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Problems Plaguing Anganwadis: A Study of Decentralised Healthcare in Rural India During the COVID-19 Pandemic

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Abstract

Anganwadi workers under the Integrated Child Development Scheme, have time and again proven themselves to be an asset to healthcare development in rural areas. The COVID-19 pandemic pushed them to become frontline workers which translated to their contributions transcending the scope of the scheme. Through this paper, the authors analyse the problems faced by Anganwadi workers in rural India during the pandemic due to inadequate decentralisation of healthcare. This has been achieved through PESTLE analysis to give a holistic understanding of the issue. This paper found that the overarching issue of inadequate decentralisation manifests itself in a myriad of ways. Politically, the implications of erroneous terminology used to define Anganwadi workers coupled with discrepancies between state policies and their execution highlighted their plight. Economically, a shortcoming in the budget, the problematic nature of an honorarium, improper distribution of essential resources and the crippling infrastructure of Anganwadi centres was observed. Sociologically, the gender wage gap, loss of confidence in the Anganwadi institution and the augmentation of malnutrition have plagued the rural areas. Technologically, the issue of a distinct lack of virtual connectedness has hampered the functioning of the Anganwadis. Legally and ethically, the undervaluation of the contributions made by Anganwadi workers is a drawback that needs to be addressed.

Keywords: *anganwadi workers, decentralisation, rural India, honorarium, community female workforce, Integrated Child Development Scheme, Ministry of Women and Child Development*

1.0 Introduction

The Anganwadi institution is highly understudied and their distressed condition awaits proper address from policymakers. The problems faced by Anganwadi workers in rural India have increased during the COVID-19 pandemic due to inadequate decentralisation of healthcare at the grassroots level. The analysis of this paper will be pan-Indian in scope, with a multidimensional assessment of the plight of women working in Anganwadi centres.

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1.1 Defining ICDS and the Anganwadi

The Integrated Child Development Services Scheme (ICDS) is a programme undertaken by the Ministry of Women and Child Development, Government of India. The scheme endeavours to enable the Ministry's various departments to work together in a synchronised and systematic manner to ensure competent policymaking, implementation and integrated distribution of essential needs to all beneficiaries (Ministry of Women and Child Development, 2009). The ICDS currently offers six major services across the country which include:

1. Supplementary Nutrition
2. Pre-school non-formal education
3. Nutrition and health education
4. Immunisation
5. Health check-ups
6. Referral services

Services	Target Group	Service provided by
(i) Supplementary Nutrition	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	Anganwadi Worker and Anganwadi Helper [MWCD]
(ii) Immunization*	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	ANM/MO [Health system, MHFW]
(iii) Health Check-up*	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	ANM/MO/AWW [Health system, MHFW]
(iv) Referral Services	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	AWW/ANM/MO [Health system, MHFW]
(v) Pre-School Education	Children 3-6 years	AWW [MWCD]
(vi) Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO [Health system, MHFW & MWCD]

Fig 1: Services provided by Anganwadi workers and the target groups (Ministry of Women and Child Development,2009)

The Anganwadi is the primary grassroots level institution in tribal blocks, urban and rural areas that facilitates the implementation of all ICDS health, nutrition, and early childhood initiatives. (Ministry of Women and Child Development, 2009). The establishment is a female-only cadre across India (Guruswamy & Kuruganti, 2018).

Key Abbreviations :

AWW: Anganwadi Workers

AWH: Anganwadi Helpers

AWT: Anganwadi Teachers

AWC : Anganwadi Centers

AOD : Anganwadi on Demand

Sr. No.	States/ UTs	No of AWC Visited	Observations											
			Space for AWC				Supplementary Nutrition				Drinking Water			
			Adequate		In Adequate		Provided		Not Provided		Available		NA	
			No. AWC	(%)	No. AWC	(%)	No. AWC	(%)	No. AWC	(%)	No. AWC	(%)	No AWC	(%)
1	AP	30	28	93.3	2	6.7	30	100	0	0.0	28	93.3	2	6.7
2	Assam	30	23	76.7	7	23.3	30	100	0	0.0	12	40	18	60
3	Bihar	30	17	56.7	13	43.3	24	80	6	20	28	93.3	2	6.7
4	DN&H	10	8	80	2	20	10	100	0		10	100	0	0.0
5	D& Diu	10	9	90	1	10	10	100	0	0.0	10	100	0	0.0
6	Delhi	30	6	20	24	80	30	100	0	0.0	27	90	3	10
7	Gujarat	30	17	56.7	13	43.3	30	100	0	0.0	30	100	0	0.0
8	HP	30	17	56.7	13	43.3	30	100	0	0.0	30	100	0	0.0
9	Karnataka	30	17	56.7	13	43.3	30	100	0	0.0	29	96.7	1	3.3
10	Kerala	30	17	56.7	13	43.3	30	100	0	0.0	29	96.7	1	3.3
11	Maharashtra	30	19	63.3	11	36.7	30	100	0	0.0	28	93.3	2	6.7
12	MP	30	20	66.7	10	33.3	30	100	0	0.0	18	60	12	40
13	Odisha	30	20	66.7	10	33.3	30	100	0	0.0	30	100	0	0.0
14	Puducherry	10	3	30	7	70	10	100	0	0.0	9	90	1	10
15	Punjab	30	23	76.7	7	23.3	30	100	0	0.0	14	46.7	16	53.3
16	Rajasthan	30	20	66.7	10	33.3	29	96.67	1	3.3	28	93.3	2	6.7
17	Tamil Nadu	30	15	50	15	50	30	100	0	0.0	29	96.7	1	3.3
18	UP	30	1	3.3	29	96.7	30	100	0	0.0	27	90	3	10
19	West Bengal	30	21	70	9	30	30	100	0	0.0	24	80	6	20
State/UTs above		**510**	**301**	**59.0**	**209**	**41.0**	**503**	**98.63**	**7**	**1.4**	**440**	**86.3**	**70**	**13.7**

