An ethnographic study of the Mathru Poorna Yojana (One Full Meal) pilot project for pregnant and lactating mothers in two blocks of two districts in Karnataka

Centre for Budget and Policy Studies (CBPS)

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Executive Summary

Research on maternal health in the last several decades has shown India's maternal health indicators to be among the poorest across the world. Over 70 per cent of women in India have been found to be anaemic over the last decades (Dahiya and Viswanathan, 2014; Mason et. al, 2005). Despite these poor indicators on maternal health, India's progress in improving the status of maternal and child health and nutrition has been slower compared to other countries in the world (Paul et al., 2011).

This is also true of Karnataka, a state among the first to receive the Integrated Child Development Services (ICDS) programme focused on child and maternal health. The ICDS, adopting a lifecycle approach, also sought to ensure adequate nutrition for mothers in order to ensure better child nutrition and health outcomes. However, even after four decades of its existence, Karnataka continues to have the highest maternal and infant mortality rates among the Southern states. The maternal mortality rate (MMR)is 133 and the infant mortality rate (IMR)is 32according to data in the fourth round of the National Family Health Survey (NFHS-4).

A combination of factors have been identified as reasons for the poor outcomes of the supplementary nutrition programme, including inadequate quantity of food provided, lack of adequate knowledge among beneficiaries regarding feeding practices and, perhaps more significantly, issues of corruption and pilferage of food supplies. Thus, the Government of Karnataka (GoK) (a government generally progressive in terms of implementing various nutrition related schemes) has sought to undertake a pilot programme to ensure adequate nutrition for pregnant and lactating (P&L) mothers by providing them a full, hot, cooked meal (HCM) at the anganwadi centre (AWC), with the assistance of the United Nations Children's Fund (UNICEF).

Known as the Mathru Poorna Yojna, this scheme aims at providing one full HCM, with IFA tablets, alongside weight monitoring and counselling for issues such as postpartum depression and early childcare. The scheme was launched between February and March 2017 and has been piloted in four blocks: H.D. Kote (Mysore district), Jamkhandi (Bagalkote district), Madhugiri (Tumkur district) and Manvi (Raichur district).

The present study was undertaken to review the pilot implementation of the programme and its uptake by beneficiaries, in order to provide data to the DWCD, before scaling up the programme to all districts of the state by October 2017. An ethnographic study spanning the first three months of programme implementation was undertaken in two blocks - H.D.Kote and Jamkhandi - to understand the programme in terms of its planning and administrative components, to assess the nutritive impact of the programme and to identify relevant socio-cultural barriers to its implementation.

The study showed that the programme has had mixed results, with better uptake in Jamkhandi, compared to H.D. Kote, though these observed trends need to be considered tentative given that the scheme has barely begun. It was also observed that the proportion of lactating women attending the programme was far smaller compared to the number of pregnant women.

While the nutritive component of the programme could not be examined given that the programme is in its nascence, significant factors have been highlighted with respect to the planning and implementation of the programme and the specific measures that need to be taken in order to address socio-cultural barriers to the implementation of the programme. What has come out prominently through fieldwork is the need for consensus-building not only with district and lower-level staff and frontline workersprimarily responsible for the implementation of the scheme but also with the extended community whose support is critical to the

functioning of the scheme. As field visits showed, panchayat support has been critical to the implementation of the scheme. Consent by elders in the family also crucially determines whether women are able to come for the meals. It is important to ensure that adequate consensus is built in the community and among frontline workers to ensure the smooth operation of the scheme.

Efforts at consensus-building are also important to address socio-cultural barriers such as caste-based barriers to receiving food, cultural beliefs regarding appropriateness of certain kinds of foods for P&L women and restrictions placed on women's movement during pregnancy and lactation. Efforts at addressing such concerns must focus on both empowerment programmes for women but also wide targeting of community through information and education campaigns (IECs) and sensitively designed media campaigns.

