode the quality of services she provides, even as it worsens her working conditions. The anganwadi worker is thus vulnerable to victimization from a number of directions and this is a serious problem that has to be understood and addressed. Although the anganwadi workers unions have been submitting petitions asking for reform of the system, their demands are seldom acknowledged.

The way forward requires democratic forces and peoples' organisations to join hands with the anganwadi workers in demanding that ICDS be institutionalised. In other words recognising it as an essential public service like schools or health centres. It also requires fair working conditions for anganwadi workers to be seen as part of the larger struggle for universalising ICDS, and providing comprehensive early childhood care for all children under six.

*Contributed by Sudha Sundararaman*

**Table 6.4. Training of Anganwadi Workers and Helpers**

	Anganwadi Workers	Anganwadi Helpers
<b>Proportion (%) of Anganwadi Workers/Helpers who have received:</b>		
No training at all	4	17
Pre-service training only	7	16
Refresher training only	22	44
Pre-service and refresher training	68	23
<b>Percentage distribution of anganwadi workers/helpers in terms of time lapsed since last training:</b>		
Less than one year	29	32
One to two years	24	30
More than two years	48	38
<b>Proportion (%) of anganwadi workers who felt that their training was "adequate"</b>	66	

Source: FOCUS Survey 2004.

workers' salaries above the central norm: Rs 1,200 per month in Himachal Pradesh, Rs 1,368 in Tamil Nadu and Rs 1,400 in Maharashtra. In the other three states (the "dormant states"), anganwadi workers had to make do with Rs 1,000 per month. This is less than the legal minimum wage, especially if the skilled nature of their work is taken into account. For instance, in Rajasthan the statutory minimum wage for unskilled rural labourers is Rs 73 per day. The monthly "honorary" covers less than 14 days of work at that rate, aside from the fact that anganwadi workers are anything but "unskilled".

Further, in contrast with other ICDS staff (supervisors, CDPOs, and so on), anganwadi workers and helpers are not entitled to the common benefits associated with being a government employee. For instance, they have limited facilities (if any) for health

insurance, maternity benefits or old-age pensions. Even their employment status is precarious: an anganwadi worker can be dismissed at short notice without compensation, or even a fair hearing.

To make things worse, salary payments are highly irregular in most states, and long delays are common. More than half of the anganwadi workers in the FOCUS sample said that they had not been paid during the 30 days preceding the survey (see Table 6.2). One in five had not been paid at all for the preceding three months, and even longer delays are not uncommon in some states, notably Uttar Pradesh. Here again, the shining exception was Tamil Nadu, where salaries were generally paid on a monthly basis with clock-like regularity.

## Inadequate training

Lack of training also contributes to the disempowerment of anganwadi workers. Minimum norms for the training of anganwadi workers are specified from time to time by the Central Government, both for "pre-service" training and for "refresher" courses. In practice, however, training programmes fall seriously short of the official norms in all the FOCUS states, except in Tamil Nadu. About one fourth of the anganwadi workers in

the sample had not received any pre-service training (Table 6.4). Half of them had not gone through any training programme during the two years preceding the survey.

The regularity of training programmes in Tamil Nadu is partly a reflection of the "decentralised" nature of training arrangements there. Active training teams have been formed at the Block and District levels, making it easier to respond to local requirements. Some of these teams have developed sophisticated training programmes, involving, for instance, joint training of ICDS and Health Department staff. Decentralised training centres also make it easier for anganwadi workers to attend extended training programmes away from home. This is one aspect, among others, of the creativity and initiative that have made ICDS work in Tamil Nadu – we shall return to this in the next chapter.

### Box 6.5. Creative Training: SEWA's Balanand Shala

Self Employed Women Association (SEWA) Child Care, was one of the ten early childhood programmes included in a world-wide study by the Bernard van Leer Foundation, Netherlands in 1998. The "Effectiveness Initiative" (EI), as the three-year long qualitative study was called, enabled an exchange of views on early child care settings and appropriate methods for the study of children, families and the community. The case study on SEWA, aptly titled "Utsah", described the energy abundantly found in our child centres. The study illustrated how even a few selected interventions could speed up the momentum of our activities. However, it also indicated an area for improvement – the in-service training given to workers, especially the components relating to children's language and cognitive development.

One of the concrete results of the EI study was the opening, in 2003, of "Balanand Shala", the SEWA centre for in-service training of teachers and child care workers. Development of the curriculum is made a collective exercise here, with courses designed to suit our specific needs, interests and talents. The 'Shala' is housed in SEWA's campus in rural Manipur, just outside the city of Ahmedabad, with a large functional kitchen and dormitory arrangements. The training period is normally two days and caters to about 60 participants at one time. Each group has a mix of crèche workers, supervisors and community leaders (*Aagewaans*) from different districts. An important aspect of the training here is to ensure that women gain some experience

of collective living under the same roof. For most of them, being away from the family for a couple of days is also a novelty, allowing them a sense of freedom.

The first unit of the training curriculum for child care workers comprised of an 'orientation to SEWA'. Developed by the SEWA academy, the focus is on Gandhian values and how these inspire and sustain SEWA as an organization. The next unit covers women's health and is conducted by a doctor and assisted by SEWA's health cooperative. All sessions are participatory, practical and interspersed with lively debates and discussions. Although the standard units on child development and parenting are included, what follows is an introduction to the innovative themes used in Balanand Shala.

From the third unit onwards, themes that are interesting and attract the trainee's attention, are selected. The themes so selected also lend themselves to easy conversion into suitable activities for young children. Three examples follow. The first theme chosen is 'the story', popular with children and adults alike. The group generates a long list of stories from which the favourites are picked. The trainees are then divided into groups of seven or eight. Each sub-group is asked to dramatise a story including plan the dialogue, improvise costumes and props and enact it. The activity brings out a surge of creativity. Different skills are brought to bear during the course of the 'production' and every person has something to do. Even though the story might be familiar, the various staged versions make for lively interaction. Lines are forgot-

ten, costumes come undone, the "props" join in the dialogue and some stage stars are born. There is laughter everywhere. Theatre, they find, is exhilarating.

Still another theme, often included in the in-service curriculum, is the 'Bal Mela'. It is a truism that everybody loves a *mela*. The medium of a children's *mela* had already been tried during the EI. Here it aimed at getting together the crèches' alumni – those who had attended the crèche in their preschool years. The 'Bal Mela' theme serves many functions. It is at once a meeting ground for parents and the community; a setting for games, painting, drama and music; and for children to pick up or test their mathematical and other skills in special games. The theme also offers many opportunities for practical work, including arts and crafts. And of course, there is a substantial, hot, nutritious snack for one and all!

The annual 'Calendar' is yet another popular theme. Everyone realized soon enough that the Hindu and Muslim religious festivals fall on different days each year. The concepts of the Solar and Lunar calendars are also introduced, with a simple explanation of the solar system, and the waxing and waning of the moon. What follows is a high level of excitement among the child care workers as they feel connected to a larger cosmic system.

Soon after and eagerly looking forward to sharing this new knowledge, the child care workers use the same techniques on children attending the day care centres.

*Contributed by S. Anandalakshmy, Advisor to SEWA Child Care*

This creativity contrasts with the dullness of training programmes in many other states. Anganwadi workers often found these training programmes too "theoretical", and removed from the ground realities. For instance, long hours are some-

times spent learning how to use "PSE kits" that are not available in real-life anganwadis. Similarly, some anganwadi workers questioned the usefulness of being taught to encourage poverty-stricken households to embellish their meals with

generous doses of health foods such as green leafy vegetables, eggs and milk. Since much of the "knowledge" imparted in training programmes is of little practical use, many anganwadi workers consider refresher trainings as a waste of time.



The impact of these rather technical training programmes on actual anganwadi activity is also doubtful.

Even the basic requirements of a successful training programme are often ignored. For instance, in Rajasthan most of the “trainers” are men, many of them rather untrained themselves. It is hard to believe that men-only training teams can provide effective guidance to anganwadi workers, especially in Rajasthan’s patriarchal environment. In Tamil Nadu, by contrast, ICDS is managed almost entirely by women, not only at the level of training and supervision but also at higher levels.

Even where active training programmes are in place, there are serious gaps in their present scope. For instance, the “pre-school education” component of training programmes tends to be quite weak. Perhaps anganwadi workers are assumed to have innate abilities to teach young children, but mastering this art actually requires much guidance and practice. Another weak component of ICDS training programmes is the field of child care for the under-threes, including the care of new-born babies, breastfeeding counselling, the management of neonatal illnesses, and the rehabilitation of severely malnourished children.

The frustration of anganwadi workers with current training programmes went hand in hand with a strong desire to learn new skills. Responding to these aspirations

through better training programmes would help not only to develop much-needed skills among anganwadi workers, but also to enhance their motivation and confidence.

### Top-heavy supervision

Anganwadis cannot be expected to function effectively, especially in remote areas, without regular and supportive supervision. Unfortunately, the supervision of anganwadis tends to be irregular as well as authoritarian.

According to the ICDS Guidelines, each anganwadi is supposed to be inspected once a month by the local “supervisor”. In practice, however, the supervisor’s visits are much less frequent. One reason for this is the large number of vacant supervision posts in most states. At the time of the FOCUS survey, 33 per cent of the posts of supervisors were vacant in India as a whole, rising to 43 per cent in Uttar Pradesh, 75 per cent in Himachal Pradesh and a staggering 92 per cent in Bihar. In Bharmour Block of Chamba District (Himachal Pradesh), the survey team found that not a single supervisor had been appointed. Likewise, in neighbouring Mehla Block, 7 out of 8 supervisor posts were vacant - a single supervisor had been appointed for 163 anganwadis! Further, debilitating vacancies often persist for a long time. In Barmer Block (Barmer District, Rajasthan), for instance, the

post of CDPO had been lying vacant for three years at the time of the FOCUS survey. The CDPO from the adjoining ICDS project was holding the fort, and stretching herself over no less than 375 anganwadis. With the best of intentions, she would not have been able to visit each anganwadi more than once every two years or so.

***“There is no ANM appointed for this centre. Also no supervisor has visited in the last two years, and no CDPO in the last three years.”***

*(An anganwadi helper in Chunota Khaas, a remote village of Bharmour Block in Chamba District, Himachal Pradesh.)*

Even when vacant posts are filled, it is often done in an ad hoc manner, without keeping in mind the requirements of the job in question. In the dormant states, many of the CDPOs we met were men on deputation from other departments, with no specific competence or interest in ICDS. The CDPO of Kapasin Block (Chittaurgarh District, Rajasthan) was handling three posts simultaneously: Tehsildar, Block Development Officer and CDPO. The only recommendation he felt able to make about the ICDS programme was to do away with it completely!

How helpful are the supervisors’ visits, when they do take place? There is mixed evidence on this. More than 90 per cent of the anganwadi workers said that the supervisor’s visits were “helpful”, which sounds en-

couraging. However, their responses have to be taken with a pinch of salt. For one thing, it would take some courage for an anganwadi worker to criticise her supervisor. For another, this apparent satisfaction may reflect low expectations of the supervisors' visits.

Indeed, further probing suggests that the supervisors' visits are, generally, quite superficial. Most supervisors seem to focus on a few routine tasks, especially checking the records and registers. Meanwhile, glaring problems often elude them. For instance, as we saw earlier (Chapter 4), most anganwadis are in urgent need of basic equipment and infrastructure. Yet the inspection system turns a blind eye to these inadequacies. Supervisors are not expected to report them, and there was no evidence of constructive follow-up in the event where anganwadi workers attempted to submit a complaint. In fact, many anganwadi workers felt that it was a waste of time to lodge complaints as they fell on deaf ears.

Similarly, supervisors rarely take the trouble of visiting parents at home. As a result, there is no feedback from the community, and parents' concerns remain unheard. This is true even of states where the need for home-based care and monitoring is clearly laid out in ICDS guidelines. In Rajasthan, for instance, ICDS supervisors and the health staff are supposed to conduct joint home visits.

In reality this is never done, judging from the FOCUS survey.

Haphazard inspections can also have adverse effects on anganwadi workers' perceptions of their work priorities. Lack of attention to activities such as home visits, nutrition counselling and pre-school education reinforces the impression that these activities are not important. Maintaining registers, distributing food and other routine tasks become the centre of attention. Further, the incentive system is largely based on "negative" reinforcement, such as sanctions in the event where registers are not properly maintained. Positive reinforcement, such as public appreciation of a dedicated anganwadi worker, has little place in the supervision system.

In the worst cases, supervision turns into extortion: inspectors take advantage of their power to extract bribes or favours from anganwadi workers. It would be an exaggeration to say that this is a common practice in ICDS (most anganwadi workers had no such complaints), but supervision-related corruption did take root in some places. It was even smoothly "institutionalised" in parts of Uttar Pradesh, where the art of corruption is unusually refined. For instance, in Varanasi District, anganwadi workers are apparently expected to bribe the supervisor to the tune of Rs 200-300 each time he or she visits, or face the risk of harassment. In other states, too, there

were occasional stories of supervisors taking bribes to secure the release of salaries, food, medicines or other items.

***The anganwadi worker has to give Rs 200-300 every time the supervisor visits, in order to be "safe" from accusations. If she doesn't pay or tries to complain, the supervisor threatens to frame charges against her.***

*(Investigators' observations, Pindra Block, Varanasi District, Uttar Pradesh.)*

### 6.3. Anganwadi Workers and the Community

The structure of ICDS is that of a centrally-designed, "top-down" programme. The community's formal involvement (whether in design, planning or implementation) is minimal, though some state governments have taken useful initiatives in this respect. At each level, ICDS is staffed with government functionaries, mostly holding regular jobs and cut off from village communities. The only exception is at the village level, where the anganwadi worker, who is not a salaried functionary, is invested with the responsibility of interacting with the community and eliciting full cooperation.

The programme, in actual reality, builds on the fact that the anganwadi worker is a local woman, who is familiar with the community members and therefore more effective in



seeking their cooperation. She also brings a personal touch, in place of the impassive formality of the government delivery system, which marks her out in the eyes of the community as someone different from the “*sarkar*”. She is generally referred to affectionately as “sister” in whatever the local language may be.

This unique persona and location of the anganwadi worker is in stark contrast to the rest of the programme structure. At the project, Block, District and higher levels, the system is completely in tune with the norms of conventional bureaucracy. There is no built-in obligation to interact closely

with the community on any aspect of the programme, whether for getting feedback or for consultation. These functionaries get no first-hand exposure to the views of the community representatives. They are also not directly accountable to the community. This accountability rests totally on the shoulders of the anganwadi workers.

At the same time, little has been done to foster active cooperation between the anganwadi worker and the community. As with many other components of ICDS, community participation has been stifled by a lack of “nurture”.

This state of affairs is amply reflected in the FOCUS survey. As mentioned in Chapter 4, the levels of community involvement in ICDS were low in most of the sample villages. In Maharashtra and Tamil Nadu, donations were often collected for painting the walls, constructing toilets, or buying various items such as toys, uniforms, electric fans, wall clocks, and cooking utensils. In Maharashtra, we found two interesting cases where contributions from the community had been arranged to rehabilitate a malnourished child (e.g. by giving her a glass of milk every day). In both states,

### Box 6.6. A Mahila Mandal takes Charge

A recent study from the National Institute of Public Cooperation and Child Development (NIPCCD) describes ICDS both as a “community-based” and a “governmental” programme! This ambivalence reflects a lack of serious thinking – and action – on this issue on the part of policy makers. Meanwhile, there have been interesting cases of proactive involvement in ICDS by the community. One real story, from Himachal Pradesh, illustrates this point. It has not yet a *complete* success story, but with good luck it well might become one.

When an anganwadi worker got married and left her job, the helper found it impossible to cope without a replacement. She is illiterate and belongs to the dalit community but had attended ICDS training sessions of a local NGO and also spent a five-year term as an elected member of the local panchayat. The anganwadi helper contacted, the Supervisor, the newly elected Gram Panchayat Pradhan and the local Mahila Mandal for a suitable replacement. The Pradhan shrugged off the issue saying that recruitment is the prerogative of the program au-

thorities. The Supervisor told her to approach the Mahila Mandal and find a ‘willing’ worker.

The Mahila Mandal (MM) members in turn went to the NGO for consultation, based on which they convened a formal MM meeting, discussed the issue threadbare and passed a resolution recommending that ‘A’ of the same village (married, passed matriculate examination on her own initiative after marriage, highly motivated, dalit, IRDP family and MM member) carry on the work of the worker on a purely honorary basis. ‘A’ was the unanimous choice of the MM. The resolution was then drafted, signed, dated and entered into the register.

The MM then took up the issue in the next Gram Sabha meeting, where a large number of women were present. The same ‘helpless’ Pradhan presided over the Gram Sabha meeting. The matter was raised, explained and approved by all those present. A formal resolution was drafted, read out, passed and recorded in the minutes by the Panchayat Secretary. The resolution said that whenever an appointment is

to be made for an anganwadi worker, ‘A’ should be appointed.

The MM pulled together all the documents – copies of their own resolution, copies of the Gram Sabha resolution as well as the Scheduled Caste certificate, the IRDP certificate, the Matriculation certificate and other personal data of ‘A’ and sent the whole sheaf to the CDPO. The Department then advertised for a vacancy for an anganwadi worker and ‘A’ has put in her application. The MM is clear they want their candidate to be selected – otherwise, they have formulated their own plans and strategies for ensuring it gets done.

Meanwhile, ‘A’ has been carrying out her work effectively, and without any honorarium for the last eight months. Since she can’t mark her daily attendance in the register, she maintains a daily diary. The NGO says that her diary maintenance is ‘excellent’. She is happy too at being able to get experience of working as an anganwadi worker.

*Contributed by C.P. Sujaya*

we also observed innovative steps towards community monitoring and accountability. For instance, in some villages of Maharashtra, mothers were taking turns to “watch” what was happening at the anganwadi. In Tamil Nadu, where many anganwadis provide crèche services, mothers made sure that the anganwadi was open every day. Examples of this kind were also observed in Himachal Pradesh. In other states, however, there was little sign of community participation in ICDS, though there were stray cases of (say) a Gram Panchayat making a building available or paying for electricity bills. Generally, parents had a relatively passive attitude towards the programme, and low perceptions of their ability to influence it in any major way.

***The parents help the anganwadi worker in the absence of the helper. The anganwadi worker is very friendly to all the parents, so during their free time they come to the anganwadi to help her.***

*(FOCUS investigators’ observations, Alawartirunagari, Tuticorin District, Tamil Nadu.)*

In the worst cases, the rapport between the anganwadi worker and the community was vitiated by a “blame game”. Some anganwadi workers thought that parents were irresponsible and failed to appreciate the value of sending their child regularly to the anganwadi. Parents, for their part, often blamed the

anganwadi worker for the poor quality of ICDS services, without acknowledging the difficult circumstances in which she works. There is something of a vicious circle here. Lack of community participation leads to low accountability and poor services. The poor quality of ICDS services, in turn, saps people’s interest in the programme and their motivation to get involved.

One way of pre-empting this vicious circle is to ensure that ICDS provides services that people value, including services that women value for themselves (and not just for their children). In Tamil Nadu, for instance, women who worked outside the household valued the crèche services provided at the local anganwadi, and this gave them a strong stake in the proper functioning of ICDS. If people don’t think that ICDS is important for them or their children, they are unlikely to take much interest in it.

The anganwadi worker too has to be valued if an active rapport with the community is to be established. There are various means of enhancing the status of anganwadi workers in the community. For instance, some of the sample anganwadi workers mentioned that being able to distribute basic medicines helps to win people’s appreciation. Proper training in pre-school education also enhances the status of the anganwadi worker, as do various forms of positive reinforcement such as honouring an exemplary worker.

Unfortunately, recent proposals to “fragment” ICDS, e.g. by delegating pre-school education to the Education Department, go in the other direction. They threaten to reduce the anganwadi worker’s status to that of a cook, no higher than the rank enjoyed by the anganwadi helper.

***The Village Health Nurse seems to be the star and is in fact called “doctor” amma. Indeed the anganwadi worker suggested that if she were taught to check pulse rate, foetal heartbeat etc, then she would probably command more respect in the village.***

*(FOCUS investigators’ observations, Palacode, Dharampuri District, Tamil Nadu.)*

Aside from this, there are various ways of creating a better environment for community participation. First, mass campaigns of awareness generation and public mobilisation, similar to the Total Literacy Campaign (TLC), are needed to create a more informed and forceful demand for ICDS services. In the context of elementary education, the TLC and related efforts have led to major increases in school participation during the last fifteen years or so. They have also helped to create a national consensus on the fundamental right of every child to go to school. Similar initiatives are needed to ensure that a functioning anganwadi comes to be seen as an essential feature of every hamlet, like a primary school.