Fig 2: Provisions of space for AWCs, supplementary nutrition and drinking water in the following states. (Programme Evaluation Organization, 2015)

1.2 The COVID-19 Pandemic

Coronavirus (COVID-19) is a disease caused by severe acute respiratory syndrome coronavirus 2 (SaRS-COV2) (Hainaut, 2021). The first case for COVID-19 was identified in Wuhan, China which spread to the rest of the world, resulting in an ongoing worldwide pandemic (World Health Organisation, 2020). Due to the sudden and intensive spread of COVID-19 globally, the government of India declared a lockdown on 24th March 2020 as a preventive measure to curb the rising cases (Nijhawan, 2020). However, India has witnessed two significant waves since then. As a result, many institutions in the urban and rural areas were temporarily closed down, which had a significant impact on several critical services, one of them being Anganwadi centres in the rural areas.

1.3 Functioning and Roles: Before and After

According to the *Integrated Child Development Scheme* (Department of Administrative Reforms and Public Grievances, 2017), some of the roles and responsibilities of the Anganwadi workers before the COVID-19 pandemic included community support and participation in running the programme. They were expected to make home visits and carry out surveys of families in their areas once a year to educate parents, specifically mothers, to ensure an effective role in the child's growth and development. Anganwadi workers' essential duties were organising informal preschool activities for children between the ages 3 and 6 and organising nutritional feeding for children between the ages 0 and 6 and nursing mothers. The Anganwadi workers also provided counselling to young mothers and informed married women about the importance of family planning. They had to maintain files and records as per their duties and were also required to guide ASHA workers employed under the National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme (Integrated Child Development Services Chennai Head Office, 2019).

Activity	Mean hours (range)
Pre-school education	14.6 (6-24)
House visits and surveys	9.5 (1-18)
Record-keeping	5 (3-12)
Supplementary food distribution	3.8 (3-6)
Health education to women	3.5 (0.17-6)
Meetings	2.3 (0.5-8)
Health check-ups	1 (0.17-6)
Immunization	0.72 (0.25-2)
Growth-monitoring of children	0.68 (0.5-6)

Fig 3: Hours per week spent by Anganwadi workers on duties (Kamath et al., 2014)

In light of the pandemic, the Anganwadi centres were given additional responsibilities. They conducted surveys and door-to-door visits to conduct contact tracing as part of the community surveillance of the COVID-19 virus's spread. Furthermore, AWWs have conducted testing drives, raised awareness about precautions behaviour, and are currently monitoring the immunisation process for the inoculation of the virus. Since the AWCs were closed during the first and second waves, AWWs are delivering all necessities to registered children's homes, supplying provisions to lactating and pregnant women, PDS rations to villages, and necessary medicines to COVID-19 patients. Anganwadi workers have also set up quarantine facilities for all returning migrants (Mathur, 2021).

1.4 Issues Faced Before the Pandemic

While this paper talks about the conditions of the Anganwadi workers during the COVID-19 pandemic, it is important to note that they faced a lot of obstacles in the smooth running of the Anganwadi centres before as well. Some of the major problems included but were not limited to infrastructural issues, insufficient water, electricity and drainage supply. They also faced complications due to the meagre honorariums they received along with the delay in receiving funds

from the government in the first place. The Anganwadi workers also voiced their concerns with the excessive burden of the job which included maintaining many records of immunization, health check-ups, nutritional services etc. (Joshi, 2018)

