A study of anganwadis in Bangalore undertaken in 2002

CONTENTS

OUR THANKS TO

- Members of Karnataka FORCES involved with data collection:
  Belaku Trust, Sanjivini Trust, DEEDS, APD, KSCCW, APSA, AVAS, MAYA

- Members of the working group involved with training, tool development, analysis and report writing:
  Lakshmi Krishnamurty; Mandira Kumar, Rekha – Sutradhar;
  Asha Kilaru - Belaku Trust; Dr Veda Zachariah - Sanjivini Trust; S.J Chander - CHC

- Participating anganwadis, of Bangalore urban:
  Goripalya, Matada halli, Vivekananda Block, Bande Slum, Lakkasandra, Ramanna Garden, Srirampuram, Valmikinagar, JJR Nagar, K P Agrahara, Faruknagar, Kavalbyrasandra, NS Garden, Okalipuram, Ashokapuram, Ramakrishna Seva nagar, Satyanagar, Neelagiri Papanna block, Gangenahalli.

  Bangalore rural: Dalimba, Bomanahalli, Doddalhalli, Chowaksandra, Thotahalli, Yelavalli, Achalu, Kadahalli, Gerahalli, Boohalli

- The Department of Women and Child Development for its support towards this study

- Savita Sastry of GGK Systems, for help with coding

- Krishna Chakravarthy for photodocumentation of the AWCs

- Maharashtra FORCES and Tamil Nadu FORCES for sharing their data collection tools

- FORCES secretariat, New Delhi; and Sir Ratan Tata Trust, Mumbai; for financial support towards the study

- Sir Dorabji Tata Trust for supporting Sutradhar

Karnataka FORCES would be happy to share its data collection tools on request.

PREFACE

For those working on early childhood issues; the Integrated Child Development Scheme (ICDS), with all of its problems and constraints, continues to be a programme whose scope is unparalleled by any other initiative, public or private. Examples of experiments and innovations in early childhood *not* related to ICDS exist; however, their contribution is significant only to the realm of ideas and 'best practices' to draw upon. These small-scale efforts cannot facilitate change for the majority of the population in need of the kind of services ICDS is supposed to offer. ICDS continues to remain the world's largest programme for Early Childhood Care and Development (ECCD).

Many ICDS evaluations have been conducted to date of varying scales. The problems, overall, are poor quality of preschool education, infrastructure deficiencies, issues affecting access, and low community awareness. When Karnataka FORCES decided to undertake its own study covering a selection of anganwadis in Bangalore Urban and Rural districts from areas where NGO members work, it was with the knowledge that other studies have been done. However, we felt that a localised study would still be of value. We believed (and still do) that a locally driven, collaborative evaluation could spark participating members to work 1) with each other and 2) with the community, focusing on change at the anganwadi-community interface in our respective areas.

In that spirit, and with the hope that ICDS can become a working community institution, we appreciate any comments and responses to this report.

KARNATAKA FORCES
Sep 2003

C/o Sutradhar - Convenor, Karnataka FORCES
599, 7 Main, 17A Cross, Indiranagar Stg 2,
Bangalore 560 038.
Tel 5215191/5288545
Email: sutra@vsnl.com

1.3 THE OBSERVATION STUDY

Through the initial meetings of the network in 2000-2001, Karnataka FORCES members reiterated their commitment to improving the situation of the underprivileged child. They acknowledged that **quality will change only if there is greater awareness and motivation among all stakeholders:** mothers and families in the community, government functionaries at all levels (from the *anganwadi* worker upwards); NGO field staff and community workers; and resource centres who play a role in training, research and advocacy.

As a necessary prelude and a process towards building pressure for change, the group decided to take up a qualitative study of *anganwadis* in Bangalore. Strategically, this study was a point of common concern, and reinforced the conviction that it is the obligation of the state to be accountable for one of its largest childcare services, the ICDS.

In the year 2002, 11 member organisations of Karnataka FORCES took up the study of 37 anganwadis. Eight organisations committed to fieldwork; while another three were engaged in training and data analysis. Of the anganwadis under study; 27 centres were in Bangalore (urban) and another 10 in Bangalore (rural).

1.4 THE OBJECTIVES OF THE STUDY

The study taken up had two distinct albeit inter-related sets of objectives. The first set was to build a **fellowship** among the members of Karnataka FORCES – and thereby strengthen them to act as an effective pressure group in advocating on behalf of the young child. The objectives were:

- To involve representatives from **diverse** kinds of member organizations in planning the study, developing the tools, conducting the fieldwork, collating and analyzing the data.

- To **demystify** the concept of 'research' through the active participation of field staff – thereby enhancing their perceptions and skills and as a result, empowering them.

- To evolve a **common perspective** to Early Childhood Care and Development (ECCD) both in conceptual terms and in terms of programming.

- To build a **relationship** with the anganwadi worker (AWW), the community and other concerned stakeholders towards creating a field-level pressure group.

The second set of objectives were to do with the **ICDS** – the largest programme in this country – government or otherwise – for the development of the young child.

- To understand what the government-run ICDS is **meant to provide**; what the actual **field situation** is, and what **further changes** can be brought about for greater effectiveness of the programme.

- To **present** the study data to the concerned communities to create local level awareness and opinion – leading to action.

- To put together concrete suggestions from the study data, for **advocacy** with government.

1.5 THE FIELD STUDY METHODOLOGY

A case study approach was decided to be the most appropriate design for the observation study, using structured as well as open-ended questions and observations. A combination of convenience and purposive sampling was used in the selection of the anganwadi centres (AWCs) chosen for inclusion in the study, to try and capture centres in a range of settings. The criteria for inclusion in the study were that AWCs should be within the field site of the participating FORCES member organisations and that the AWC should not be run by any NGO.

The first step was to devise a **format for data collection** that could be easily administered by the field workers of the participating organizations. Two existing formats (developed by the Maharashtra and the Tamil Nadu FORCES) were drawn upon to devise the different tools for data collection.