Another critical factor in the operation of the programme is adequate provisions made in terms of infrastructure, resources at the AWC to undertake the programme and addressing vacancies. As field visits showed, an owned building with good infrastructure facilities contributed to the better uptake of the meals, while in other contexts, lack of adequate staff contributed to the poor monitoring and implementation of the programme. Similarly, adequate training and mentoring for frontline workers to address field-level issues and challenges in the implementation of the scheme is vital. In this context, training needs to be designed and planned differently, taking into account the real challenges that workers face in the field.

Finally, field observations suggest that perception of the AWC as a resource centre for the poor remains a huge barrier in convincing all beneficiaries to avail of its services (even in poor blocks such as H.D.Kote). Thus it is important to transform the perception of the AWC as a community centre offering services in health and nutrition through personnel skilled in childcare and health. It is critical also to position the anganwadi worker (AWW)as a professional with relevant skills and

knowledge, allowing her to gain respect and authority over the community that she has to work with and convince about the benefits of the scheme.

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Abbreviations

ADI	Average Daily Intake
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activists
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BP	Blood Pressure
BVS	Bal Vikas Samiti
CBPS	Centre for Budget and Policy Studies
CDPO	Child Development Project Officer
DPO	District Programme Officer
DWCD	Department of Women and Child Development
ENMR	Early Neonatal Mortality Rate
FGD	Focus Group Discussion
GoK	Government of Karnataka
GP	Gram Panchayat
HCM	Hot Cooked Meals
HFW	Health and Family Welfare
ICDS	Integrated Child Development Services

IEC	Information Education and Communication
IFA	Iron/Folic Acid
INR	Indian Rupee
IMR	Infant Mortality Rate
LBW	Low Birth Weight
MMR	Maternal Mortality Rate
MDG	Millennium Development Goals
MPS	Mathru Poorna Scheme
NFHS	National Family Health Survey
NIPCCD	National Institute of Public Cooperation and Child Development
NMR	Neonatal Mortality Rate
PDS	Public Distribution System
PESA	Panchayat (Extension to Scheduled Areas)
PHC	Primary Health Centre
PRI	Panchayati Raj Institution
RDA	Recommended Dietary Allowance
RDPR	Rural Development and Panchayati Raj
SC	Scheduled Caste
SDG	Sustainable Development Goals
SHG	Self-Help Group
SNP	Supplementary Nutrition Programme
SMC	School Management Committee
ST	Scheduled Tribe
THRs	Take home rations

VHNSD	Village Health Nutrition and Sanitation Day
UN	United Nations
UNICEF	United Nations Children's Fund

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Chapter 1: Introduction

1.1 Background

Notwithstanding the impressive economic growth record in the recent past, India continues to have high rates of malnutrition, especially among women and children. Not only does India have a large number of malnourished women, it also has one of the highest proportions of malnourished women among the developing countries of the world (Mason et al, 2005; Jose and Navaneetham, 2008). Research studies (Dahiya and Viswanathan, 2014; Mason et. al, 2005) conducted over the last decade have clearly shown that more than 70 per cent of Indian women are anaemic.

Despite facing the challenge of poor performance on maternal health and mortality indicators (as well as child-related indicators), India's progress on improving reproductive and child health and nutrition has been much slower compared to other countries with similar political and historical trajectories since independence (Paul et al., 2011). Attention to maternal nutrition and health indicators become particularly significant in this context owing to the large body of research that suggests that maternal nutrition is linked to later child outcomes. Eight hundred thousand neonatal deaths annually are attributed to maternal nutritional status (Bhutta et al., 2013). The prevalence of underweight children in India is higher than that for even sub-Saharan Africa (Kumar et al., 2010). The IMR for India stands at 47, while under-five mortality rate stands at 59. Seventy five per cent of all children in India are also anaemic (Centre for Budget and Policy Studies - UNICEF Hyderabad Field Office [CBPS-UNICEF], 2017). Nutrition-based interventions focused on improving food and micronutrient intake among women have been found to counter low birth weight (Ramakrishna, 2004).

