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# Daycare, Decision-making, and the Determinants of Health: A Mother-centric Approach to Understanding Childcare and Child Health in Rural Dharamshala

Arielle Rawlings  
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DAYCARE, DECISION-MAKING, AND THE DETERMINANTS OF HEALTH:  
A MOTHER-CENTRIC APPROACH TO UNDERSTANDING CHILDCARE AND CHILD  
HEALTH IN RURAL DHARAMSHALA

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SIT Study Abroad

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## ABSTRACT

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Indian children have long suffered from some of the world's worst rates of malnutrition. However, there is an evident mismatch between the macro proliferation of India's inter-generational cycle of malnutrition and the micro ways in which it is often approached, as established views that place blame on mothers for the poor health status of their children have systematically removed blame from underlying structural determinants of health such as government policies, social inequalities, and economic conditions. Taking a mother-centric approach, this study examines the links between childcare practices and maternal decision-making in the context of Dharamshala, Kangra District, Himachal Pradesh. Interviews were conducted with mothers in rural Dharamshala to gain a complete understanding of their childcare decision-making in their respective contexts, as well as with frontline Anganwadi workers, health workers, and staff members of an NGO working for women's well being in the area. Results indicate that child health outcomes are profoundly impacted by restraints and responsibilities placed on mothers in the rural, agrarian context, and that the provision of affordable and accessible childcare services through the Integrated Child Development Services program and at government-managed worksites is critical to lessening this burden and successfully ameliorating child health inequalities.

## INTRODUCTION

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Despite staggering economic growth over the past few decades, India has seen very little improvement in its massive incidence of child malnutrition. The connections between the macro-economic conditions of the country, which are rapidly changing as one of the fastest growing major economies in the world, and India's alarmingly poor child health outcomes are profound and have heavy implications for the future: persistent under-nutrition is a major obstacle to human development, and given its impacts on health, human-capital, education, and productivity, a major barrier in the pathway to sustained economic progress.

However, there is an evident mismatch between the large-scale proliferation of India's inter-generational cycle of malnutrition and the family-focused ways in which it is often approached in the public health context. When it comes to addressing poor child health outcomes, especially among poor and marginalized groups, "blame and liability directed at women as mothers occurs from the very moment of their infant's conception, and continues throughout the pregnancy and the child's life." Through this mechanism, individual "mothers become held responsible for the actions, behavior, health, and well-being of their children" in a way that systematically removes blame from underlying structural determinants of health such as government policies, social inequalities, and economic conditions.<sup>1</sup> This is especially true when it comes to child health outcomes related specifically to nutrition, as understandings of the importance of breastfeeding for physical and psychological development place expectations on resource allocation, value systems, and routine practices that in most cases rest solely on the biological mother of a young child. In India, with its dual histories of widespread child

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<sup>1</sup> Debra Jackson and Judy Mannix, "Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming," *International Journal of Nursing Practice* 10, no. 4 (2004): 150-158, accessed March 3, 2017, doi: 10.1111/j.1440-172X.2004.00474.x.

malnutrition and rigid, gendered family structures, the incidences of both implicit and explicit “mother blaming” surrounding child health are even more evident.

Under the aegis of the Department of Women and Child Development, the government of India adopted the National Nutrition Policy (NNP) in 1993 to provide formal guidelines on infant and young child feeding. This targeted effort to “trigger appropriate behavioral changes among mothers” was considered under the NNP to be a “direct intervention for reducing child malnutrition in India,” and focused on educating mothers on empirically determined “best practices” surrounding infant feeding, nutrition, and health-seeking behavior.<sup>2</sup> Since then, India has come to adopt *National Guidelines on Infant and Young Child Feeding* that specifically direct mothers to initiate breastfeeding as early as possible and exclusively breastfeed their children for the first six months, then introduce complementary foods thereafter with continued breastfeeding up to the age of two years or later.<sup>3</sup> For the purposes of understanding maternal decision-making surrounding childcare and child health within this context, the later stage of a young child’s life—from six months until toddlerhood—is particularly interesting because, even within the National Guidelines, there is immense room for variation: for how long will a mother engage in complementary feeding? What types of food will she feed to her children in addition to breast milk? What will be the frequency of feeding? Will others make these nutritional determinations beside herself?

The point at which a child stops exclusively breastfeeding is a turning-point when it comes to his or her childcare; when a child begins to consume other foods besides breast milk, they become able to receive necessary sustenance from individuals other than just her mother—

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<sup>2</sup> Ministry of Human Resource Development, Department of Women and Child Development, Government of India, “National Guidelines on Infant and Young Child Feeding,” 2004, accessed March 3, 2017, [wcd.nic.in/sites/default/files/nationalguidelines.pdf](http://wcd.nic.in/sites/default/files/nationalguidelines.pdf).

<sup>3</sup> Ibid.

say from other family members, friends, or childcare workers. This point in a child's life is perhaps less pronounced in other contexts such as in the developed West, where breast milk-pumping is common, professional childcare more readily available, and male members of the family more involved in childcare-related responsibilities due to a variety of cultural, economic, and historical reasons. However, in the Indian context—especially in rural areas like Himachal Pradesh—a child's biological mother is near-invariably required to be around when the child needs to eat if that child is consuming exclusively breast milk. This is multiplied by a variety of constraints placed on rural Indian women: a lack of access to childcare, especially for young children, a pronounced lack of male participation in childcare, and crippling levels of poverty. The deep links between the context in which a mother exists and the health status of her children are evident.

As a result, when a mother begins to introduce other foods into her child's diet, she is often faced with more options when it comes to childcare. This is not to say that the aforementioned constraints disappear—she is of course still faced with financial strain, limits on her time, and expectations placed upon her as a female, a wife, and a mother. However, the fact that other individuals can provide necessary sustenance to her children allows for a new autonomy in her life, even if the degree of that autonomy is limited.

Childcare decision-making has clear and lasting implications for child health. First, the thoroughness, amount, and quality of the care itself is an important part of ensuring that the child is safe from harm, healthy, and receiving adequate affection and attention. Young children require full-time monitoring not only to protect them from basic hazards and health risks, but to promote their long-term social, emotional, and physical development. In this way, care during early childhood not only impacts the health of a child when they are young, but long into later

childhood, adolescence, and adulthood. Second, a child's health status is intrinsically linked to the childcare they receive through their diet, as they are wholly reliant on a caregiver to determine the type of food they eat, the timing and frequency of their meals, and the source from which the food is provided. Because child malnutrition is so widespread, this is especially important to investigate in the Indian context. And third, child health is indirectly linked to childcare through the ability of the child to receive professional medical attention. If a child requires immunizations, they also requires a care provider to take them to the local dispensary; similarly, if a child has a medical emergency, they are reliant on a responsible individual to notice the event, interpret it as an emergency, and take them to receive immediate care.

In these ways and others, studying childcare practices based around the lives and decisions of mothers becomes wholly necessary in the study of child health. However, this perspective seems conspicuously absent in public health approaches to addressing child health inequities. Simply examining health conditions alone will not improve the health status of children; instead, we must examine child health within the larger social, economic, and cultural context that inequities are perpetuated within, both for children and the mothers who care for them.

This study aims to do exactly that—by taking a holistic approach to understanding child health and wellness that acknowledges its inherent links to maternal decision-making, investigates the policy landscape and the provision of state-provided services, and takes into account socio-economic conditions and constraints. Taking a mother-centric approach, this study acknowledges the fundamental relationship between the health outcomes of children and the lives of their mothers that exists in all societies, but especially in ones that are hierarchical, patriarchal, and resource-limited. By studying the links between childcare practices and maternal

decision-making in the context of Kangra District, Himachal Pradesh, this study aims to move public health approaches to child health away from misplacing blame on mothers and towards an analysis that acknowledges the systematic ways in which child health is determined by societal structures more broadly: the economic context of the rural Indian village, conceptions of family, women, and motherhood, and the state policy landscape. This approach is critical to addressing the root causes of child health inequities, both in the context of Dharamshala and in the rural Indian village more generally, and aids in an analysis of the current policy landscape of state-provided services related to child health and rural poverty—providing a framework to situate future directions of social, cultural, and policy reform.

## BACKGROUND

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### *Dharamshala, Kangra District, Himachal Pradesh*

A small hill state located in the Western Himalayas, Himachal Pradesh is one of the fastest growing states in India. Agriculture is the main occupation and the main source of employment for individuals living within the state, as 90 percent of the state's population lives in rural areas.<sup>4</sup> Due to lack of alternative options, subsistence farming is supplemented with certain common cash crops and short-term wage labor. Males of the family often migrate to more urban areas of India in search of menial labor work and leave women behind to look after their homes, farms, and families.<sup>5</sup>

Within Himachal Pradesh, Kangra is the biggest district population-wise and makes up a particularly hilly region of the state. The terrain can be difficult to cultivate, and thus much of Kangra is covered with uniform patches of barren land. Within this hilly economy, it is estimated that more than 80 percent of the field work in agriculture—including sowing, harvesting, post-harvest management, and animal rearing—is done by women.<sup>6</sup> In Dharamshala, an area of Kangra District that provided the context for this study, men's participation in farm work is much more variable, and generally based on seasonal fluctuations around plowing and harvesting. Some men in the region also migrate to supplement the family income during the farming off-season. By contrast, women's involvement in agriculture is continuous. As one woman joked, “the farming “off-season” [...] hmm, I don't know of such a thing.”<sup>7</sup> Her tone was sarcastic, but the sentiment of her words speak to a truism of life in rural Himachal Pradesh: in

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<sup>4</sup> Directorate of Economics and Statistics of Himachal Pradesh, “Himachal Pradesh State Report,” April 2017, [www.ibef.org/states/himachal-pradesh.aspx](http://www.ibef.org/states/himachal-pradesh.aspx).