It was decided to leave many questions open-ended, to capture qualitative details and nuances; and to allow scope for the collection of data over and above that conceived of in the study tools.

Several meetings were held in evolving the format. The final format for investigation consisted of **five tools**. There was an overlap of areas between the different tools – so as to capture the same data from different angles. The tools were:

- Observation
- Questionnaire for the anganwadi worker
- Detailed discussions with the AWW
- Examination of records in the AWC
- Community meetings and group discussions

Field workers underwent a **3-day training**. This included an orientation to ECCD, the ICDS, and research methodologies.

The formats for data collection were translated into Kannada and field-tested. Each group carried out a **pilot** in their own areas, in one or two AWCs. Based on the field-testing, the formats were further refined before data collection.

Field staff spent 3 to 5 days in data collection at each centre. They visited the centres several more times, as often AWCs were found closed or the AWW absent.

The data collected from the 37 *anganwadis* was collated, analysed, and based on the responses, a preliminary **code list** was developed for quantitative analysis. These codes were then collapsed into fewer relevant categories, and the data **re-aggregated**. The quantitative and qualitative details were then woven together; and the preliminary findings shared with the larger group of data collectors. A day-long meeting was held to **corroborate and discuss the findings** in smaller groups, add on qualitative details, suggest recommendations, and articulate the learning that different people experienced through the study.

1.6 THE INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS)

The ICDS is an early child development programme that was launched in 1975 in 33 blocks on an experimental basis. Karnataka was one of the states where ICDS was first started.

"The ICDS is unique in that it postulates a holistic development of the young child. The programme is designed to address the needs of India's majority population of the poor and the undernourished. In India, there is a need to synergise the effects of good nutrition, good health and psychosocial stimulation, to bring about an observable change in ground realities." (The Government of Karnataka Report on 'Early Childhood Development', 2001)

The objectives of ICDS

The aims and objectives of the ICDS were and continue to be:

- To improve the nutritional and health status of children in the age group of 0-6 years.
- To lay the foundations for psychological, physical and social development of the child.
- To reduce the incidence of mortality, morbidity and malnutrition and school dropout rate.
- To have co-ordination and implementation of policy amongst the various departments to promote child development.
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.
- To take care of the essential needs of pregnant women and nursing mothers in socially and economically backward villages and urban slums.

These objectives are to be realized through a package of **services**, consisting of:

Health

- Immunization
- Health check-ups
- Referral services
- Treatment of minor illnesses

Nutrition

- Supplementary feeding
- Growth monitoring and promotion
- Nutrition and health education (NHED)

Early Childhood Care And Pre-School Education

- To children in the age group of three to six years

Convergence

- Of other supportive services such as safe drinking water, environmental sanitation, women's empowerment programmes, non-formal education and adult literacy

The National Evaluation of ICDS, NIPCCD, 1992, states that:

"The most significant feature of the ICDS is to improve the capabilities of the parents to take care of the child and thus involve the community by encouraging self-help in improving the quality of life and well-being of the child and family. ICDS has been envisaged and conceptualized as a community-based programme. It calls for community participation in its process of implementation by utilizing local resources. Its objectives are not limited to mere delivery of services, but emphasize initiation of a process aimed at bringing about **social change in the life of the community**.

"This is likely to be reflected in heightened awareness, change in attitudes, beliefs and practices. The choice of having the AWW at the grassroots level as a voluntary worker and not a paid functionary makes it a scheme of the people. The assumption is that the AWW, being a local woman, would be much more effective in delivery of services due to her familiarity with the community. This would facilitate acceptance of the programme and the community's participation in it."

II. THE FIELD REALITY AND RECOMMENDATIONS FOR CHANGE

In this section, we will look at the functioning of the ICDS centres against the stated objectives of the ICDS, to understand where it is meeting its objectives and where it falls short.

The **stated objectives** relate to the health, nutritional and educational status of the young child and to enhancing the mother's capabilities in these areas through non-formal education. These objectives are sought to be fulfilled through **services** which relate to health, nutrition, pre-school education for the child and non-formal education for the mother.

The site for the delivery of these services is the **anganwadi**. The key person through whom the services are delivered is the **anganwadi worker**.

The outcomes from the implementation of the ICDS – positive, negative or indifferent, depend on the shifting nexus between **three** intrinsic, albeit variable factors:

- The **quality** of services and the **"efficiency"** with which they are delivered. Here 'quality ' includes basic standards as well as relevance, and 'efficiency' includes regularity and accessibility.

- The **effectiveness** of the AWW in playing out her role as the coordinator of services delivered. 'Effectiveness' is partly determined by her acceptance and relationship with the community; the regularity with which she conducts the services, the training she receives for carrying out her duties and the support she receives in doing so.

- The **readiness** of the community to accept and utilize the services of the AWC.

2.0 THE ANGANWADI CENTRE: the site for the delivery of services

According to ICDS

The anganwadi or courtyard play center is a child care center located within the village or the slum area and is the focal point for the delivery of services at the community level to children below 6 years of age, pregnant women and nursing mothers. The population served by one AWC is approximately 1000 in rural and urban areas, and 700 in tribal areas.

The Child Development Project Officers (CDPO) provides the link between ICDS functionaries and the government administration. This officer is responsible for securing anganwadi premises besides identifying beneficiaries, ensuring supply of food to centers and the flow of health services, monitoring programs and reporting to the state government. The community or the Bal Vikas Mahila Samiti also plays a major role in the identification of the site for the anganwadi center. The anganwadi worker is trained to make the anganwadi adequate and safe for the delivery of services.

(ICDS: Department of Women and Child Development, MHRD, New Delhi, 1995)

Our Findings

Problems of shared space

Field workers' data revealed that most of the AWCs have adequate ventilation, light and space to store material. However, **not many have buildings meant for the sole use of the AWC.** Some are housed in temples, others in 'choultries,' some in the helper's house, many in community halls.