Second, community participation needs an institutional basis. It cannot be expected to happen in a vacuum, or through a hastily-formed committee left to its own devices. If a committee is involved, specific activities (other than meetings) are needed to activate and motivate it. The monthly “health and nutrition day” to be initiated under the National Rural Health Mission (see Chapter 5) is an example of the sort of activities that could be used to foster community involvement. An annual “social audit” of ICDS is another possibility.

Third, resources are needed to sustain these institutions and activities. Small funds for specific activities can sometimes be generated through voluntary donations from the community. But sustained community participation requires assured resources. This could, for instance, take the form of annual untied grants to anganwadis for community activities. Such grants could be used to renovate the buildings, paint the walls, acquire better equipment, organise special functions, and so on.

Fourth, the institutions of community participation need to have a real

“say” in significant aspects of the programme. For instance, they should be consulted (at the very least) about the location of anganwadis and selection of anganwadi workers. Complaints of arbitrary appointments of anganwadi workers were common in the FOCUS villages, and it is important to ensure greater transparency in this process.

Last but not least, there is a need for greater involvement of the Panchayati Raj Institutions (not only at the village level but also at the Intermediate and District levels) in the management and monitoring

### Box 6.7. Community Mobilization for ICDS in Andhra Pradesh

In rural India, the health of infants and children is not a public concern. If a baby is born with a low birthweight, or if an infant dies, it is seen as the mother’s problem. The M.V. Foundation is working in about 300 villages of Ranga Reddy District to change these perceptions, and to bring accountability in Anganwadis and Primary Health Centres.

To create a feeling of social responsibility for children’s right to nutrition and health, public meetings were held with Gram Panchayat members, women, youth and others. Data on children aged 0-6 were presented, and the reasons for each child death were discussed. The groups were also informed about ICDS and the role of the Anganwadi worker. It was decided that the Anganwadi worker (AWW), the Auxiliary Nurse Midwife (ANM), the school headmaster, Gram Panchayat members and others in the community would jointly review the state of all children in the village every month.

Many changes have happened due to these review meetings. For instance, in

village Burugupally (Mominpet Mandal) the Anganwadi worker used to come once a fortnight. The Sarpanch warned her at the review meeting that he would have to make a complaint if she did not attend regularly. The AWW was politically influential and paid no heed to the warning. The Sarpanch, youth leaders and mothers’ committee then sent a petition to the CDPO. The CDPO sent a memo to the AWW and she finally yielded to the pressure.

The village youth also noticed that children were given supplementary nutrition powder in their pockets or in plastic covers, and were dropping it on the way as they walked home. Dogs were chasing these children, most of whom were dropping the packets and running away. In the next review meeting, the AWW was asked to make ‘*laddus*’ of the powder and feed the children at the Anganwadi itself.

The AWWs now discuss their problems with the Gram Panchayat. These problems are then raised by the Sarpanches in Mandal General Body meetings that are attended by officials of all departments. Some issues,

such as lack of plates at the Anganwadi or repair of play equipment, are resolved at the village level itself.

The M.V. Foundation has also involved the AWWs in intensive follow-up of children in the 0-3 age-group who are suffering from Grade III or Grade IV malnutrition. The MVF volunteer and the AWW visit the houses of these children together, counsel the mother, and give double rations of the supplementary nutrition. The AWW, who used to “hide” these children in the records for fear of being reprimanded by her supervisors, now showcases them as her success when the supervisor or CDPO visits the village.

As a result of the review meetings, and close monitoring of over 30,000 children, many of the Anganwadis in these eight Mandals of Ranga Reddy District are now active. Children attend regularly, malnourished children are taken care of, and the health of infants and young children has become a public concern.

*Contributed by Dipa Sinha*

of ICDS. Indeed, “women and child development” is listed in the Eleventh Schedule of the Constitution as one of the fields of public policy that are expected to be brought within the jurisdiction of the PRIs. As things stand, the involvement of the PRIs in ICDS is quite limited. For instance, only half of the anganwadi workers interviewed in the FOCUS survey said that the *sarpanch* (village headman) played any role in the management of the anganwadi. Yet there is no dearth of possible means of activating the PRIs on this issue, as Box 6.7 illustrates.

All this is easier said than done, but the first step is to recognize the im-

portance of community participation in ICDS and the possibility of facilitating it in various ways. Most people are fond of young children and would like to see them thrive – not only their own but also the children of their community or neighbourhood. In that sense there is an untapped potential for community involvement in ICDS. We shall return, in the concluding chapter, to various means of making better use of this potential.

The importance of community participation is not limited to the role it can play in ensuring better ICDS services. It is also an essential “bridge” between the home and the

anganwadi – the two essential sites of child development. As things stand, there is a counter-productive dichotomy between the two. Parents look after the children, and so does the anganwadi, but little is done to ensure that these respective efforts complement each other. Home visits, discussed in the preceding chapter, are one example of the sort of activities that are needed to make better use of this complementarity. Community participation also has an essential role to play in this context. Better integration of home care with anganwadi services is one of the biggest challenges ahead for ICDS.

### Box 6.8. Tribal Children Inside and Outside the Anganwadi

The primitive tribes, the Pando and Pahari Korva of Surguja district of Chattisgarh are accustomed to adjustment.

The Pandos previously lived in the forests and practiced shifting cultivation. There was a concern however that this practice would deplete the forest cover and endanger those dependent on the forest for their livelihood. The Pandos were thus established in a number of forest villages with the aim of introducing them to a settled life. This shift from forests to forest villages happened in the 1960's. The background of the Pahari Korva is different. Cultivation of coarse crops on the hard surface of hill tops, where they live, is their primary source of living. Collection of non-timber forest produces (NTFPs) like mahua, chara beej, sal seed and tendu leaf are also important supplementary sources of livelihood for both tribes.

The children in these tribes often help their parents both with agriculture and collection of forest produce. But their single most important responsibility is grazing goats and bullocks. This was the way of life for most tribal children before formal schooling and ICDS were available near their homes.

A recently conducted survey in three Pando and one Pahari Korva village of Surguja district of Chattisgarh, indicates that the midday meal served in primary schools and supplementary nutrition served in anganwadis, provides much solace for mothers and their children. We got a chance to see the daily activities of an anganwadi in Semighogra, a Pando inhabited village. It functioned in an old concrete house constructed around 1960s, when the forest

village was established during Pandit Nehru's regime. At the time of the visit, the children were playing and mothers singing traditional songs, which in fact drew our attention towards the centre. The anganwadi worker and helper, both tribals, came forward to welcome us in their traditional style. We were told, in response to our query, that today's menu was rice and dal. Though pudu and subjee were served once or twice a week, the children preferred rice. We asked the children and their mothers about the regularity and quality of food served to them, and they seemed satisfied on both counts.

Our survey also threw light on other issues including attendance and reasons for its fluctuation. The survey suggests that less than half (43%) or 83 out of 195 children aged 1 to 5 years, attends the anganwadi. The factors that are correlated with attendance include economic condition of the family and distance to the anganwadi. Villages with greater number of people getting food for less than one month from agriculture, have higher rates of attendance as well. This indicates that the benefits of the anganwadi are valued more by people of lower economic status rather than those relatively better off. This also corroborates with the finding of declining attendance rates in the harvesting season and when forest produce has to be collected, when children accompany their mothers to the field or forest for these economic activities. This was the main finding from the Pando inhabited villages.

The case in the Pahari Korva village was different. Here the attendance rate was only 37%, quite low compared to that of the Pando inhabited villages. The main reason for this

seems to be the physical location of the houses that are scattered over hill tops. This makes it difficult for children from one hill top to go to the anganwadi in another. This also suggests a clear need to establish more anganwadis in such areas.

Finally we tried to understand the extent to which the anganwadi as an institution impacts tribal society. The first positive impact we found was the acceptance of the institution not just as a medium to distribute food, but rather as an integral part of their society and culture. This is aided by the fact that the main functionaries of the anganwadi – the worker and helper are all tribal women. The anganwadi also offers a space for children to play, a place for social communication among women and serves as another venue to strengthen the cultural bond and tribal identity.

Second was the positive impact the anganwadi had on education and related activities. Rough calculations suggest that close to 15 per cent of the tribal population cannot raise goats as a secondary source of income. This is because the children previously responsible for grazing animals have started attending primary school or the anganwadi.

All these positive attributes provide some hope of a better future for the anganwadi and to make better use of it as an instrument of change. The challenge however is to bring those children currently outside the anganwadi, inside it.

*Contributed by Govinda Rath with inputs from Chhattisgarh Kisan Mazdoor Andolan, the Pahari Korva Maha Panchayat and the Chaupal, Ambikapur.*



## 7. Tamil Nadu and Beyond



Anita Khemka

For someone accustomed to how anganwadis function in (say) north India, the sight of an anganwadi in Tamil Nadu is a real pleasure. It is a symbol of how two village women can be a powerful force of social change and development, given a supportive context. The anganwadi is a proof of the possibility of giving children a sound start in life with resources that are well within our command. This chapter focuses on Tamil Nadu to illustrate what is possible and to point out the missed oppor-

tunities elsewhere. Tamil Nadu's experience is also of great importance in the context of building a national commitment to universal child development services.

The success of ICDS in Tamil Nadu is not an accident. It is built on sustained political commitment, reasonable resources, creative innovation, a conducive social context, and – last but not least – the remarkable agency of women. Moreover this success cannot be understood out-

side the context of functional school and health systems. Learning from Tamil Nadu's experience involves paying attention to these larger issues as well as to various aspects of the implementation of ICDS.

## 7.1. Tamil Nadu's Achievements in Context

Tamil Nadu's achievements in the field of child development have already been noted in earlier chapters. For instance, in Chapter 2 we saw that Tamil Nadu has relatively good indicators of child development, pertaining for instance to child survival, immunization rates, nutrition levels

and school participation. In fact, Tamil Nadu is second to Kerala in terms of the "achievements of babies and children" (ABC) index presented there.

Further indicators are presented in Table 7.1, where we contrast Tamil Nadu with Rajasthan as well as with India as a whole. Tamil Nadu and Rajasthan have similar population sizes – about 60 million at the time of the 2001 Census. They also have similar levels of poverty, in terms of standard indicators such as the "headcount ratio" (the proportion of the population below the poverty line). Yet, as the table indicates, they differ sharply in terms of child-related social indicators, with Tamil Nadu doing much better in every respect.

This comparison is of special interest in so far as it helps to focus on the role of women's agency in Tamil Nadu's achievements – we shall return to this.

Table 7.1 also gives Tamil Nadu's "rank" among major Indian states (in brackets, second column) for each indicator. For half of these indicators, Tamil Nadu is second to Kerala. For immunization and ante-natal care, Tamil Nadu ranks number one, ahead of Kerala. Just as Himachal Pradesh has "caught up" with Kerala in the field of elementary education, in a remarkably short period of time (see Chapter 2), Tamil Nadu seems to be bridging the gap in the field of child health. This is no mean achievement, considering Kerala's exceptional social indicators.

These achievements have to be seen in the context of the distinct history of social policy in Tamil Nadu. For instance, a crucial feature of Tamil Nadu's approach is an effort to provide basic services to everyone, rather than to create islands of excellence or to focus on limited "target groups". The social reform movement in Tamil Nadu, from the 1930s onwards, had a profound impact on state politics and the role of the state, and fostered this commitment to providing opportunities to all. This "universal" approach has become a distinguishing feature of so-

**Table 7.1. Health Indicators: Rajasthan and Tamil Nadu, 2005-06**

	Rajasthan	Tamil Nadu <sup>a</sup>	India
<b>Infant mortality rate</b> (per 1,000 live births)	65	31 (3)	*
<b>Proportion (%) of children below 3 years who are underweight</b>	44	33 (4)	*
<b>Total fertility rate</b>	3.2	1.8 (2)	*
<b>Proportion (%) of mothers who had at least 3 ante-natal care visits for their last birth</b>	41	97 (1)	*
<b>Proportion (%) of institutional deliveries</b>	32	90 (2)	*
<b>Proportion (%) of children below 3 years who were breastfed within an hour of birth</b>	13	55 (2)	*
<b>Proportion (%) of children 12-23 months fully immunized</b>	27	81 (1)	*
<b>Proportion (%) of adult women who have heard of AIDS</b>	34	94 (2)	*

<sup>a</sup> In brackets, Tamil Nadu's "rank" among India's 20 major states (those with a population of at least 5 million in 1991).

Source: Third National Family Health Survey 2005-6 (International Institute for Population Sciences, 2006), based on a random sample of ever-married women in the 15-49 age group.

### Box 7.1. Tamil Nadu Viewed from the North

Sometimes a little bit of fieldwork is worth years of academic study. So I felt last month after returning from a brief reconnaissance of rural Tamil Nadu with a former student. It was a revelation.

Our main object was to visit schools, health centres and related facilities. I have done this off and on for some years in north India, and it is almost always a depressing experience. Millions of children waste their time and abilities in dysfunctional schools. Health centres, where they exist at all, provide virtually no services other than female sterilisation. Ration shops are closed most of the time. And other public amenities, from roads and electricity to drinking water, also tend to be in a pathetic state.

The situation seems radically different in Tamil Nadu. Though we visited only three districts (Kanchipuram, Nagapattinam and Dharmapuri), the basic patterns were much the same everywhere and are likely to reflect the general situation in the state. For instance, each of the nine schools we visited enjoyed facilities that would be quite unusual in north India: a tidy building, basic furniture, teaching aids, drinking water, a mid-day meal, free textbooks, and regular health checkups. More importantly, the teachers were teaching, and most of them were even using the blackboard, a rare sight in north Indian schools. There was, of course, much scope for improvement, but at least children were learning in a fairly decent and stimulating environment.

It was a joy to observe the mid-day meal programme in government schools. Everywhere, the meals were served on time according to a well-rehearsed routine. The children obviously enjoyed the whole affair, and the teachers also felt very positive about this arrangement. Nowhere did we find any sign of the alleged drawbacks of mid-day meals, such as stomach upsets or disruption of classroom activity. Seeing this first-hand, one wakes up to the fact that mid-day meals should really be seen as an essential feature of any decent primary school, like a blackboard.

We were also impressed with the health centres. They were clean, lively and well staffed. Plenty of medicines were available for free, and there were regular inspections. The walls were plastered with charts and posters giving details of the daily routine, facilities available, progress of various programmes, and related information. Patients streamed in and out, evidently at ease with the system. What a contrast with the bare, deserted, gloomy, hostile premises that pass for health centres in north India.

Another pleasant surprise was to find functional anganwadis in most villages. In north India, anganwadis are few and far between, and those that exist have little to offer. In Tamil Nadu, however, a functional anganwadi seems to be regarded as a normal feature of the village environment. Anganwadis have independent buildings, adequate staff, cooked lunches, teaching aids, health check-ups, and regular inspections. The anganwadi workers we met were

well trained and gave us credible accounts of their daily routine.

The public distribution system (PDS) provides yet another example of the striking contrast between Tamil Nadu and north India as far as social services are concerned. In north India, collecting wheat or rice from the local ration shop is like extracting a tooth. The cardholders are sitting ducks for corrupt dealers, especially in remote areas where the latter have overwhelming power over their clients. Quite often, people have no idea of their entitlements and are unable to take action when they are cheated. But in Tamil Nadu we found that even uneducated, Dalit women were quite clear about their entitlements and knew how to enforce them. This pattern is consistent with secondary data: the National Sample Survey indicates that consumers in Tamil Nadu get the bulk of their PDS entitlements, in contrast with north India where massive quantities of PDS grain end up in the black market.

I am not suggesting that public services in Tamil Nadu are adequate. Even there, civic amenities fall short of the norms prescribed, say, by the Directive Principles of the Constitution. Also, there are significant social inequalities in the provision of public services. But at least the foundations of a system of universal basic services are in place, and Tamil Nadu's experience (like Kerala's) points to far-reaching possibilities in this domain.

*Contributed by Jean Drèze  
(as published in Times of India, May 2003).*

cial policy in Tamil Nadu. For example, priority has been given to creating a functional primary health care accessible to all, rather than to tertiary health care as has been the model in some other states. Similarly, Tamil Nadu has a universal "public distribution system" (PDS), and the uni-

versal coverage was maintained after 1997, when most other states shifted to a "targeted" PDS in response to the changed food policy of the Central Government. School meals, too, have been provided on a universal basis since 1982, and are even accessible to the aged destitute.

Tamil Nadu also stands out for many pioneering initiatives in related fields, such as the extension of social security (including maternity entitlements) to the informal sector. The priority attached to the social sector in Tamil Nadu is also evident in party manifestoes, Assembly debates,

### Box 7.2. For Mother and Child: Maternity Entitlements in Tamil Nadu

The first two years of a child's life, as well as the intra-uterine period, are the most critical from the point of view of nutrition. Experts recommend six months of exclusive breastfeeding and after that breastfeeding (up to two years) with adequate complementary feeding (appropriate foods in sufficient quantity four or five times a day). The most dangerous period in terms of onset of malnutrition is the period between six to eighteen months of age, if the mother is unable to give such appropriate feeding. Once malnutrition sets in, it may be very difficult to correct. So this is the time when nutrition interventions have to begin. Unfortunately, this is also the most difficult time to reach the young child.

Take the case of Ponnamma, an agricultural labourer in a village in the dry district of Tiruvannamalai (Tamil Nadu). She and her husband, Selvam, have no source of income except labouring in other people's fields, where they manage to get hardly hundred days of employment in a year. This is barely enough for them to survive, leave alone bring up a family. During the off-season, Selvam goes to nearby towns to look for work on construction sites or as a loader. But Ponnamma stays in the vil-

lage to look after her two year old son, her hut with its tiny kitchen garden, her few fowl and two goats. She gets by with whatever odd jobs she can find in the village. Now she is pregnant with her second child. How will she earn enough to feed herself and her sickly first child, as well as respond to the demands of a new baby that needs to be fed throughout the day? How can she afford to stop work to care for the little one?

The new Tamil Nadu Childbirth Assistance Scheme helps her to do exactly that. It provides an allowance of Rs.1000 per month for six months (two months before childbirth and four months after) to all women below the poverty line, and above the age of nineteen, for the first two children. So Ponnamma can stay off work without worry to take care of herself and her family, and lay a strong foundation for her new baby's nutritional future. Not only that, the ICDS provides a "take-home" nutritious powder which she can prepare into a porridge for both children. Such supplementary feeding is important at this stage because children cannot eat regular family food.

Ponnamma is one of the few in the country who has access to such maternity entitle-

ments, so far reserved only for the 10% of women in the organized sector, and not available for women like her working in the unorganized sector. Yet this is what every mother and child in the country should get, as part of social security to protect both mother and child.

Meanwhile, are Ponnamma's problems over? What will happen when the busy season starts and she has to go back to work? Where will she leave her two young children while she is at work? Alone in her hut, and tell the patti (grandmother) in the next hut to keep an eye on them? Or take her ten year old niece out of school to mind the babies? Who will feed them, three or four times a day, even if there is food in the house? In fact, this is how the poor manage but the price is paid by the child in terms of poor nutrition. Where are the crèches for young children, especially the ones below three? Do we really believe that in the poorest families, there are a host of kindly relatives with lots of free time to spare who will volunteer to care for young children? Without crèches for infants, can we reduce the levels of under-nutrition and malnutrition among young children?

*Contributed by Mina Swaminathan*

media reports, and the powerful signals sent by ministers and elected officials to bureaucrats and other functionaries.

Along with physical accessibility, social accessibility has been given equal importance in Tamil Nadu. For instance, a significant proportion of doctors, teachers and other service providers are women. In particular, almost all ICDS workers, helpers, CDPOs and trainers are women. This helps in many ways: for instance, it makes it easier for village women to

participate in the programme, and also makes ICDS more receptive to their needs and aspirations. There are few other examples, anywhere in the world, of such a large scale social programme being run completely by women.

The importance of overcoming other social barriers in the provision of public services is also well understood in Tamil Nadu. As Leela Visaria points out (see Box 7.3), one reason why health services in Tamil Nadu are relatively effective is the limited "social distance"

between doctors and patients (and more generally, between providers and users of public services). This reduced social distance, in turn, has its roots in the active implementation of affirmative action and reservation policies. There is a sharp contrast here with the corresponding situation in, say, Rajasthan, where *"the medical officers, if they are found present, behave with certain superiority, distance themselves from their poor rural patients and openly deride or despise them for being ignorant, uncouth, and dirty"*.