<sup>5</sup> Ibid.

<sup>6</sup> Rashtriya Krishi Vikas Yojana, “Women Empowerment in Agriculture,” [rkvy.nic.in/static/download/RKVY\\_Sucess\\_Story/Himachal/Women\\_Empowerment\\_in\\_Agriculture-HP\\_revised\\_240212.pdf](http://rkvy.nic.in/static/download/RKVY_Sucess_Story/Himachal/Women_Empowerment_in_Agriculture-HP_revised_240212.pdf).

<sup>7</sup> Jagori Rural Charitable Trust Health Workers, Personal Interviews, 21 April 2017.

Dharamshala, the “village housewife” is truly the “veritable backbone of the agriculture-based economy” that provides the vital underpinnings of daily life.<sup>8</sup>

The impacts that this context has on the health status of young children are profound. India’s most recent National Family and Health Survey, NFHS-04, estimates that only 10.9% of children age 6-23 months receive an adequate diet in Himachal Pradesh.<sup>9</sup> This means that the state faces severe problems when it comes to child malnutrition: 26.3% of children in Himachal Pradesh are stunted (height-for-age), 13.7% are wasted (weight-for-height), and 21.2% are underweight (weight-for-age).<sup>10</sup> These percentages are slightly lower than the averages across India, but remain alarming. Even in a state where fresh food is being grown by almost every household—in which food production makes up nearly the entirety of most family’s livelihood—only 1 in 10 young children receive an adequate diet that can support their short- and long-term development.

### ***Anganwadi Centers under India’s Integrated Child Development Services Program***

India’s policy landscape surrounding child nutritional health revolves almost entirely around a single program set up almost a half-century ago. In an effort to directly intervene in the poor health status of huge proportions of Indian children, the government created the Integrated Child Development Services (ICDS) welfare program in 1975 with the goal of ensuring universal availability of care and health services to its young children. Since its inception, the program has grown to become one of the largest integrated family and community welfare

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<sup>8</sup> Abha Bhaiya, Personal Interview, 30 April 2017.

<sup>9</sup> Ministry of Health and Family Welfare, Government of India, “State Fact Sheet: Himachal Pradesh,” National Family Health Survey-4: 2015-2016, [rchiips.org/NFHS/pdf/NFHS4/HP\\_FactSheet.pdf](http://rchiips.org/NFHS/pdf/NFHS4/HP_FactSheet.pdf).

<sup>10</sup> Ibid, 3.

schemes in the world.<sup>11</sup> Food, childcare, pre-primary education, and health services are provided to children under six years of age through localized *Anganwadi* centers. Under the direction of *Anganwadi workers*, or the frontline workers carrying out the program, the centers provide and/or sponsor the provision of the following six services at the village level:

- (1) immunizations
- (2) supplementary nutrition
- (3) health checkups
- (4) health referral services
- (5) non-formal pre-school education
- (6) nutrition and health information

The ICDS targets its services to a variety of important stakeholders in the program: young children, pregnant mothers, and adolescent girls. This format attempts to address malnutrition at multiple stages, such as during childhood when it is most prevalent, during adolescence for female children who are particularly vulnerable, and during the stages of pregnancy in which poor nutrition outcomes are most likely to be passed on to the next generation of Indians.

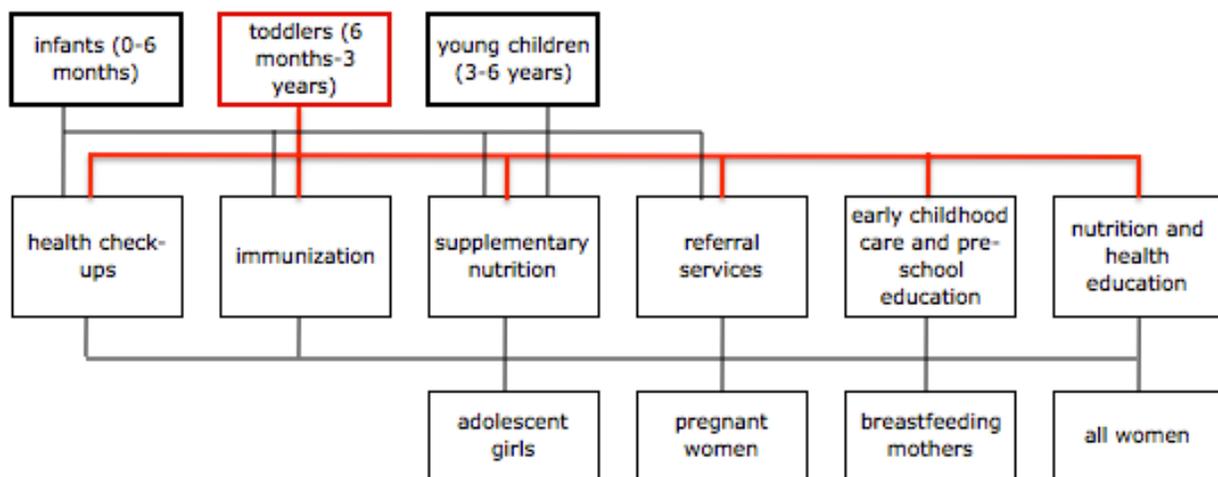


Figure 1. Chart adapted from the *Integrated Child Development Services (ICDS)*, Department of Women and Child Development, Ministry of Human Resource Development, Government of India, page 17. Pathways highlighted in red show the services that reach this study’s target age group: children between the ages of six months and three years.

<sup>11</sup> United Nations Children’s Fund (UNICEF), “State of the World’s Children: Respecting the rights of the Indian child,” [www.unicef.org/sowc01/panels/panel7.htm](http://www.unicef.org/sowc01/panels/panel7.htm).

The program breaks down its services to meet the health needs of children at three different stages in their development: infancy (up to six months), toddlerhood (between six months and three years), and early childhood (three to six years).

To address widespread child malnutrition, the ICDS places a major and perhaps disproportional focus on the “supplementary nutrition” portion of its policy. Supplementary nutrition services are provided to bridge the gap between the Recommended Dietary Allowance (FDA) for children at each growth stage, determined by the government, and the Average Daily Intake (ADI) empirically observed to form Indian children’s nutritional reality. Under the ICDS scheme, government-provided nutrition is to be given to children between six months and six years, and to pregnant and lactating mothers to support healthy nutritional growth of the fetus before birth and to promote breastfeeding. There are four primary principles that guide state implementation of the ICDS when it comes to providing supplementary nutrition to its citizenry:

- (i) Food supplement of 500 calories of energy and 12-15 grams of protein per child per day **in the form of a Take Home Ration (THR)** for children **between 6 months and 3 years**.
- (ii) Food supplement of 500 calories of energy and 12-15 grams of protein per child per day **in the form of a hot, cooked meal** for children **between 3 and 6 years**.
- (iii) Food supplement of 800 calories of energy and 20-25 grams of protein per child per day **in the form of a Take Home Ration (THR)** for **severely underweight** children of all ages.
- (iv) Food supplement of 600 calories of energy and 18-20 grams of protein per child per day **in the form of a Take Home Ration (THR)** for **pregnant women and lactating mothers**.<sup>12</sup>

These four food supplementation programs are meant to address the high rates of poor nutrition present in groups of marginalized Indian children, especially among young girls, the rural poor, and lower castes. As highlighted above, the program provides free food in two ways: in the form

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<sup>12</sup> Ministry of Women and Child Development, Government of India, “Supplementary Nutrition Program,” access May 6, 2017, [pib.nic.in/newsite/PrintRelease.aspx?relid=104046](http://pib.nic.in/newsite/PrintRelease.aspx?relid=104046).

of a cooked meal or as a Take Home Ration (THR). Within this distinction is an implicit recommendation about the childcare of young children: those younger than three should be at home, where their mothers or other full-time caregivers can cook food for them, and those older than three should be attending the Anganwadi center and receiving pre-primary education along with their meals. In other words, though the Anganwadi center is supposed to provide optional daycare services to all children in a given village under the age of six, its method of distributing food to different age groups of children implicitly guides mothers to adopt certain childcare practices dependant on the age of their child.