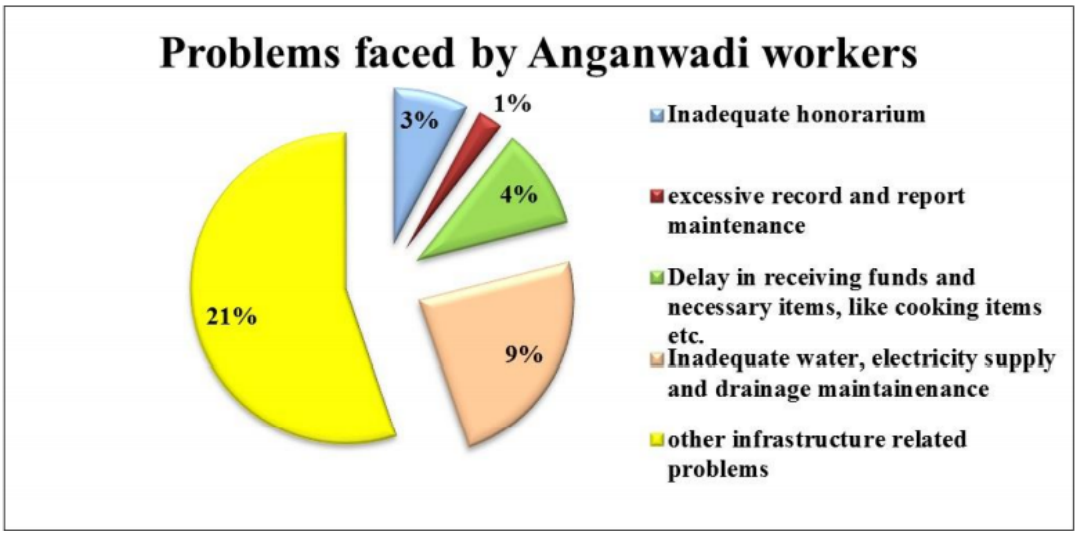

Fig 4: Representation of problems faced by the Anganwadi workers (Joshi, 2018)

1.5 Literature Review

"Perceived responsibilities and operational difficulties of Anganwadi workers at a coastal south Indian city", explores the perceived responsibilities, operational difficulties, workload, and satisfaction of the Anganwadi workers in the region of Mangalore, India (Kamath et al., 2014). The data in this study suggests that the Anganwadi workers perceive their responsibilities to be bounded to pre-school surveys, house visits/surveys, and hence, the amount of time spent on these activities was higher. An important observation to be made here is that despite immunization, supplementary nutrition, health check-up, referral services, pre-school non-formal education, nutrition, and health education being their primary roles as stated by the ICDS department, the Anganwadi workers gave less priority to immunization, monitoring the growth of children, and health checkups (Kamath et al., 2014). The disregard of these tasks and a general misperception of the work of an Anganwadi worker negates the objectives of the ICDS program.

A study on "The factors influencing the performance of community health workers" (John et. al, 2020) found a knowledge and evidence gap on how to support the Community Health Worker (CHW) to ensure the quality of such programs, as well as on the factors that influence their performances. Through this study, the researchers identified three broad factors affecting the performance of the Anganwadi workers: the individual factors such as financial reasons and support of the family, programme factors that include work environment and the services preferred by the AWWs; community factors including caste dynamics and communal and seasonal migration; and organizational factors include corruption. The findings of the study, however, fail to consider the impact of the Coronavirus pandemic on the working conditions of the Anganwadi workers.

The report *Response to COVID-19 by the Anganwadi ecosystem in India* (Poddar & Mukherjee, 2020) analyses the future repurposing of the Anganwadi. While this article talks about the different initiatives taken by the government, it does not explicitly highlight the shortcomings of these policies resulting in hardships for the workers. The measures stated to ensure that the Anganwadi ecosystem can adapt to the pandemic, although valid and pertinent, do not keep the ground reality of the current state of this scheme in mind. The current digital divide and rampant illiteracy in rural India are two key factors that need to be considered.

"A circle of fire: a study on rural Anganwadi workers during the COVID-19 pandemic" assesses the socio-economic and demographic profiles of 100 Anganwadi workers in the Arambagh block of the Hooghly district (Sengupta & Pal, 2021). Results showed a lack of social and occupational safety nets amongst workers. Only a small fraction of workers were satisfied with their jobs, and even fewer had gotten specific training on a regular basis. It was emphasised that Anganwadi workers require adequate nutrition-related training and other essentials at a low cost, as well as adequate attention to their needs. The need for the government to ramp up its engagement with grassroots level frontline workers and empower them was also highlighted. One of the most important themes of the research was the lack of adequate remuneration and funding. While the study has stated the

caste composition of its respondents, it does not provide any information on the implications of caste inequalities in the Anganwadi in the context of the pandemic.

Peering into complicated yet unrecognised roles of the Anganwadi Workers (Gulati, 2020) is a case study of Jammu and Kashmir. Deprivation from benefits, AWC accommodations being subpar, bureaucratic corruption and the negative impact of gender identity were significant findings. Cross and co-learning policies were recommended along with mother support groups, strengthening of teacher banks and kitchen gardens. The paper explicitly states that the current literature lacks adequate assessment of CHW programmes and that most studies have focused on the northern region of the country, which further creates a knowledge gap.