This not only **restricts** the space for carrying out pre-school activities, but sometimes makes it **unsavory** and **unsafe** for children to be there. In 24 of the 37 AWCs visited, there were cigarette butts lying around, indicating that the space is used by men for smoking and, we were told, drinking also. In some other AWCs, items like sewing machines, rusted iron sheets, chains, etc., were found lying about.

In people's homes and other such shared spaces, everything has to be put away, so that the AWC material does not impinge on the other users of the space and so that it does not get stolen.

Some anganwadi centres are simultaneously being used by families.

> *"As other families live in the AWC, it is not clean. There is a lot of disturbance too. Also the smoke while cooking comes towards the children. Even if toys are given there is no place to store them."* (photo 1). (Observations in Goripalya AWC)

Cooking in the AWC causes discomfort – smoke gets in children's eyes, or they are sent out while the cooking is done. In one AWC the cooking was done in the middle of the room!

"Often 2 or even 3 AWCs are run in the same space –this makes it cramped and suffocating. Besides, AWWs and helpers tend to chat with each other rather than pay attention to the children." (photo 2) (Observations in Srirampuram AWC)

When many centres are run in the same space it provides an opportunity for the AWWs to **absent** themselves or work out a shift system for managing the centre — which they in any case do with their helpers (more on this later).

Where the AWC is situated in a temple, apart from the fact that toys and other materials cannot be left behind, **caste discrimination** is observed. SC/ST children are usually not allowed here. (photo 3)

Lack of privacy for the anganwadi worker

"I can't teach them action songs as it is an open place. People stand and watch. I feel shy." says the AWW who runs a centre in a temple courtyard.

A common concern that AWWs have is the lack of private space in which they can teach in an unselfconscious manner, away from public gaze. This has been reported by AWWs from both urban and rural areas. It is alright for the helper – usually an older woman; but younger women are self-conscious of playing with children in the open. We did not come across any AWC that provided open-air privacy by way of a compound wall.

Poor infrastructure

Structural defects are not uncommon. There were cases where the **floor** of the AWC is broken and likely to cause hurt when children run around or fall. (Photo 4). The majority (33 of the 37 AWCs) visited had structural problems such as a leaky roof, a roof made of tin sheets, etc. About 50% had dysfunctional doors and windows.

It is significant that, however shaky the infra-structural conditions of the place where the children play and eat and learn, 33 of the 37 AWCs reported that there was adequate space for the storage of materials – i.e. the records, the food, the cooking vessels and the toys. Supervision takes a dim view of the loss of such items.

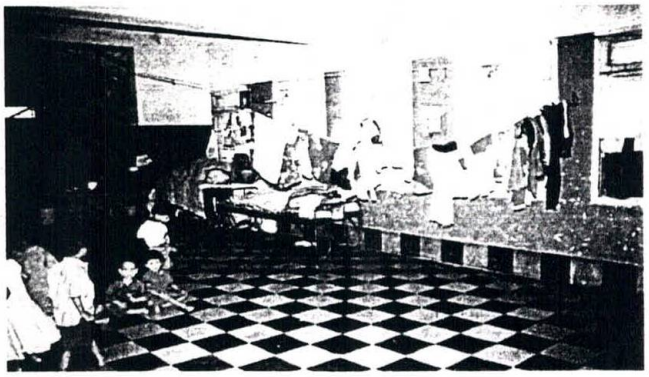
However small or shared the AWC, one symbol is ubiquitous – the AWW's table and chair! The power differential between the teacher and the taught is evident. (photo 9).

Lack of play space outside the anganwadi

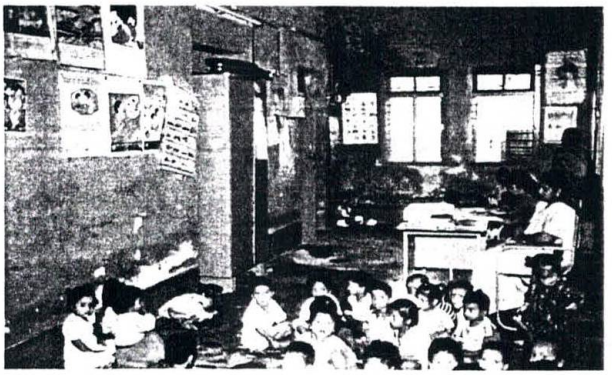
In many cases, the question of the AWW playing with the children outside the AWC does not arise, as there is simply no space. Many an AWC is on the roadside where vehicles ply. Most AWCs have dirty surroundings; with garbage, open drains, and children's toiletry done there.

The AWC: Physical environment

Pic 1 – centre in community hall, cramped and smoky space



Pic 2 – two centres in the same room



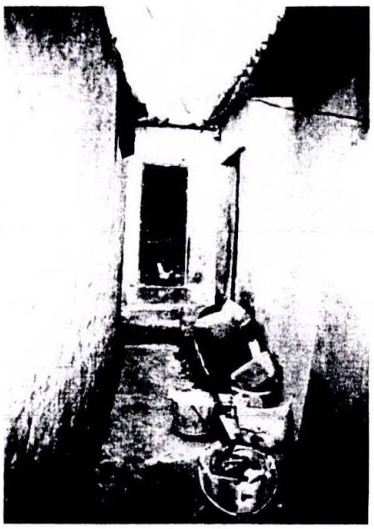
Pic 3 – dark and dingy centre in temple

Pic 4 – look at the floor!

AWC: the outside surroundings

Pic 5 – centre on busy road ... and where is the outdoor space to play?

Pic 6,7 – single file entry to centre...children tumble out to be photographed!



Pic 8 – no toilet... and no clean outdoor space

In one case the entrance to the AWC was so narrow that it allowed single file entry only. And the AWC was so small that the children had to come out to be photographed. (photos 5, 6, 7)

Lack of water and sanitation

25 of the AWCs had no toilets; and of the rest, 4 were non-functional. Children use the outside of the centre. (photo 8). AWWs are reluctant to wash up children when they defecate; helpers sometimes do, or the child is sent home. Where toilets are functional, they are not much used, excepting by the AWW as *"children tend to dirty the toilet and water is in short supply, in any case."* Water was available in only 22/37 of the AWCs.