Related to the program's heavy focus on supplementary nutrition, one large criticism of the ICDS is that there is a mismatch between the program's practice of providing targeted food rations to specified groups of children and its ability to address the root causes of child malnutrition. In certain cases the "program's dominant focus on food supplementation is to the detriment of other tasks envisaged in the program which are crucial for improving child nutritional outcomes. For example, not enough attention is given to improving child-care behaviors, and on educating parents on how to improve nutrition using the family food budget."<sup>13</sup> Thus, just because the program aims to "address child malnutrition" does not mean it is truly addressing child malnutrition in its most critical social, cultural, and economic foundations. Beyond this, the groups that are receiving supplementary nutrition through the program may not be the groups that require it the most: research on the program has found that older children (between three and six years) participate much more than younger ones, children from wealthier households participate much more than poorer ones, and that it fails to

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<sup>13</sup> The World Bank Group, "The Integrated Child Development Services Program: Are Results Meeting Expectations?" in *India's Undernourished Children: A Call for Reform and Action*, May 18, 2006, [siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1147272668285/undernourished\\_chapter\\_2.pdf](http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1147272668285/undernourished_chapter_2.pdf).

“preferentially target girls, lower castes, and poorer villages, all of whom are at higher risk of under-nutrition.”<sup>14</sup>

Anganwadi workers are often over-burdened, serving a population larger than they are supposed to according to the policy and providing an ever-increasing number of services, and many argue that their pay scale is insufficient to properly motivate them to do such critical, expansive, and time-consuming work. This is evidenced by a large number of protests that have been staged by groups of Anganwadi workers and labor activists over the past few years demanding the ICDS to adopt better labor conditions, higher wages, and more extensive training for Anganwadis. The frequency and intensity of these protests has increased in the past few months (as of May 2017).

### ***Mahatma Gandhi National Rural Employment Guarantee Act***

To address poor economic conditions, the Mahatma Gandhi National Rural Employment Guarantee Act, or MGNREGA as it is often abbreviated, is a federal policy initiated to enhance livelihood security in rural states in India. The program provides at least 100 days of guaranteed wage employment in each financial year to every household whose adult members volunteer to do unskilled manual labor.<sup>15</sup> Work done under the scheme is most often targeted at improving state-wide infrastructure and creating durable assets for India, and thus often includes construction-related tasks for the creation of roads, canals, ponds, wells, etc. Because the scheme assures short-term employment within fifteen days of an application, or alternatively provides applicants with an unemployment allowance, employment under MGNREGA is a legal entitlement—thus situating the policy in a rights-based framework. Additionally, because one-

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<sup>14</sup> Ibid, 30.

<sup>15</sup> Ministry of Rural Development, Government of India, “The Mahatma Gandhi National Rural Employment Guarantee Act 2005,” [www.nrega.ap.gov.in/Nregs/](http://www.nrega.ap.gov.in/Nregs/).

third of the employment opportunities provided by the scheme are reserved for women, an important goal of the program is not only to address widespread poverty and wage volatility but to increase the opportunities for paid work available specifically to women. Funding for the program is covered jointly by the federal government and state governments, and individual states are responsible for providing the work itself in accordance with the scheme.

Research on the program's impacts since its inception suggests that MGHREGA reduces wage volatility,<sup>16</sup> increases the overall wage levels in a given district,<sup>17</sup> and specifically increases agricultural wages, especially for women.<sup>18</sup> Evidence on the impacts of MGHREGA on migration rates for men, women, and families alike are mixed; however, at least in theory, the scheme has potential to reduce rates of short-term migration by providing adults with locally-based, guaranteed employment. If MGHREGA is indeed reducing labor migration, then its impacts on child health, child grade completion, and nutrition are likely positive. By increasing the economic status of rural families, especially mothers, the program may serve as a positive intervention to the poor child health outcomes, especially surrounding nutrition, observed in many rural Indian states.

Additionally, under the formal policy, all MGHREGA worksites are required to have a childcare facility to promote mothers' participation in the program. This is intended not only to increase the number of women who are willing to work under the scheme, but to promote the safety and care of young children whose parents work for the scheme and are often particularly

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<sup>16</sup> Thiemo Fetzer, "Social Insurance and Conflict: Evidence from India," working paper, November 14, 2014, <http://trfetzer.com/nrega.pdf>.

<sup>17</sup> Erlend Berg et al., "Can Rural Public Works Affect Agricultural Wages? Evidence from India," CSAE working paper, May 15, 2012, [conference.iza.org/conference\\_files/worldb2012/bhattacharyya\\_s8177.pdf](http://conference.iza.org/conference_files/worldb2012/bhattacharyya_s8177.pdf).

<sup>18</sup> Laura Zimmerman, "Labor Market Impacts of a Large-Scale Public Works Program: Evidence from the Indian Employment Guarantee Scheme," IZA discussion paper no. 6858, September 2012, [ftp://ftp.iza.org/RePEc/Discussionpaper/dp6858.pdf](http://ftp.iza.org/RePEc/Discussionpaper/dp6858.pdf).

economically vulnerable.<sup>19</sup> However, research on the program's on-the-ground implementation has found that "one of the major shortcomings of the Act is non-availability of child care and rearing facilities at the work site even though the Act includes this provision." Different studies show that, due to a lack of promised daycare facilities, "many women remained worried about their children while they are working at MGNREGA worksites," and "some women do not accept the jobs provided by MGNREGA because of non-availability of proper child care facilities."<sup>20</sup>

If childcare centers are not being built on all MGNREGA worksites as promised, then the impact of the scheme on child well-being may be variable. On one hand, the program guarantees employment to economically vulnerable parents and may raise the income status of families, thereby raising the health status of rural children by increasing financial resources, empowering women, and "increasing mothers' control over decisions relating to children's healthcare."<sup>21</sup> On the flipside, young children who are being brought to the worksites and are not receiving proper childcare during the workday may suffer from all sorts of health and development-related inequities, further exacerbating their already unequal access to health resources as rural, low-income children. In this context, the potentially ambiguous relationship between maternal employment and child health outcomes becomes clear... justifying the need to take a mother-centric approach to the study of child health that acknowledges the economic structure that both mothers and their children exist within.

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<sup>19</sup> Ministry of Rural Development, Government of India.

<sup>20</sup> Sanjay Kanti Das, "A Brief Scanning on the Performance of Mahatma Gandhi National Rural Employment Guarantee Act in Assam, India," *American Journal of Rural Development* 1, no. 3 (2013): 49-61, doi: 10.12691/ajrd-1-3-3.

<sup>21</sup> A Celebration of Women, "The Mahatma Gandhi National Rural Employment Guarantee Scheme," March 14, 2013, [acelebrationofwomen.org/2013/03/the-mahatma-gandhi-national-rural-employment-guarantee-scheme-mgnregs/](http://acelebrationofwomen.org/2013/03/the-mahatma-gandhi-national-rural-employment-guarantee-scheme-mgnregs/).

### ***Jagori Rural Charitable Trust***

The Jagori Rural Charitable Trust (JRCT) is a non-profit organization based in Rakkar, Dharamshala that is “committed to the cause of building a just and equitable society,” specifically by strengthening the voices of women and girls and ensuring their rights to life, health, and safety.<sup>22</sup> Through various community-based engagement programs, Jagori attempts to address the root causes of inequality and ameliorate the effects of discrimination based on gender, caste, class, religion, disability, and all other forms of social exclusion. Within the specific goal of seeking gender justice within Dharamshala communities, JRCT has formalized four separate, targeted intervention and training programs that are being implemented throughout the Kangra Valley. These programs acknowledge the intersectional identities of women in Himachal Pradesh as mothers, wives, farmers, and economic contributors and the deep impacts that these identities have on female health, autonomy, and livelihood.

Among them, the Sustainable Agriculture, Forest and Land (SAFAL) program aims to revitalize traditional agricultural knowledge to “promote environmental health, long-term economic sustainability, and gender equality” while working closely with female farmers to “help women claim their identity as farmers and recognize their invaluable contributions to the local economy and their family’s self-sufficiency.”<sup>23</sup> Through this work, Jagori acknowledges the links between agricultural production, household labor, economic responsibilities, and female health within the greater context of patriarchy, hierarchy, and the conditions of rural poverty in the context of Dharamshala. The Aware Women’s Action for Justice (AWAJ) program focuses on targeted interventions into female health and well-being in communities throughout Himachal Pradesh, with the goal of “challenging the state’s limited approach to women’s health care” and

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<sup>22</sup> Jagori Rural Charitable Trust, “Our Mission,” [www.jagorigrameen.org/index.html](http://www.jagorigrameen.org/index.html).

<sup>23</sup> Jagori Rural Charitable Trust, “What is SAFAL?” accessed April 27, 2017, [www.jagorigrameen.org/what-is-safal.html](http://www.jagorigrameen.org/what-is-safal.html).

pushing for “the integrated development model, which includes the socio-cultural, economic and political growth as well.”<sup>24</sup> This program acknowledges that the health structures of family, society, and state in the Indian context have ignored women for a long time, and to combat this, works to empower females to take decision-making roles within their households, claim autonomy over their bodies, and refuse to reinforce a “culture of silence” around female health inequities.