However, with a special emphasis on the states of Bihar and Telangana, the study conducted on "High Risk without Recognition: Challenges faced by the female front-line workers" (Sinha et al., 2021) gives us a comprehensive insight into the southern region of India while also contrasting it with the North. The findings in this paper make it clear that despite the workforce facing similar problems in their respective regions, the situation in Telangana was better as opposed to Bihar in terms of health and nutrition levels, the standard of living, education, and work conditions. It throws light on the overworking and exhaustive nature of their work before and during the COVID 19 pandemic.

"India: the dual battle against undernutrition and COVID-19" is an article published by the World Bank (2020) that gives an insight into the change in the functioning of the Anganwadi during the pandemic, including infant feeding practices and tackling hunger and undernourishment. The article relies on both government sources as well as workers' testimonials; however, it does not shed any light on the difficulties that the workers face. The NDTV article "The Unsung Heroes of India's Primary Healthcare: The Anganwadi workers and ASHAs"(Mathur, 2021), on the other hand, has reported testimonials of challenges that the workers face daily. Overburden of additional duties, lack of adequate protective gear and social security, insufficient income and working environments were essential findings.

1.6 Methodology: PESTLE Analysis

PESTLE analysis is a tool used in research to analyse the various external macro factors influencing a particular institution. The acronym stands for Political, Economic, Social, Technological, Legal and Environmental. A PESTLE analysis is used as an overview to understand the external factors that affect the functioning of an institution. For this paper, an analysis will be done on problems faced by Anganwadi workers from a Political, Economic, Social, Technological, Legal and Ethical vantage, a slightly modified version of the PESTLE framework. Our focus here will be the macro environment of the AWWs and its implications in magnifying the gaps and cracks in the healthcare system in rural areas.

2.0 PESTLE Analysis

2.1 Political Aspect

The Ministry of Women and Child Development's nomenclature for defining Anganwadi workers leads to their exploitation. Anganwadi workers, according to the ICDS, are part-time, voluntary, honorary social workers who can not be assigned to a permanent civil position. The women, on paper, are supposed to work for only six hours a day; however, the additional roles and responsibilities in the case of the pandemic amounts to a full day's work (John et al., 2020). In Bihar and Telangana, 60% of the AWWs are working for more than seven hours a day (Sinha et al., 2021). Due to their employment status, Anganwadi workers are denied "government benefits" like the "provident fund" and "Pension ESI cards" (Chaudhary, 2018). Therefore the definition stated in the scheme allows the state to evade taking responsibility for including these women in the formalised workforce as government employees.

While the state attempted to provide insurance coverage for rural community healthcare workers through the 'Garib Kalyan Package Insurance Policy', Anganwadi networks in Andhra Pradesh alleged that only the families of 10 out of 150 workers who died, received the life insurance money (Johari, 2021). This points to a larger issue of inadequate execution of provisions and schemes on the part of the government and the adverse effects it has on the Anganwadi institution. Even before the

pandemic, "provisions of insurance and maternity leave" as well as incentives were not even informed to the workers (Chaudhary, 2018). Discrepancies between what the government claims and the policy's implementation has also been noted in the absence of sufficient training of the AWWs during the lockdown. Although the state is alleged to have conducted online coaching for AWWs, testimonials have been recorded contrary to this. For example, workers claimed to have received no instructions on how to help victims of abuse when a significant spike in the same was observed during the lockdown (Nigam, 2020). Periodic training during the lockdown also did not occur in Odisha, hampering the AWWs from properly disseminating information about the virus (Bauza et al, 2021). Such gaps in policy reduce the effectiveness of the Anganwadi.

Faults in policy stem primarily from a lack of a medium through which AWWs can express their opinions as they are largely excluded from the decision-making process. A major lack of transparency in the allocation of provisions by Panchayats and District magistrates undermines the AWW's ability to help rural areas curb the spread of the virus, even though they are considered integral to the Samiti. The Samiti in Odisha expressed "not being kept in the loop regarding decision making, administrative and fiscal roles" (Sahoo & Kar, 2020). Jammu and Kashmir saw widespread protests by the Anganwadi workers when the state put the gram panchayats in charge of honorarium as "the women's force were against being led by unknown men"(Gulati, 2020). Due to their inability to express their grievances, the Anganwadi workers' needs are seldom materialised or translated into legislation.