There is always the argument that the conditions in and around the AWC are no worse than the homes of the children -- something they are used to. However, keeping in mind that the ICDS is mandated to bring about a change in the health and nutritional status of the child, it is obvious that if the AWC does not demonstrate the rudiments of what it preaches, then all the 'education' to parents is not likely to be convincing, leave alone put into practice. To that extent the value of the programme is diminished. **The 'unstated' conveys as much 'message' as the vocally articulated statement.**

Recommendations: physical environment

The AWC should have **its own building**, one not shared with or used for any other activity. This is the only way to ensure that it will be safe and clean, with storage and play space. Ideally, the AWC should have a compound wall for safety and privacy. Apart from the actual and the practical need for such a building, there is the extremely important symbolic value - of demonstrating and practicing what is preached. To unpack some of this:

- There should be safe water for drinking, cooking and for keeping the children clean.
- There should be toilets with a sufficient supply of water to keep them clean.
- Building parameters for the AWC should be laid down; the building should be properly supervised and maintained – no sheet roofing, leaky roof, damp and pitted floors, etc.
- Cooking space should be outside the main area of the centre, as has been prescribed for the school mid-may meal, by the Government of Karnataka.
- The AWC should be away from the main road and be centrally located in the habitation.

SERVICES

What are ICDS' 'stated' ways of achieving programme objectives? The ICDS document says "The objectives are to be realized through a package of services." It is important to remember that the first step is to check on the delivery of services. **If services are not delivered, it is futile to look for outcomes.**

2.1 SUPPLEMENTARY NUTRITION

According to ICDS

Supplementary feeding is given for children below the age of 6 years for 300 days in a year. It is also to be given to pregnant and nursing mothers. By providing this supplementary feeding, the anganwadi attempts to bridge the caloric gap between the recommended dietary allowance and the average intake of children and women in low income and disadvantaged communities. This pattern of feeding aims only at **supplementing** and not substituting family food.

The type of food varies from state to state, but usually consists of a hot meal cooked at the anganwadi, containing a varied combination of pulses, cereals, oil, vegetables and sugar. Some states provide a ready-to-eat meal, containing the same basic ingredients. There is flexibility in the selection of food items, to respond to local needs.

Special care is also taken to reach children below the **age of two years**, and to encourage parents and siblings to either take home ration or to bring them to the anganwadi for supplementary feeding. Identified severely malnourished children (those placed in grade III and IV), are given special supplementary food which may be therapeutic in nature, or just double the ration, and they are also referred to medical service providers.

(ICDS: Department of Women and Child Development, New Delhi, 1995)

Our Findings

In 25 of the 37 AWCs visited the AWWs stated that food was not served regularly because of transport problems in delivery. In 21 /27 urban Bangalore AWCs, children were served two slices of bread each; in the rest, it is cooked food – chitranna, energy food in powder or laddu form and sweet pongal. (photo 10)

At least half the AWWs felt that the quality of the food is bad. Where cooked food is served, the community feels *"The energy food has black worms in it and the rice has white worms. If the children eat this food they get dysentery – they may even die."* About the bread – *"Children's health will not improve by giving two slices of bread."* Bread is only a snack – it is not 'food'. And in any case children take the food home (photo 11) where it is shared. With other siblings at least, if not with the adults too.

Having said all this, in many of the AWCs a lot of children turn up at the time of food distribution. At one AWC which has an enrolment of 22 children aged 3-6 years, as many as 40 children below the age of three turned up at mealtime. When attendance is low, as it often is, this serves to dispose of extra food. (The AWW cannot be blamed for taking food home; her records for attendance/food consumption are complete – if not she is reprimanded; and, not least of all, she avoids the wrath of the parents on herself for not feeding hungry children).

In most cases children come on an empty stomach in the morning. The appropriate time to feed children is then, as confirmed by child development specialists. But if they were given the food first, then they would all go home – as food outweighs the rest of the activities at the AWC.

The ICDS mandates that malnourished children be given extra food according to the degree of malnourishment. Of the total AWWs, 27 said that they were in the practice of doing this; while the rest said parents would hound them out of the village if they gave some children more and some less food.

In these circumstances, looking for outcomes in the form of a better nutritional status does appear to be a bit of a pipe dream.

2.2 GROWTH MONITORING

According to ICDS

Growth monitoring and nutrition surveillance are two important activities that are to be in operation at the field level in ICDS. Both are important for assessing the impact of the health and nutrition related services. Children below the age of three years are weighed once a month and children from three to six years are to be weighed quarterly. In ICDS, weight-for-age growth cards are to be maintained for all children below six years. Their growth is charted both to detect growth faltering and also to assess their nutritional status.

Growth monitoring helps the mother in taking timely, cost-effective preventive action to arrest any stagnancy or slipping down in weight through early detection of growth faltering. A community chart maintained at each anganwadi reflects the nutrition status of all children registered with the anganwadi at any given point of time – helping the community in understanding what the nutrition status of its children is, why it is so and what can be done to improve it.

(ICDS: Department of Women and Child Development, New Delhi, 1995)

Our Findings

One of the ways of assessing the health of the child is regular weighing. Weighing and maintaining of growth charts is a powerful tool for tracking a child's growth and of educating mothers – if properly carried out. NGO programmes have amply proved this.

In our study, it was observed that 13 of the 37 AWCs had weighing machines. But 33 of the 37 AWWs said that they weigh children regularly, which is supposed to be done in the presence of parents.

> *"We don't know that they weigh. We are learning from you." "Helper says they check weight, but they have not told us a single day as to how much they weigh and also about their growth."* (Parents of children who attend the AWC)

The AWWs feel that parents object to weighing because they believe children grow thin. The net result seems to be that very little weighing is done, either to keep track of growth or as a demonstration for parents. Weighing appears to be somewhat of a ritual; in any case, the prescribed amount of supplementary nutrition is not consumed.