The Jagori Rural Charitable Trust employs a team of field-based health workers who work in five blocks throughout the Kangra Valley. Local members of the community who have been trained in health and empowerment, these women have become well-known faces to the women in the communities in which they work. Through this, the Jagori health workers impart knowledge related to reproductive health, health rights, and health seeking behavior to rural women in Dharamshala. As many—if not nearly all—of these women are mothers, the Jagori health workers naturally take on a role of supporting these rural women in their health seeking behaviors for their young children, while attempting to simultaneously empower them to seek their own health rights that transcend their attachment to their children. This is a struggle that many of the Jagori health workers speak to directly: finding the balance between integrating a mother’s own health with the health of her children, navigating practices such as breastfeeding and childcare in their impacts on maternal well-being, and supporting women in claiming a right to their own health.<sup>25</sup>

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<sup>24</sup> Jagori Rural Charitable Trust, “What is AWAJ?” accessed April 27, 2017, [www.jagorigrameen.org/what-is-awaj.html](http://www.jagorigrameen.org/what-is-awaj.html).

<sup>25</sup> Jagori Health Workers, Personal Interview, 21 April 2017.

## **METHODOLOGY**

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### ***Data Collection and Limitations***

To gain both a quantitative and a qualitative understanding of childcare and child health practices of rural mothers, women with children between the ages of six months and three years were sought out to provide information on their decision-making regarding the health of their children. Data was collected through in-depth interviews with 17 mothers across 6 small villages in Dharamshala, Kangra district—identified anonymously as Villages A, B, C, D, E, and F. Interviews with local Anganwadi workers, health workers, and Jagori staff members also provided important primary data. The interviews were conducted verbally, both one-on-one and in groups, and with the help of a translator. Formal consent was obtained before conducting each interview. All interviews were recorded upon permission and were subsequently transcribed for the purpose of gaining substantive qualitative data.

Interviews with mothers took place in the villages in which the women lived, either in their homes or at the local Anganwadi center. In the case of three villages, the local Anganwadi worker was used as a resource to recruit mothers with young children as participants in the study. These three Anganwadi workers were also interviewed beforehand to gain a more complex understanding of the villages in which they work, as well as to inform the Anganwadi workers about the study and ask for their assistance in finding research subjects. Important challenges came with both research spaces: interviews conducted in a mother's home where often done in the presence of family members, neighbors, or friends, and interviews conducted at the local Anganwadi were done in the presence of the local Anganwadi worker. It is possible that the presence these other individuals in both cases may have biased some of the responses provided by the women.

It is similarly critical to address certain situational factors that likely influenced the data collection process: the researcher conducting this study was white, American, and has never been married or had children—three identities that lay in stark contrast to the Indian, married mothers sought out for this research. With an outside perspective on rural village life in India, the responsibilities of motherhood, and the cultural, social, and political-economic context of the study comes certain inherent difficulties that are hard to fully understand or identify; however, the help provided by Jagori health workers and staff members was critical in acknowledging differences in perspective and addressing certain divides, as discussed in the following section.

### ***Working with Jagori***

At least one Jagori health worker assisted in each of the six village visits, and was therefore present for all of the interviews with mothers and Anganwadi workers conducted in that village. This allowed for multiple benefits: the identification of women in the village with young children, village members' associations of the project with Jagori's health work, and knowledge and experience provided by the health worker herself in conducting the research. Jagori's institutional understanding of each village studied and rural Dharamshala's context more broadly was important to conduct quality research in the area. Working with team members at Jagori, the methods, objectives, and theoretical premises behind the research were refined both before the commencement of research and slowly through the entirety of the research process.

### ***Interviewing Mothers: Redefining the “Working Woman” in the Rural Indian Context***

In the Western context, a distinction is often forced between the “working woman” and her non-working counterpart. This harsh dichotomy ignores numerous identities that fall somewhere in-between these two poles—the part-time worker, women employed in informal

sectors of the economy, and those engaged in non-paid labor such as household work and childcare. Nonetheless, this conception of work—especially regarding a woman’s autonomy surrounding her work-related choices—fits much better into the context of the developed, Western economy, where the majority of women is employed in the formal economy and receives a regular income. This is not to say that the distinction between the “worker” and the “non-worker” is appropriate, but to acknowledge that it comes from heavily Western, capitalist roots.

The Indian context is much different. According to labor statistics, more than 90 percent of women workers are concentrated in the informal sector “because the flexibility, especially in home-based work, is advantageous to them given their other needs and demands upon their time in the form of unpaid labor.”<sup>26</sup> As a result, though a focus of this study is examining the ways in which woman balance their responsibilities of work and childcare, “work” is defined much more broadly than it generally is in academic research and scholarship. The definition of work as used by this study takes into the account the totality of an Indian mother’s responsibilities within the hilly economy of rural Dharamshala. This includes farm work, labor related to her husband’s profession, housework, childcare, and any additional employment she takes on for income, such as through the Mahatma Gandhi National Rural Employment Guarantee Act (MGHREGA).

Within this, it is important to take into account the concept of “choice” when it comes to female labor. Though a woman does of course make choices related to her schedule, her work, and her childcare practices, her decision-making—specifically when it comes to her intersectional identities as a female, a village-dweller, and an Indian—is heavily constrained by her socio-political environment. Defining work too narrowly would eliminate these critical

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<sup>26</sup> National Statistical Commission, Government of India, *Report of the Committee on Unorganised Sector Statistics*, February 2012, [www.lmis.gov.in/sites/default/files/NSC-report-unorg-sector-statistics.pdf](http://www.lmis.gov.in/sites/default/files/NSC-report-unorg-sector-statistics.pdf).

factors from being a central focus of analysis. Expanding the concept of the “working woman” to fit appropriately within the context of Indian village life is crucial to understanding the totality of burdens placed on mothers in rural Dharamshala, and therefore to acknowledge their profound impacts on the health outcomes of their children.

## **CHILDCARE PRACTICES AND INFANT HEALTH IN RURAL DHARAMSHALA**

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### ***Study Sample of Mothers in Rural Dharamshala***

To investigate childcare and child health practices in Dharamshala Block, Himachal Pradesh, interviews were conducted with 17 young mothers living in 6 rural villages across the area. These 17 mothers had a total of 26 children between them, though due to the sample sought for this study (mothers with child between the ages of six months and three years), just about half (9 of out 17) of them were first-time mothers. Interestingly, every first-time mother mentioned that she planned on having more children in the future. The remaining 8 mothers interviewed had more than one child, and the average age-gap between their children was 3.5 years, which follows general recommendations for healthy child spacing.<sup>27</sup> It seems that based on this sample of women, especially if we are to take intentions to have children as an indicator of future fertility, the average fertility rate of women in rural Dharamshala is higher than that of greater Himachal Pradesh (1.9 in 2016) and around the same as India as a whole (2.2 in 2016).<sup>28</sup> The average age at which the 17 mothers represented in the sample had their first child was 21.12—an age that falls in line with cultural norms across India, but is still too young for general health recommendations, as studies have found that in India, both a mother’s young age at marriage and young age at first child is a “particularly relevant driver of poor nutrition in children.”<sup>29</sup>

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<sup>27</sup> World Health Organization, Department of Reproductive Health and Research, “Report of a Technical Consultation on Birth Spacing,” Geneva, Switzerland, June 2005, [www.who.int/maternal\\_child\\_adolescent/documents/birth\\_spacing05/en/](http://www.who.int/maternal_child_adolescent/documents/birth_spacing05/en/).

<sup>28</sup> Ministry of Health and Family Welfare, Government of India, “Fertility Rate—Statistics,” *National Family Health Survey-4: 2015-2016*.

<sup>29</sup> Neha Raykar et al., *India Health Report: Nutrition 2015* (New Delhi, India: Public Health Foundation of India, 2015), [www.indiaenvironmentportal.org.in/files/file/INDIA-HEALTH-REPORT-NUTRITION\\_2015.pdf](http://www.indiaenvironmentportal.org.in/files/file/INDIA-HEALTH-REPORT-NUTRITION_2015.pdf).

According to the definition outlined earlier, all of the women included in the survey are “working.” One hundred percent of the women included in this study engage regularly in substantial farm work, do all of the cooking for their households, and are the primary caregivers for their children. The universality of these roles within the study sample speaks to the strong enforcement of specified gender roles in the context of the village in Dharamshala, Himachal Pradesh. A few women included in the study took on additional work responsibilities, including daily-wage labor or short-term employment under MGHREGA. The myriad of responsibilities these women balance on a given day plays profoundly into their decision-making related to their children; because of the constraints their various responsibilities place on their autonomy, power, and resources, all practices surrounding the care of their children exist within the larger framework of their socially, culturally, and political-economically determined role as rural women. As such, the health status of these mothers’ children is inherently and deeply linked to their status as working mothers. This link is explored below in the following sections on child health outcomes in rural Dharamshala.