Table 6: Equipment or training received to face the pandemic

Equipment received to face the pandemic	*No of AWWs*
Mask	*87*
Sanitizers	*81*
Others Protective gear	*54*
Counseling or training about new duty	*22*

Fig 5: In the survey conducted among 100 respondents, "above 10 % felt the problem of adequate masks and sanitisers, only 54% obtained other protective gear, and only 22% of our respondents were trained and counselled to take up the new challenge" (Sengupta & Pal, 2021)

2.2 Economic Aspect

One of the key objectives of the ICDS programme is to encourage decentralisation in order to establish community-based and locally responsive childcare. The goal here is to strengthen AWCs as the village's primary healthcare and education provider (Department of Administrative Reforms and Public Grievances, 2017). The process of decentralisation has however seen a setback with the budget for 2021-2022, which introduced Poshan 2.0, an umbrella initiative that encompasses the ICDS and Anganwadi networks, the Roshan Abhiyan, and other initiatives. This overarching scheme has been allotted a total expenditure of 20,105 crores (Barnagarwala, 2021), which is 400 crores less than the 20,532 crores that were granted solely for the Anganwadi in the 2020-2021(“Activists Slam”, 2021). Keeping in mind the overburden of duties on the Anganwadi during the pandemic, this cut in expenditure will deepen the cracks in the system and augment the plight of the beneficiaries as well as the workers.

The lack of fixed payment and poor rate of remuneration coupled with unpaid extra hours of work is a major cause of economic insecurity and distress amongst Anganwadi workers. Due to their voluntary status, AWWs are given an ‘honorarium’ instead of a salary. This amount is usually below the minimum wage and does not adequately compensate workers for additional duties that they are expected to perform. For 2021, The Ministry of Women and Child Development has decided to peg the honorarium at ₹4,500 and ₹3,500 per month for workers of main and mini AWC’s respectively. AWHs are to receive ₹2,500 (PIB Delhi & Ministry of Women and Child Development, 2021). Many Anganwadi workers have complained of being “overburdened by Booth Level Officer duties and surveys that do not fall under ICDS"(Chaudhary, 2018), and are not receiving an “extra wage for COVID-19 related duties” (Mathur, 2021). Working overtime with an insufficient income has made it extremely hard for AWWs to support themselves and their families.

Child mortality, malnutrition, and food insecurity are expected to rise in India, according to UNICEF and WHO, and evidence shows that the situation has worsened as a result of the pandemic (“Activists Slam”, 2021). Despite this, this year's nutrition funding was cut by 1,000 crores in the

2021-2022 budget (Barnagarwala, 2021). Improper distribution of provisions and resources for children, women and COVID-19 patients by the state has left the Anganwadi unprepared to protect the rural population and a lack of basic essentials will lead to a deficit in their welfare. Furthermore, negligence in providing adequate protective gear for the AWWs puts them in danger of contracting the virus and increases the risk of escalating the transmission rate, especially in underdeveloped areas. The Anganwadi Karamchari association in UP claimed that workers were not given any medical resources during the second wave (Rashid, 2021). AWWs in Jammu and Kashmir were not provided with any PPE kits even though they were made to come in contact with infected people (Gulati, 2020). Karnataka, West Bengal, Punjab and Maharashtra saw protests by AWWs after being placed in the "least-risk category"(Majumder, 2020). To alleviate the shortfall, officials urged AWWs to mix water with sanitisers, and workers eventually had to pay for more sanitisers out of their own pockets (Mathur, 2021). Punjabi workers had no choice but to sew their own masks (Vasudeva, 2020). Compromising sanitation and medical facilities because of poor allocation of essentials puts the rural areas in great danger.

This year's budget has no specifications for the ICDS or the operation of the Anganwadi. Because of this ambiguity, it is unclear how the issue of the institution's crippling infrastructure will be addressed. Before the pandemic, basic infrastructure in terms of accommodation was insufficient, but as the need for quarantine facilities in rural areas became critical, and as migrants left cities and returned home, the necessity to develop a better strategy for accommodation became critical. Over 97 per cent of the Anganwadi centres in J&K during the COVID-19 pandemic are running from rented accommodations, only 48% have drinking water facilities while only around 44% have toilets(Gulati, 2020). Workers in Uttarakhand and Odisha have expressed their concern over congestion in the AWCs and in some parts of Andhra Pradesh, workers pay for the rent of these centres from their own income (Gulati, 2020). There is no proper mechanism in place to distribute basic requirements to remote communities, demonstrating a serious divergence between rural and urban areas, as well as a major disconnect between policymakers and frontline workers. Anganwadi

centres in remote parts of Uttarakhand face several "challenges due to its geographical conditions" with "no road connectivity" (Mathur, 2021). Anganwadi workers from remote areas are expected to buy all required rations from the money that the government transfers to their bank accounts due to a lack of connectivity (Mathur, 2021).