Most of the growth charts maintained by the AWW appeared normal and the percentage of malnourished children according to the records was insignificant. However, observation of the children at the anganwadi did not conform to the above. This raises the question of the **authenticity** of the growth records maintained by the AWW. This may be due to:

a. the pressure of maintaining a number of records
b. the fear of her supervisors taking her to task
c. her multiple responsibilities and duties

Recommendations: nutrition and growth monitoring

- A proper meal, as is being served in schools would be much appreciated. If the AWC is to run the whole day, then a snack could be given first thing in the morning, followed by the meal at noon. Parents may be willing to contribute to this extra feeding. Bread is not seen as a substitute for a meal – it could be the morning snack.
- Weighing the child and maintaining a growth chart must be done as a guide for referral and to educate and convince parents of the health status of their children.
- The AWW must educate families on the importance of weighing and supplementary nutrition so that she has their co-operation.

2.3 HEALTH AND HYGIENE

According to ICDS

The health component of ICDS comprises health check-ups, immunization and referral services. Health check-ups include health care of children under 6 years of age, ante-natal care of expectant mothers, and post-natal care of nursing mothers.

The primary health centre staff and the anganwadi worker are to provide the following health services for children:

- Regular health check-ups
- Recording of weight
- Immunization
- Management of malnutrition
- Treatment of diarrhoea
- De-worming
- Distribution of simple medicines

Children are to be **immunized** against 6 vaccine-preventable diseases (Poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles) and pregnant women immunized against tetanus. The anganwadi worker helps in the organization of fixed-day immunization sessions, maintains immunization records and follows up to ensure full coverage. **Referral** services for sick or malnourished children in need of prompt medical attention are also provided. The anganwadi worker has also been oriented to detect **disabilities** in young children. She is to enlist all such cases in a special register and refer them to the medical officer.
(ICDS: Department of Women and Child Development, New Delhi, 1995)

Our Findings

Health

Most of the AWWs said that they do organize monthly or quarterly health check-ups – this is what they are supposed to do. Many were vague about details. In an AWC in Bangalore (rural); the AWW reports that the doctor has not visited in three years.

> Field worker: *"What if a child comes to the centre with a common ailment?"*
> AWW: *"We give them medicines from our first-aid box."*

However the list of medicines has not been maintained for several years. This is one of the registers that is not properly maintained. There is no procedure for replenishing the medicine chest. In some centres in Bangalore (rural) there has been no supply of folic acid and iron for mothers for the last two years.

Here it must be remembered that 'medicines' are not an item in the AWW's direct line of supervision – which is the Department of Women and Child Development. The health department is a subsidiary partner, with no policing or punitive powers.

When asked "To whom do you refer sick children?" 17 AWWs said the PHC and another 19 said variously, the ANM, private clinics and hospitals. What referral means is that the AWW gives the mother a chit naming the place she should go to. Most mothers do not follow this instruction – it means at least one day's wages lost, with no guarantee that the doctor sees the child, let alone treats her.

11 of the 37 AWWs have not organized immunization camps.

> *"Parents do not allow doctors to give injections. They feel the children will get fever. Therefore we give drops, syrups and medicines."* (AWW)

Hygiene

Regarding hygienic practices, most AWWs are reluctant to clean leaky noses (with what would they do this? Handkerchiefs are a luxury and tissues unheard of/prohibitively expensive). The helper perfunctorily cleans behinds after defecation – on the rare occasion when it is called for. Children usually run home if the need arises. The children were asked to wash their hands before eating in less than half the centres. This again becomes a formality, as water is in scarce supply. The situation in the children's homes is no different.

Disability

Children with disability were seen in only 3/37 AWCs. In only one centre the AWW reported that they had received Portage training. This suggests that not enough effort is being made to train AWWs to identify and integrate children with disability in the AWC.

Recommendations: health, hygiene and disability

- The first-aid kit and its upkeep/updating should be taken more seriously, and relevant training to the AWW and the helper made more rigorous.
- Referrals should be more than giving slips of paper – the health chain needs to be tightened up to perform.
- Basic hygiene and cleanliness should be emphasized to promote health; and the habit of washing hands instilled early on.
- Early identification of disability and integration need to be encouraged.
- A special attempt to identify area specific ailments and treatments should be made.

2.4 COMMUNITY INTERACTION: NUTRITION AND HEALTH EDUCATION

According to ICDS

Nutrition and Health Education (NHED) is a key element of the work of the anganwadi worker. This has the long term goal of capacity building of women (age group 15 - 45 years) so that they can look after their own health and nutrition needs as well as that of their children and families.

The components of NHED comprise basic health and nutrition messages, related to childcare, infant feeding practices, utilisation of health services, family planning and environmental sanitation. NHED is to be provided through home visits and demonstrations.

(ICDS: Department of Women and Child Development, New Delhi, 1995)

Our Findings

20 of 37 AWWs say that they visit a maximum of two houses a day. A few AWWs, who stay far away, do not make house visits as they have to rush home – they have their own children and homes to look after.

> *"They go for house visits once in 2-3 months. Even in that they visit houses of people they know."*
> *"You can ask anybody. She has never talked to us about women's health nor has she done house visits."* (Community members)

The **location** of the AWC also makes a difference. If it is in the centre of the village/slum, interaction between the AWW and the community is more likely. If it is in the outskirts of the settlement, home visits are rare.

Caste, religion and language are all forms of social exclusion. If the AWW is of an acceptable caste to the community, there are more chances of her visiting homes. An AWW of a higher caste discourages participation of lower caste children and families, as was observed in Kanakapura. Social barriers to accessing the anganwadi have been observed in urban and rural settings.

> Says a field observer: *"In Goripalya, in Bangalore (urban), there is a large Muslim population and a small number of Tamil speaking people. However, the two Anganwadis that exist are entirely segregated, with one AWC serving exclusively Tamil-speaking children and the other serving exclusively Urdu-speaking children. At the community meeting, community members comfirmed this segregation."*

In any case, with three months of training at the time of joining – and many of the AWWs have been in service from 10 to 15 years – it is difficult to interest mothers with the same messages, year in and year out. Many AWWs have had refresher trainings, but these are mostly about topics of current interest: pulse polio, Stree Shakti programme, etc. There is no training that is a follow-up on problems faced in the field.