Evidence suggests that improvements in child outcomes need a life cycle approach that also addresses women's nutrition and health, particularly in the early years (Ramakrishna, 2004). Poverty remains a major cause of malnutrition in India and has been argued to have a continued effect on later outcomes for children and adults in life (Kaliamoorthi, 2013).

It is against this context that the government of India (GoI) launched the ICDS in 1975 with the aim of tackling child and maternal malnutrition and morbidity through a comprehensive set of services addressing healthcare, nutrition and education for the mother and child (Rajan, Gangbar and Gayithri, 2015). The lifecycle approach of the programme aims to provide continuous care for the mother and the child by providing supplementary nutrition, immunisation, health check-ups and referral services on nutrition, health education and pre-school education. The supplementary nutrition programme (SNP) component provided in the form of take home rations (THRs) for women and younger children and HCM at AWCs for children between three and six years was designed to bridge the gap between the recommended dietary allowance (RDA) and the average daily intake (ADI). The aim was clearly to compensate for gaps in nutrition, especially for economically deprived households.[1]

However, despite the existence of the scheme for over four decades, it has been noted that the ICDS has been less than successful in combating malnutrition, particularly due to implementation problems (Lokshin, DasGupta, Gragnolati and Ivaschenko, 2005). This has been true also for Karnataka, a state among the first to receive the ICDS programme in 1975. As seen from the table below, Karnataka continues to have high rates of maternal mortality, under-five mortality and infant mortality. Particularly, Karnataka's IMR of 32 per thousand live births in 2011 has

[1] The ICDS was initially started for families from marginalised communities and later universalised in 2008 to all children and families.

only been slightly better than that of Andhra Pradesh (35 per 1000 live births), while significantly higher than that of Tamil Nadu (22 per 1000 live births) and Kerala (12 per thousand live births) (SRS Bulletin, October 2012, Registrar General of India; Rajan, Gangbar and Gayithri, 2015). Similarly, Karnataka's three-digit (133) MMR is also the highest among the four southern states (Munshi, Yamey and Verguet, 2016).

Table 1: Child and maternal mortality indicators in Karnataka

Sl. No.	Indices	Present status (2015-16)
		Karnataka
1	Maternal mortality rate (MMR) (per 1 lakh live deliveries)	133
2	Mortality of children below 5 years of age (U5MR) (per 1000 births)	32
3	Child Mortality Rate (per 1000 births)	28
4	Neonatal Mortality Rate (NMR)	22
5	Early Neonatal Mortality Rate (ENMR)	18

Source: NFHS-4, SRS 2013

Despite the long presence of the ICDS programme's supplementary nutrition component, Karnataka is yet to achieve the desired results of improved maternal and child health indicators, as well as in breaking the intergenerational cycle of malnutrition. One major reason for this failure has been both the quantity and quality of the SNP provided to women and younger children. First, with respect to the former, the CBPS-UNICEF (2017) study showed that beneficiaries, particularly pregnant and lactating (henceforth P&L) women, found the given SNP to be

inadequate.[2] The study raised the question of examining the quantity of the SNP, particularly for P&L women, which is marginally higher than that provided to children, in relation to the economic circumstances of the beneficiaries' households, wherein supplementary nutrition may actually even be the only source of nutrition.

In addition, the CBPS-UNICEF (2017) study along with other studies, also pointed out to the challenge of ensuring that the SNP provided as THRs are consumed by the beneficiaries themselves. As observations made in field by the CBPS-UNICEF team showed, food provided to women and children often was shared in the family, or was thrown away or fed to cattle when the specific food item did not appeal to the beneficiary's tastes [CBPS-UNICEF, 2017; National Institute of Public Cooperation and Child Development (NIPCCD), 2009; UNICEF, 2016].