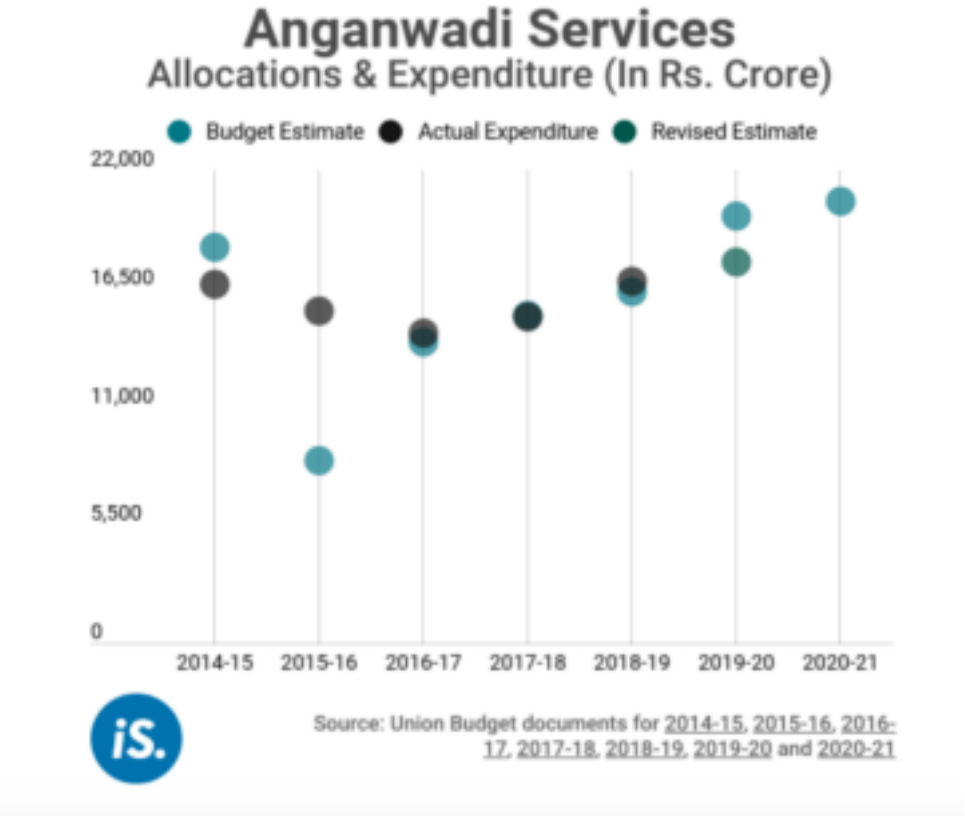

Fig 6: "Allocation not enough to offer higher compensation to AWWs across the country" (Pant & Ambast, 2020)

2.3 Social Aspect

The Anganwadi workers - who bear the excessive burden of the job as well as the lack of acknowledgement and stable income from the government - consist of only female workers. The employment of women by the government in this sector was aimed to improve their participation in the Indian labour force. However, it is important to note that the perception of women labour in

society played a big role in this decision-making process. Patriarchy impels its people to believe that it is a woman's inherent duty to provide unpaid care and labour devoid of any monetary value, thereby, making it easy to underpay them. According to a testimonial given by a union leader, (Krishnan, 2020), "organizers of noon meals in schools and Anganwadi teachers receive the same salary." The former, which include men, work a four-hour shift while the latter are entrusted to carry out a multitude of responsibilities over the course of a full working day. This throws light on the country's deep-rooted patriarchy which has led to the gendered separation of work along with the depreciation of women's labour and an even wider gender gap in wages. These factors essentially play into the lack of recognition they receive from the government as well as the society at large

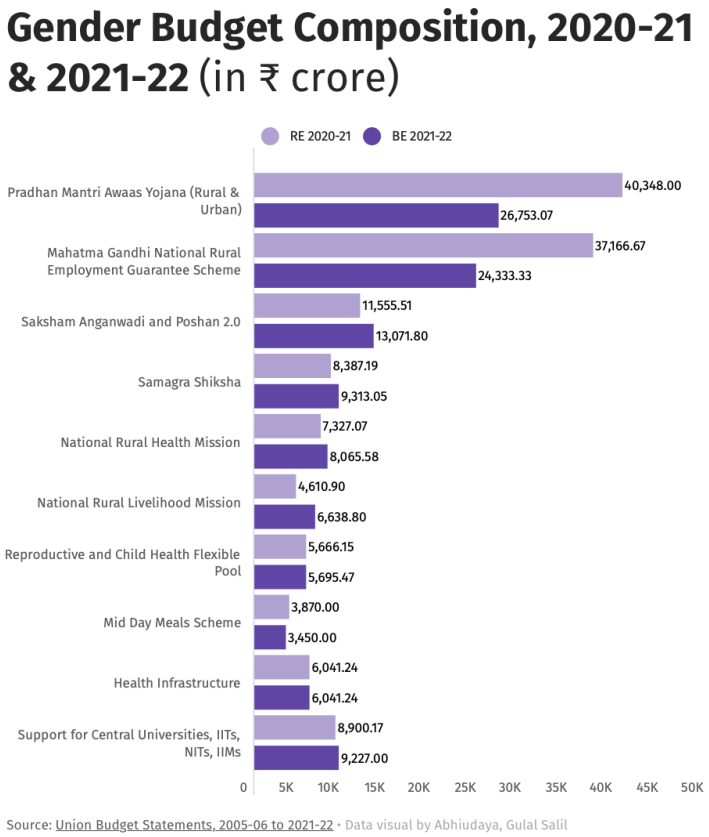

Fig 7: Gender budget composition 2020-21 and 2021-22

Childcare and elderly care services, under the National Creche Scheme, were combined with the Saksham Anganwadi and Poshan Scheme 2.0 in 2021-22, therefore a separate division was not provided. (Nikore et al., 2021) The closure of Anganwadi centres has deprived pregnant and lactating women along with children of an alternative source of food and has augmented the cycle of malnutrition as in times of acute food shortage; patriarchal norms force women to restrict their intake for the rest of the family (Dutta et al., 2020).