### ***Childcare Practices***

When asked the question “who all in your family participates in childcare?” nearly every mother sampled was quick to respond that “everyone does.” This reflects ideals of the “communal, village family” in rural India, in which everyone, including parents, grandparents, aunts, uncles, and young children, are participatory members in communal family life.<sup>30</sup> However, upon being asked further questions, nearly all of the women who had previously stated that “every family member participates in childcare” revealed that the female family members

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<sup>30</sup> Susan Christine Seymour, *Women, Family and Child Care in India: A World in Transition* (Cambridge Cambridge University Press, 1999).

take on all or nearly all of the related responsibilities. Thus, though surveyed women seemed to hold a belief that all members of their family—female and male—participate in child-related work, they also simultaneously seemed to hold a belief that it is only the women that do the work. An example of these contrasting statements regarding male participation in childcare is from an interview conducted with a woman in Village B:

*Researcher: Who all in your family participates in childcare?*

*Village Mother: Everyone.*

*Researcher: Does everyone in your family feed your son when he needs it?*

*Village Mother: When he was only eating the breast milk it was only me. But now it is also my mother-in-law who will sometimes feed him if I cannot, who cooks for him.*

*Researcher: Does your husband ever watch your son, say, if you leave the house... or even if you are still in the house?*

*Village Mother: No. My husband works during the day. He is gone from the home. When he is back in the home he is very tired. \*laughs\**

*Researcher [rephrasing first question]: Would you say that every member of your family is involved in caring for your son?*

*Village Mother: It is me who cares for the child... who does the work. Sometimes my mother-in-law will help me out when I am too busy or when I need to do other things.*

Therefore, what appears to be one of the most important factors in a woman's decision-making surrounding childcare is the presence or absence of her mother-in-law. In much of India it is common practice for women to move into their husband's village after they marry, and with that, to move into the same home as their husband's parents. In the present sample, about three quarters of mothers lived in the same home as their mother-in-law. This had a significant and positive impact on their ability to leave their young children at home while they engaged in farm work or other income-generating activities, especially after the period of exclusive breastfeeding and before the time before the child began to attend the Anganwadi.

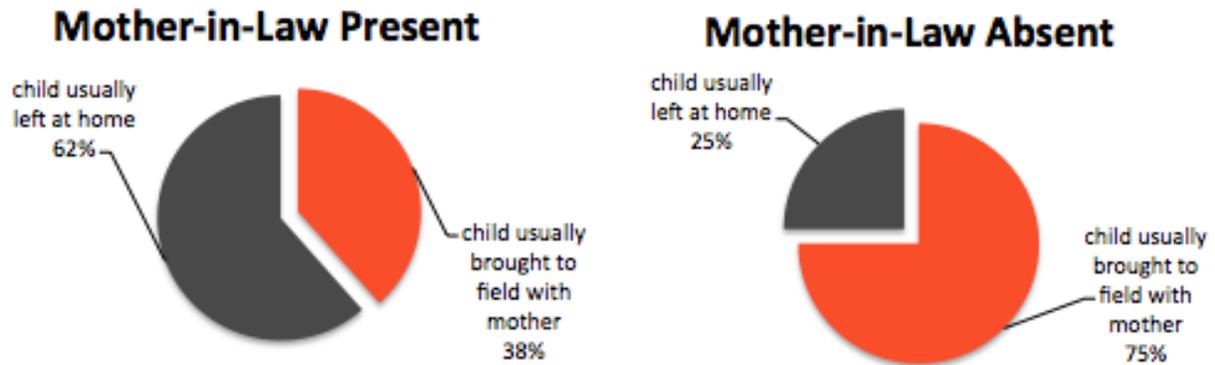


Figure 2. A comparison of percent of children left at home while their mothers do farm work versus percent of children brought into the field. The left chart shows these percentages for children who are living with their paternal grandmothers; the right chart shows these percentages for children who are not living with their paternal grandmothers.

Because childcare in the rural Indian context is, again, considered to be the work of women, having another female family member to share in the responsibilities of childcare was something that mothers cited as important to their care-related decision-making. One mother mentioned “[her] mother-in-law can watch the child when [she] goes to work on the farm, and this is good for the baby because he is not out in the hot sun and can receive food and water.”<sup>31</sup> For her, having a female family member who could watch her child is indubitably linked to her young child’s health, as allowing her son to remain indoors while she works protects him from the elements, keeps him hydrated, and allows him to regularly receive food. Similarly, a mother with one infant daughter and one older, thirteen-year-old daughter spoke to the importance of her eldest daughter’s participation in childcare; having her older daughter, she said, “allows [her] to leave her two daughters at home while [she] does chores” while knowing that “the older daughter can cook food for the younger daughter.”<sup>32</sup> Here, the links between the presence of a female family member, the discontinuance of exclusive breastfeeding, and childcare decision-making are evident: the older daughter is able to participate in the care of her younger sibling

<sup>31</sup> Village B Mother, Personal Interview, 25 April 2017.

<sup>32</sup> Village E Mother, Personal Interview, 23 April 2017.

and relieve some of the work burden from her mother, but only after the younger sibling passes the stage of exclusive breastfeeding and can receive nourishment that is not limited to breast milk.

Another factor important to childcare decision-making is the practices surrounding the local Anganwadi center. The typical age at which children began to regularly attend the Anganwadi for daycare differed between sampled villages. For example, in one village (*Village E*), all children sampled were sent to the Anganwadi starting when they turned one year old. In other village (*Village F*), a handful of children began to attend the Anganwadi when they turned two, while the vast majority did not start until they were two-and-a-half.

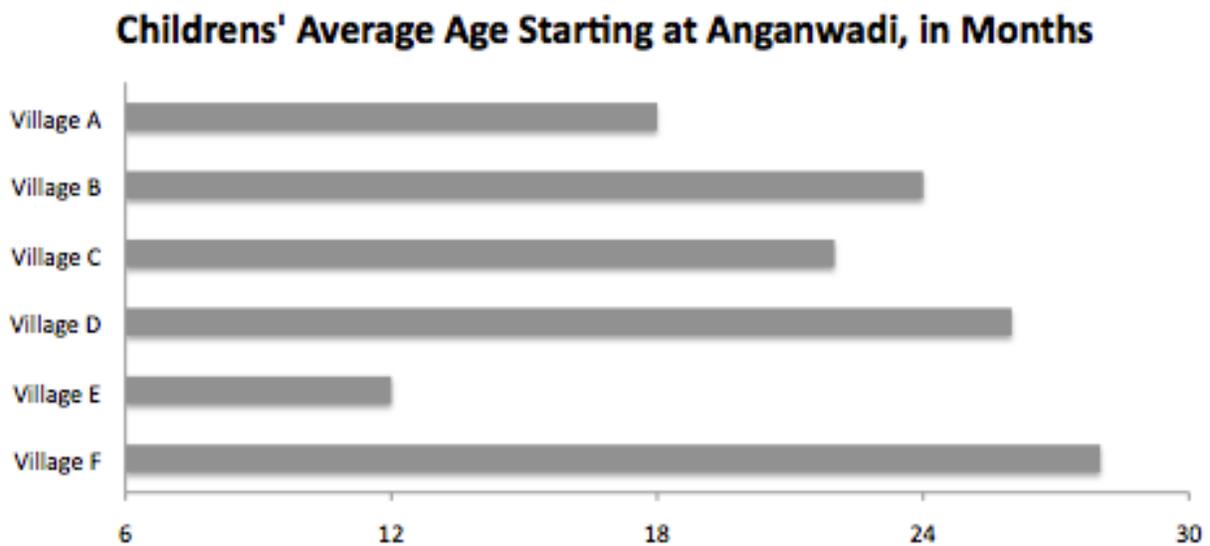


Figure 3. The average age at which sampled children were first sent to the Anganwadi center for daily care for each of the six villages. Average ages are show in months.

In the long run of a child’s life, the distinction between starting at a childcare center at one year versus at two and a half years may seem inconsequential; however, in the short-term, there are clear implications for the child’s health. In general, when a child begins to attend the Anganwadi, they begin receiving one—or sometimes two—meals from the center each day. In this manner, the nutrition and overall health status of the child becomes immanently linked to the center from

which they are receiving care. Mothers felt that there were both positive and negative impacts on their child's health status from leaving the child at the Anganwadi center for part of the day:

*Village Mother: "My son interacts with other children, which is good for his development. He receives meals [at the Anganwadi] that are nutritious and they do not cost us anything because the food is provided by the government [...] Once the Anganwadi worker told me when my son was very sick because he had been coughing all day."*

*Other Village Mother: "I am very busy... I bring him to the Anganwadi so that I can do my work but he cannot breastfeed there. He is very young, and he eats normal foods at the Anganwadi instead of breastfeeding."*

Therefore, it seems that mothers' decisions to start regularly bringing their child to the Anganwadi center were based at least partly on considerations of their child's health. Whether these considerations led to the child being brought for care earlier in his life—say, around one year old—or later in his life—around two or three—depends on multiple factors, including a mother's perception of the Anganwadi's nutrition program as being beneficial or harmful to her child's health. Considerations were also based on the mother's schedules, and again on the responsibilities allotted to them as village women and the limits these responsibilities place on their time. Additionally, considerations were based on local practices of the Anganwadi, decided jointly between village members and the Anganwadi worker, which will be explored in a later section of this paper.