2.5 PRE-SCHOOL EDUCATION

According to ICDS

The pre-school education component is to be the backbone of the ICDS program. This activity aims to bring and keep young children at the anganwadi centre for three hours a day. Preschool education is to focus on the total development of the child. It includes promotion of early stimulation of the under threes through intervention with mothers/care givers; and a program for the three to six year old in the anganwadi providing a stimulating environment with emphasis on necessary inputs for growth and development.

Child centred playway activities, which build on local culture and practices, using local support materials developed by the AWW are to be promoted. The pre-school education program conducted through the medium of play aims at providing a learning environment for the promotion of social, emotional, cognitive, physical and aesthetic development of the child. It also contributes by providing the child the necessary preparation for primary schooling.

(ICDS: Department of Women and Child Development, New Delhi, 1995)

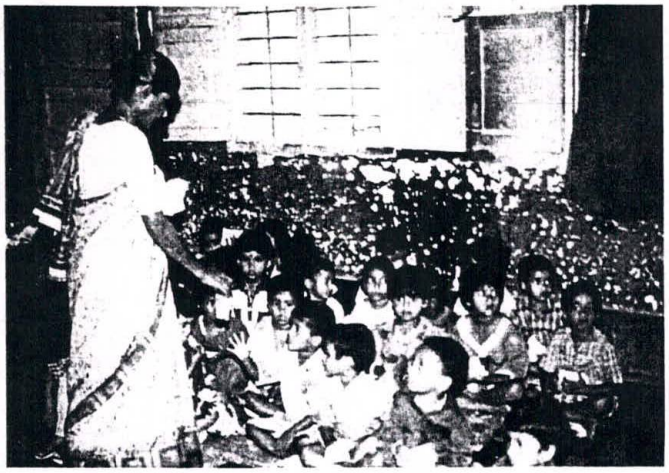
Our Findings

The one thing that parents and AWWs are agreed upon is that attending the AWC makes it that much **easier for children to adjust to school**. There are no tantrums; they mix better with other children; the children are less trouble to the teacher as they have already spent continuous time sitting still, and being managed by a teacher. No school-time is wasted in getting children to adjust to school. In short, they have already been broken in to school and school culture – as conceived of and experienced by all those whom these children come in contact with.

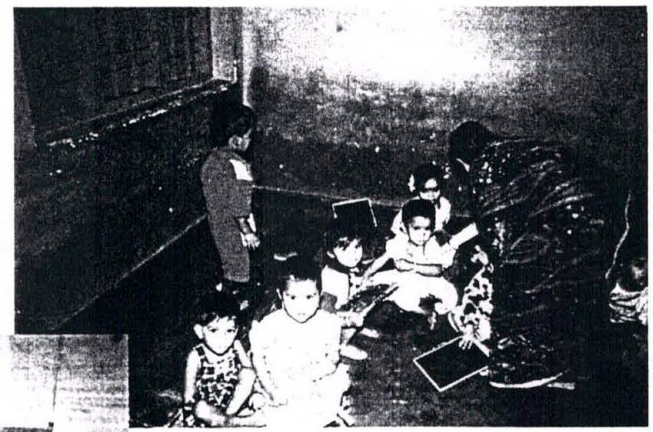
This pre-school conditioning is perfectly suitable for the presently existing government school. It is another matter that the vision of 'education as enabling the child to realize her potential', does not figure in the current practice of the AWC-government school stream of education – the concept has only recently entered the language of school education and still remains firmly in the realm of discourse.

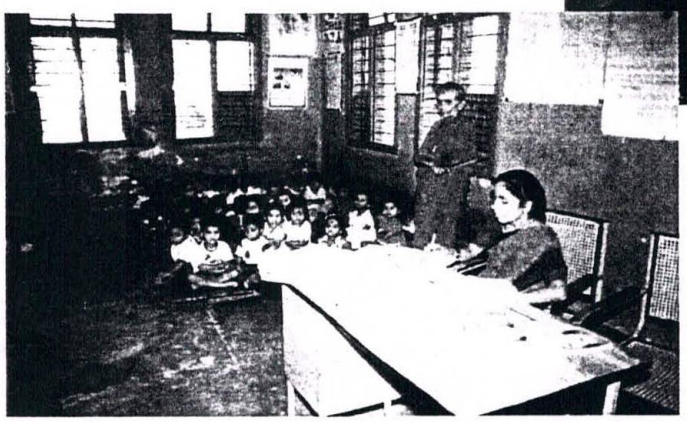
The services seen

Pic 10, 11 – two slices of bread as supplementary nutrition – children take it home to share



Pic 15 - slates are one of the few teaching aids





Pic 9 – teacher on desk, the taught on the floor

Educational activities, reading and writing

In 22 of the 37 AWCs, field workers found that there was **no activity** going on – children were crying, fighting or just sitting around – while the AWW was busy with the AWC and the Stree Shakti records. (see pic 9, 13)

Only in 11 centres was there anything "educational" observed. In 8 AWCs children were playing with toys and in a few other centres, children were learning the 3 Rs.

About 50% of the AWWs interviewed said that they teach **reading, writing and numbers.** This is the way they learnt and this is the way they teach – teaching in the play-way method and giving the child space (unstructured time) to learn and grow according to her own inclinations, is an alien concept. It implies a change of attitude which needs concerted and repeated trainings spread over a long period of time. Most AWWs do teach children games and songs – but for the most part this is in the spirit of children 'performing' and not that of a group activity.

Apart from the fact that the AWW is most comfortable teaching reading, writing and numbers, the community too feels that this is what the children should be learning. Their complaint is that the AWW does not do this properly.

