The unsung heroines of India

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Underpaid and overworked anganwadi workers are the real providers of many basic services for the poor across India. Improving their wages and working conditions is the need of the hour.

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Anganwadi volunteers of Chhattisgarh taking out a rally demanding a hike in their honorarium, in Raipur on April 13.

THE appalling and brutal attack in Madhya Pradesh recently on a woman anganwadi worker who was assisting a government campaign against child marriage ought to have served to highlight the huge contribution made by such workers in general in the face of terrible conditions. Unfortunately, we live in a callous and ungrateful society, where those who make the most positive contribution are not only unsung but also left unprotected against all sorts of violence.

In the long and mostly depressing chronicle of living conditions of the majority of the Indian population, there are still some instances of minor successes. Some of these successes result rather directly from the process of what is broadly called "development", such as the expansion of basic infrastructure, the extension of some public services and the like. But, these processes have a more particular micro aspect in terms of the people who are actually providing the most important public services.

Among the most critical of such services are those related to health, nutrition and basic sanitation. These are not simply determined by the public programmes directed towards them, but are probably more affected by macro policies and processes which affect food security, employment and income generation possibilities, and so on. Nevertheless, some of the programmes do play important roles.

Of course, progress in these areas is still far from adequate, and the slow spread and unsteady improvement of such services is a major indictment of the development process thus far. Further,

the economic policies of the past one and a half decades have had adverse impact on many such conditions by reducing the levels of crucial public expenditure in these areas and removing important forms of public protection.

Nevertheless, there are signs of some hope, particularly among the most destitute groups. These are expressed most clearly in the significant declines in the number of severely malnourished and moderately malnourished children and the infant mortality rates (IMR) in the country. According to National Family Health Surveys (NFHS), the percentage of children suffering from severe malnutrition declined from 15.3 per cent during 1976-78 to 8.7 per cent during 1988-90. IMR declined from 94 per 1,000 live births in 1981 to 73 in 1994. Subsequently, IMRs have stagnated in most parts of the country and average levels of nutrition remain poor and may even have worsened. But the evidence is that severe undernutrition continues to decline.

What explains the areas of progress and the contradictory features of the recent past? One important factor is the role of one of the largest schemes of the Government of India, which relies dominantly on poorly paid and overworked women workers to provide some of the most essential public services in the area of health and nutrition.

This is through the Integrated Child Development Scheme (ICDS), which was initiated nearly 30 years ago in October 1975 in response to the evident problems of persistent hunger and malnutrition especially among children. Since then, the ICDS has grown to become the world's largest early child development programme.

The coverage of the scheme has expanded rapidly, especially in recent years. From an initial 33 blocks in 1975, the programme covered an estimated 6,500 blocks by 2004. There are almost 600,000 anganwadi workers and an almost equal number of anganwadi helpers - all women - providing services to beneficiaries throughout the country. According to the government, the programme currently reaches 33.2 million children and 6.2 million pregnant and lactating women.

The ICDS involves the setting up of anganwadi centres, each of which is intended to cater to a population of around 1,000 in rural and urban areas and to around 700 in tribal areas. The anganwadi worker and helper, who are the basic functionaries of the ICDS, are not treated on a par with other government employees, but are called "social workers" or "voluntary workers". They are not paid "wages" (which would provide them with some minimum service conditions) but only an "honorarium", which was until recently only Rs.1,000 a month for the worker and Rs.500 for the helper. Even now anganwadi workers do not get more than Rs.2,000 a month in any State.

Despite this very low remuneration, the activities these workers and helpers are required to perform are very extensive. Each anganwadi is meant to provide supplementary nutrition to the children below six years of age, and nursing and pregnant mothers from low income families and immunisation of all children less than six years of age and immunisation against tetanus for all the expectant mothers.

The anganwadi workers are to provide nutrition and health education to all women in the age group of 15-45 years, as well as basic health check-up, which includes antenatal care of expectant mothers, postnatal care of nursing mothers, care of newborn babies and care of all children under six years of age. They are supposed to be able to refer serious cases of malnutrition or illness to hospitals, Community Health Services (CHS) or district hospitals. In addition, the same two workers on their own are to provide non-formal pre-school education to children in the three to five age group.