However, it is interesting to note that the GoK has been proactive in implementing various programmes pertaining to nutrition. In fact, Karnataka is one of the few states that has in the recent past spent substantial amounts of its own resources on nutrition in the form of various state schemes such as Anna Bhagya, Ksheera Bhagya, Mathru Pustivardhini and Mathru Sampoorna as well as enhanced state share for schemes such as the ICDS. The GoK spends about 70 per cent of total expenditure on ICDS and about 72 per cent of total nutrition expenditure from its own resources (CBPS-UNICEF Draft Report on Nutrition, 2017).

1.2. Mathru Poorna Yojana: The scheme

In order to tackle the issues identified with THRs and address issues of anaemia, malnutrition and other health concerns for P&L women, the DWCD, GoK, decided to adopt the Mathru Poorna Yojana or the One Full Meal scheme in 2017 in collaboration with UNICEF. The scheme not only aims at reducing the death rates of mothers and infants at the time of delivery but also seeks to tackle the issue of low

[2]As part of the SNP programme, items consisting of fortified foods, rice, wheat, green grams, milk, eggs, etc. amounting to 500 calories along with 12-15 gms of protein are provided to children according to age, and 600 calories with 18-20 gms of protein are provided to women.

weight births due to maternal anaemia by encouraging consumption of 40-45 per cent of the required nutritional content for pregnant women and lactating mothers per day in the AWC. Further, it attempts to counter the oft-levied criticism[3] regarding the side-lining and neglect of other low-cost components of the ICDS such as immunisation, advice on feeding, health monitoring, referral and antenatal services, with a disproportionate emphasis placed on the SNP. The Mathru Poorna scheme (MPS) attempts to do this through counselling services rendered by AWWs on these aspects, along with addressing the oft-neglected issue of postpartum depression through the building of women's support groups.

The key elements of the MPS include:

1) one full HCM

2) administration of iron/folic acid (IFA) tablets

3) weight monitoring

4) counselling to address post-partum depression, delivery process, vaccinations, etc.

A pilot phase of the scheme has been launched in four districts, and specifically in four blocks with higher incidence of anaemia amongst children and women in comparison to other regions (UNICEF, n.d). The four blocks are H.D. Kote of Mysore district, Madhugiri of Tumkur district, Jamakhandi of Bagalkote district, and Manvi of Raichur district.

1.3. Current study

Against this backdrop, CBPS (with the cooperation of DWCD, GoK and funding support from UNICEF) undertook a pilot study to review the implementation and uptake of the newly launched MPS. Adopting an ethnographic approach to the study, qualitative fieldwork was conducted in two of the four selected blocks – H.D.

[3] As cited in *Economic and Political Weekly*, 2006, pp. 1732 and CBPS-UNICEF ICDS Study 2017.

Kote and Jamakhandi - for a period of three months. The aim was to review and evaluate the pilot phase of the programme in order to provide feedback to the government with respect to its implementation and uptake. The study focused on three main aspects of the programme:

a) Operational aspects: This involved an examination of the planning and administration of the scheme. The aim was to review the end-to-end working of the scheme, from the state to the beneficiary level, by undertaking a multi-method approach involving policy review, interviews with key state officials, observations and 'thick descriptions' from the field, which provided a worm's-eye view of the actual functioning of the scheme on the ground. The objective was to examine all processes that were part of the functioning of the scheme, starting from the roll-out to the enrolment of beneficiaries and delivery of services during the first four months of implementation. Under this theme, the study also explored the satisfaction and dissatisfaction with the meals among beneficiaries; issues of quality, hygiene and pilferage; issues of regional variability/availability of food between south and north Karnataka. Further, the study of the operational aspects of the scheme also involved documenting the challenges/obstacles that the various stakeholders faced in relation to the implementation and uptake of the scheme, other hindrances as perceived by the beneficiaries in availing the scheme (for example, issues of distance, timings, mobility etc.) and finding out the existence of strategies/mechanisms (if any) devised by the beneficiaries to avail the benefits of the scheme.[4]