### Box 7.3. Social Context of Health Care in Tamil Nadu

Tamil women's ability to access healthcare for themselves and their children has roots in the social awareness movement that was started in the 1930s by a social reformer 'Periyar' Ramasamy (E.V. Ramasamy Naicker), who rejected the Brahmanical religion and the practice of untouchability. He recognized the need to raise the status of women and advocated increase in their age at marriage and acceptance of a small family norm. The movement attracted people from backward and scheduled castes and influenced the ideology of a political party dominated by members of non-brahmin groups.

Over the years, the ideology of upliftment of backward social groups translated in making education, jobs and other benefits available to them through reservation policy. The dominant groups felt threatened but the affirmative action or reservation policy was implemented relentlessly. As a result, in the past half a century, higher professional education has become available to those belonging to backward social groups from district towns and even rural areas. A cadre of trained doctors, teachers and government employees has been created with roots in small towns that are willing to work in primary health centers, in rural schools and in block offices. During visits to the primary health centers in Tamil Nadu even today one would see medical officers belonging to backward social groups and who dress, speak and have mannerisms that are akin to the village health nurses and even rural patients. Many of the patients who come for healthcare and for immunization or other treatment for their children are able to freely discuss their ailments and seek services

from the officers. The situation in rural or district level health facilities in a north Indian state like Rajasthan is very different, where the medical officers, if they are found present, behave with certain superiority, distance themselves from their poor rural patients and openly deride or despise them for being ignorant, uncouth, and dirty.

The social background of medical officers from small towns and rural areas has also meant that they do not enjoy the luxury of spending several years specializing in some advanced branch of medicine or have the necessary resources to set up private practice requiring huge investment in equipment or space to practice. The alternatives before them are either to become general practitioners or to take up government jobs that ensure a steady and assured income. Many young doctors from rural areas and district towns prefer the latter option.

In Tamil Nadu women from the backward communities also came forward to acquire higher education, especially in the fields of medicine and teaching. Taking up government jobs for them has been a relatively easy option and a large number of women doctors are employed as medical officers in primary health centers. According to recent estimates, almost 60 percent of doctors in primary health centers are women. Although in Tamil Nadu, there is no evidence that women prefer female doctors their presence enables women to seek health care more freely. Contrast this with Rajasthan, where women are reluctant to seek treatment from doctors, majority of whom are males, given the huge disparities between educational attainment of men and women in the state.

In order to ensure that the doctors are available and present at the health facilities and do not abscond, the Tamil Nadu government has made employment as medical officers in the primary health centers attractive on several counts. It allows private practice by medical officers under certain conditions. By reserving 25 percent of postgraduate seats in all branches of medicine for those doctors who have completed a minimum three years of service in primary health centers or district hospitals, the Government has made the position of medical officer quite attractive. Many of the doctors have gone on to enroll in postgraduate courses specializing in advanced branches of medicine. Also, by recruiting doctors on a zonal basis (each zone comprises of two or three adjacent districts), the Tamil Nadu government ensures that the doctors stay close to their places of origin. Further, a certain percent of the seats for medicine and dentistry courses are reserved for students from rural schools and the state government bears the entire cost of medical education of a few students who have no graduate in the family.

No doubt, some of the reforms evident in the health sector in Tamil Nadu have roots in history and the social reform movement, but the commitment of the government and the results of the efforts to ensure that free health care is available to all and especially to the vulnerable and marginalised sections of society, are evident during visits to the health facilities.

*Contributed by Leela Visaria*

The result of these public priorities can be seen in well-rounded development in the state in both eco-

nomie and social spheres. Tamil Nadu's early emphasis on child development has proved highly re-

warding, as is evident from the social indicators presented earlier (see especially Tables 2.5 and Table 7.1).



There have also been major changes in gender and caste relations. There is much evidence that women tend to have more freedom and power in Tamil Nadu than in many other states, for instance in terms of decision-making within the household. These changes should not be seen in isolation from each other. For instance, while education of women is empowering, greater empowerment of women has also been an important force behind the commitment to universal education. Simi-

larly, Tamil Nadu's achievements in the field of child development are partly an outcome and partly a springboard of social progress in other fields.

## 7.2. ICDS with a Difference

The relatively healthy state of ICDS in Tamil Nadu has already been noted in earlier chapters (see especially Chapters 4 and 5). Further evidence on this is presented in Table 7.2.

Whether we look at the ICDS infrastructure, or child attendance rates, or the quality of pre-school education, or immunization rates, or mothers' perceptions, Tamil Nadu shines in comparison with other FOCUS states, especially the northern states. Perhaps the best sign of real achievement is the fact that 96 per cent of the sample mothers in Tamil Nadu considered ICDS to be "important" for their child's well-being, and half of them considered it to be "very important".

**Table 7.2. Tamil Nadu is Different**

	Tamil Nadu	Other FOCUS states
<b>Proportion (%) of Anganwadis that have:</b>		
Own building	88	22
Kitchen	85	29
Storage facilities	88	50
Medicine kit	81	23
Toilet	44	15
<b>Average opening hours of the Anganwadi (according to the mothers)</b>	6½ hours a day	3½ hours a day
<b>Proportion (%) of children who attend "regularly"<sup>a</sup></b>		
Age 0-3	59	19
Age 3-6	87	60
<b>Proportion (%) of mothers who report that:</b>		
Pre-school education activities are taking place at the Anganwadi	89	42
The motivation of the Anganwadi worker is "high"	67	45
The Anganwadi worker ever visited them at home	58	26
<b>Proportion (%) of women who had at least one pre-natal health checkup before their last pregnancy<sup>b</sup></b>	100	65
<b>Proportion (%) of children who are "fully immunized"</b>	71	43
<b>Average number of months that have passed since Anganwadi worker attended a training programme</b>	6	30
<b>Proportion (%) of Anganwadi workers who have not been paid during the last 3 months</b>	0	17

<sup>a</sup> Among those enrolled at the local Anganwadi; responses from mothers.

<sup>b</sup> Among those who delivered a baby during the preceding 12 months.

Source: FOCUS Survey, 2004. See also Tables 4.1 and 4.2 in Chapter 4.

The central feature of Tamil Nadu's experience with ICDS is initiative and innovation. Unlike many other states, which have passively implemented the central guidelines on ICDS, Tamil Nadu has "owned" ICDS and invested major financial, human and political resources in it. For instance, anganwadis in Tamil Nadu are typically open for more than six hours a day, compared with an average of barely three hours a day in the northern states. Similarly, high child attendance rates in the age group of 0-3 years show that many anganwadis in Tamil Nadu include crèche facilities for small children (Table 7.2). Tamil Nadu has also developed sophisticated training programmes, involving the formation of active "training teams" at the Block level, joint trainings of ICDS and Health Department staff, regular refresher courses for anganwadi workers,

### Box 7.4. A Thriving Anganwadi in Tamil Nadu

*“God bless mummy, god bless daddy, god bless teacher who will teach us, and make them happy”.* Standing in a perfect circle, at 10 am sharp, children chanted this prayer to start their activities of the day at the Anganwadi. In the next five hours they would learn through play, have one nourishing meal, take a noon nap, and return home to their mother, who had the comfort of having her child taken care of for a significant part of her working day.

Immediately after the prayer was a round of physical exercises, accompanied by poems created for the purpose. This was the only time of the day when children danced to the tune of the Anganwadi worker! After this short round the teacher shifts to a round of lessons, but children hardly notice the change – for them it’s all one big game.

The teacher is well trained for pre-school education. Keeping with the spirit of joyful learning, all her lessons are in the play-way. Her syllabus for the fortnight was flowers. She had an assortment of creative games ready. She started her lessons with a simple game of matching pairs of flowers, painted on cards. We observed that the elder children had learned the names of flowers. For example you could hear them say, *“hey, the other lotus in the pair is here, keep it with the other one”*. As the day proceeded children played with flower-shaped facemasks, jumped over flowers she drew, heard stories about the lotus and the bee and amused themselves.

Behind this simple set of activities lay much thought and creativity. Each game was carefully designed to cultivate important skills for the 3-6 year olds such as recognition, identification, comparison, learning language in an interactive fashion, etc. The syllabus prescribed one topic per fortnight, to introduce children to things in their immediate environment: flowers, vehicles, fruits, and so on.

While this was on, the Anganwadi helper was busy preparing lunch. Before serving the children, she tasted the food herself and asked the teacher to do so. A sample portion was kept in a clean steel box that could be used for lab tests in the event of food poisoning. By twelve, children filed out to wash their hands, received their clean plates and sat in a neat circle for the food to be served. As the food was being served, the little ones looked at the helper curiously for permission to start eating. They were asked to wait until all children were served and the prayer had been recited. These little gestures go a long way in making the child accustomed to the ways of the world. At the Anganwadi the child also learns to socialise, share a meal, and in general gets used to a classroom atmosphere.

The lunch was quite nourishing - a sambhar made with pulses, green leafy vegetables and carrot. The teacher told us that a variety of spinach is always there since it contains iron, which is good for anaemia. Like many other Anganwadis in Tamil Nadu, this one too had a small garden sporting tomatoes and other vegetables. The helper

proudly told us that children would eat vegetables from their own kitchen garden.

We continued chatting with the teacher as she put children to sleep. *“Children will get up after an hour or two, play for a while and then go home by three”*, she told us. This was another attraction for working mothers who were relieved of childcare for a good part of the day.

The teacher’s day was far from over. She had to do some home visits to counsel pregnant mothers. On other days she conducts “nutrition and health education” (NHE) classes, checks out on newborn babies, etc. She often finishes her working day at home by preparing games for the next section in the syllabus.

As our visit drew to an end we were left wondering about the significant work that she does. She was a simple village girl who had completed class ten and had been trained to do this fine job. All it took to prepare children for school and to lay foundations of a healthy life was one well-trained person and very moderate additional expenditure. As we departed, children from the nearby school were streaming out. She pointed to one young girl and said: *“She was my student here and has now joined school. The school teachers tell me that just like other children who have gone through an Anganwadi, she is doing very well at school”*. The pride and sincerity in her voice touched us.

*Contributed by S. Vivek*

inter-district “exposure tours” for ICDS functionaries, and more.

It is important to note that the basic structure of ICDS in Tamil Nadu is no different from the rest of India. Guidelines from the Government of India outline the basic parameters of the programme. Tamil Nadu’s

achievements stem largely from the thought and creativity that has been applied to the basic structure of ICDS in order to make it work. Each component of ICDS in Tamil Nadu has been planned with care and is backed with appropriate resources. The remainder of this section illustrates this

point with reference to specific ICDS services, based on data and observations from the FOCUS survey.

### Pre-school Education

One of the highlights of ICDS in Tamil Nadu is its lively pre-school education (PSE) programme. The impor-

### Box 7.5. Games at the Anganwadi

In Tamil Nadu, many of the 'games' children play at the anganwadi are carefully designed to develop the essential skills of children aged between three to six years. The following is an account of such games, based on the observations of one of the FOCUS investigators at an anganwadi in Kanchipuram. The visit happened during 'flower week', when flowers were the main theme of the games.

**Find the duplicate:** Several pairs of pictures of different varieties of flowers are jumbled together. Children are then asked to place the pairs together. In the process, we observed that the older children had learnt the names of all the flowers. We heard them say for example, *"hey, the other pair of lotus is here, keep it with the right one"*.

**Flower, flower come and touch me:** Children are made to sit in two opposing rows. In one row, the anganwadi worker writes the first letter of the name of a flower in front of each child. She then covers the eyes of a child and chants in Tamil *"flower, flower, jasmine flower, come and touch me"*. The child who sits by letter "J" stealthily comes and touches the nose of the child whose eyes are covered, and reverts to her seat. Then the child whose eyes were covered is asked to find out the name of the person who came and touched her. Children were completely involved and it was wonderful to watch the anganwadi worker sit with each child when she covered their eyes and talk to them gently through the process. While some children were unable to guess many of the elder kids were actually able to read the letter and figure out who came and touched them.

**Run around the circle:** This was the game with the widest approval among children. The anganwadi worker drew pictures of three different flowers in a circle, and divided the circle into three parts. Three children were then asked to run around the circle while the rest of them clapped. When the clapping stops, each

child must rush to the circle and occupy one flower. Each child is then asked to name the flower they were standing on and where it grows. Needless to say, all the children had their favourite flowers, which they wanted to occupy. One child ran so hard that he was panting for the next five minutes inviting guffaws from the rest.

**Fill the flower:** The anganwadi workers first drew a set of flowers in large size on the floor (with amazing speed). She then took out a packet of colourful 'plum sized' stones. The stones were gathered by the children and she makes them paint the flowers in different bright colours. Children then sit in groups and arrange the stones over the contours of the flowers. It was a pretty picture watching not just the contours, but also the way children were working as a team.

**The ladder game:** A table with two columns and five rows is drawn. In one column different flowers are drawn in each row. The other column is kept empty. Each child then jumped across each row shouting the name of the flower in the corresponding column.

**Face masks:** Children are made to wear facemasks of various flowers and identify themselves as lotus, jasmine, etc.

**Play with flowers:** Girls in Tamil Nadu invariably wear flowers on their heads before setting out from home. The children that day were sporting a wide variety of flowers, of which the anganwadi workers picked parts. She made the children sit in a circle and each one was called to identify the name of the flower, the colour (in English and Tamil), the smell, whether it feels rough or soft and where it grows.

**Story telling:** The anganwadi worker assembles the children in a circle. She has made small placards in the shape of a lotus, a large (mother) bee and one smaller (child) bee. She uses the placards like a puppeteer and proceeds to tell the story. The mother bee tells the child bee not to go out in the absence of the mother. The mother then

flies off to gather food. Soon after the child bee starts dreaming of the honey in the lotus. At that point one child shouts, *"teacher, teacher...I drank honey yesterday. But it was not lotus honey!"* The story then continues with the child bee flying to the lotus to drink honey and subsequently falling asleep after drinking too much. But the flowers close when evening comes and while saying so she replaces the placard of a blooming lotus with one of a closed flower. *"What happened then?"* she asks. The children reply in chorus *"the child bee got caught within the flower!"* On returning in the evening the mother bee does not find the child, gets worried and searches frantically. The child bee also wakes up, but is unable to come out of the flower. So both of them cry all night. When the morning comes, the flower opens again, and the child joyously returns to its mother. After this she asks them a series of questions such as, *"what do we learn from this"... "that you should not go out without your mother"*. She also asks them if they know where the lotus grows. A child immediately says, *"in the pond, but there is a pond near my house and the lotus does not grow there"*. The story session is definitely a hit with the children.

Most of these games are taught at training but anganwadi workers in Tamil Nadu are also known to innovate regularly. There were many tales about poems, stories and so on, that workers had written. One such modeled on the popular show Kaun Banega Crorepati - the "KBC" game, would be a fitting way to end this note. One child plays Amitabh Bacchan, asking questions (which are descriptions of various objects) and giving options to choose from. The other children have to guess. The reply is them 'locked in'. The winner at the end is given a 'cheque' by the child conducting the game.

*Contributed by S Vivek.*

tance attached to PSE in Tamil Nadu is well illustrated by the fact that anganwadis there are known as “baby schools”, rather than “*dalia kendras*” (or the Tamil equivalent) as in much of North India. The anganwadi worker, for her part, is known as a “teacher”. There are many other hints of this sort. For instance, when one of us visited Uttar Pradesh, the husband of the anganwadi worker told us: “*Is umar ke bacchon ko kya padha sakte hai?*” (what can we possibly teach a child of this age?). Such a question is unlikely to be asked in Tamil Nadu. One anganwadi worker there explained to the investigators that some of the essential skills that children develop in this age group are identification, comparison, language and knowledge of the environment. Games are carefully developed in order to enhance these skills and to enable children to socialise at a young age. The whole method is based on play-way learning to help the development of motor skills apart from cognitive skills.

Attention is also given to what is appropriate for each age group. For example, education does not start with the alphabet since young children are still developing an ability to understand symbols. The syllabus typically consists of taking up one topic per fortnight that relates to the child’s environment (e.g. flowers, fruits, vehicles, etc.). An array of educational games is developed around the topic of the day, catering to various needs of children. The worker is

trained and retrained to teach children and also to produce the educational materials for them. The anganwadi helper too is trained to assist the worker in producing these materials. These are supplemented with other resources, including periodic visits of Block level trainers and even a colourful ICDS magazine.

The walls of the anganwadis are typically painted with a variety of colourful pictures to provide a stimulating and educative environment for children. Another feature that often greets the visitor is the “sand bed”. A narrow bed of sand is made in the far corner of the anganwadi to plug in mini placards with educational materials that are regularly changed according to the topic of the day. Parents and children also have a say in the activities. Many anganwadi workers recounted that they teach children English poems since parents demand them. Despite advice from educationists, workers are often forced to teach children alphabets due to parental pressure. While parental pressure may have some drawbacks, on the whole it plays a positive role in the smooth functioning of the system. The children naturally have their own preferences for particular games, often accommodated by the anganwadi worker to ensure that they keep coming!

### Food and Nutrition

Turning to nutrition interventions, the food routine in ICDS is also well conceived, in keeping with the po-

litical commitment to child nutrition in Tamil Nadu. Supplementary nutrition has three components: a fresh cooked meal for children who come to the anganwadi, processed food delivered daily to children under three, and a nutritious mix delivered to pregnant and lactating women every day. There is also a special weaning food for young children, given the importance of effective weaning. Additional food rations are given to undernourished children, identified through regular growth monitoring.

The anganwadi helper takes a lead in these operations. Her day starts at 7 am when she boils ‘Sattu Mavu’ (a nutritious mix), makes small balls of it and home delivers these “*laddoos*” to each house with children under three. On her return, she starts preparing lunch for children who come to the anganwadi, based on a weekly menu. The food is typically filling and well-planned. Rice, dal and some green leafy vegetable are included on a daily basis. Potatoes, green gram and one other vegetable are added in rotation during the week. These are served as rice and sambar on some days, some sort of pulao, and in other forms to make the food variegated and interesting for the child.

Some rural anganwadis in Tamil Nadu have a vegetable garden, and some of the anganwadi workers and helpers in the FOCUS survey were proud to show it to the investigators. Veg-



### Box 7.6. Tamil Nadu's Two Worker Model

Tamil Nadu's spectacular success in minimizing undernutrition and malnutrition among young children is very largely due to the two-worker model of child care centres. Twenty-five years ago, levels of malnutrition among young children in Tamil Nadu were roughly similar to that of many other Indian states. Today, third and fourth degree malnutrition in children below six has been practically wiped out and second degree is becoming rare. Only first degree malnutrition continues to some extent. How did this happen?

In 1980, a unique programme called the Tamil Nadu Integrated Nutrition Programme (TINP) began with World Bank assistance. In this targeted programme, the most vulnerable children below two were identified and fed a specially prepared nutritious mix daily. The child's growth was carefully monitored, while the mother was given guidance in preparing suitable foods for young children. Mothers also received nutritional supplements. As soon as the child's growth levels touched the normal curve, the food supplements were tapered off,

but growth continued to be monitored to ensure that mothers were continuing to feed the child appropriately.

Since preschool children (3-6 years) in ICDS centres were already getting the noon meal (the Noon Meals scheme became operational in schools in 1982), the new programme was integrated with ICDS. TINP centers also got the noon meals, and added some preschool education to their programme, while ICDS offered a snack to the under-twos. Soon a network of child care centres was established throughout the state, though some emphasized the nutritional component and others the educational one.

In Tamil Nadu and in other southern states, child care centres run for about six hours, from 9.00 am to 3.00 pm (or from 10.00 am to 4.00 pm). The extra work load could not be added on to the anganwadi worker's already full day. To ensure the success of such a scheme, a dedicated worker was needed. This is how the two-worker model came into existence - one worker focused on the below two's, feeding children and

maintaining their growth and health records, visiting homes, counseling mothers, registering pregnant women, while the other worker was more centre-bound and organized educational activities for the older group. The first was a community nutrition worker, and the second a preschool teacher. Some of the larger centres had up to two helpers.

This is how Tamil Nadu successfully dealt with child malnutrition, and Tamil Nadu had become a model for the rest of the country. Is the rest of the country going to follow? If we are serious about wiping out child hunger, this must be done. But it seems that Tamil Nadu has begun to follow the rest of the country. With the closure of World Bank support in 2001, the Tamil Nadu Government has been struggling to maintain the programme. Gradually, because of lack of funds, the two-worker model is being given up, but the consequences will be disastrous for children, in terms of both nutrition and educational quality.