During the COVID-19 pandemic, the closing of the Anganwadi centres and the erratic availability, inadequate quantity, and low quality of food supplies have severely impacted the vulnerable families (Menon et al., 2021). To ensure the regular supply of nutrients for the ICDS beneficiaries, the Anganwadi workers had to resort to delivering the food directly to their houses. However, during the lockdown, this posed new problems for the Anganwadi workers due to the distrust of the community members in their work. A testimonial given by an Anganwadi worker stated that even though they "are getting insufficient ration from the state" the people of the community think that the workers "are not distributing and are either selling it off in the market or consuming it" (Mathur, 2021). The lack of confidence in the Anganwadi workers is hampering their ability to help the rural areas meet their nutritional needs (Mathur, 2021).

The lack of support displayed by the community members in the Anganwadi workers can be assessed from a caste vantage. Caste-based segregation is still prevalent in rural areas. In the context of the Anganwadi workers, their work demands them to cover areas where they tend to the needs of people from multiple caste groups. Upper caste communities do not appreciate the services from the Anganwadi workers belonging to lower castes. Similarly, Anganwadi workers from Upper castes struggle to satisfy the needs of the lower caste communities. In a study conducted by Krishnan (2020) it was found that people from upper caste and OBC communities sometimes choose to not send their children to an Anganwadi located in a Schedule Caste (SC) neighbourhood or to an Anganwadi where the teacher or helper belongs to the SC community.

Now, with the risk of COVID-19, community support has further decreased. Due to the risk of getting infected with the virus, there is a deep sense of fear around the home visits made by the Anganwadi workers. Stigmatization and even physical abuse have been reported to many community health workers, including AWWs during the pandemic. (Behera et al., 2020)

2.4 Technological Aspects

Many Anganwadi workers from remote areas of rural India are struggling due to a lack of virtual connectedness, especially during the pandemic. A shortage of network towers in isolated tribal areas makes it difficult for workers to perform their duties as they find themselves disconnected from any updates on their honorariums and meetings. Regions such as Bhivalpada in the Ase village of Mokhada Taluka do not even have a cellphone tower (Ghatge, 2020). In an article written by Shraddha Ghatge (2020), an Anganwadi worker stated that they have to “climb up a hill to talk to the supervisor” to “upload data on a Common Application Software (app) which is compulsory."

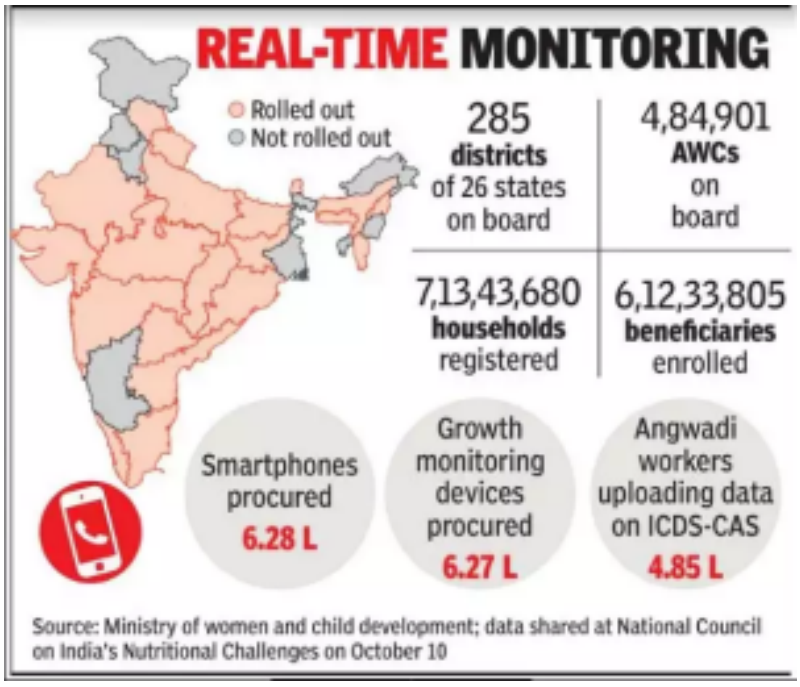

Fig 8: The government of India took an initiative to link all Anganwadi centres to a nutrition dashboard known as the Common Application Software (app) in 2019. However, the implementation has been unsatisfactory as seen during the pandemic (Pandit, 2019)

The issue further translates to inaccessibility to smartphones. While there have been initiatives such as the Kejriwal government's scheme to equip the rural areas with smartphones, their implementation has not been satisfactory(Alam & Afroz, 2020). During the lockdown, states like Delhi and Madhya Pradesh called for the Anganwadi workers to "mark the attendance" of the children every morning by "sending live locations and photographs on WhatsApp groups." (Chaudhary, 2018). Those who did not have access to smartphones were asked to "borrow from the neighbours or buy it". (Chaudhary, 2018).