### ***Childcare Practices in the Context of Formal Maternal Employment under MGHREGA***

Two women included in this sample had at some point done wage labor under the Mahatma Gandhi National Rural Employment Guarantee Act (MGHREGA) while their children were under the age of three. Though the scheme is supposed to provide daycare services for mothers with young children at every worksite, both mothers sampled (from two different villages, and therefore from two separate worksites) stated that there was no available daycare

center when they had worked under the scheme. Because of this, one mother mentioned that she brought her infant daughter to her worksite with her when she was employed under the scheme. The other mother said that she usually left her son at home with her mother-in-law, or more recently at the Anganwadi center, but that occasionally she had brought him to the worksite with her. Without access to a childcare facility at their respective worksite, these two mothers' decision-making surrounding childcare was heavily constrained. Again, the two same factors seem to be key in determining the direction of the relationship between maternal work and childcare: the presence of a mother-in-law, and the availability of childcare services at the Anganwadi center.

The impacts of childcare practices on child health outcomes are highlighted by the ability of working mothers to breastfeed their infant children. One of the two mothers who had gained temporary employment under MGHREGA mentioned that she was forbidden from breastfeeding during the hours she was working under the scheme; she explained that “even though [her] daughter came with [her] to the MGHREGA worksite, [her] daughter did not receive food during the daytime because she was still exclusively breastfeeding.” The other mother said that by the time she began working under the scheme, her child had already stopped breastfeeding; additionally, because this second mother's child only rarely came along to the worksite and instead was left with a family member or at the Anganwadi on most days, the child was presumably receiving regular meals.

Clearly, financial responsibilities taken on by women, such as engaging in formal employment under MGHREGA, have impacts on the care received by their children, which therefore have short- and long-term impacts on child health through the pathways of nutrition, access to food, and breastfeeding. There is evidence to believe that with lack of access to an on-

site daycare center, at least some children of women working under the scheme receive less monitoring, less frequent meals, and less overall care during the hours which their mothers work. With lack of childcare facilities at their worksites, women have two options: to bring their young children along with them or to seek out alternative sources childcare, if available. Though children are in physical proximity to their mothers in the former case, it appears that the labor-intensive demands of the job and explicit restrictions on child feeding means that the physical proximity between mother and child during working hours has no more than notional value.

### ***Exclusive Breastfeeding***

Of the 26 children included in the dataset, all but two met or exceeded the government recommendation of being exclusively breastfed for the first six months. This speaks positively to the work of various health-related initiatives in the area—the government Accredited Social Health Activist (ASHA) program, the Anganwadi program, and the work of the Jagori health team—as it seems that the six-month target length of exclusive breastfeeding is becoming common-knowledge among women within Dharamshala. Many women were confidently able to cite the “six month target” when describing the reasons behind their breastfeeding decision-making, and beyond this, spoke about health-related government and NGO initiatives to increase the amount of health education available to rural women.

*Researcher: Why did you decide to breastfeed exclusively for the first six months?*

*Village Mother: “The Anganwadi knew that I was pregnant and she talked to me about waiting to introduce normal foods until after six months.”*

*Other Village Mother: “Many people [referring to various health workers] talk about how important breastfeeding is for six months. Without breastfeeding for so long the child might be weak or might develop diseases.”*

Because of widespread knowledge regarding the importance of early and exclusive breastfeeding, mothers were intentional about weaving breastfeeding into their daily routines while balancing their other responsibilities when their children were six months old and younger. Thus, the work responsibilities placed on women did not seem to have a negative impact on exclusive breastfeeding, at least in the short-run. At least half of the women sampled mentioned that they brought their infant children (usually on their backs) into the field with them at least some of the time when they were doing farm work, and that this allowed them to incorporate regular feeding into their work routines. Another subset of women mentioned that their infant children were left at home with another family member, most often a mother-in-law, but that the biological mother would regularly return to the home to breastfeed her child.

This suggests that, when children are still in the “exclusive breastfeeding” stage, mothers are very intentional about incorporating feeding practices into their schedules; though they are still burdened with a myriad of work responsibilities beyond childcare, awareness about the importance of exclusive breastfeeding leads them to fuse these responsibilities with what they view as a primary responsibility of feeding their child. One mother’s words on this topic highlight the correlation between socialized views of “womanhood” and exclusive breastfeeding practices: “I know as a woman that I must breastfeed my child for six months... I know from many sources: television, magazines, my friends and family...”<sup>33</sup>

### ***Complementary Breastfeeding***

When it comes to the duration of complementary breastfeeding, which includes any time in which children receive a combination of food and breast milk, practices were much more variable—from a low of one month to a high of six years. Additionally, women were much less

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<sup>33</sup> Village E Mother, Personal Interview, 23 April 2017.

likely to cite the role of a health worker in influencing their decision-making regarding total duration of breastfeeding, and instead cited reasons related to their specific child's needs, personal needs, intuition, and family life.

*Researcher: Why did you breastfeed your [daughter/son] for this length of time?*

*Village Mother: "I [breast]fed him until my mother-in-law told me to stop. She wanted me to stop... but also I wanted to stop because I needed to return to doing work around the house and the farm."*

*Other Village Mother: \*laughs\* "I planned to breastfeed for less time but even when my daughter was four it seemed very healthy for my daughter so I continued. Sometimes you want to stop but... After that if our children are not wanting to stop we cannot help it." \*laughs again\**

*Other Village Mother: "I stopped because I felt like she could eat normal foods and that she was healthy [...] I did not know exactly when to stop, but it was hard for me to keep breastfeeding throughout the day."*

Practices surrounding breastfeeding duration and general child nutrition differed greatly between each village sampled. Beyond this, specific villages tended to display clear patterns regarding the breastfeeding decision-making of young mothers—in other words, many of the decisions made by a woman regarding breastfeeding practices were similar to those made by other women in her village. For example, in one village (*Village E*) it seemed to be common practice to breastfeed children, in combination with others foods, well into their fifth or sixth year, as this was true of all four mothers sampled. In another village (*Village C*), no mothers sampled breastfed for longer than one year [see *Figure 4*].

These contrasts in the health practices of mothers in different villages highlight various causal pathways that may explain some of the observed discrepancies. First, different villages—even those that are fairly close together geographically—may receive different information from doctors, health workers, and other professionals.

## Duration of Breastfeeding (in months), by Village

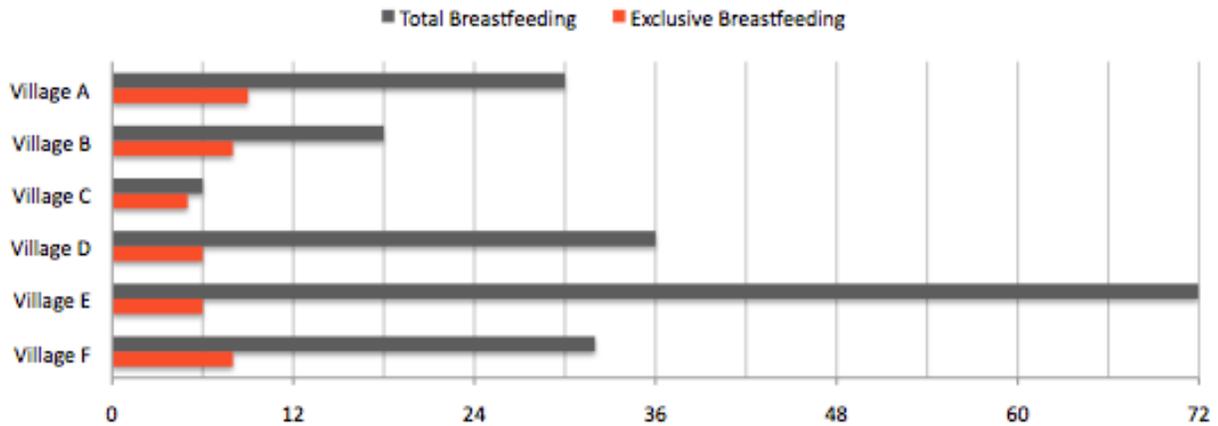


Figure 4. Average duration of breastfeeding for sampled children in each of the six villages, including both total breastfeeding (grey) and exclusive breastfeeding (red). The duration of both is measured in months.

Not only are the professionals working in these villages different individuals with different beliefs and backgrounds, but the degree of access that villagers have to the health professionals working in their villages tends to be variable. Second, each village provides its own unique cultural, social, economic, political, and religious context in which decisions regarding children are made; the ways in which these various aspects play into individual-level decision-making are complex and cannot be understated. And third, breastfeeding decision-making tends to be social in nature, meaning that women tend to base their own decisions on the decisions made by other women around them. For example, when asked why she planned to breastfeed her daughter for “as long as [she] physically produced milk,” a mother explained that “this is what other mothers do who have healthy babies... like neighbors and friends.” She again restated: “I will do it too because I know that their babies are very healthy.”<sup>34</sup> In another village where average breastfeeding duration was markedly lower, a mother explained that “women who have already raised children give advice on when to introduce food and why it is important to feed children

<sup>34</sup> Village E Mother, Personal Interview, 23 April 2017.

normal foods so that they don't develop digestive issues.<sup>35</sup> Thus, her belief about the importance of feeding children normal foods over breastfeeding was informed by the beliefs of others around about child digestion.