*Contributed by Mina Swaminathan*

etables from the garden are used in addition to what can be bought with existing budgets. The local community often chips in on special occasions to prepare sweet Pongal or other dishes. Anganwadi workers are officially encouraged to solicit involvement of the community in such activities.

Careful steps have been taken to avoid food poisoning. Most anganwadis have a proper storage space and indoor cooking area. Reliable arrangements are made for clean water and there is an emphasis on keeping the premises clean

and dry. The helper is also trained to cook hygienically and in ways that would preserve nutrition. When an investigator asked a helper what the food tastes like, the helper promptly brought him a shining steel container with the daily "sample" that she has to keep for purposes of testing in the event of food poisoning. Despite occasional stories of food poisoning elsewhere, most workers and helpers did not remember an occasion when this had happened in their own anganwadi.

Nutrition education is conducted in association with the local health

worker. These cover various topics such as sanitation, food preparation, healthy foods and related practices. This is getting a further fillip with the "malnutrition free Tamil Nadu" policy. The policy goal for 2020 is "to reduce human malnutrition of all types including sub-clinical deficiencies, to the levels of the best performing countries in the world". This policy recognises the importance of behavioural changes in addressing malnutrition, and places a strong emphasis on nutrition and health education.

Another important feature of ICDS in Tamil Nadu, with particular significance



for the nutrition programme, is the “two workers” experiment. As discussed in Chapter 5, it would be hard to achieve a real breakthrough in child nutrition without paying much greater attention to children below the age of three. And that, in turn, requires an extra anganwadi worker, since a single worker cannot be expected to provide effective services to both age groups (under-threes and others). Tamil Nadu adopted a two-worker model under the second phase of the Tamil Nadu Integrated Nutrition Project (TINP-II). Unfortunately, despite good reviews, the two-worker model is in danger of being phased out as TINP has been merged with ICDS under central norms, which do not support a second worker.

### Health Services

In Tamil Nadu, ICDS is relatively well integrated with the health system. Apart from immunization, a wide range of child health services are provided at (or through) the anganwadi, in coordination with the anganwadi worker. The ANM and anganwadi worker work closely together in providing health services to women before and after delivery. The anganwadi worker, for example, is expected to visit the mother after delivery in the hospital to check the reflexes of the child and to advise her on issues relating to the young child.

Coordination with the health system is planned at various levels. On a day-to-day basis, the ANM represents the Health Department’s liai-

son with the anganwadi. The ANM herself has a well specified routine and a manageable number of villages to cover. The dates of the ANM’s visits are clear and specified well in advance. Typically she is also well equipped with basic medicines and a functional Primary Health Centre (PHC) is rarely far off.

Primary health care has been high on the political priority in the state and so PHCs are reasonably well equipped and functional. This makes it possible in the first place to monitor children and cater to their basic health needs. Many coordination mechanisms have been put in place. For instance, there are periodic joint meetings between the Health Department and ICDS staff – often held at the PHC. The training programme itself tries to involve health workers (from the ANM up to the Health Secretary) in order to sensitise them to the needs of the ICDS programme. Some anganwadi workers told us that secretaries of various departments had spent full days with them during training sessions. The involvement of senior officials from different departments often helps in sorting out problems that cannot be addressed at the grassroots level.

ICDS in Tamil Nadu cannot be understood without reference to its unique training programme. Trainers of the ICDS programme in Tamil Nadu realised that it is difficult for anganwadi workers to come to the state capital for extended periods of training. If the workers find it difficult to come to the train-

ers, the trainers can go to the workers instead, they argued. This simple innovation resulted in the Block Level Training Programme (BLTP) – see Box 7.8 for further discussion.

## 7.3. Enabling Conditions and Child Politics

We have noted earlier that the distinguishing feature of Tamil Nadu’s experience with ICDS is not so much the design of the programme (which is much the same throughout the country) as the way in which it has been implemented – including adequate resources, responsible administration and creative thinking. This raises the question as to why “Tamil Nadu is different” in this respect. While it is difficult to give a full answer to these questions, some “enabling conditions” can be mentioned.

Perhaps the most important factor, already mentioned in Section 7.1, is political commitment to the social sector, including nutrition-related programmes. Irrespective of the party in power, successive governments have shown a sustained interest in social policy, backed by budgetary and other resources. Nutrition, education, health and child development have been among the enduring political priorities of the state for many decades. An assortment of schemes has been built to tackle hunger, including a universal public distribution system and exten-

### Box 7.7. Public Sector Health Initiatives in Tamil Nadu

Tamil Nadu has been more successful than most other Indian states in ensuring access to basic health care to the people, especially the marginalised social groups. Some of the public sector initiatives that have made this possible are highlighted here.

#### Coordination at the top

Unlike other Indian states, the Tamil Nadu government has created a separate department of medical and rural health services with its own directorate. The members of this department interact and work closely with the office of the secretary, health and family welfare. There is mutual respect for each other's expertise, knowledge, experience and understanding of the issues. They meet regularly to discuss the problems encountered in providing health care and work out health programmes. This facilitates quick decision-making and problem-solving.

#### Provision of drugs

By creating an autonomous corporation for the procurement and distribution of drugs under the aegis of Tamil Nadu Medical Services Corporation (TNMSC) in 1994, the state has ensured steady and uninterrupted supply of essential drugs (including some surgical material) to the primary health centres and government hospitals. The TNMSC has evolved a system of "passbooks" that are given to each institution, indicating the amount for which they can procure any drugs from the list of essential drugs available with the corporation. The list is periodically reviewed keeping the WHO guidelines in focus. The amount available to each institution is based on their workload of out-patients and is adjusted from time to time. Instead of making the drugs available from the state capital, they are sent directly to 24 zonal warehouses around the state. In most

cases, the Primary Health Centres (PHCs) are able to lift drugs within three days of placing the order with the nearest zonal warehouse. During visits to several PHCs and other health institutions, we very rarely saw a patient leaving the medical facility without drugs and never saw anyone having to pay for them.

#### Twenty-Four Hour PHCs

Under the RCH-I programme, the Tamil Nadu government initiated the process of providing round the clock services, especially delivery services. This involved constructing labour rooms and adopting the three-nurse model, of which one or two are hired contractually and provided accommodation on the premises of the PHC. At the PHCs with 24-hour services, doctors are available on telephonic contact in the event of an emergency. The scheme is being expanded and it is expected that all the PHCs will be equipped to provide 24-hour delivery services by the end of this decade.

Although a large number of PHCs in Tamil Nadu have two medical doctors each, the government is seriously questioning this model and feels that well-trained nurses can handle most of the primary health care (including normal deliveries) at the PHC level, with emergency cases being referred to higher-level care. Unlike PHC doctors, who often view the PHC as a stepping stone to join tertiary health care institutions or post-graduate education programmes, the nurses are likely to stay on in the villages. Also, by upgrading a number of PHCs to 30-bed block-level hospitals, promotional avenues have been opened for the PHC nurses to become sector nurses at the upgraded PHCs.

According to recent estimates, more than 90 percent of deliveries in Tamil Nadu take place in institutions, of which more than half take place in government-run facilities. In no other

state of India are public sector facilities used to this extent by women for giving birth. Further, the average out-patient load at a PHC in Tamil Nadu exceeds 100 per day and 60 to 75 percent of the out-patients are women and children. PHCs are the main service providers for the rural population, especially women and children. Women come not only for curative care but also for antenatal checkups and other services. Almost all women in Tamil Nadu receive at least one antenatal checkup, and more than 75 percent receive an average of four checkups.

#### Effective Record Keeping

The Tamil Nadu government spent a lot of time and effort to evolve a simple but effective record keeping system at all levels and particularly at the subcentre level. After detailed discussions with the Village Health Nurses (VHNs), the government evolved eight-colour coded task-specific registers for the VHNs. At every block PHC, computers are provided for transmission of all the subcentre information with the help of trained statisticians. Since the data are computerized, it is possible to see the trends and changes over time (for example, in infant mortality, death rates or immunization coverage), and take mid-course correction measures whenever required. Another interesting use of the data is the compilation of PHC-specific monthly tables and charts for all the major programmes and outcomes. This enables the medical officers to compare the performance of their PHC with that of others. This, it is believed, creates a healthy competition among the medical officers and motivates them to further strengthen health care services in their PHC.

*Contributed by Leela Visaria*

sive feeding programmes at anganwadis and schools. Taken together these programmes cover a large section of the population. For

instance, virtually every child from the age of two to fifteen is entitled to a free mid-day meal (many senior citizens and destitute people are eli-

gible as well). Tamil Nadu's universal public distribution system is another important element of the food security system. Though many of these

### Box 7.8. Training Programmes in Tamil Nadu

If ICDS is to become a means of social change and a place that prepares the child for life ahead, high-quality training of anganwadi workers is a must. The innovative Block Level Training (BLT) system adopted by Tamil Nadu is a good example of constructive state initiative in this respect.

BLT is a decentralised approach where a training team is appointed in each block to continuously train anganwadi staff. The team consists of three women trainers with qualifications in pre-school education, health and nutrition. The trainers are called 'grade 1 supervisors' and each training team is responsible for 75-80 anganwadis, usually the number in one block. They tour the field after training for feedback and to assist anganwadi workers with special issues. Their work is complemented by 'grade 2 supervisors' who supervise 15-20 anganwadis each. Though training is not their main responsibility, this group assists the grade 1 supervisors and also tour extensively on a regular basis through the year. In this way training is improved in the following rounds with feedback from the ground. A master trainer at Chennai called

the BLT system a 'de facto refresher course' at the worksite.

While block level training teams are appointed in rural districts, a 'Mobile Training of Instructors' (MTI) cover urban blocks in seven districts. These are a set of trainers who travel to the block as and when a training programme is scheduled. In consultation with NIPCCD, District Technical Teams (DTT) have also been formed in all districts to train the block level training teams. The DTT typically has four persons with expertise in education, nutrition, health, communication & publicity. A nodal 'Central Training Centre' at Taramani, Chennai coordinates the activities and organises training programmes for CDPOs.

Decentralised training is one of the distinguishing features of ICDS in Tamil Nadu. The duration of training and the overall themes are set by norms laid down by the National Institute of Public Cooperation and Child Development (NIPCCD). Although these are centrally determined norms, the state has been innovative in applying them. The gender aspect of the training programme cannot be overemphasised. All CDPOs, Block level Trainers, and most Master Trainers are

women and are highly attuned to gender and children's issues. They are also likely to be highly attuned to the health and nutrition related issues faced by adolescent girls and young mothers, who are important targets of the programme.

The intensive and continuous training programme shows visible results on the ground. Anganwadi workers and helpers are typically well trained to do their work and have a high level of awareness about issues relating to child development. This system also enables the state to systematically incorporate new priorities. For instance, in 2004 early detection of disability among children had become a priority in ICDS in Tamil Nadu. When a member of the FOCUS team visited the training programme for CDPOs in June 2004, he was greeted by a CDPO playing the role of a new born child with the other trainees invited to do a series of simple tests to check the reflexes of the newborn. This priority appears to be replicated on the ground as well. During field visits, anganwadi workers regularly talked about disability and the importance of identifying it early.

*Contributed by S Vivek*

schemes are centrally sponsored today, Tamil Nadu's initiatives often preceded central assistance, and the state government spends significant budgetary resources to enhance centrally-sponsored schemes in their quality and reach. This political backing also sets clear terms of reference for the administration to deliver.

Tamil Nadu is perhaps the only state in India where nutrition is a major political priority. Nutrition programmes, including the mid-day meal scheme, have a long history in the state. The coverage increased sharply from 1982.

According to a recent study, the outlay for nutrition programmes increased almost one hundred times between 1981-82 and 1994-95, and by the turn of the millennium, Tamil Nadu was spending more on nutrition related programmes than all other states put together (Harriss-White, 2004). The crucial role of political will in universalizing mid-day meals can be seen from the fact that it was achieved in spite of strong opposition from the mainstream media, professional experts, economic advisers and others (Harriss-White, 2004; Pratap, 2003). Po-

litical commitment has also ensured that these schemes survive and thrive over a long time, irrespective of support from the Central Government, international agencies and others.

The fact that political commitment itself remained irrespective of the party in power suggests that the driving force behind it was not so much the vision of particular "leaders" as popular demand. For instance, while the credit for introducing universal mid-day meals often goes to "MGR" (M.G. Ramachandran, former film star and Chief Minister of

Tamil Nadu), the scheme was not only retained but expanded by successive governments and has become a major focus of electoral politics in Tamil Nadu. Thus, it is important not to confuse political will with benevolence or public-spiritedness on the part of particular political leaders. In Tamil Nadu as elsewhere, political leaders have been accused (and often found guilty) of corruption, nepotism, opportunism and other colourful attributes of political life in India. MGR's own rule has not escaped such criticisms – far from it. Nevertheless there was also a major expansion of social services (as well as profound social changes) in Tamil Nadu during this and other recent phases of the state's eventful political history.

The importance of political commitment goes well beyond garnering resources. It is essential to ensure that resources are well used, and to ensure high levels of accountability. As Anuradha Rajivan has observed, an anganwadi centre in Tamil Nadu cannot remain closed without immediate enquiry. In effect, the functioning of anganwadis is monitored not just by appointed supervisors but also by health officials, elected representatives and the local media, among others. In contrast, anganwadis in North India can stay closed for extended periods without any action being taken. A feeling that “nothing will come out of it” also discourages parents from voicing

complaints. Official apathy and parental inertia feed on each other.

Needless to say, accountability cannot be understood in a top-down fashion entirely. The political priority to ICDS and other nutrition programmes in Tamil Nadu reflects people's ability to get the political bosses to respond to their concerns. For example, when AIADMK lost the Parliamentary elections in 2004, one of the first measures introduced by the Chief Minister (who belonged to AIADMK) to regain popularity was to reinstate eggs in mid-day meals and ICDS. One of the respondents in the FOCUS survey proudly told the investigator “*votu pottu mutai vangittom*”, i.e. “*we got eggs back into the scheme with our votes!*”. Similarly, when the state government tried to switch to a “targeted” public distribution system in 1997, following Central Government directives, it was forced to back-track in just four days.

Unlike senior officials, parents tend to know what is happening at the local anganwadi. Parents who are well informed about their entitlements, and socially empowered, are likely to add significant pressure from below to make the anganwadi function effectively. The influence of parents in the working of anganwadis can be seen in many ways. As we saw, for instance, some anganwadi workers interviewed in the FOCUS survey mentioned that they had introduced English poems and alphabet in response to paren-

tal pressure (this is not part of the syllabus). In another case, the worker mentioned that she would never dare to hit children since parents would immediately complain.

Last but not least, women's agency also played a crucial role in this story, in several ways. First, as noted earlier, ICDS in Tamil Nadu is managed almost entirely by women, not only at the anganwadi level but also at higher levels. Second, women have helped to hold the system accountable. The “pressure from below” comes largely from women – women who value ICDS services and are able to voice their demands. Third, women have also helped to make health and nutrition political issues. For instance, women's votes in Tamil Nadu matter a great deal, and this forces political leaders to respond to their aspirations, including those relating to child development. It is perhaps no accident that the only north Indian state in our sample where ICDS is doing relatively well, namely Himachal Pradesh, has much in common with Tamil Nadu in terms of gender relations and the role of women in society.

These are some of the enabling conditions that help to understand Tamil Nadu's experience with ICDS and related interventions. Needless to say, this success is “relative”, and while Tamil Nadu has an exemplary programme compared with other states, much remains to be done to



### Box 7.9. Politics of Child Nutrition in Tamil Nadu: Social and Political Dividends Coincide

Tamil Nadu has a long history of state funded child feeding outside homes. The political value of publicly visible feeding was clearly understood. Who does not like a good snack? Even among the well-fed, on social occasions or official meetings, it is pretty common to look forward to the refreshments. Among the poor, hunger and malnutrition are serious issues. Aspirants for elected positions understood hunger rather well, using it as a potent tool to address the twin objectives of basic needs and electoral victory. Starting in 1982, Tamil Nadu successfully integrated its noon-meal programme with the national ICDS, leveraging its massive network of existing centres and staff, making a policy shift from hunger to malnutrition and child development. Unlike other states, here, child hunger and malnutrition was recognised as a priority, well before judicial intervention triggered responses at the centre. This clearly demonstrates that when leadership recognises the potential for a coincidence of political and social dividends, it is possible to universalise and budget-proof nutrition-related policies.

Human malnutrition is less visible than poverty, and less dramatic than death. It is rarely addressed in an 'emergency' mode. Yet, it is devastating in its effects – harming the current generation and also extending its reach to future generations as underweight mothers give birth to underweight babies. Countries of South Asia have been far more successful in combating income-poverty, rather than another kind of human deprivation: malnutrition. Even though income-poverty has declined steadily, malnutrition has been much more resistant to change. While population living under a-dollar-a-day is 33 percent, the share of un-

der-five children moderately or severely underweight is far higher, at 46 percent. This excludes other nutritionally high-risk people like adolescents, pregnant and nursing women and the elderly. If micronutrient deficiencies, anaemia among women and adolescent girls, and newer forms of malnutrition arising out of lifestyle changes are added, more than half the population is malnourished – the poor and non-poor. Carbonated drinks and highly processed snacks have penetrated food habits of the poor as households increasingly use up limited incomes for nutritionally-poor, but expensive, diets. Clearly, poverty reduction, by itself, will not eliminate widespread malnutrition. India already has a tool available to all states: the ICDS could be used for managing children already malnourished and preventing the new generation from following suit.

In Tamil Nadu, virtually any child between 2-15 years of age is eligible for a daily hot lunch at the cost of the state. While school children get their lunches at school, for preschoolers it is the actively functioning network of anganwadis that combine regular feeding with a host of other child development services. Take-home rations are an exception. Other vulnerable groups like pregnant and nursing women, the destitute, pensioners, and the disabled, are also covered. Over 30,000 centres for pre-schoolers benefit around 1.5 million persons everyday. Though there was an income criterion, in practice, any willing child in the eligible age group is accepted. Universalisation had a practical reason – it would have been hard for staff to selectively feed some children and deny others, based on some BPL list (itself faulty and changing), when all children watch the cooking and serving of food. This also promotes social equity through common dining. In practice, children

from poorer households predominate in anganwadis. As compared with some of the Northern states, quality of services is better: centres remain open longer; a higher share of children under three attend regularly; more preschool education is available; infrastructure is better in terms of an own building, kitchen and storage facilities; more staff are in position and paid regularly.

The TN case provides several interesting pointers. One, political will can exert pressure from above, resulting in sustained public policy attention backed by budgets. Two, once a programme becomes popular and accepted, as a right, it can generate pressure from below - a centre cannot remain closed without immediate reaction from the neighbourhood and local media. Three, pressure from below can, in turn, contribute to retention of political will over time, making it independent of the party in power. Four, the visibility itself contributes to maintaining quality through pressure on local staff and higher officials. Five, near-universalisation can help establish de facto child rights to nutrition, important when malnutrition extends beyond poverty. Six, near-universalisation, when well managed, opens up potential for other benefits like better preparing six year olds for school-readiness through well developed social and cognitive skills and contributing to social equity through common dining, more so in rural, caste-class conscious Indian contexts.

The interests of nutritionally vulnerable groups can match prospects for democratic success: a coincidence of social and political dividends.

*Contributed by Anuradha Khati Rajivan*



achieve standards that would truly correspond to “universalization with quality”. There are also areas of concerns in Tamil Nadu’s experience as well as some recent setbacks, such as the spread of sex-selective abortion in parts of the state and the phasing out of the “two-worker” model in ICDS. Another disquieting trend, not restricted to Tamil Nadu, is the apparent decline in child immunization coverage between 1998-9 and 2005-6 (see Tables 2.5 and 7.1). Thus, Tamil Nadu still has a long way to go in giving adequate protection to the rights of children under six. But this does not detract from the immense value of what has been achieved so far.

### Box 7.10. The FOCUS Survey in Retrospect

The FOCUS Survey took me many miles – from the hills of Himachal Pradesh, to Rajasthan, to hidden-away villages in interior Tamil Nadu. Those were very busy weeks. Things had to go like clockwork. Questionnaires had to be filled-in, checked and accounts maintained. I needn't have worried that I lacked fieldwork experience. Between a teammate's militant insistence on my building a rapport with the interviewees (which sometimes had the opposite effect of interrupting the interviews!), and another's deep empathy with the people we met, it turned out to be easier than I had anticipated.