> *"Children should be given slates and taught ABC."*
> *"Like the children in convents -- our children should be taught to read and write."*
> *"They teach 3 year-old children in the convent."*
> *"We feel it is important to teach children a few alphabets rather than be given bread."* (community members)

The AWW says, *"Children should be given uniforms and play materials appropriate to their age, like a toy horse. But the villagers insist we teach alphabets."*

Toys and other educational material

The toys available at the centres are far from adequate. In 10 centres the observers saw wooden toys, beads and horses. In five they saw an assortment of materials such as puzzles, kitchen set, charts, animals, dolls, balls, slates etc. (pic 15)

These materials are supplied on a one-time basis and are not used every day – the AWW is reprimanded if there is any loss or breakage. By and large they are kept locked up, at best allowed to be used under strict surveillance.

Charts, etc. are hung high up on the wall, where children can't get at them – children have to look way up and use a long stick to point to whatever it is that they have been asked to identify: an animal, a plant, an alphabet. (pic 2, 12)

Planning

28/37 of the AWCs had a pre-school activity book; 9 did not. More than 30 AWWs say that they have a daily plan and have been given a monthly and yearly programme schedule. But they have mixed feelings about the usefulness of these.

> *"It is of a higher level than what children understand. Therefore we are unable to teach according to this."*
> *" It is not possible to follow as they say. We should keep in mind how children understand and learn."* (AWW)

Recommendations: preschool education

- Toys and other material should be replaced regularly. Evaluation should take into account evidence of the usage of a toy, rather than of its good condition.
- The AWW and the community need more awareness on ECCE and the relationship between play, language and cognition.
- While spending time on pre-reading and pre-writing activities, children could be taught alphabets too – middle class children are given this advantage – why not poor kids?
- Songs and stories could be shorter and more child-friendly.

2.6 RUNNING THE ANGANWADI CENTRE

According to ICDS

The anganwadi worker is a community based voluntary, frontline worker of the ICDS program. Selected from the community, she assumes a pivotal role due to her close and continuous contact with the people, especially women she works with. She is a crucial link between the village population and the government administration and becomes a central figure in helping the community identify and meet the needs of their children and women.

The ICDS team comprises of the anganwadi worker, the anganwadi helper, the supervisors and the Child Development Project Officers (CDPO).

(ICDS: Department of Women and Child Development, New Delhi, 1995)

Our Findings

AWW and Helper

In the study the field staff met AWWs in 26 centres out of 37, and helpers in 30 out of 37 centres. Field staff had to make repeated visits to meet the AWWs.

The majority of AWWs stay **outside** the village; a few quite a distance away – which prevents them spending too much time inside the village. The AWW is expected to spend at least half a day in the village – her jobs, which keep getting added to all the time, are too many to pay efficient attention to any one of them. Writing up her multifarious records, and keeping track of the Stree Shakti programme, are two essential tasks – they are the visible evidence of the discharging of her job.

Of the 37 centres, 16 are, by and large, managed by the **helpers**. Helpers are invariably from the same village and are usually around 50 years of age. They have had no training and being from the same village, have their own daily chores to attend to (photo 14).

Then there is the **sub-contracting of jobs** as observed by the field staff:

> *"The AWW has paid Rs. 25 to a blind man to teach the children."*
> *"As the helper works as a housemaid, she has asked a lady who is a TB patient to look after the children. This lady spits on the floor itself and they give bread to the children in the same place."*
> *"Teachers in the 2 AWCs under the same roof, were absent. Helpers were taking care of the children. There was no educational activity, as both of them are illiterate and one of the helpers is deaf and dumb."*

According to ICDS, there is to be one **supervisor** for every 20 AWWs. From earlier studies we know that there are only 500 supervisors for the 1800 posts allotted in Karnataka (Lakshmi Krishnamurty et al, Early Childhood Development Programmes in Karnataka, 2001). If this situation is remedied, it is possible that some of these problems may be sorted out.

One problem that both the helper and the AWW have is that, in many cases, children attending the AWC speak different **languages** — Kannada, Tamil, Telugu — and communication becomes somewhat confused. The use of any one single language handicaps those who speak other languages. The observer in an AWC in Bangalore (rural) sees that *"Children's language is Lambani and AWW's language is Kannada. AWW can't follow what the children speak".*

Many of the AWWs have worked from 10 - 15 years. There is no permanency; no promotions. Except for the exceptions, their teaching has become routine and stale. And so it goes.

The community and the AWC

With all their grumblings and complaints, the community is still sympathetic about the erratic timings that the AWW keeps. Mothers are glad that their children are looked after at least for half the day. They unanimously felt that the AWC should run for the whole day as this would cover the time that they go to work: they can feel easy that their children are safe. This is true of both urban and rural communities.

The Government has constituted a **Balasevika Samithi** for bringing members of the community and the AWW into a relationship of closer co-operation to improve the working of the AWC. This structure and space for dialogue was revitalised in its present form in the year 2000. It is still in its infancy and it remains to be seen how effective it will be. Yet, there is no doubt that an informed community is willing to contribute and monitor the running of an AWC. In 10 centres in Bangalore (rural), the community contributed firewood. In two centres they have helped to build the AWC and the compound wall around it. While they are willing to contribute; the community feels that it is the government's job to provide a proper building, good food, toilets, outdoor space and toys.

Recommendations: Training

- Helpers should get training in different aspects of ECCD, so that they can assist the AWW more effectively than they do now.
- The AWW's training should be experiential, looking into and reflecting on her own life - rather than just content and method based. The content and methods should be woven into reflection.
- Re-trainings and monthly meetings should be for the purposes of problem-solving sessions. This could give more meaning to the meetings with mothers.
- Trainings and follow-up should be tuned to changing attitudes -- of the AWW and of the community.