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[4] For example, during our field experiences from other research projects, we came across a couple of AWCs in Maharashtra where women were giving tiffin carriers to the AWWs earlier itself for them to fill it up with the HCM. These women just come and pick up the carriers during the lunch break. Although we did not probe into this in much depth, the reasons behind this can be attributed to work or other social/cultural factors and we need to explore such aspects in our ethnographic research on HCM in Karnataka.

b) Nutritional aspects: This was undertaken to gauge the effectiveness of the nutritional inputs/interventions given to the beneficiaries by documenting and capturing the effects of the changes in nutritional inputs on women's health over a period of time.[5]

c) Social aspects: A study of the social aspects of the programme involved understanding the socio-cultural context within which the MPS has been launched, against which the efficacy and effectiveness of the programme could be reviewed. Examination of the social aspects of the programme involved undertaking a study of cultural perceptions regarding food, especially with respect to its intake during pregnancy and post-partum, with an attention to how these perceptions are embedded in the cultural meaning systems of local communities. This involves examination of issues of purity, pollution, taboo, caste, religion, social and cultural practices, norms, family and neighbourhood relationships in determining the enrolment and consequent availing (attendance) of the scheme by the beneficiaries.

The findings based on a review of the three aspects of the scheme are presented in the chapters that follow. The report is organised in the following manner: Chapter 2 and 4lay the background for the study, presenting a review of literature on the issue of maternal nutrition and health and programmes, and introducing the MPS in more detail, respectively. Chapter 4presents the methodology adopted for the study by describing the ethnographic approach that has been followed for the study. Chapter 5 presents the findings of the study, and Chapter 6 concludes with a set of recommendations hopefully helpful for the post-pilot phase of implementation of scheme.

[5]Note: While the intention was to undertake a comprehensive qualitative review of the nutritional effects of the scheme, this has not been fully possible in the pilot phase as nutritional monitoring and required resources for this had still not been set up in many of the AWCs visited.

Chapter 2: Literature Review

The aim of the present chapter is to review the available literature around women's health, reproductive health, nutrition and well-being in order to contextualise the findings from our study of the MPS. A review of literature helps us identify the current status of interventions concerning women's health and development, approaches to it and broad frameworks and outlooks for planning adopted in addressing women's health.

The current approaches and interventions to women's empowerment and well-being (including concerns around women's health), can perhaps be best summarised through Naila Kabeer's (1999) observation that: "Advocacy on behalf of women which builds on claimed synergies between feminist goals and social development priorities has made greater in roads into the mainstream development agenda than advocacy which argues for these goals on intrinsic grounds."This is an important point to note, as it highlights the instrumental nature of policy-making around issues of women's empowerment and well-being, which, as Kabeer (1999) argues further, has led to a loss of the "original political edge of feminism" within the policy space. Instead feminist goals of empowerment have taken on the form of targets or quantification, this being especially true for programmes around women's health, reproductive rights and nutrition.