As we travelled across, from one anganwadi to another, the range of what we saw was immense. We felt delight one day and despaired the next. There were anganwadis that were open, inviting and happily active; there were others whose locks I could bet had rusted months ago. While there was much variation even within each district, overall, it was Tamil Nadu that was a consistent joy. Even where the infrastructure or facilities was no better than the ones I saw elsewhere, the anganwadis in Tamil Nadu seemed to provide much more to the children in the community. There was also a certain professionalism in the way the *teachers* ran these *baby schools*. The parents in Tamil Nadu also seemed better informed and perhaps as a result, more demanding than their counterparts in the other states. For instance, we met mothers, both in Rajasthan and Himachal Pradesh, who had no more than the vaguest notion of what the anganwadi was meant for. In contrast, in a relatively 'backward' village in Dharmapuri, Tamil Nadu we met a father who, even in the highly spirituous state we found him in, could tell us that his child was supposed to get 80 gms of rice!

The tastiest supplementary nutrition was in Tamil Nadu – *sattu* and rice with *sambar*. The *channa* in Himachal's anganwadis came second. I struggled a bit with the

crunchy *murmura* in Rajasthan. I doubt if the children fared any better, although they didn't complain. In this respect, the anganwadis I saw in Tamil Nadu were notches above the others, sometimes despite inadequate kitchens. There was obvious attention to preparing a nutritious meal - some of it set aside in shiny stainless steel cups for possible inspection by higher authorities. In a village in Kanchipuram, vegetables were sourced from a kitchen garden on the premises.

In fact, while our discussion in most other places focussed on regularity and availability of supply, in Tamil Nadu it was different. An anganwadi worker in Dharmapuri was annoyed, for instance, that she had been instructed to use coconut sparingly - "as if it were gold"! Similarly, a parent in a neighbouring village challenged me on the nutritional content of the particular variety of greens that the children were given in the anganwadi, arguing that another variety was more nutritious.

Parents across the three states, but especially in Himachal Pradesh and Tamil Nadu, seemed to value the pre-school education provided in the anganwadi as much as, if not more than, supplementary nutrition. Sometimes, education seemed to be an overriding factor. In a village in Kanchipuram (Tamil Nadu), parents were sending their three-year olds to (relatively expensive) private, English-medium nursery schools rather than the anganwadi. In general, the pre-school education provided in the anganwadi was of variable quality, and seemed to be positively associated with the motivation level of the worker. There was hence much variation here, even within the same district.

In so many anganwadis I saw, especially in Rajasthan and Tamil Nadu, the effort of the anganwadi worker was nothing short of inspiring. Some of them had put in their own money to get toys for the children or had prepared charts to help teach the alphabet. One could empathize when some of them

complained. In Dhaultpur, the anganwadi workers told us that not only was too much expected from them, but they were asked to receive every passing VIP in the district, usually at the railway station and even on holidays! As one worker put it "*Yahan kucch bhi nahin hai jisme humko kincha nahin jata*". Just as we rejoiced quietly at the dynamism of these women who were clearly working against the odds, we would run into a listless ICDS official who spent the afternoons, doing nothing in particular. A CDPO in Himachal Pradesh even used dramatic metaphors such as how "even Lord Krishna" would find it difficult to run the ICDS!

We frequently tried to ferret out issues of local politics that might affect the functioning of anganwadis; one of my teammates had a particular talent for this line of enquiry. We felt that workers, who belonged to the local political elite, were not particularly invested in the functioning of the anganwadi. They merely oversaw its running, if at all – leaving most of the work to the helper. This was particularly evident in one part of Himachal Pradesh. I felt too that, on the whole, the involvement of the larger community was quite limited. In a village in Himachal, when asked about the anganwadi that did not seem to function very well, residents merely shrugged. In Tamil Nadu, when asked about the Panchayat president's involvement, the worker laughed saying that he promised a well for the anganwadi, but instead "*dug a hole and ran away!*" ("*kuzhi thondittu oditar!*")

The most enjoyable part of the survey was interacting with the children. Often, children ran away as soon as they saw me. We soon learnt that they assumed I was an ANM, who had come to give them an injection. (That was somehow comforting since it served as an indicator for regularity of immunization services.) When they didn't run away, we usually generated a lot

Contd...

*Contd...*

of excitement. They had great fun, sometimes at our expense, mimicking us and so on. They often urged us to join in their activities; we always complied. They also recited rhymes for us. In an anganwadi in Himachal, the chosen rhyme was one I had learnt as a toddler – “Johnny, Johnny, Yes papa..” And then, a few weeks later, more than 2000 kms away in a Tamil Nadu village, another group of children went “Johnny, Johnny Yes papa...” As the children yelled to impress us, I recall thinking to myself that this had to be the most enduring and far-reaching rhyme in the country.

We had our share of misadventures as well, although I am certain it pales in comparison to those of my friends who went to places more remote. In one village, they were convinced that we had come to shoot a television advertisement. Even before we could clarify, word got around. We spent the better half of that day trying to persuade all of them otherwise. On another occasion, a team mate was stopped by a senior police official for questioning, in connection with a murder in the district. We never let him forget that he was suspicious-looking!

The survey holds many pleasant memories. But there was much to reflect on as well. Village after village, day after day, we met people working hard merely to make ends meet, and yet offered what little they had with warmth that is difficult to describe. In a village in Tamil Nadu, we were hosted most generously by a family that worked on construction sites in Bangalore. In Bangalore, our paths might have never crossed. We got a glimpse of the problem of female infanticide in Dharmapuri. An ANM told us that a doctor had now started a home for girls, for unwanted babies, hoping that parents would abandon, rather than kill, their girl children. The ANM had herself adopted one of them. We also encountered deep caste divisions – across regions, but more obvious in some. In a Himachal village, even as parents and worker alike claimed emphatically that there was no caste-based division in any sphere of life, that day, at an uppercaste wedding, a certain half of the village was not invited, or even allowed in the vicinity. Oddly enough, we, as visitors from distant Delhi, were!

It is hard too for me to forget the personal narratives of the anganwadi helpers. So many

of those I interviewed were deserted or widowed, and abused, usually from the Scheduled Castes. If there was one commonality across the states, it has to be this. These interviews were usually emotionally intense as they shared with me the painfully hard circumstances of their life. Only one did not break down. Content though they were at work, for these women, every day was a battle to establish self-worth. It was with difficulty that one walked away after the interview thanking them for their time. On more than one occasion, we met children who were incapacitated by illness; the parents had lost all hope and had no means. There was so little we could do. Yet, in so many anganwadis, we met children – happy, carefree and clever. We left hoping that they would have futures as bright as those we wished for ourselves.

By the time the survey wound up, one thing was clear. I started the survey with an interest in children’s well-being; within a span of weeks it had grown into something much deeper. It now felt more like a commitment, a responsibility.

*Contributed by Sudha Narayanan.*

## 8. What We Can Do



Sashi Pandit

Many things can be done to further the rights of children under six, and specifically, to ensure that every settlement has a lively anganwadi. Action is required at all levels, from remote villages to the far off capital. And there is a role for many different types of public action, involving political parties, trade unions, women's organizations, Panchayati Raj Institutions, NGOs, as well as concerned citizens from various backgrounds – parents, teachers, journal-

ists, lawyers, researchers, health activists, among others. There is no single way to go about it – much depends on local conditions and people's imagination. This concluding chapter presents some ideas of possible action.

### 8.1. Policy Priorities

Reports of this kind often end with "policy recommendations". This is based on an implicit assumption that the government is the main agent

of change. The temptation, then, is to address oneself to the “policy-makers” (whoever they are) and hope for the best. This report does not share this touching faith in policy-makers or government initiative. Rather, it addresses itself to the wider public, and regards government policy as an outcome of democratic politics. As we saw in Chapter 1, Indian democracy has shown severe limitations in its ability to do justice to the rights of children. But this situation is not immutable, and all of us can play a part in changing it.

This approach is not a denial of the crucial role of government action in protecting the rights of children. To illustrate, consider the goal of “universalization with quality” (in the context of ICDS). This is much more than a “policy recommendation”. It is, at this time, one of the core demands of the movement for child rights. Yet this goal cannot be achieved without certain policy changes, such as higher financial allocations, improved norms for the creation of anganwadis, active steps to combat social exclusion, and so on. It is, thus, appropriate to think about the kinds of policy changes we could try to bring about, as concerned citizens.

A good deal of thought and discussion has gone into this issue, in the months that preceded the writing of this report. For instance, wide-ranging recommendations were included in the Concluding Statement of a

convention on “Children’s Right to Food” held in Hyderabad in April 2006. Further deliberations followed in various forums around the country. In the Appendix, we have attempted to consolidate the main suggestions that emerged from this process of action-oriented reflection and dialogue. Needless to say, this Appendix should not be read as a “blueprint” for public policy - the dialogue continues.

One reason for including this document here is that drastic policy changes are required not only at the level of the Central Government but also at the state level, and even below – all the way down to the Gram Panchayat. At every level, something can be achieved, and there are further prospects of effective action as the system moves in the direction of greater decentralization. Effective action, however, requires clarity about the kinds of change we are trying to bring about. It is in this spirit that we have included, in the Appendix, detailed suggestions of practical change in the design and implementation of ICDS, as well as related recommendations on crèches, maternity entitlements, and “infant and young child feeding” (IYCF).

## 8.2. Legal Action

We have argued that “policy-makers” cannot be relied on to initiate changes in state policies, let alone state action. A question, then, arises as to how government priorities can

be influenced. One answer is that, in a democratic political system, there are many ways of doing so: legal action, parliamentary debates, media campaigns, and various forms of “street action”, to mention a few examples. Often the same means can also be used to bring about practical change without the agency of government, for instance through changes in public perceptions and attitudes. Indeed the “anganwadi movement”, so to speak, began with people’s initiatives outside the realm of state action, such as Tarabai Modak and Anutai Wagh’s pioneering efforts to set up balwadis in adivasi villages of Maharashtra (see Box 6.2 in Chapter 6).

Legal action can be of great help in holding the government accountable to its social responsibilities. We have seen this quite clearly during the last few years in the context of mid-day meals in primary schools. Within five years of the Supreme Court order of 28 November 2001 (see Chapter 3), cooked mid-day meals were extended to more than 120 million children (it is another matter that this was supposed to be done within six months). It is very unlikely that this would have happened, at a time of general retreat of the state from its social responsibilities, without the Supreme Court’s firm stand and constant vigilance.

There is also much scope for legal action in the context of ICDS. Indeed, as we saw in Chapter 3, the Supreme



### Box 8.1. The Mid-day Meal Campaign in Jharkhand

There have been lively campaigns for mid-day meals in many states during the last few years. These campaigns have played a key role in persuading the state governments to implement the Supreme Court order of 28 November 2001.

To illustrate, consider Jharkhand. The campaign for midday meals there began with the “Dhanbad appeal”, issued on 17 February 2002 by Bharat Gyan Vigyan Samiti (BGVS). The appeal drew attention to the Supreme Court order of 28 November 2001 and called for a “day of action” on 9 April 2002. The highlight of this day of action was a “people’s school meal” organised by local communities. The aim was to shame the government and show that people were tired of waiting for the implementation of the Supreme Court order.

This action day was preceded by a major programme of awareness generation using posters, leaflets, wall painting, street plays, etc. On 9 April 2002, many

organisations joined the “day of action”. A people’s school meal was prepared in hundreds of schools with the involvement of Panchayats, Gram Sabhas, teachers, and the general public. In Ranchi, some 2,500 children gathered at the Town Hall to demand the introduction of midday meals in primary schools.

Another agitation took place on 11 July 2002. Hundreds of children marched to Chief Minister’s residence in Ranchi. Ignoring “Section 144” and slipping around security guards, they invaded his house and gave him a petition. The Chief Minister listened sympathetically and promised to “look into the matter”.

However, the Jharkhand Government continued to drag its feet, and to find one excuse or another to postpone the launch of the mid-day meal scheme. In November 2003, there was another wave of campaign activities including an extensive signature campaign, another “people’s school meal”, a “bal

sansad” (children’s parliament), and a sit-in outside the Secretariat.

In response to these agitations, the Jharkhand Government finally introduced midday meals in primary schools in December 2003. As elsewhere, there were many problems in the initial phase, including logistic problems, cases of food poisoning, and some resistance from upper-caste parents. However the reach and quality of midday meals is steadily improving over time.

A survey conducted by Gram Swaraj Abhiyan in late 2004 found that midday meals were being served every day in most of the sample schools. The quality of food was generally considered “good” by the parents, and major increases in school attendance were observed, especially among girls and disadvantaged children. All the teachers except one wanted mid-day meals to continue.

*Contributed by Gurjeet*

Court has already issued strong orders on ICDS, including clear directions on time-bound universalization. The implementation of these orders, however, depends on supplementing Court orders with organized public action, as has happened with mid-day meals. Without public vigilance, it is not very difficult for the government to ignore Supreme Court orders. In the case of mid-day meals, there have been relentless public demands for their implementation, to the extent that mid-day meals even became important electoral issues in some states (see Box 8.1). This made it much harder for the state governments to ignore the

orders. A similar momentum is yet to build up for the implementation of Supreme Court orders on ICDS.

Further legal action is possible, going beyond the existing Supreme Court orders. Petitions and “interim applications” can be filed as part of the ongoing public interest litigation on the right to food (*PUCL vs Union of India and Others, Civil Writ Petition 196 of 2001*). Legal action can also be initiated in the High Courts. An interesting example of effective action in the High Court is the recent “suo moto” order issued by the Bombay High Court in response to media reports of nutrition-related child deaths in tribal areas of

Maharashtra. The order includes a severe indictment of the government for its failure to protect the fundamental right to life enshrined in Article 21 of the Constitution:

*It needs no emphasis by us that by such large number of child deaths, malnutrition being a major contributory factor, there is wholesome violation of Article 21 of the Constitution of India by the State Government. The salutary directive given in Article 47 of the Constitution of India that the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties*

### Box 8.2. Landmark Order in the Bombay High Court

On 20 September, 2006, the Bombay High Court issued the following interim orders, in “Suo Motu Writ Petition No. 5629 of 2004”

(i) *The State Government shall make functional additional 12,684 Anganwadi Centres as per the Government of India guidelines as set out in the affidavit dated 4.10.2005 by 31.10.2006. Failure to do so shall expose the Principal Secretary, Women and Child Development Department, Mantralaya, Mumbai, to an action under the Contempt of Courts Act, 1971.*

(ii) *The State Government shall initiate the Mission “Bal Mrutyu Mukta Maharashtra” (by whatever name called) as suggested by Dr. Abhay Bang Committee and, accordingly, modify “Rajmata Jijau Maternal Child Health and Nutrition Mission” started from 11.3.2005 to ensure that the infant mortality rate due to malnutrition is reduced to almost nil within five years from today. In other words, the State Government shall ensure that by 30th September, 2011, the infant mortality rate due to malnutrition is brought down to almost nil in tribal as well as non-tribal areas.*

(iii) *To begin with, the State Government shall, as suggested by Dr. Abhay Bang Committee, identify malnutrition free villages and maternal death and child death free villages and felicitate such villages. To achieve that more and more villages are malnutrition free and maternal death and child death free, the State Government shall give responsibility and funds to Gram Panchayats and self-help groups.*

(iv) *The State Government shall involve the local Gram Panchayats, self-help groups and non-Governmental organisations for control of child deaths and malnutrition.*

(v) *While reviewing the assessment of the officers/workers working in the Health Department, officers and workers who have contributed in controlling child deaths and malnutrition and in prevention of child mortality, adequate incentives shall be given to such officers and workers.*

(vi) *The scheme, ‘Rajmata Jijau Maternal Child Health and Nutrition Mission’, be adequately modified by providing more facilities, adequate medicines and kits to Anganwadis which may help in eradicating malnutrition deaths.*

(vii) *The State Government, as far as possible, may involve Tribal Gram Sabha where tribal areas are concerned, for the development programme planning.*

(viii) *The Female Pada volunteers who have been appointed in the districts must be suitably trained for management of common childhood problems and also for home-based neonatal care. Training programme must start, if not started so far, by 1.1.2007.*

(ix) *For emergency referral of pregnant women, transport should be made available or the provision for delivery vans should be made.*

(x) *As per infant mortality rate and severe malnutrition, high risk areas should be identified and these areas should be provided with additional budget and requisite re-*

*sources. If necessary, Nav Sanjivani Programme initiated by the State Government be modified to ensure that it has the desired impact.*

(xi) *The State Government shall issue instructions to the Collectors of 15 tribal districts to spend minimum of two days in a month in the tribal villages of the district where there is high rate of infant mortality and severity of malnutrition and during their stay in the tribal villages, the Collectors shall coordinate with all agencies, including NGOs, involved in the mission. If there is no substantial improvement in combating the tribal villages, the Collectors shall coordinate with all agencies, including NGOs, involved in the mission. If there is no substantial improvement in combating the child deaths due to malnutrition in a particular district, the poor performance in this regard must be reflected in the service record of the concerned Collector.*

(xii) *The Chief Secretary shall ensure that every single rupee allocated in the State budget to the various schemes for the purposes of combating child mortality and malnutrition, issued for such purposes timely and percolates down to the needy.*

(xiii) *The State Government shall ensure the availability of the Doctors and the emergency obstetrics Centres not only in district hospitals but also in small places.*

*appears to be distant in tribal areas. If the thousands of children die every year in the State of Maharashtra, more particularly in tribal areas, malnutrition being major contributory factor, the only inference that can be drawn is that the State Government has failed in its primary duty...*

Following on this, the High Court directed the state government to take various measures to protect children from malnutrition in tribal areas of Maharashtra (see Box 8.2).

Another useful endeavour would be to demand or propose legal safeguards for the rights of children un-

der six. The orders of the Supreme Court on ICDS are, strictly speaking, “interim orders”, and they cannot act as a substitute for permanent legal entitlements. In this respect, the fact that children under six were “separated” from those in the age group of 6-14 years in the 86<sup>th</sup> Constitu-

### Box 8.3. Grassroots Mobilisation for ICDS in Koriya Chhattisgarh

Mitanins (community volunteers) from Adivasi Adhikar Samiti in Koriya District started their campaign on ICDS in 2003, with large-scale weighing of children. This exercise showed that 79% of girls and 67% of boys below the age of 3 were malnourished. Of these 21% girls and 17% boys were severely malnourished (Grade III or IV). The State Government, however, did not recognise the gravity of the problem. Only 48% of children below the age of 6 were enrolled in ICDS, as half of the hamlets had no Anganwadi. The attendance rates were even lower, due to the irregular functioning of Anganwadis. In many Anganwadis the stipulated amounts of wheat *dalia*, oil, *gur*, Vitamin A and iron tablets were not being provided.

After receiving some training in child nutrition, the Mitanins conducted village-level meetings and family counseling sessions. Dekh Rekh Samitis (nutrition monitoring committees) consisting of tribal and Dalit women were set up in each hamlet. Encouraged by the Mitanins, more and more people started using the Anganwadis. And

as the mobilisation gained strength, major improvements were observed in many of the poorly-functioning Anganwadis.

Mitanins asked women to give their complaints in writing in the form of a collective affidavit. These complaints were sent to the District Collector but no action was taken. Adivasi Adhikar Samiti (AAS) attempted to mobilize Gram Sabhas to replace erring ICDS workers but Panchayat officials refused to write the resolutions. These setbacks led AAS to approach the Supreme Court Commissioners, who wrote to the State Government demanding an enquiry. This resulted in action being taken immediately.

A revival campaign for Anganwadis was planned. This campaign was jointly implemented by the ICDS supervisors, ANMs of the Health Department, and Mitanins. A series of revival meetings were organised in 45 villages with “problem” Anganwadis. ICDS staff and the community were brought together and each side’s duties were explained. This campaign was a success: there was a major improvement in the functioning and

utilization of most Anganwadis. But it is only when they joined hands against domestic violence that the relationship between Mitanins and ICDS workers finally improved.

The number of Anganwadis in Koriya was increased by 40% by opening mini-Anganwadis, to be upgraded in due course. The Mitanins and Dekh Rekh Samitis ensured a fair selection of Anganwadi workers and monitored their work.