Overall, it appears that decision-making regarding complementary breastfeeding—as opposed to exclusive breastfeeding—is much more open to influence from other factors that determine a mother's willingness and ability to continually breastfeed her child after the introduction of normal foods. Here, the impact of work responsibilities, social expectations, and political-economic conditions of mothers on child health outcomes is evident. Women cited reasons like their need to go back to work, the difficulty of incorporating breastfeeding into their routines, advice from other women, and the health and nutritional needs of their children when commenting on the total length of time that they decided to breastfeed. This highlights the intrinsic role that a mother's context—socially, politically, economically—plays in her breastfeeding decision-making for her child.

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<sup>35</sup> Village C Mother, Personal Interview, 22 April 2017.

## THE ANGANWADI PROGRAM UNDER THE INTERGRATED CHILD DEVELOPMENT SERVICES

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### *Utilization of the Program in Rural Dharamshala*

As the target age group of children sought for this study were between the ages of six months and three years—a time during which children bridge the gap between receiving care at home and receiving care at a formal daycare center of facility—decisions surrounding utilization of the Anganwadi for childcare varied both inter- and intra- village. Mothers' decisions to send their children to the Anganwadi center on a daily or near-daily basis were found to be due to three primary factors: the educational and socio-emotional development of children, relief of the responsibility of childcare, and child health. Commonly, mothers stated that they sent their child to the Anganwadi center so that their child would “be ready for school,” would “learn to be around other children and play with them, like at school,” would “learn to sit still,” or would “learn things such as the alphabet and the numbers” before formal enrollment in primary school.<sup>36</sup> These statements highlight the value that mothers in rural Dharamshala place on formal education for their children, and also maternal values supporting the social, emotional, and psychological development of children starting at a young age.

Mothers also stated that they brought their children to the Anganwadi so that they could “have time to work on the farm,” could “earn income by helping build a road [under MGNREGA],” and in one case, could “do housework, chores, and care for an even younger, two-month-old child” while knowing that the older child was receiving his own attention. In these statements, the impacts of the Anganwadi program on village women are clear: having access to free daycare for their young children provides them with more time to complete work-related responsibilities, ameliorates the burden of childcare for a portion of the day, and in some

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<sup>36</sup> Village Mothers, Personal Interviews, April 2017.

cases, may be a necessary factor to allow them to earn income. One mother spoke to this quite explicitly:

*Village Mother: “After my child starting attending the Anganwadi each day, I began to help my husband run [his] business. I work on the farm for many hours each day and I engage in animal husbandry [...] We have more animals on the farm because we have learned that it is a profitable source of income and [now] I have the time to care for the animals for many hours each day.”*

Though the ICDS’s explicit goals surround raising the health status of young children and ameliorating malnutrition, it is clear that the program also has indirect—but important—effects on mothers as well. The provision of affordable and accessible childcare is important to village women in lessening the daily responsibility of caring for a child, and this has profound impacts on the economic responsibilities that women take on either by choice or necessity.

Lastly, a handful of mothers addressed the health benefits of bringing their children to the Anganwadi more directly. One mother mentioned that she brings her two sons to the Anganwadi center each day so that they get a “free, cooked meal... a meal that is very nutritious and good for the growth of the child.”<sup>37</sup> Another mother stated that her daughter “is watched during the day, the Anganwadi feeds her and the other children, the Anganwadi also gives food for them to take home.”<sup>38</sup> Based on these statements, it appears that the Anganwadi program is indeed making positive improvements to the nutrition status of young, rural children by providing them with food that is perceived to be “nutritious and good for the growth of the child.” Though it is beyond the scope of this study to determine the actual nutrition value of the government-provided food at the Anganwadi center, mothers’ perception of the value of the program speaks positively to the impact it is having on the general health status of children. Additionally, one mother mentioned that if her daughters did not receive food from the Anganwadi center for them

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<sup>37</sup> Village F Mother, Personal Interview, 25 April 2017.

<sup>38</sup> Village E Mother, Personal Interview, 23 April 2017.

to consume daily, then she would instead feed them with food produced by her and her husband on their farm.<sup>39</sup> In this way, the Anganwadi program has positive effects on the socioeconomic status of rural families... not simply by providing parents with an increased opportunity to seek employment while their children receive care, but by decreasing the proportion of their farm work they must devote to their own families' nutrition and increasing the amount they are able to sell for profit to meet subsistence.

Beyond this, mothers in rural Dharamshala tend to maintain some decision-making power when it comes to determining the age at which the child will begin regularly attending the Anganwadi; however, this decision-making is constrained. Recommendations from the Anganwadi worker—which differ by village—often specify an age at which “most children” should start coming to the center on a regular basis. Village-level decision-making regarding the Anganwadi tends to be highly social in nature, meaning that clear patterns were found within mothers in the same friend group, neighborhood, and village. Mothers often mentioned that their decision to send their child to the Anganwadi starting at a certain age was based on the decisions of other mothers around them, and this is clear in the patterns of data collected that tend to cluster by village. Beyond this, the typical age at which village children begin regularly attending the Anganwadi is linked to the typical age at which they begin attending primary school... if children in a given village attend school starting at a young age, then they will similarly attend the Anganwadi starting at a young age. Because age of school attendance in Dharamshala is often determined by whether the school is public or private (private schools tend to enroll children starting at an earlier age), age of Anganwadi attendance may be determined in some part by a family's socioeconomic status and/or the average income-level of a village.

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<sup>39</sup> Village E Mother, Personal Interview, 23 April 2017.

### Childrens' Average Age Starting School, Compared with Average Age Starting Anganwadi, in Years

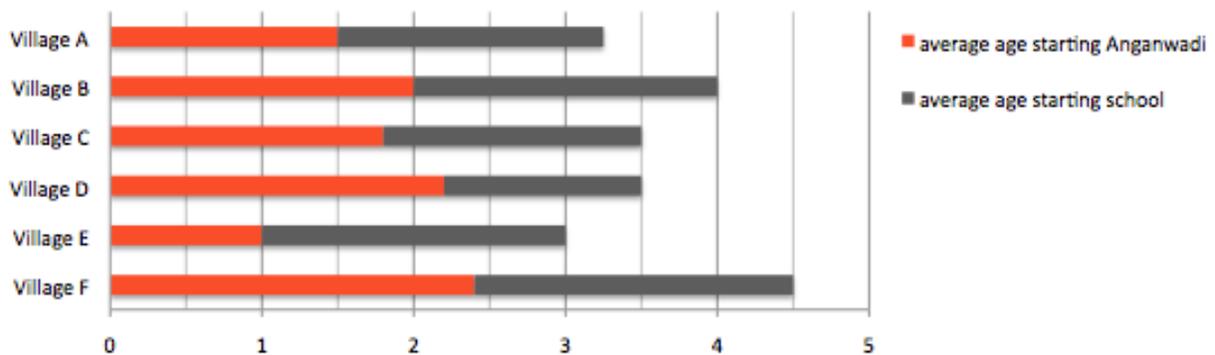


Figure 5. The average age at which children begin attending the Anganwadi (red), followed by the average age at which children begin attending formal school (grey) for each of the six sampled villages, measured in years. As shown in the chart, children in all six villages regularly attend the Angwandi up to the age at which they begin attending school; there is no gap between the two.

#### *Village Anganwadi Centers: Discrepant Practices*

In the villages sampled under this study, there were found to be important differences in the ways Anganwadi centers are run by Anganwadi workers, utilized by village families, and conceptualized by mothers. There are of course many reasons for this: variations in local culture, education levels, economic structures, and the breakdown of caste and class within each village. However, because the Integrated Child Development Services (ICDS) program is meant to be the state's targeted intervention into health outcomes for Indian children, small discrepancies in the policy's on-the-ground implementation can have large impacts in the health status of children across various villages. It is therefore important to pay significant attention to the discrepancies in Anganwadi practices to understand the impact that these differences in policy approaches may have on child health, village life, and maternal well being.

When it comes to child health interventions, a cornerstone of the ICDS is the provision of food to families with young children—both by providing cooked meals to children attending the Anganwadi (between three and six years), and by providing raw food rations to children younger than this age in the form of a Take Home Ration (THR). In theory, the state has created formal

policy guidelines that are meant to guide individual Anganwadi centers in the provision of their supplementary nutrition services; children 0-3 receive the THRs, and children 3-6 receive cooked meals at the Anganwadi center. However in practice, it appears that individual Anganwadi centers maintain certain autonomy in deciding how exactly they provide food to young children in the village that they serve. Based on the interviews conducted with village mothers and village Anganwadi workers, there were found to be major differences in four areas: whether the Anganwadi provides THRs to families with young children or does not, until what age children are entitled to receive these THRs, if at all, the proportion of families in a given village that are actually receiving THRs according to the aforementioned practices, and whether the Anganwadi provides cooked food to the children at the Anganwadi center. *Table 1* compares the six sampled villages in their Anganwadi practices based on these four factors:

	provides take-home rations to families with young children	until what age do children receive these rations?	did all sampled children get rations until this age?	provides cooked food to children attending the Anganwadi
<b>Village A</b>	yes	2	yes	yes
<b>Village B</b>	yes	2 ½	yes	yes
<b>Village C</b>	yes	3	<b>no</b> (3 out of 4)	<b>no</b>
<b>Village D</b>	yes	2 ½	yes	yes
<b>Village E</b>	yes	5-6	<b>no</b> (2 out of 3)	yes
<b>Village F</b>	<b>no</b>	--	--	yes

Table 1. Anganwadi supplementary feeding and food distribution practices in each of the six sampled villages.