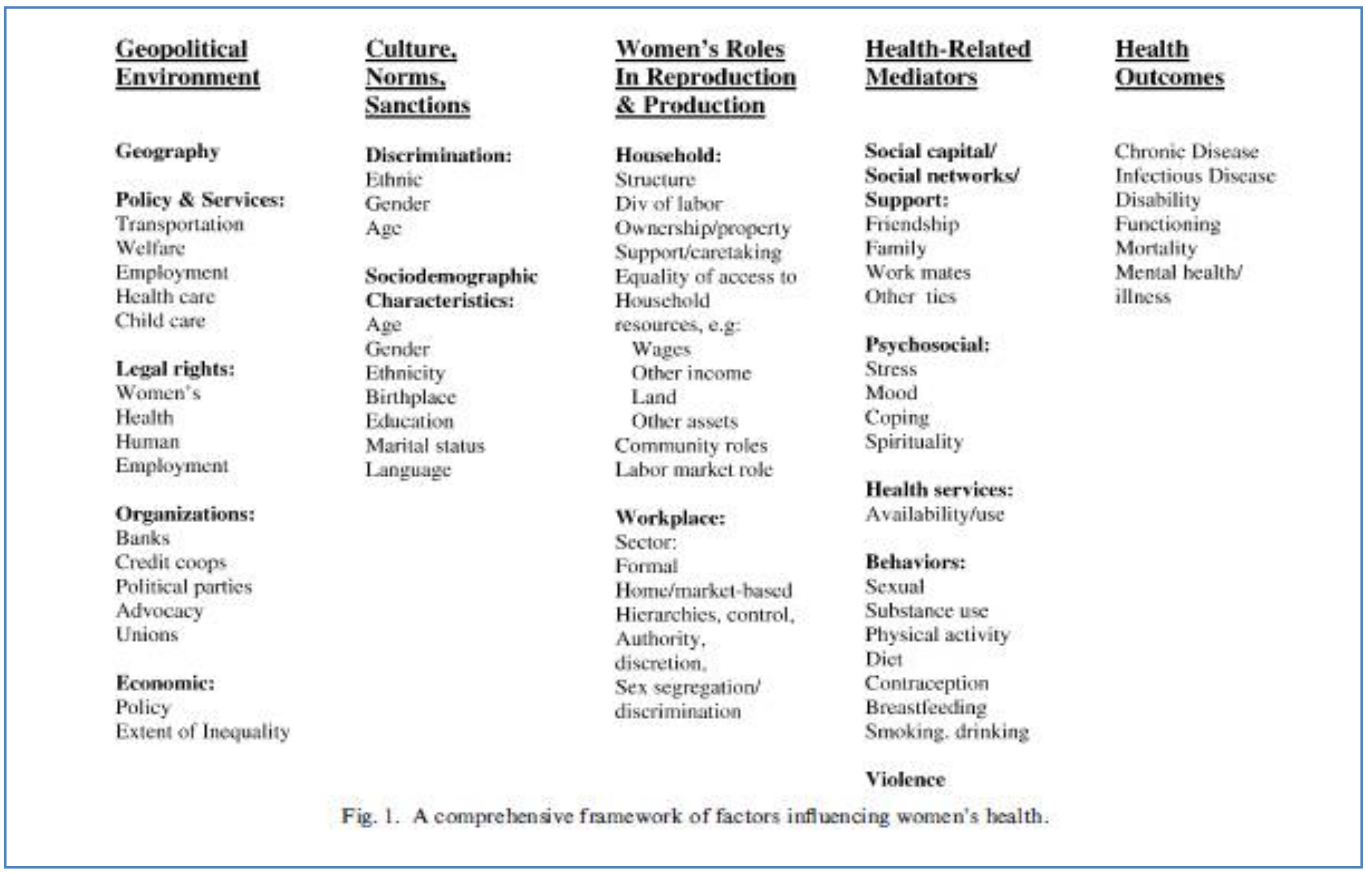
This observation is borne out by a review of literature in the fields of gender, women's health and development which are seldom connected and do not in fact talk to each other (Sethuraman and Duvury, 2007; Jose and Navaneetham, 2008; Rao, Pradhan and Roy, 2017). Women's empowerment programmes do not always

address nutrition or food security per se, but they promote sustainable livelihoods by empowering women through knowledge and awareness of and access to key resources that facilitate their livelihood activities, giving women an opportunity to meet their basic needs. Nutrition programmes, on the other hand, tend to focus on providing services to improve nutrition, but often overlook the socio-cultural contexts. In fact, nutrition programmes are rarely equipped to address socio-cultural dimensions that affect women and children and that are in fact related to improving nutrition. The issue of women's nutrition in India, much like their well-being, has for long been subsumed under the rubric of 'family welfare' and has been ignored. However, this unwillingness or failure on the part of the state or market has often been disguised under reasons like widespread prevalence of gender inequality and constraints of culture. These have been time and again posed by the state as impediments to address the issue of women's malnutrition effectively.