In March 2005 a public hearing on food issues was held, with special focus on ICDS. More than 2,000 tribal women from over 135 villages participated. The authorities promised remedial action, but the situation has been slow to improve. Mitanins have documented the denial of entitlements and are approaching the Commissioners again. They are confident that this will strengthen their struggle to combat corruption at higher levels, and that lasting improvements will be achieved soon.

*Contributed by Samir Garg*

tional Amendment was a setback. The fundamental right to education was restricted to children aged 6-14 years under Article 21A. For children under six, the right to “early child care and education” was relegated to the amended version of Article 45, which belongs to the Directive Principles (see Chapter 1). As discussed in Chapter 1, the Directive Principles are supposed to be “fundamental to the governance of the country”, and it is “the duty of the state to apply these principles in making laws” under Article 37 of the Constitution. For children under six, this would involve

enacting laws that protect various aspects of their right to early childhood care and education. For instance, a law could be passed to specify minimum norms for the creation and placement of anganwadis. If laws can be enacted to impose minimum specifications for buildings, cars, aircrafts, and so on, why not anganwadis?

We end on this with a note of caution. Legal action is not a magic wand for quick results – far from it. The legal process can be very slow, expensive and undependable. It is also very undemocratic in some ways, even though the legal system

is part of the institutional foundations of modern democracy. A judge who passes an order on ICDS may not know much about the ground realities of child development, and Court proceedings rarely make room for an informed discussion of the issues. Legal action can also “backfire”, when the Court passes orders that are hostile to the petitioner – as has happened with legal action on the Narmada dam and many other issues. Perhaps this is less likely to happen in the context of children’s rights, but one cannot be too careful in these matters.

If you are contemplating legal action for the rights of children under six, you may wish to seek guidance from a legal aid centre or human rights organisation. Many non-profit organizations can give you expert advice and in some cases even legal aid.

### 8.3. Community Mobilization

One of the most useful things “we can do” is to create an interest in ICDS (and more generally, in the well-being and rights of children under six) within the local community. People need to understand that ICDS is now an entitlement of all children under six, and that they can help in making this right a reality. They also need to know about the Supreme Court Orders. There are many ways of doing this. For instance, you can take people to the local anganwadi, so that they can see for themselves what is happening on the ground and how it relates to what the Court orders say. You can also take them to an anganwadi that functions relatively well, to give them a sense of possibility.

Another crucial step is to investigate the situation on the ground. This can be done in various ways: through formal surveys, informal enquiries, “focus group discussions”, and so on. Conducting these enquiries in a participatory mode, with the involvement of the community, is a useful means of getting people involved in this issue. Examples of pos-

sible matters to investigate include: the location of the anganwadi, and whether it is accessible to marginalized children; the state of the building; the availability of basic facilities and equipment; the regularity, diversity and nutritious value of the food provided to children in the age group of 3-6 years; the arrangements that have been made for younger children; the accuracy of the growth charts; the adequacy of health services and pre-school education activities; any possible evidence of corruption or social discrimination; and the concerns of parents and anganwadi workers.

After conducting these enquiries, and involving the community, various kinds of activities can be envisaged: from supportive activities (such as renovating the local anganwadi or helping the anganwadi worker) to building up public pressure for “universalisation with quality”. Below are some examples of such follow-up activities.

#### Ensuring that every hamlet has an anganwadi

It is the right of every child to have an anganwadi near home. If there is no anganwadi, you need to act. It is best to start at the local level, e.g. by contacting the CDPO or the District authorities. A petition can be sent to the Secretary in charge of the department, to politicians, and others. If nothing works, you can contact the Commissioners of the Supreme Court or their state advi-

sors (for further guidance, see [www.righttofoodindia.org](http://www.righttofoodindia.org)). Well-documented appeals to the Commissioners have often proved effective in the past.

#### Monitoring the local anganwadi

A lively anganwadi can be a wonderful place for the child. As the FOCUS survey illustrates, however, many anganwadis are in poor shape. In such cases, it is useful to organise a village-level meeting along with the anganwadi worker and discuss how the functioning of the anganwadi can be improved. If there is no cooperation on the part of the anganwadi worker, you can contact the CDPO. But very often, the anganwadi worker can be motivated to take more interest in her tasks without confrontation – by working with her and taking interest in her own problems.

In cases of serious irregularities (such as disruptions in food supply, erratic visits from the ANM, or harassment by the supervisors), you should talk to the CDPO or even to the District authorities. Involvement of the anganwadi worker will be helpful in this case too. Here again, you can get in touch with the Commissioners or their advisors in the event of serious problems that cannot be solved locally.

#### Reviving the anganwadi

People often fail to appreciate the importance of ICDS because they do not know what a lively anganwadi



### Box 8.4. Community Adoption of an Anganwadi

Seema and Prakash, founders of Spandan Samaj Seva Samiti, have lived and worked among Dalit communities of Madhya Pradesh for many years. They have recently taken up the rights of children under six as a major campaign issue. Among other initiatives, they have facilitated “community adoption” of Anganwadi No. 1 in village Dabiya (Khandwa District).

The first step was a dialogue with the community, to convey the importance of the Anganwadi’s activities for child development. Seema and Prakash, with their co-workers, spent time with the villagers. They taught them songs, helped them to make low-cost toys, and explained to them the importance of pre-school education and health checkups. The Anganwadi worker and helper often accompanied them, and this exercise enhanced their motivation.

Seema and Prakash also encouraged the Mahila Mandal to get involved in this process, and to prepare the children’s food using local products. Women of the Mahila Mandal collected donations from parents and others in the entire village to supplement the ICDS budget.

Side by side with this dialogue, Seema and Prakash initiated the renovation and revival of the Anganwadi. Villagers painted the Anganwadi in bright colours of pink and

blue. They also painted blackboards, all across the lower interior walls. They bought learning charts, toys, and plastic bowls for the meals. The cost of this renovation process was only around Rs 5,000.

An inauguration ceremony for the renovated Anganwadi was held on 12 January 2006. This was also the occasion for the release of a booklet on ICDS in Hindi (adapted from an earlier draft of this Primer). The CDPO, Doctor, Supervisor and ANM participated in this ceremony.

Seema and Prakash had also invited me. When we reached the Anganwadi, about 55-60 children were sitting there. They were busy singing, and enacting the song. The Anganwadi worker and helper were present with two young girls. One of these girls was teaching the children through games and other fun activities. It is interesting that the children didn’t know the name of their Anganwadi worker but they knew this girl’s name very well, and also the name of their ‘Dalia Bai’ (helper). There were many charts on display, like the alphabet chart and health chart, apart from toys, blocks, drawings. There was also a chart with the photographs of eminent women like Kalpna Chawla and Teejan Bai. When I asked who these women were, the children recalled their names easily. One child recited the roman alphabet in

sequence, from A to Z, and another said the table of 15. All this showed the community’s interest in their children’s pre-school education through the Anganwadi programme.

Meanwhile, the Mahila Mandal women were preparing the children’s food. They had bought the material using the donations that they collected. More than 100 children sat and ate *dal-chawal* together, including children from another Anganwadi. There was enough food for everyone and the children relished the food.

I felt that the women wanted to convey two things through this lunch. First, local food is more acceptable to the children than pre-cooked or packaged food. Second, a nutritious meal can be prepared from local foods, even within the norm of “two rupees per child”.

Dabiya is only one village, but this initiative is likely to have a wider impact. Seema and Prakash are planning to invite workers and helpers from other Anganwadis to make a visit to Dabiya. The event was covered in Dainik Bhaskar and the local editor is willing to support the community adoption of 40 Anganwadis in Khandwa District.

*Contributed by Navjyoti*

looks like, or what it can achieve. If the anganwadi is merely a place where the child gets some bland *dalia* or *khichri* every day, parents are unlikely to value it. But no mother will fail to support the anganwadi if she understands that an effective anganwadi can help her son or daughter to become a healthy, confident and educated child.

There are many ways of winning people’s support for the local

anganwadi. For instance, some villages and communities have started celebrating “anganwadi divas” – a special day when the anganwadi becomes the focus of attention and support. Possible activities for anganwadi divas include renovating the facilities, providing special food to the children, organising games, and expressing public appreciation of the anganwadi worker. In a similar vein, it is possible to help the

anganwadi worker to run the anganwadi in an exemplary manner for (say) a week, with nutritious food, creative activities, health checkups, updating of growth charts (children love sitting on scales), and so on. The experience of a well-functioning anganwadi will motivate families to send their children and also inspire the anganwadi worker.

Another interesting activity would be to paint the anganwadi and make



### Box 8.5. Mobile Crèches

*“Naukriwadi Zindabad”!*

*“Paisawadi Zindabad”!*

*“Anganwadi Zindabad”!!!*

There is a melee of slogan-shouting and banner waving followers of *kurta clad netas*. The location is the Kirby Place slum in south-west Delhi, which houses godowns of building contractors commissioned by the Military Engineering Services, and is home to approximately 2000 *jhuggis* of the workers' families. Many are migrants from Bihar and most of them work in construction.

But this is not election time - so why are the *netas* here? A closer look will reveal the fake moustaches and the stuffed girth – these are actors in their late teens, alumni children of Mobile Crèches, now part of its *Lokdoot nukkad natak* (street theatre) group. While two candidates make empty promises about more jobs and prosperity, the *Anganwadi Party* proposes a pro-active approach: focus on the young child by laying the right foundations, for health, learning and social development; employment and income will follow! And it recommends the local *anganwadi* as the vehicle of action and change – use it if it exists, demand one if it doesn't and watch it like a hawk to make it work.

Mobile Creches intervention take many forms, of which this is one: others range from home-based crèches by trained women in Seemapuri to community-based childcare arrangements for tussar-reeling women in a remote village in Jharkhand. These are all milestones in a journey that started 37 years ago.

The first mobile crèche was set up in 1969 on the Gandhi Centenary site at Rajghat in Delhi, for the hitherto ignored children of migrant construction workers – one among many mobile groups, such as those engaged in agriculture, or working in brick kilns and salt pans, who are always on the move in search of work. Mobile Creches saw up-close the vulnerabilities of these mobile populations, particularly the children.

*“Mobile Crèches ‘guesstimate’ places the number of ‘under-six migrant children’ at 3 crores. For the very young child, migration and migrants’ work makes exclusive breast feeding impossible, delays weaning, denies immunization and causes malnutrition, morbidity and even mortality. For the preschool child it blocks access to ICDS or other services for preschool, supplementary nutrition and health and compromises emotional and cognitive development.”*

Report of Consultation on “Labour Mobility and Rights of Children”, Mobile Crèches, Delhi, 2006

The first challenge to intervention at a site was, and continues to be, entry: talking to the main employer, the developer or the site manager. After getting a foot in the door, other elements are considered - the number of families/children, the length of the project, distance and travel time for the staff – which help assess the costs and benefits of the engagement. Then start the negotiations with the builder to provide infrastructure, people and funds. In six months' time, in one out of five cases, the crèche is up and running.

The Mobile Creches Centre is situated on the work site, next to the *jhuggis* where the workers live. It is a temporary structure, about 250 square feet in size - walls of bare brick and a roof of tin sheets. Two low brick walls divide the room into three parts: the crèche with little cloth hammocks, for children 2 years and under, the *“balwadi”* for the 3-5 year olds, and the non-formal-education (NFE) sections for 6 years and above. The interior wears a festive look - coloured streamers strung from the roof and children's drawings, teaching aids and attendance charts on the walls. By 9 A.M., the mothers arrive to leave their babies for the day.

The centre-in-charge manages the centre with the help of four other childcare workers. The morning is taken up in feeding the crèche children - a mixture of cereal and milk. Supplementary nutrition, a Health Card for every child and close monitoring in the early years

are a critical part of the programme. At lunch time, mothers drop in to breast-feed their babies, without their wage being slashed. In the *balwadi* section the playthings are simple: pebbles, bottle caps, pieces of string, cut up cardboard, wooden blocks, etc. Soon the children gather in a large circle, for story time ... The older children, in the NFE, are happy to be free of their mothering responsibilities for some time! If they stay longer, some will go to the local municipal school. By 5 P.M. the mothers are back, weary from work, to pick up their children. All is quiet till 9 the next morning...

The construction industry in the capital is changing. Work is becoming mechanized; projects are shorter; construction activity is increasingly relocated to the outskirts of Delhi and beyond, including Greater Noida, Ghaziabad, Faridabad, and Gurgaon.

Mobile Creches' partnerships for childcare at construction sites have also evolved over time, to arrive at certain guidelines – regarding minimum wages for trained childcare workers, infrastructural support of a minimal nature, and a maximum investment of one year for the negotiations to bear fruit. The traditional model - in which MC provided the services and the builder “reimbursed” a percentage - has given way to a more participatory one in which the builder plays a bigger role. The contractor provides nutrition and educational materials, hiring local women, trained by MC, to run the childcare programme (initially also under MC supervision). The idea is to reach more children and build a local community of childcare workers.

The MC Creche at work sites and slums is the hub – training ground and springboard - and the Crèche Worker the lynch pin – the caregiver, communicator and mobilizer. The challenges for Mobile Creches remain – to ensure that young and migrant children fall within the reach of care, nutrition, health and pre-school services; to accord recognition and build capacities of childcare

*Contd...*

*Contd...*

workers, on whom depends the success of any intervention with young children; to strengthen the common platform for issues of common concern to the labour, women and child rights movements.

The construction boom of the seventies constituted the backdrop of this pioneering

movement in ECCD, and the migrant child was its unlikely protagonist. We are in the midst of another boom today that carries the promise of NRI lifestyles and the whiff of successful IPOs for a new generation of consumers and investors. The saga of the migrant worker epitomized in popular imagination by Balraj Sahni in Bimal Rai's classic, "*Do*

*Beegha Zameen*", is now replaced by the travails of the NRI migrant in New York and London.

The story of the flight from land and the onward journey to the margins in the city – just as real today – is now a cliché, to be replaced by a happy ending and swept under the 8% GDP growth carpet.

*Contributed by Anjali Alexander*

it a beautiful place. This, too, can be a community activity. Flowers, fruits, animals and other things that the child learns about can be painted on the walls. A blackboard should be painted for the teacher to use. These will make the anganwadi beautiful and turn it into a place that the child will want to go to. As mentioned in Chapter 6, painting a list of the services that are supposed to be provided under ICDS on the walls of the anganwadi is also a useful way of making sure that people are aware of their entitlements.

Making toys is another creative activity that can catch people's imagination. Children love to play, and to learn through play. Parents, neighbours, elder siblings and others can help to make toys from locally available materials: dolls from shreds of cloth or leaves of corn; balls from crushed paper, pasted over with strips of old magazines or waste cloth; numbers and letters of the alphabet from cardboard or old slippers; painted cards with animals, flowers, vehicles and other things for children to recognise and match. People get truly absorbed in such activities, and this is also a

means of providing the anganwadi with play and learning materials at little or no cost.

Many other activities of this type can be planned, from starting an "anganwadi garden" (fresh vegetables are important for a child's diet) to convening a "nutrition mela" to spread better understanding of nutrition matters and promote healthier food habits. CDPOs, doctors, anganwadi workers and others can be involved in such activities. Organising these activities is also a useful step towards greater community participation in ICDS on a permanent basis.

### **Self-management of anganwadis**

Protecting children's rights is, first and foremost, a responsibility of the state. However, nothing prevents concerned citizens and organisations from getting involved in the provision of child development services. Indeed, constructive work on the ground has an important role in the campaign for "universalization with quality". It is an opportunity to explore new ap-

proaches, to acquire a better understanding of the issues, and to foster public involvement in this issue. Citizens' initiatives should not, of course, give the state an opportunity to wriggle out of its social responsibilities. But constructive work combined with a firm commitment to universal child development services as a responsibility of the state can be a source of great strength and inspiration. We have already encountered some interesting examples in earlier chapter, such as the work of the Self Employed Women's Association (see Chapters 1 and 6) in Gujarat. Further examples are given in the accompanying boxes.

## **8.4. Advocacy, media and research**

Some problems are difficult to resolve through "local action", and require policy changes at higher levels. For instance, if the budget allocation for supplementary nutrition is low, the local anganwadi worker and even the CDPO may not be able to do anything about it. This is because budget allocations are de-

### Box 8.6. Learning with Children

The Rajkumari Amrit Kaur child study centre (RAK-CSC) is an integral part of the Lady Irwin College, Delhi. It was started with a cheque of Rs 100 given by the College. Donations by Rajkumari Amrit Kaur, the Red Cross and the Teachers' Association in Elmira New York State, present and past students of the College helped to create the preschool. The purpose of having a preschool on the college premises was to provide students with an opportunity to gain practical knowledge in the field of Child Development and Early Childhood Education. Ms. Mathews, founder teacher of RAK-CSC recalls how one morning, Mrs. Tara Bai, Director, Lady Irwin College, said *"here is Rs 100, start the school!"*. *"No building, no equipment, and no children! How do we start the school?"* replied the founder teacher. *"That's your task"*, she said.

Presently, the Centre serves the developmental and educational needs of approximately 250 children, aged up to twelve years. This includes nearly 50 children with different physical and mental abilities. It has several programmes for care and education of children including a play centre, nursery school, inclusive pre-school programmes for children with special needs, day boarding, 'Setu' (the early intervention programme), 'Saathi' (the counselling cell), vocational training and placement for youth with special needs.

The educational philosophy of respecting the individuality of each child has led to the use of creative methods of educating children. Their learning experiences are not limited to the confines of the classroom. Outdoor excursions, visits to the zoo, parks, the post office and museums are an ideal way of introducing children to a myriad of learning opportunities. Children's love for music, rhythmic move-

ments and make-belief play form the basis for including performing and visual arts in the school curriculum.

The basic principles of the Centre include: the child sets the pace, routine and activities; no interviews or admission tests; respect for the varied needs and potentials of children, and nurturing them accordingly; the medium of communication is the child's first language; family is the nucleus that facilitates the child's learning, and must be empowered; faculty and college students provide the academic inputs through research.

The Centre has always made an effort to reach out to the community. With an increase in the number of 'working mothers', we felt the need to provide good quality alternative child care. This prompted the Centre to add childcare facilities for children aged 6 months to 12 years.

The Centre aims to provide a stimulating and secure environment for young children with varying learning potentials. With this guiding philosophy, the Centre became an inclusive preschool programme in 1980 by admitting children with special needs. Dr. Shanti Auluck, mother of a 4-year old boy with Downs Syndrome, walked up to Dr. Anandalakshmy, then head of the Child Development Department and said, *"You have a model nursery school, a beautiful building, trained staff and the necessary expertise! Why don't you start a school for children with disabilities? If you don't take the initiative, who else will?"* The Centre's services now extend to children with various disabilities including mental retardation, cerebral palsy, autism, hearing and visual impairment, orthopaedic handicaps, speech disorders and behaviour problems. Home-based training, early intervention, individualized education, specialized therapies and group experiences with non-disabled peers

enable children to optimize their strengths and minimize their limitations.

The family plays a pivotal role in the growth and development of children and requires support services to fulfil this task. 'Saathi', a counselling cell was started in 1992 to support families. Sessions with children, adults, couples and families form a part of the counselling services. Home-based training programmes for families of children with disability and child guidance services are also offered. One day Amita walked up to the Coordinator, seeking admission for her 3 year old son Atul, a child with physical disability. As soon as she walked into the room, she said, *"My child is not normal! If you don't want to admit, I will understand."* The Coordinator offered her a seat and a cup of tea, and began talking. Amita talked for more than an hour and shared how she had lost her husband in a tragic accident, the difficulties she faced in taking hold of the family business, the feeling of loss at the realization that her child was handicapped, and being deserted by her husband's family. When the conversation finally concluded, Amita was crying and said, *"Nobody ever asked me about how I felt. The focus has always been the child, that too mainly his handicap. I feel like a 'person' once again."*

The Centre has been conscious of its responsibility towards children from economically weaker sections of society who do not have access to quality services. We have a sponsorship programme for children requiring financial assistance and we also encourage parents to sponsor children's education and care. The Centre also coordinates with other institutions in the field of childhood care, health and education to optimize community outreach and teamwork.

*Contributed by Indu Kaura and Shraddha Kapoor.*

### Box 8.7. Bal Adhikar Yatra in Delhi

*“Lots of well meaning people get satisfaction by distributing foodgrain all their life amongst the poor and the weak. But these people fail to understand that the problem of hunger and poverty in India cannot be solved by doing charity” - Bhagat Singh (from ‘Bhagat Singh ke Dastavez’, edited by Chaman Lal, Adhar Prakashan, Panchkula, Chandigarh).*

In Delhi, of the twenty lakh children under the age of six, about 50% reside in *jhuggi bastis*, resettlement and unauthorized colonies where the numbers of anganwadis are limited. In Delhi, about 4,42,800 children are covered by the ICDS, less than one fourth of the total children under six. Data on the children from *jhuggi bastis*, resettlement and unauthorized colonies covered by the ICDS is not available. To further compound the situation of neglect in Delhi, the aggressive demolition drive of recent years in the name of beautification has pushed out large numbers of families to outlying areas of the city, increasing the threat to the survival and development of children.