For all of these, not only are the wages paid to the workers and helper low, but the other resources and facilities provided for undertaking all this work are minimal. Nevertheless, by most accounts, thus far the scheme has been a success, and is counted among the more effective of government programmes. Most studies conducted on the functioning of the ICDS have recognised its positive role in the reduction of infant mortality rate, in improving immunisation rates, in increasing school enrolment and reducing the school dropout rates.

Nevertheless, it is also clear that for a scheme that has been in operation for three decades, the benefits are still far too limited, and maternal and child health and nutrition are still areas of major concern for policy. Even today, around one-third of Indian children - and more than half in rural areas - are born with low birth-weight. More than 30 per cent of children under five years are severely stunted, and around 20 per cent are severely underweight. These indicators are particularly bad in some ostensibly more "developed" and relatively high-income States such as Gujarat, Maharashtra and Karnataka.

The high incidence of premature births, low birth-weight and neonatal and infant mortality can be attributed to poor nutritional conditions of the mothers. The majority of women still do not get proper nutrition and health care during their pregnancy. In some areas, 60-75 per cent of pregnant women receive no antenatal care at all. More than 85 per cent of women in rural areas and 95 per cent in the remote areas give birth at home. Only 42 per cent of women in the country have access to safe delivery facilities. Surveys indicate that even the immunisation services are still less than desired: around 30 per cent of children in the age group of one to two are not adequately immunised.

The main reason for this continuing dismal picture even after 30 years of the ICDS is that not enough resources have been devoted to this scheme to meet the huge requirement. Quite simply, there are not enough anganwadis or anganwadi workers, and they do not have adequate resources to meet all the nutritional requirements of those pregnant and lactating mothers, infants and small children who need them. If the declared norm of one anganwadi per 1,000 population is to be met, there should be 14 lakh anganwadis, as against the current 6.5 lakh such centres, of which only around 6 lakh centres are operational.

There is the further problem of overloading the tasks assigned to anganwadi workers. The worker and helper in such centres who receive the paltry "honorarium" are seen as "part-time workers" in the centres that are supposed to open for only four hours a day. Yet, they have been found to be among the most dedicated and committed of public servants who have developed grassroots contacts and are able to identify particular individuals and groups in any community easily. They are, therefore, increasingly engaged in a wide range of other public interventions,

especially in rural areas, including health mobilisation, total literacy and education programmes. They are called upon to help in election duties, to assist in other public programmes as and when the State or local governments require them. The fact that the woman who was attacked in Madhya Pradesh was involved in a public campaign against child marriage is proof of this.

All this amounts to much more than a full-time activity, yet the anganwadi workers and helpers are hardly compensated for all this. In any case there are simply not enough of them to cater to all of these varied demands even within a small population. The obvious need, therefore, is to increase the number of such workers and to provide them with higher wages that would reflect all the work that they really do perform. In addition, of course, they simply must be provided with the minimum wherewithal required to perform these services in a satisfactory manner.

There are other problems that stem directly from this inadequacy of centres, staff and resources to run this programme effectively. It has been found that one of the primary reasons for poor coverage of needy groups under the scheme is the location of the anganwadi centre, which typically tends to be in the main village or in "upper" or dominant caste hamlets in rural areas in most States. This restricts the access to such services by deprived communities such as the Scheduled Castes and Scheduled Tribes, which are precisely the groups who require it the most.

There are frequent complaints of the delay in Central government transfer of resources for this programme, while State governments differ substantially in the amount and quality of supplementary nutrition that is provided. This makes the scheme uneven and sometimes even problematic in terms of the quality of food provided and its acceptability to small children. Also, the way the programme has been implemented, it effectively ends up concentrating mainly on the three to six age group. There are no facilities to allow for reaching out to such children and their mothers at home in an effective way.

The working hours of the anganwadi centres also effectively keep out many of the poorest households; they are open only for four hours a day. When both parents are working, which is typically the case among rural labour households in many parts of the country, it is difficult to deliver and pick up the child from the centre in time, and so children in such households get excluded from the services. Once again this really boils down to a question of resources, since these centres should be open for longer durations with higher associated expenditure.

But then this would require a change not only in the level of resources provided for these activities, but also a change in the mindset of the government, which still treats the anganwadi workers and helpers as less than full workers even while making more than full use of their services. If we as a society truly value those who are making this crucial input towards the future, then there should be much greater public outcry over the wages and working conditions of the anganwadi workers, and also greater public demands for the rapid and effective expansion of the ICDS.