2.5 Legal Aspect

The Supreme Court issued a judgement in 2021 mandating all states to reopen their Anganwadis after the National Human Rights Commissions urged that the institution be recognised as an essential service(Tripathi, 2021). Despite the Anganwadi network being categorised as an indispensable service, the need to pay its workers a minimum wage has been neglected.

The AWW's union filed a case in Karnataka demanding a minimum wage back in 2014. The Supreme Court withheld the government's argument of the Anganwadi workers holding a voluntary and honorary status (Mitra & Sinha, 2021). Not acknowledging the additional duties carried out by AWWs, the extra hours they work, and snatching away their rightful position as an employee based on a mere technicality of definition undermines their right to employment and excludes them from the purview of The Minimum Wage Act, 1948. Keeping the manifold increase in the AWWs' duties during the pandemic in mind, the employment status of these workers needs to be reconsidered. In Bihar, the income that Anganwadi workers and helpers receive is currently lower than that of unskilled manual labour under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) (Mitra & Sinha, 2021). Anganwadi workers fall under the 88% of women in India who are employed in the informal sector (Mitra & Sinha, 2021). However the Code on Wages 2019, and its commitment towards "equal pay for all genders" only includes the formal sector (Sahgal, 2019). They, therefore, do not come under the sphere of its legislation.

2.6 Ethical Aspect

The arguments raised in the preceding research shed light on the grave injustices that Anganwadi employees have been suffering from throughout the pandemic. These women and the centres they work for are not adequately supported by the state fiscally and have virtually no platform to express their grievances in the public domain. Downscaling the ICDS endowment and virtually no money being allocated towards these women in our budget is incredibly disrespectful to them as frontline workers, especially in the face of the pandemic. The service they are providing to curb the spread of the virus is outside of the sphere of the work that is expected of them, and they are currently not getting remunerated for any of it. It is unjustified to compensate them for an essential and skilled service with an honorarium that is below minimum wage. Undervaluing the health care service provided by these women in rural areas "implicitly signals to the market" to sustain the gender pay gap (Kasliwal, 2020). This kind of disregard for the Anganwadi shows an inconsistency in their policies and claims of empowering women.

3.0 Recommendations

First and foremost, the government needs to recognize the Anganwadi workers for all their work. The Anganwadi institution needs formalization, and the workers need to be given the status of government employees. It is necessary to ensure that these workers are given appropriate nutrition-related guidance, equipment and resources, and access to medical facilities and supplies. They require satisfactory rest, mental support, family protection, recognition, and rewards to make AWWs provide adequate care. On a larger scale, there is an immediate need to conduct extensive primary research to bridge the knowledge gap and understand the on-ground reality. This data is essential to carry out fair and just policymaking.

4.0 Conclusions

By holding onto the erroneous nomenclature that these women work part-time and voluntarily, the state perpetuates a false narrative far from reality. The ramifications of this problem in policy can

be seen in the inability of the workers to sustain themselves with the meagre income they receive, no benefits or safety schemes and provisions, and social insecurity and unrecognition. Due to a significant exclusion from decision making as the lack of support from authorities at the central, state and local levels, Anganwadi workers have to grapple with issues that the centres face independently. Management of poor infrastructure, working around the absence of a proper goods distribution network or insufficient road connectivity and dealing with the inadequate access to medicines, food and other resources are all issues that Anganwadi women have to solve independently. Identifying the Anganwadi as an institution providing an essential service is a step in the right direction towards giving these women a voice and recognizing their need to be supported. The necessity of formalizing the Anganwadi workforce is a critical issue that still must be addressed. There is a dire need to view the state of the Anganwadi workers through an intersectional lens, taking into factors such as gender and caste to alleviate the impacts of the patriarchal notions of society and their influence on the recognition of these workers. Problems such as the lack of food security and community support during the COVID-19 pandemic led to a social strain in the communities that the Anganwadi workers served. During the lockdown, the Anganwadi centres in remote areas grappled with the lack of virtual connectivity due to the scarcity of network towers and isolation from the urban areas. The growing importance of the Anganwadis during the pandemic needs to be taken into consideration and addressed in state policies. The strengthening of grassroots level health is vital to ensure the welfare of rural India in the coming years.

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