The slogan *Sehat Shiksha Poshahar - Har Bachche ka ye Adhikar!* (Health, Education and Nutrition is the Right of Every Child) was in the air during the Bal Adhikar Yatra which was held from the 14<sup>th</sup> to 21<sup>st</sup> November in Delhi’s slum/resettlement colonies. The main purpose behind organizing this event was to pressurize the government to establish an anganwadi in each and every settlement of Delhi as per the Supreme Court Orders. This would enable all pre-school children, adolescent girls, pregnant women and nursing mothers to get proper nutrition, health care and related services. The Yatra was organized with the active participation of various Networks,

NGO’s, women’s wings of trade unions and members of the ‘Right to Food Campaign’.

Given limited resources we planned to organize the programme to cover the whole of Delhi by involving the maximum numbers of stakeholders possible. It was decided to distribute the limited time of Central Kala Jatha judiciously in North, North West (resettlement corridor), South and South West Delhi. Street Plays, Songs, Rallies, Painting competitions, wall painting, Baal Melas, and signature campaigns were organized at various places by the local groups.

The beauty of the group organising the Bal Adhikar Yatra was its diversity. During the process various individuals and organizations from diversified backgrounds joined, and after several brainstorming sessions, the ‘programme committee’ for the Yatra was formed. Its minimum common agenda was to celebrate the Bal Adhikar Yatra with the demand that every settlement should have an anganwadi centre delivering quality services.

Apart from setting the agenda for the campaign, the other issue heavily debated was that of generating funds. The practice of taking money from individuals was implemented for about two months but no substantial amount could be raised, so the group decided to send a general appeal for funds. Finally from individual contributions and support fund from like minded organization, we collected about Rs. 1.5 lakhs.

The Yatra started from Madan Pur Khadar resettlement colony. Anganwadi workers from the area and five organizations were involved in organizing this programme. After this the Yatra went to various places like Kushumpurahari, Bawana, Holambikalan Dakshinpuri, Khanpur J.J. colony, Rohini,

Dwarka, Madoli, Trilokpuri, Seemapuri, and Khajuri respectively. Everywhere the attendance ranged from three hundred to four hundred people. The Kala Jatha conducted street plays & songs to give the basic message and build awareness in the community.

The final day of the campaign was organised as a ‘Bal Adhikar Sammelan’ to involve all the stakeholders; government, non-government and community organizations. The main slogan was *“Abhi to aiy Angadaee hai, Aage aur ladai hai”*. Harsh Mandar Special Commissioner, Right to Food Secretariat, Ms. Rashmi Singh Joint Director, ICDS and Dr. Vandana Prasad Advisor to Commissioner in Delhi, along with about one thousand stakeholders (majority of whom were women from the community) and 80 NGOs from different part of Delhi, took part in this ‘Sammelan’. In the Sammelan, the coordinator of the Bal Adhikar Yatra presented the Report of the Yatra, and other team members shared their experiences. Community representatives presented their views on the present situation of the Anganwadi and the Bal Adhikar Yatra’s efforts at awareness building.

When the Kala Jatha was performing its programme in Sector 24 Rohini, a funeral procession of a child of less than six months passed from that spot. Surprisingly none of the community person asked our team to stop or suspend the programme even for a while, which reflected the insensitivity of the community. However, seeing the responses of the community during the campaign gave us some relief as people are ready to fight for their rights to a well functioning quality anganwadi in their vicinity.

*Contributed by Gurminder Singh*

cided by the State and central Governments.

Achieving policy changes requires organised “advocacy”. This involves

activities like lobbying Members of the Legislative Assembly (MLAs), sending petitions to the Chief Minister, organising rallies in the state capi-

tal, writing in the newspapers, and so on. For instance, state-wide campaigns are required to ensure that every hamlet has an anganwadi, as



### Box 8.8. Hunger and the Media

The name of Madhya Pradesh has become synonymous with high levels of child malnutrition and low survival rates. Yet these issues rarely figure in the mainstream media. Before 2001, when organized action for the right to food began in Madhya Pradesh, the media were doing very little to promote informed debate on child nutrition.

Starvation deaths have always been a political issue. They lead to much controversy, allegations and counter allegation, but never a healthy debate. Governments never accept that deaths due to malnutrition or hunger have occurred, and the real issues are lost in the maze of debates and discussions. The media too seem to have bought the government's argument. Changing this perception was a challenge for media advocacy.

During 2001-2, only two articles and 270 news items on ICDS appeared in Madhya Pradesh, most of which were promotional items. Vikas Samvad, along with grassroots civil society organizations, began training local media persons and initiated a discussion of the scientific and social aspects of malnutrition with sensitive journalists. Recognizing that the media has its own information needs (authentic information that can be made into news items), we disseminated information packs with an analysis of ICDS and malnutrition.

In 2004, a report on malnutrition among Sahariya children in Shivpuri district was issued strategically. This was followed by a detailed analysis of 13 child deaths due to malnutrition in Patalgarh village of neighbouring Sheopur district, a Sahariya-dominated area. In April-May 2005, a fact-finding team was also sent to Ganjbasoda tehsil (Vidisha district), where similar incidents had occurred, and a detailed report was prepared. Instead of releasing the re-

port at a press conference, Vikas Samvad discussed it with a state and nationally reputed newspaper. After a week, Dainik Jagran (one of the biggest Hindi-medium newspapers in India) published a news item on the Ganjbasoda incident and also decided to publish a series of articles on malnutrition and ICDS in other parts of the state. The Dainik Jagran's "Jagran Abhiyan" (awareness campaign) included news items, articles, editorials and other media reports on child malnutrition and related issues. As a result, the issue was taken up in the Supreme Court, and the Court summoned the State Government. The media focus on child malnutrition also led to a lively debate in the Legislative Assembly.

The Government of India took note of these reports, and in August 2005 declared six villages of Ganjbasoda as "special affected area". The Government of Madhya Pradesh eventually accepted that the situation was serious and that the incidents of hunger deaths could not be denied. Those six villages now have Jhoolaghars (crèches) where the children receive nutritional supplements and health care.

This breakthrough marked the beginning of the next phase of Vikas Samvad's campaign. A press conference was organized at Bhopal on 18 August 2005, where the gravity of the nutrition situation in Madhya Pradesh was highlighted and fungus-infested *dalia* samples distributed in anganwadis of Khalwa block (Khandwa district) were also displayed. After the conference, the media admonished the government through news and situational report articles. "Aaj Tak", a national news programme, covered this issue and visited the villages with campaign partners.

When one newspaper raised this issue, other media groups were forced to get involved in the debate. As the issue of malnutrition ap-

peared continuously, the ongoing Legislative Assembly session could not ignore it and an extensive debate took place on the Ganjbasoda issue. Many social organizations that hitherto considered this an unimportant issue were also influenced by the media coverage. The W&CD Department became an important department for the first time, and began to pay attention to monitoring and evaluation along with increasing the budget. A range of new projects and schemes related to child health and nutrition were introduced.

However, serious cases of malnutrition recurred in Patalgarh (Sheopur). Despite the Supreme Court Commissioners' directives and previous starvation deaths, the media posed the question - why is the government not accountable? The Patalgarh report (2006) was first shared with the local media but no one gave it a space. When NDTV raised this issue, national English dailies like Hindustan Times, The Hindu, The Statesman, and Pioneer also carried this news. Local dailies followed. Whenever cases of malnutrition deaths were reported, care was taken to refer to broader issues, such as budget allocations and structural problems.

The Right to Information has been an important tool in the hands of the media. With the advent of consumerism, the priorities of the media have changed but the social responsibilities have not. Media advocates are trying to utilize whatever is available. Today, hardly a day passes without issues related to food insecurity and child nutrition appearing in the media. More than 2771 news items have been published, and the depth of analysis has improved. Most of the regional and district bureaus of the daily newspapers cover nutrition issues on a routine basis.

*Contributed by Sachin Kumar Jain*



per Supreme Court orders. The Boxes in this Chapter illustrate how various campaign activities can be organised for this purpose.

If you take up advocacy work, don't forget the media. Mass media such as daily newspapers and TV programmes are a good way of reaching a large audience in a short time. Also, politicians and bureaucrats tend to be quite concerned to avoid critical media reports, so this is a good way to keep them on their toes. However, getting attention for social issues like ICDS in the mainstream media is not always easy. It requires taking time to write, motivate friendly journalists, conducting "newsworthy" investigations, organising effective media events, and so on. "Learning by doing", with a little help and advice from people with media experience, is the best approach here. Effective media work is hard work, but it is a powerful tool of action.

Research is another useful tool of action. If you have solid facts, it will be that much harder for the concerned authorities to ignore your demands. Like media work, good research is hard work and there is no alternative to "learning by doing". But much can be learnt from earlier studies and surveys. For instance,

the FOCUS survey presented in this report (or a simplified version of it) could be extended to new areas or new issues. A wealth of research-related material is available on the website of the right to food campaign ([www.righttofoodindia.org](http://www.righttofoodindia.org)), including samples of survey questionnaires, guidelines for field investigators, research reports, training material, and more.

## 8.5. The Future of Children Under Six

It is often said that "the future is not what it used to be". There is a note of nostalgia in this remark, but as far as Indian children are concerned, it is perhaps just as well that the future is not what it used to be. Indeed, there are unprecedented possibilities today of freeing children from the deprivations and inequalities that have ruined their lives for so long. As we have argued, ensuring that these opportunities are used is a matter of political choice, itself a reflection of democratic practice.

In this report, we have attempted to present a fair account of the current situation – both its negative and positive aspects. On the gloomy side, we have noted the pathetic condition of Indian children as well as the low qual-

ity of child-focused public services (notably ICDS) in many states. On the positive side, we have found evidence of major achievements in some states, both in terms of the quality of child development services as well as in terms of the wellbeing of children (captured for instance in the "ABC index"). Our findings reinforce the general point, made in Chapters 1 and 2, that rapid improvements in the wellbeing of children require active social intervention, and are very unlikely to happen through economic growth alone. The need – and scope – for concerted action in this field is one of the most important lessons of this enquiry.

It would be naive to expect these achievements to be easy to "replicate" in other states. As we saw in the preceding chapter, and also earlier in the report, the progress of child development in (say) Himachal Pradesh or Tamil Nadu builds on a conducive social and political context. The latter involves deep-rooted features of society such as gender relations, political priorities, and the history of social movements. Nevertheless, India's democratic institutions provide much space for influencing these political and social conditions. This is an integral part of the struggle for the rights of children under six.

## Postscript

If you found this report helpful, please share it with others also. This can be done, for instance, by organising a group discussion of the report, arranging for a translation in the local language, or using portions of the report to prepare posters, leaflets, training material, press notes, and so on. This "abridged" report can also be further abridged and printed as a short booklet addressed to a wider audience. Finally, please remember that we are interested in your comments and suggestions on this report – this is only the first edition!



# APPENDIX

## CHILDREN UNDER SIX IN THE 11<sup>TH</sup> PLAN

(Recommendations submitted to the Planning Commission's  
Steering Committee on Nutrition)\*

October 2006

**Part A: Integrated Child Development Services**

**Part B: Maternity entitlements**

**Part C: Crèches and daycare arrangements**

**Part D: Infant and young child feeding (IYCF)**

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\* These recommendations were prepared by Citizens' Initiative for the Rights of Children Under Six, based on the proceedings of a convention on children's right to food held in Hyderabad on 7-9 April 2006 (convened as part of the "right to food campaign"), and follow-up deliberations with a wide range of individuals and organizations concerned with this issue. The convention report and related documents are available at [www.righttofoodindia.org](http://www.righttofoodindia.org). The recommendations on ICDS also build on recent work by the third sub-group of the Working Group on Food and Nutrition Security.

## Part A: Integrated Child Development Services (ICDS)

### I. General Recommendations

#### I.1. Overarching Goal

**1. Universalization with quality:** The core objective for ICDS in the 11<sup>th</sup> Plan should be “universalization with quality”. This would involve: (1) ensuring that every hamlet has a functional Anganwadi; (2) ensuring that all children under six and all eligible women have access to all ICDS services; and (3) enhancing the quality of ICDS services.

#### I.2. Coverage of ICDS

**2. Universal coverage:** Every household should have convenient access to an Anganwadi (or to a mini-Anganwadi, for the time being, in the case of tiny settlements).

**3. Improved norms:** The “population norms” used for the creation and placement of Anganwadis should be revised, in line with the goal of universalization with quality. The improved norms should ensure that every household has convenient access to an Anganwadi (or mini-Anganwadi, if applicable). Our recommendations on improved norms are presented in the Annexure.

**4. Anganwadis on demand:** As a safeguard against possible failure to apply the “improved norms”, rural communities and slum dwellers should be entitled to an “Anganwadi on demand” (within, say, three months) in cases where a settlement has at least 50 children under six but no Anganwadi. The list of settlements eligible for Anganwadi on demand could be gradually extended over a three-year period, starting with the most vulnerable communities (e.g. SC/ST hamlets and urban slums) and ending with “all settlements”.

**5. Open enrolment:** Every child under six should be eligible for enrolment at the local Anganwadi. There should be no eligibility criteria other than age (and especially no restriction of ICDS to “BPL” families), and no ceiling on the number of children to be enrolled in a particular Anganwadi.

**6. Full services:** All ICDS services should be available to those (children under six, pregnant or nursing mothers, and adolescent girls) who wish to be enrolled at the local Anganwadi.

**7. Time-bound universalization:** An explicit time frame for universalization (based on the improved norms),

not exceeding five years, should be clearly specified in the 11<sup>th</sup> Plan. We recommend 2010 as the target date.

**8. Equity:** In the process of extending the coverage of ICDS, priority should be given to SC/ST hamlets and urban slums. For rural areas, this would involve conducting a survey of SC/ST-dominated habitations and ensuring that all new Anganwadis are placed in these habitations until such time as universalization has been achieved for this group. Special provisions should also be made for other disadvantaged communities.

**9. Inclusion:** Special provisions should be made for the inclusion of marginalized children in ICDS, including differently-abled children, street children, and children of migrant families. For instance, migrant children should be entitled to admission at the nearest Anganwadi.

**10. Special focus on children under three:** A major effort should be made to extend ICDS services to all children under the age of three years, without affecting the entitlements of children in the 3-6 age group. In particular, this would involve posting a second Anganwadi worker in each Anganwadi (see below). Her primary

responsibility would be to take care of children under three as well as pregnant or nursing mothers. This new focus would also involve giving much greater attention to “infant and young child feeding”, nutrition counselling, ante-natal care and related matters.

### I.3. Infrastructure

**11. Independent buildings:** By the end of the 11<sup>th</sup> Plan, each Anganwadi centre (AWC) should have its own, independent pacca building. Construction grants should be made available for this purpose, and also for the maintenance of buildings. A specific proportion of ICDS funds could be earmarked for construction (e.g. 30%, as with Sarva Shiksha Abhiyan).

**12. Dovetailing with NREGA:** To facilitate large-scale construction of AWCs, “construction of AWCs” should be added to the list of permissible works under NREGA. Additional funds for the material component could be mobilized from Bharat Nirman, the Backward Regions Grant Fund and related sources.

**13. Minimum infrastructure:** Each AWC should have the minimum infrastructure and equipment required for effective delivery of ICDS services. A checklist of minimum facilities (including weighing scales, storage arrangements, drinking water, cooking utensils, medicine kits, child-friendly toilets, a kitchen shed, toys, etc.) should be drawn up.

**14. Untied grants:** Each AWC should receive an annual untied grant (similar to the various untied grants under Sarva Shiksha Abhiyan and the National Rural Health Mission), to facilitate local initiatives aimed at improving the AWC facilities and environment.

### I.4. Staff

**15. Two-worker norm:** Each AWC should have at least two “Anganwadi workers” (AWWs), and an “Anganwadi helper” (AWH). The primary responsibility of the second Anganwadi worker should be to take care of children under three and pregnant or nursing mothers, in collaboration with the local Accredited Social Health Activist (ASHA) if any.

**16. Concerns of Anganwadi workers:** AWWs should be recognized as regular, skilled workers and their concerns should be addressed, particularly those relating to work overload, inadequate remuneration, delayed salary payments and poor working conditions. Anganwadi workers should not be recruited for non-ICDS duties and their official job description should be adhered to.

**17. Integration with ASHA:** Specific arrangements should be put in place to facilitate smooth coordination between AWWs and ASHAs. Examples include joint training programmes for AWWs and ASHAs, joint participation in the monthly “health and nutrition day” (see below), and joint home visits.

**18. Improved training:** The regularity and quality of AWW/AWH training programmes should be improved. Training programmes should include training for care of new-born babies and children under three, nutrition counselling, and pre-school education. Improved training is also required for supervisors, CDPOs and related staff. Joint trainings with ASHAs, ANMs and medical officers should be conducted to facilitate smooth coordination of ICDS with health services as well as supportive supervision.

**19. Gender issues:** Women should be better represented among supervisors, CDPOs and other ICDS staff above the Anganwadi level. Training programmes and reinforcement structures should be sensitive to women’s concerns, and geared to the empowerment of Anganwadi workers.

**20. Staff recruitment:** Urgent action is needed to address the shortage of ICDS staff at all levels. Programme management structures should also be strengthened by inducting subject-matter specialists (e.g. for pre-school education, health and nutrition) at the District, State and Central levels, especially women.

## II. Service-specific Recommendations

### II.1. Nutrition-related Services

#### *SNP for children aged 3-6*

**21. Cooked food:** For children aged 3-6 years, the supplementary nutri-



tion programme (SNP) should consist of a cooked meal prepared at the Anganwadi, based on local foods and with some variation in the menu on different days of the week.

**22. Cost norms:** A provision of at least Rs 3 per child per day (at 2006-7 prices) should be made for SNP in the 3-6 age group. This is similar to the current norms for mid-day meals in primary schools (two rupees per child per day, plus 100 grams of grain). To achieve this norm, central assistance of at least Rs 1.50 per child per day would be required. The cost norms should be adjusted for inflation every two years using a suitable price index.

#### *SNP for children below 3*

**23. Take-home rations:** For children below the age of three years, nutritious and carefully designed take-home rations (THR) based on locally procured food, delivered every week, should be the recommended option.

**24. Nutrition counselling:** Supplementary nutrition should always be combined with extensive nutrition counselling, nutrition and health education (NHE), and home-based interventions for both growth and development, particularly for children under three. Special priority should be given to counselling and related services for "Infant and Young Child Feeding" (IYCF).

#### *SNP for pregnant and nursing mothers*

**25. Take-home rations:** Nutritious take-home rations should be provided to pregnant and nursing mothers every month, on "health and nutrition day" (see below). Anganwadi workers should ensure that THRs also reach mothers who may have missed the "health and nutrition day".

#### *Micronutrient supplementation*

**26. Iron and Vitamin A:** For children under six, national programmes for the prevention of Iron and Vitamin A deficiency should be implemented through ICDS. Appropriate doses and formulations should be specified by the Auxiliary Nurse Midwife (ANM).

**27. Iodine:** Iodised salt should also be used in all Anganwadis.

## II.2. Health-related Services

**28. Monthly "health and nutrition day":** In each AWC, a pre-fixed day of the month should be reserved for specific activities such as distribution of take-home rations to pregnant and nursing mothers, immunization sessions, NHE sessions, weighing of children under three, identification of severely malnourished children, and so on. The "health and nutrition day" can also act as a meeting point for the Anganwadi worker, ASHA and ANM, and an entry point for the involvement of PRIs.<sup>1</sup> (See also "Anganwadi Divas" below.)

**29. Medicine kits:** Every AWC should have a medicine kit with basic drugs (including ORS and IFA tablets), to be distributed by the Anganwadi worker with appropriate training as well as guidance from the ANM (unless adequate provision has been made for the ASHA to provide this service). The procurement of medical kits should be decentralized (detailed guidelines should be prepared for this purpose). Medicine kits should be inspected and replenished at the time of the monthly "health and nutrition day".