Recommendations: AWW and the AWC

- The AWW must be regularly present and come to the AWC on time. All forms of accountability must be in place to ensure this – through support from the supervisor, the community and the Balavikasa Samithi. This 'support' is essential if all field level stake-holders are to be enabled to work together towards effective programming.
- The AWW needs to be motivated, rather than coerced/frightened into dispensing her duties.
- The AWW should not be burdened with all sorts of extra jobs, which have nothing to do with ECCD.
- A promotion line and benefits should be available for the AWW.
- A track should be kept of the AWW's and the helper's health status (e.g. TB).
- Younger helpers and AWWs from the community should be chosen.
- The AWW and the helper could be from different local language groups and castes so that no child gets marginalized.
- The AWC should run the whole day as desired by the community. This will make the AWC more meaningful for them.
- The multiplicity of records emphasizes the distrust of the system in its workers and as a monitoring mechanism is ultimately self-defeating. The AWWs are fully aware of the implications of maintaining the records. They are very careful to properly maintain the children's and their own attendance registers and the food-stock register – never mind how much this is at variance with reality. Everybody up the line is silently aware of this – nothing is done – each one is wary of the one higher up..... It is indeed a tough culture to crack. But crack it must, if social change is expected to be an outcome of this programme.

III. SOME CONCLUDING THOUGHTS

The study achieved its first set of objectives of **strengthening the FORCES network** – this is a process which needs constant attention and interaction; this study has certainly started the process rolling. As for the second set of objectives, the study has not found anything that has not been commented on, in one or another of the myriad evaluation/review studies that have been conducted, by many a government and non-government organization, since the inception of the ICDS programme in 1975. What is alarming is not that the study has not found anything new, but that the same findings and problems in one form or another have been cited, either in toto, or piecemeal, in evaluation after evaluation, since the '70s.

The ICDS mandate says, "The objectives are not limited to mere delivery of services, but emphasize initiation of a process aimed at bringing about social change in the life of the community." Today, after more than 25 years of existence, the anganwadi centre has remained peripheral to community life. The school, yes. The idea of schooling generates a certain sentiment, desires and aspirations for children – it has become an intrinsic reality of daily life. If the school were closed down tomorrow, we can safely hazard that the various sections of the community would come together and there would be an uproar. Can we honestly say that closing down an AWC would even be noticed, leave alone protested against?

This raises the question "Why are such studies carried out?' If little or no changes (in terms of quality; not in terms of expansion) have come about, as between one study and another, at least from time to time, one could assume that we need to rethink our strategies for advocacy – both with the community as well as the government. It also points to the need for many groups to come together for **advocacy** such as the Forces network.

Also, whether it is in the area of immunisation, weighing, nutrition or reading-writing, the beliefs and practice of the AWW, the primary school teacher and the community are at variance with child development experts and the planners, who go by the advice of expert opinion. Can a strategy for better dialogue be adopted to **align** the two?

"

Voices of the FORCES network members who participated in the study

"

APD "Though we were working with anganwadis we had not documented our understanding systematically. It gave us an opportunity to understand other aspects of anganwadis like preschool education."

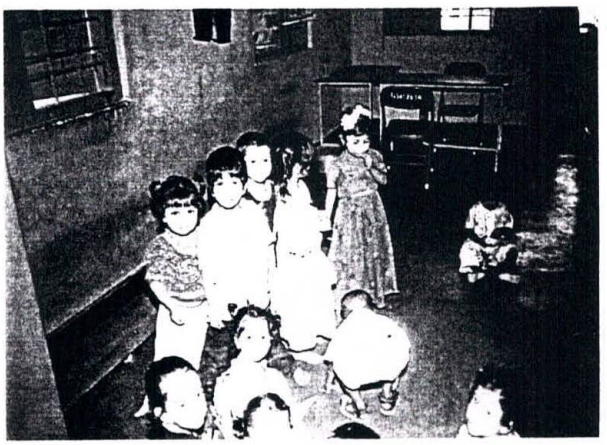
Sanjivini Trust "We got first hand experience of understanding an anganwadi. It has inspired us to study further about the nutritional practices and activities to stimulate children (0-3 years)."

Sutradhar "The study gave us an opportunity to know the field realities in which the AWC functions. It was also our first experience of coordinating a research study. Listening to the experience of other members has benefited us. It has thrown open a Pandora's box of problems challenging us to prioritize strategies."

Belaku Trust: " It has enthused us to plan other programmes for the AWCs and the communities from whom we collected the data".

The AWW and helper

Pic 12 – old helper, no AWW



Pic 13 - no helper, no AWW!

Pic 14 – helper cleans greens for her *vada* business, no AWW, children unattended

IV. THE WAY FORWARD...

We plan to present this report to **all stake-holders at the community level**. We hope to quicken interest among those for whom the programme is meant, so that they may be the core of any group that demands/is working for bringing about a change in the lives of their children.

We have recorded all the recommendations that follow from this study and as evolved by participating members for **advocacy with the government**. The Karnataka Government, reputed to be more responsive than most, will hopefully pay heed, in implementational terms, to more rather than fewer of the recommendations made here.

The recommendations listed earlier are all-encompassing and 'ideal.' Let us constantly keep the ideal in mind. Financial, political and practical considerations tend to skew the picture; so that this, the 'what is,' becomes the norm; rather than the aspiring for the 'what should be'.

6 key recommendations

- Each centre to have its own space adequate for 40 children with minimum facilities
- The AWW must be present at the centre
- The centre should be open the whole day
- Provide a hot cooked meal; use seasonal and nutritious vegetables and fruit
- Growth monitoring should be properly carried out
- Reduce the number of records to be maintained by the AWW

ABBREVIATIONS

AWW - Anganwadi Worker

AWC - Anganwadi Centre

ANM - Auxiliary Nurse Midwife

ATC - Anganwadi Training Centre

CDPO - Child Development Project Officer

ECCD - Early Childhood Care and Development

ECCE - Early Childhood Care and Education

FORCES - Forum for Crèche and Childcare Services

ICDS - Integrated Child Development Scheme

MHRD - Ministry of Human Resource Development

NHED - Nutrition and Health Education

NGO - Non Government Organization

NIPCCD - National Institute of Public Cooperation and Child Development

PHC - Public Health Centre