Village F was the only village that did not provide Take Home Rations to families with young children; instead, all children regardless of age can receive cooked meals at the Anganwadi. Among the other five villages that did provide THRs, the age until which children are receiving these rations varied between two years and six years. This is an important point to highlight: certain children are receiving food rations for three times longer than other children in Dharamshala. In some villages, all of the mothers sampled confirmed that their child received the

rations until this age, while in other villages only some of the sampled mothers confirm this (the proportion of sampled children who received the rations at all appears in *Table 1*). Lastly, Village C was the only sampled village that did not provide cooked meals to children at the Anganwadi center. The Anganwadi worker in Village C explained that this was the case because children were only being sent to the Anganwadi center irregularly, and so it makes more sense for them to receive their meals from home.<sup>40</sup>

### ***Trade-Offs: Consistency versus Adaptability***

The fact that village Anganwadis in Kangra District, Himachal Pradesh follow different practices when it comes to their supplementary nutrition program has both positive and negative implications for child health. The qualitative and quantitative data provided by village mothers, health workers, and village Anganwadis highlight an important trade-off in allowing for discrepant practices between Anganwadi centers: consistency versus adaptability.

On one hand, data collected through interviews with village mothers lead to the conclusion that inconsistent Anganwadi practices may have certain negative implications for the general health outcomes of children across villages. In Village C, the Anganwadi center does not provide cooked food to children who attend the Anganwadi center; families with young children (under the age of three) are provided with raw, take-home rations to be prepared at home, and that is the extent of the supplementary nutrition program. As this practice is inconsistent with the ICDS mandate to provide supplementary nutrition to children between the ages of three and six years, it seems that children in Village C in this older age group are being deprived of government-provided nutritional assistance. On top of this, only 3 out of the 4 mothers interviewed in Village C affirmed that they received Take Home Rations from the Anganwadi to

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<sup>40</sup> *Anganwadi Worker*, Village C, Personal Interview, 22 April 2017.

feed to their under-three-year-old child; one mother did not get the food, and was wholly unaware of the THR program. This coincides with the fact that Village C had the shortest durations of both exclusive and total breastfeeding out of all sampled villages, although this relationship can only be said to be correlational.

On the other hand, data collected through interviews with Anganwadi workers highlight the adaptability that they practice in catering their Anganwadi practices to the specific needs of the villages in which they work. The Anganwadi worker in Village D stated that she provides take-home rations to families with young children before the children start attending the Anganwadi, then switches to providing cooked meals to children after they start attending the Anganwadi (usually between two and three years). This is because “in [her] village, children start attending the Anganwadi when they are young... sometimes two years old or even younger... and thus it is better for the mothers for their children to receive the food in the form of cooked meals at the Anganwadi center so that [the mothers] do not have to cook.”<sup>41</sup> In other words, the Village D Anganwadi worker made the determination to provide cooked instead of raw food to children after they begin attending the Anganwadi, regardless of their age, rather than following the government policy’s prescription to provide only raw food to all children under the age of three years. In contrast, all mothers in Village F stated that their young children received cooked meals at the Anganwadi center, but not rations, until the age of two-and-a-half, after which the provision of supplementary nutrition services stops. The mothers in Village F liked this system because their village is very small, they live in very close proximity to the Anganwadi, and they can conveniently walk their young children to the center at lunchtime while being relieved of the responsibility of preparing the food themselves.<sup>42</sup> Thus, in the context

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<sup>41</sup> Anganwadi Worker, Village D, Personal Interview, 24 April 2017.

<sup>42</sup> Village F Mothers, Personal Interviews, 25 April 2017.

of Village F, the system put in place by the Anganwadi seems to be working for mothers because it provides their children with necessary supplementary nutrition while subsequently relieving them of what they consider to be a burdensome duty.

### ***Bringing it Back to the Anganwadi Worker***

Ultimately, the efficacy of the ICDS cannot be understood without a deep and nuanced understanding of the people who are doing the program's on-the-ground work: namely the Anganwadi workers. Interviews with Anganwadi workers and the village mothers benefitting from the ICDS program confirm that ultimately, the flexibility and broadness of the policy allows for certain discrepancies in its implementation, and that nearly all of the determinations of how the Anganwadi runs in a given village rest with that village's Anganwadi worker. The Anganwadi in each given village has her own unique identity, including her caste, class, education level and status as a formally employed female, and these factors play into her ability, attitude, and approach as an Anganwadi worker. Additionally, though she receives formal training before beginning her work, the training is variable across states and districts, concise, and time-limited. Above all, what is true is that "there is a written policy framework... but maybe the Anganwadi worker has not even read it. So she is implementing the program by experimenting with her job and relying on her knowledge of what childcare is. If she is committed and she is honest and she is not lazy, the Anganwadi works better."<sup>43</sup>

However, Anganwadi workers around the country are taking to the streets, arguing that they are not properly motivated to do the work they have been assigned to do. The state must consider that perhaps some Anganwadis want to give the minimum because "their pay-scale does not justify the amount of time, energy, and money that is required to be good Anganwadi

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<sup>43</sup> Abha Bhaiya, Personal Interview, 30 April 2017.

worker.”<sup>44</sup> Can certain failures in the Anganwadi program be addressed through modifications to the policy’s formal content, its allocation of responsibilities to workers, or its economic incentive structure? It is an open question whether or not making changes to the economic incentives provided under ICDS will result in sufficiently sized improvements to the program’s implementation and ultimately to the quality of services received by its beneficiaries– but one that the state should explore empirically in the interest of expanding the degree to which it ameliorates health inequalities among its next generation of citizens.

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<sup>44</sup> Abha Bhaiya, Personal Interview, 30 April 2017.

## CONCLUSIONS

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Given the totality of responsibilities taken on by mothers in the rural, agrarian Indian village, a more expansive view of the determinants of child health must be adopted by the public health community that encompasses the profound links between a mother's context and the type of care received by her child. This is not to reinforce an understanding of child health that inappropriately and unfairly blames mothers, but instead to do the opposite: to acknowledge the impacts of various contextual constraints and to view maternal decision-making as a function of broader institutional and societal structures. In rural Dharamshala, programs to promote immediate and exclusive breastfeeding of infant children have been successful in normalizing the practice of feeding a child only breast milk from zero until six months; however, duration of complementary breastfeeding remains variable, and this is not something that should be automatically assumed to be negative. Interviews with mothers highlight the social nature of breastfeeding, childcare, and child health practices—supporting an approach to addressing health, especially of rural Indian children, that originates from a nuanced, community-based perspective. The variable practices of village Anganwadi centers surrounding supplementary feeding of young children highlight both the positives and negatives of allowing flexibility in the implementation of the ICDS and other government health programs. Supplementary nutrition programs that attempt to ameliorate malnutrition in India's rural communities must allow for adaptability to best address the needs of each specific village, while assuring that quality remains consistent and supporting the frontline workers carrying them out.

It is ultimately political, economic, and moral determinations that will dictate the direction and the degree of the state's involvement in childcare and child health. However, what is clear is that the state has a significant interest in assuring the health of its future generation of

citizens, and that the provision of affordable and accessible childcare services is critical not only to addressing inequalities in child health outcomes, but to raising the income-level of families and narrowing gender-based inequities. Gaps in the implementation of state-provided services such as the Mahatma Gandhi National Rural Employment Guarantee Act have important consequences for the health, wellness, and economic status of Indian families, especially when they implicate the precarious health status of already marginalized groups of children by depriving them of care facilities. Ultimately, India must take a critical look at both its attempts to address child malnutrition through the ICDS and to intervene in rural poverty cycles through MGNREGA, and consider ways in which it can work to further improve the health status of rural children by reforming the larger economic, political, and social landscape of the country. An approach that does not take into account these larger, institutionalized determinants of child health and well-being would be ineffective at best, and actively perpetuate existing systems of inequality and reinforce health-related disparities at worst.

## RECOMMENDATIONS FOR FURTHER STUDY

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- Similar studies conducted in other rural contexts throughout India would shed light on inter- and intra- village variations when it comes to maternal decision-making surrounding child health, and would assure that work done in highly specific contexts such as that of this study is not over-generalized to cover the diversity of conditions that makes up India as a whole. Additionally, future research should investigate the childcare-related state policy landscape under the ICDS and MGHREGA as it is carried out in various contexts across India.
- Research on the decision-making and childcare practices of mothers in urban settings is critical understanding the differences in options, practices, and outcomes between India's rural communities and its urban counterparts. Mothers in urban India face an entirely different economic, cultural, and policy context. Apprehending the scope of these differences is of the upmost importance in working to narrow India's urban-rural divide when it comes to child health.
- Studies on the contextual determinants of a variety of child health outcomes such as vaccination rates, disease rates, and professional health-seeking would be beneficial in removing the burden of blame placed on mothers when it comes to the health status of their children, especially among marginalized groups of women. Qualitative research into the ways that "mother-blaming" affects Indian mothers and influences their child-related health decision-making would likely serve as a guide to public health approaches to reducing child health inequities in the future.

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