**30. Severe malnutrition:** Rehabilitation facilities (e.g. Nutrition Rehabilitation Centres) should be available at the PHC level for children suffering from Grade 3 or 4 malnutrition, and their mothers. Anganwadi workers should be responsible for identifying such children and referring them to rehabilitation facilities. Financial provision should be made to support these children's families during the period of rehabilitation. Also, these children should be entitled to enhanced food rations under the Supplementary Nutrition Programme. ICDS and the Health Department should be jointly responsible for the prevention of severe malnutrition and hunger deaths.

**31. Special training:** Anganwadi workers should receive training in Integrated Management of Neonatal and Childhood Illnesses (IMNCI).

<sup>1</sup> Similar activities are being planned under the National Rural Health Mission (NRHM). Note, however, that it is important for this monthly activity to be a "health and nutrition day", and not just a "health day" as currently proposed under NRHM.

### II.3. Pre-School Education

**32. Right to Education Act:** Entitlements to pre-school education facilities for children under six should be included under the Right to Education Act.

**33. Sarva Shiksha Abhiyan:** Pre-school education programmes, suitable for implementation through ICDS, should be developed under Sarva Shiksha Abhiyan. SSA funds should also be made available to strengthen existing PSE activities under ICDS, e.g. by arranging training programmes or supplying better equipment.

**34. PSE facilities:** Each AWC should have basic PSE facilities including adequate space for indoor and outdoor activities (with clean and hygienic surroundings), appropriate charts and toys, etc.

**35. Training and supervision:** Pre-school education should receive higher priority in AWW training programmes, and also in the support activities of ICDS supervisors and CDPOs.

**36. Location of AWCs:** New AWC buildings should generally be situated on or near the premises of the local primary school, unless the latter is at some distance from the children's homes. When AWC and primary school are close to each other, they could share a common kitchen shed.

## III. Further Recommendations

**37. Outreach facilities:** An "outreach model" should be developed under

ICDS to extend essential services (including immunization and nutritional support) to hitherto excluded groups (e.g. street children and migrant families) through designated outreach workers.

**38. Right to information:** All ICDS-related information should be in the public domain. The provisions of the Right to Information Act, including pro-active disclosure of essential information (Section 4), should be implemented in letter and spirit in the context of ICDS. All agreements with private contractors (if any) and NGOs should be pro-actively disclosed and made available in convenient form for public scrutiny. All AWCs should be sign-posted and the details of ICDS entitlements and services should be painted on the walls of each Anganwadi. Social audits of ICDS should be conducted at regular intervals in Gram Sabhas and/or on "health and nutrition day".

**39. Record maintenance:** The burden of record maintenance at the Anganwadi level should be reduced. As far as possible, record-keeping should be confined to registers that are mandatory under the ICDS Guidelines. The possibility of assigning some of the responsibility of record-keeping to persons other than the Anganwadi worker (e.g. educated adolescent girls under the Kishori Shakti Yojana) should be explored. This would also help to ensure some independence, objectivity and transparency in record-keeping.

**40. Involvement of PRIs:** Steps should be taken to promote more

active involvement of PRIs in the management and monitoring of ICDS, bearing in mind that "women and child development" is listed in the Eleventh Schedule of the Constitution. In particular, PRIs should be actively involved in the monthly "health and nutrition day" at the AWC, and in the selection of ICDS functionaries. Resources should be made available for training and capacity building of PRIs, e.g. under the Backward Regions Grant Fund.

**41. Anganwadi Divas:** As an extension of the "health and nutrition day", a pre-fixed day of each month could be reserved not only for health and nutrition related activities but also for various forms of community participation in ICDS, such as wall painting at the Anganwadi, renovation of the AWC, preparation of PSE aids, social audits of ICDS services, and so on. This would help to foster public interest and involvement in ICDS.

**42. Bal Adhikar Patra:** Each child under six should have a "Bal Adhikar Patra", combining birth certificate with immunization details, weight at various ages, AWC registration, health checkup and sickness records etc. Essential NHE messages could also be printed on this card. The card would be kept by the parents but the Gram Panchayat would be responsible for updating it regularly with the assistance of the Anganwadi worker as well as for maintaining a copy of the records at the Anganwadi and/or Panchayat Bhawan.

## Annexure to Part A Proposed Norms for the Creation and Placement of Anganwadis

1. In habitations with a population above 300, the number of Anganwadis should be such that the Anganwadi/population ratio is *at most* 1,000. Thus, there should be at least one Anganwadi in habitations with a population between 300 and 1,000, two for those with population in the 1,000-2,000 range, three for those in the 2,000-3,000 range, and so on in multiples of 1,000.
2. Habitations in the 150-300 population range should have a "mini-Anganwadi", if it is not possible to provide a full-fledged Anganwadi.
3. For habitations with a population below 150, case-by-case proposals for the creation of Anganwadis/mini-Anganwadis, or for the provision of ICDS services through other means, should be prepared by the Child Development Project Officer (CDPO).
4. As a safeguard against possible failure to apply the "improved norms", rural communities and slum dwellers should be entitled to an "Anganwadi on demand" (within, say, three months) in cases where a settlement has at least 50 children under six but no Anganwadi. The list of settlements eligible for Anganwadi on demand could be gradually extended over a three-year period, starting with the most vulnerable communities (e.g. SC/ST hamlets and urban slums) and ending with "all settlements".
5. In the process of extending the coverage of ICDS, priority should be given to SC/ST hamlets and urban slums. For rural areas, this would involve conducting a survey of SC/ST-dominated habitations and ensuring that all new Anganwadis are placed in these habitations until such time as universalization has been achieved for this group.
6. In residual cases where some children do not have convenient access to an Anganwadi, due to distance, difficult terrain, or other reasons, proposals for additional Anganwadis or mini-Anganwadis should be prepared by the Project Officer.
7. As far as possible, a mechanism should be put in place to ensure that the clearing of proposals for additional Anganwadis from the Project Officer is decentralized. For instance, presumptive financial allocations could be made for this purpose to the state governments, leaving it to them to clear specific proposals and facilitating further decentralization.
8. All Anganwadis in habitations with a population above 500 should have at least two Anganwadi workers (AWWs).

## Part B: Maternity Entitlements

### The Issue

Current WHO guidelines recommend that children should be exclusively breast fed during the first 6 months of life. In 2003, *The Lancet* published a child survival series, where breastfeeding was identified as the single most effective intervention to prevent child deaths, which could prevent 13 to 16 per cent of all such deaths. Thus, adequate breastfeeding (early, exclusive for months, and prolonged for two years) has a major potential impact on the high rates of malnutrition, IMRs and NMRs plaguing the country.

This issue is well understood and not under debate. Nevertheless, when it comes to actually supporting the close proximity of mother and child for a minimum period of 6 months, and up to 2 years if possible, India has little to offer, especially to women working in the informal sector (there are more than 150 million) and their children. Maternity entitlements and crèches on worksites - the two key interventions that support breastfeeding - are practically missing in the entire

jigsaw of interventions for promoting child health and nutrition. In contrast, a small number of women working as government employees may receive up to 6 months of paid maternity leave (and their husbands 15 days of paternity leave) to care for their first two children.

Delivering maternity entitlements to women working in very diverse, sometimes invisible situations is a difficult task. Nevertheless, there are feasible, specific interventions that should be taken up as a matter of priority within the 11<sup>th</sup> Plan. Some of these are discussed below.

### Currently Available Benefits and Schemes

- National Maternity Benefits Scheme: Rs 500, all BPL women. Most recently - no restriction by age of mother or birth order.
- Maternity Benefits Act, ESI Act: 12 weeks, prevailing wage.
- State Schemes: Most recent (Tamil Nadu), Rs 1000 per month for 6 months - 3 months before and 3 months after delivery.

- Construction workers TN: Rs 2000, though Rs 8000 demanded (Rs 80 per day for 100 days). Assured Rs 6000 for consistency with new scheme.

The current scope and coverage of these is minimal. The Maternity Benefits Act, for example, does not rule out benefits for women working in the informal sector, but neither does it determine any mechanisms to enable women to avail them in the absence of a well-defined employer or employment.

### Recommended Principles and Strategy

In terms of underlying principles for maternity entitlements, we recommend the following:

- All women - including adoptive mothers.
- Two weeks before and 6 months after child birth.
- Prevailing wages in case of those employed.
- Minimum wage for those working without wages.
- No discrimination on grounds of age, marital status, number of

children or any other basis, but poverty may be the criterion for priority.

In terms of strategy:

- Need to use many different modalities for covering the huge gap and large variations of situations of labour.
- The 11th National Labour Commission proposed 4 categories:
  1. Lowest level, or “safety net”, for those who cannot afford to contribute. Provision to be made entirely by the State (Central and State Governments).
  2. First level for all those who are employed in establishments. Provision to be shared between Government, employer and employee. Proportion of contribution by each sector to be determined.

3. For those employed in casual labour, contract labour, piece work, self-employed, or where employer is otherwise not visible, Government and employee alone will share.

4. Highest level, or “voluntary level”, for those who can afford to contribute in the insurance model, shared by employee and employer. Contributions to be determined.

However, our recommendations on principles of strategy are as follows:

- All existing laws (MBA, ESI Act, proposed Unorganised Workers Social Security Act, etc.) to be brought in line with the recommended principles.
- Tripartite boards and funds to implement for all sectors of infor-

mal work, so that employers contribute.

- Expanded and improved National Maternity Benefits Scheme for women left out of all above.

Other supports are critical and have been dealt with separately in detail. For the purposes of completion, these are:

- Ante natal care to all pregnant women.
- Nutrition counselling to all mothers for Infant and Young Child Feeding (IYCF).

Crèches on work sites (crèches in neighbourhoods, support to a range of players, AWC+Crèche, outreach models) or continued care and IYCF, with breast feeding breaks and flexible work hours if required.



## Part C: Crèches and Daycare Arrangements

### Rationale

Crèches are an intervention in:

- Reduction of IMR, CMR.
- Prevention of malnutrition by facilitating continuing breast feeding and complementary feeding;
- Promotion of growth, all round development and emotional security children under six.
- Facilitation of girl child school entry and retention.
- Protection of children from sexual abuse and neglect.
- Empowering women to become economically productive and participate in national life.

Crèches feed into national strategies for elimination of discrimination against women and for ensuring the Rights of Young Children to survival, protection and development. They are integral to all health, nutrition, education strategies.

Crèches are an essential requirement for families where mothers need to work for survival, especially in the unorganized sector. It is estimated that 6 crore children under six are in

need of Daycare. In the context of increasing nuclearization of families, breakdown of family support systems and casualization of work, the need for childcare support for women has become critical.

### Core components for a creche

- Safe space with washable floor, boundary wall, toilet, kitchen space , water.
- Trained responsible creche worker (1 trained worker + 1 helper for 10 children under the age of 3 years; 1 trained worker + helper for 25 children aged 3-6 years).
- Equipment for cleaning, sleeping, feeding and play/learning, storage.
- Nutrition ( provided by families along with supplementary nutrition from State Schemes)
- Health services provided through linkage with health care systems.
- Timings: suitable to women's work timings.
- Groups/systems for management/monitoring/training.

### Current status

Currently crèches are provided under the Rajiv Gandhi Scheme for Crèches and under labour legislation . The coverage under the former is 22,038 crèches till 31<sup>st</sup> March 06.

The provision of crèches under labour laws is negligible.

The need: According to the NSS 55<sup>th</sup> Round, 1999-2000, there were 10.6 crore women in the workforce. 40-50% of them were in the reproductive age group. The gap between the need and provision of crèches is clear from the above.

### Recommendations for 11<sup>th</sup> Plan

The following multiple strategies are recommended to increase coverage:

- 1. Crèches through State/ NGO partnership:** Increased coverage of children under the Rajiv Gandhi Scheme (a scheme geared to NGO management and ability to raise additional resources).
- 2. Crèches as part of Government Schemes:** It is recommended that anganwadi-cum-crèches are pro-

vided under ICDS on a pilot basis in all NREGA districts so that women can avail of employment opportunities and have a safe place to leave infants where their basic needs are addressed. The above is a convergence strategy to maximize use of investments in the NREGA Scheme.

Provision of Anganwadi cum crèches under ICDS will require additional budget, additional human resources with suitable training and remuneration for 8 hours of responsible work; attention to space, infrastructure and equipment.

Also needed is an outreach model for ICDS to cover hitherto excluded children on temporary worksites (sugar, cotton, paddy harvesting etc.). Systems to provide supplementary nutrition, immunization, nutritional support to lactating and pregnant women, and linkage to health care systems in such situations through designated outreach workers need to be developed as a strategy under ICDS.

3. Financial support for flexible models of Daycare arrangements to a range of players - Mahila Mandals, Labour Unions, Self Help Groups, Cooperatives etc. to manage and monitor need based Daycare for diverse occupational groups in diverse regions, on a per child basis of Rs 15/- per day per child. The above will permit flexibility in timings and need-based inputs as opposed to fixed budget components.

Support to local women willing to be trained for running home-based

crèches is also an additional strategy for enlarging the coverage of children in need of Daycare.

## Limitations of the Rajiv Gandhi Scheme

The rationale for the above mentioned flexible models in addition to the Rajiv Gandhi Scheme is because the Scheme, while suitable for certain sections of the population, is limited in the following ways:

- It is NGO dependent.
- The schematic pattern and norms of the Scheme cannot respond to the diversity of situations in the country. For example in some areas, more expenditure is required for rented space.
- The schematic pattern cannot respond to the needs of women engaged in occupations as varied as fisheries, forestry, seasonal agricultural occupations etc.
- The scheme's criteria of eligibility are limiting. The terms "working women" and "income criteria", need to be revised as follows:
  - i. The concept of working mothers needs to be enlarged and replaced by "Daycare for children of poorer sections where either or both parents are working with special reference to sectors (artisans, home based workers, workers in agriculture, construction, etc.)".
  - ii. Rather than an income criterion for eligibility, a criterion of occupation and residential location needs to be introduced: since

incomes fluctuate according to season, employment availability and size of family, eligibility should be defined as "poorest sectors" with occupations like home-based work, artisans, agricultural workers etc. who reside in urban slums, dalit bastis, and other area where marginalized groups live.

The above will provide flexibility to reach populations more accurately than the income criteria currently used.

**4. Crèches which are industry linked:** Labour Welfare Boards as under the Building and Construction Workers Act, 1996, need to be brought in as players for providing crèches. They can draw on Cess Funds, use Creche Workers certified and trained by NIPCCD, NGOs, ICCW etc. and develop a cell for initiating crèches for workers.

5. A cess needs to be levied on industry which will go to build up a Childcare Services Fund which can provide national support to developing a network of crèches across the country, support training of personnel, data collection and evaluation.

The Rajiv Gandhi Scheme, while enhancing the budget, has only marginally touched the tissue of better remuneration for crèche workers and resources necessary for adequate space/infrastructure for the crèche and other essential components required for Daycare.

## Part D: Infant and Young Child Feeding (IYCF)

1. Reorganise resources and make wise investments: Currently most of our resources are directed to children aged more than 2 years, whether it is for immunization or supplementary nutrition. There is a need to channel our resources to children aged between six months to one year or so. These resources should be used for skill building, training, capacity development and counselling services for infant and young child feeding. These resources should also equal what we spend on immunization services.
2. Efforts should be coordinated rather than an ad-hoc response to improve breastfeeding and complementary feeding practices. The 'National Guidelines on IYCF' should be implemented in letter and spirit.
3. Ensure that interest in the issue is persistent and coordinated at the highest levels. Possible ways of doing so include creating an 'Authority on Infant Nutrition and Survival' led by the Prime Minister and ensuring that exclusive breastfeeding figures in development reports.
4. The 11<sup>th</sup> plan should aim at increasing coverage of children under Timely Initiation of Breastfeeding (TIBF); Exclusive Breastfeeding (EBF) for the first six months; and timely complementary feeding (TCF) to over 90%.
5. "IYCF Counseling" should be included in the list of services that are delivered under RCH/NRHM and ICDS.
6. Skilled support at birth and for early and exclusive breastfeeding: provision of skilled support at birth and for the first few hours to ensure timely initiation of breastfeeding within one hour should be made an entitlement, both in the public and private sector.
7. A mechanism to lead changes in implementation at the state level should also be put in place.
8. Finally there is a need for legislation as part of the overall legislation for protecting children's rights.



# SUPPLEMENT\*

## Extracts of the Supreme Court Judgement on ICDS (13 December 2006)

Keeping in view the submissions made and considering the materials placed on record we direct as follows:

- (1) Government of India shall sanction and operationalize a minimum of 14 lakh AWCs in a phased and even manner starting forthwith and ending December 2008. In doing so, the Central Government shall identify SC and ST hamlets/habitations for AWCs on a priority basis.
- (2) Government of India shall ensure that population norms for opening of AWCs must not be revised upward under any circumstances. While maintaining the upper limit of one AWC per 1000 population, the minimum limit for opening of a new AWC is a population of 300 may be kept in view. Further, rural communities and slum dwellers should be entitled to an "Anganwadi on demand" (not later than three months) from the date of demand in cases where a settlement has at least 40 children under six but no Anganwadi.
- (3) The universalisation of the ICDS involves extending all ICDS services (Supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of 6, all pregnant women and lactating mothers and all adolescent girls.
- (4) All the State Governments and Union Territories shall fully implement the ICDS scheme by, inter alia,
  - (i) allocating and spending at least Rs.2 per child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1 per child per day.
  - (ii) allocating and spending at least Rs.2.70 for every severely malnourished child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.35 per child per day.
  - (iii) allocating and spending at least Rs.2.30 for every pregnant women, nursing mother/adolescent girl per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.15.
- (5) The Chief Secretaries of the State of Bihar, Jharkhand, Madhya Pradesh, Manipur, Punjab, West Bengal, Assam, Haryana and Uttar Pradesh shall appear personally to explain why the orders of this Court requiring the full implementation of the ICDS scheme were not obeyed.
- (6) Chief Secretaries of all State Governments/UTs are directed to submit affidavits with details of all habitations with a majority of SC/ST households, the availability of AWCs in these habitations, and the

\* This "Supplement" presents verbatim extracts of an important Supreme Court judgement on ICDS, dated 13 December – just a few hours before this report went for printing!



plan of action for ensuring that all these habitations have functioning AWCs within two years.

(7) Chief Secretaries of all State Governments/UTs are directed to submit affidavits giving details of the steps that have been taken with regard to the order of this Court of October 7<sup>th</sup>, 2004 directing that “contractors shall not be used for supply of nutrition in Anganwadis and preferably ICDS funds shall be spent by making use of village communities, self-

help groups and Mahila Mandals for buying of grains and preparation of meals”. Chief Secretaries of all State Governments/UTs must indicate a time-frame within which the decentralisation of the supply of SNP through local community shall be done.

(8) It is a matter of concern that 15 States and Union Territories have not submitted any affidavit in compliance with the order dated 7.10.2004. They are the States of Orissa, Uttar Pradesh, Sikkim, Arunachal Pradesh, Nagaland,

Goa, Punjab, Manipur, Tamil Nadu, Andhra Pradesh, Mizoram, Haryana, Bihar and the National Capital of Delhi and the Union Territory of Lakshadweep. Within four weeks reply shall be filed through the concerned Chief Secretary as to why action for contempt shall not be initiated for the lapse.

The matters shall be listed after three months. Upto date statistic report shall be filed by the different States, Union Territories and the Central Government.

.....J.  
(Dr. ARIJIT PASAYAT)

New Delhi,  
December 13, 2006

.....J.  
(S.H. KAPADIA)

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# FOCUS ON CHILDREN UNDER SIX

Focus On Children Under Six (FOCUS) is an action-oriented report on the wellbeing and rights of Indian children under the age of six years. It argues that child care is a social responsibility, and makes a case for universal child development services.

The report draws on a detailed survey of the Integrated Child Development Services (ICDS), the only major national programme addressed to children under six. The findings show that ICDS can make a big difference to the lives of children, provided that this programme receives the attention and support it deserves. Following on this, there is a special focus on “universalization with quality” as the core objective of a plan of action for ICDS.

The report also covers a wide range of related issues, such as maternity entitlements, social exclusion, the politics of child rights, the concerns of anganwadi workers, alternative views of pre-school education, Supreme Court orders on ICDS, and Tamil Nadu’s pioneering work in the field of child development, among many others. More than 60 specific topics are discussed in concise “boxes” contributed by different authors.

FOCUS draws on two years of sustained reflection and dialogue among individuals and organisations committed to the rights of children under six. The report is written in an accessible style and ends with wide-ranging ideas for action.

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