While the former is based on feminist and human rights models and frameworks that follow an empowerment paradigm, the latter is predominantly based on a bio-medical model that follows from a welfare paradigm. This is evident when large international frameworks and mandates for development, such as the Sustainable Development Goals (SDGs) passed by the United Nations General Assembly in 2015 (which replaced the Millennium Development Goals), and which have influenced policies across several countries, are reviewed. At least one of the SDG goals (Goal 3: Gender Equality) directly, and at least two other goals (Goals 2: Zero Hunger, and Goal 3: Good Health and Well-being) indirectly, can be said to be linked to women's health and nutrition (UN Women, n.d.). However, as noted by Bradshaw (2015), the framing of the goals, despite moving further than the MDGs by assigning gender a separate place, has continued to emphasise the economic advantages of paying attention to women's sexual and reproductive health, viewing these goals as 'development enablers'. Broader policies that seek to address women's health and nutrition need instead to examine how women's health, reproduction and

production are situated within proximal contexts of intra-individual characteristics (e.g., psychosocial stressors, coping strategies, spiritual inclinations, biologically rooted aspects of development, mood, etc), household and community relations (e.g., family and social networks, access to social capital, life stage and cohort experiences), as well as distal contexts framed by geographies, histories, political and legal structures (Moss, 2002).

Figure 1: Factors Influencing Women's Health



Geopolitical Environment	Culture, Norms, Sanctions	Women's Roles In Reproduction & Production	Health-Related Mediators	Health Outcomes
Geography **Policy & Services:** Transportation Welfare Employment Health care Child care **Legal rights:** Women's Health Human Employment **Organizations:** Banks Credit coops Political parties Advocacy Unions **Economic:** Policy Extent of Inequality	**Discrimination:** Ethnic Gender Age **Sociodemographic Characteristics:** Age Gender Ethnicity Birthplace Education Marital status Language	**Household:** Structure Div of labor Ownership/property Support/caretaking Equality of access to Household resources, e.g: Wages Other income Land Other assets Community roles Labor market role **Workplace:** Sector: Formal Home/market-based Hierarchies, control, Authority, discretion, Sex segregation/ discrimination	**Social capital/ Social networks/ Support:** Friendship Family Work mates Other ties **Psychosocial:** Stress Mood Coping Spirituality **Health services:** Availability/use **Behaviors:** Sexual Substance use Physical activity Diet Contraception Breastfeeding Smoking. drinking **Violence**	Chronic Disease Infectious Disease Disability Functioning Mortality Mental health/ illness

Fig. 1. A comprehensive framework of factors influencing women's health.

Source: Moss (2002).

Keeping this in mind, our review of literature identified three critical strands within which we contextualise our study - that is i) literature on public policy and governance ii) significance of nutrition on women's health, using the lifecycle approach of the ICDS and iii) the impact of socio-cultural beliefs and practices on food from a gendered perspective. These strands are discussed in further detail below.

2.1: Public policy and governance

Public policy can be broadly defined as a “system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives" (Kilpatrick, 2000). Considerations of reviewing policy are pragmatic (Dunn, 2016) and can take on many forms: it may involve the analysis of policy (with a view to understanding it further), or an analysis for policy (with the aim of improving it further) (Hill and Varone, 2017).

Dunn (2016) argues that policy analysis adopts a multidisciplinary framework and review of the efficiency and fairness of policy requires an examination of the normative economic rationales, decision-making processes and ethical considerations couched within it. While economic rationales guide policy-making in terms of the trade-offs to be made amongst competing values of efficiency, equity, security, liberty and democracy, based on the means and ends finally selected (Dunn, 2016), policy- making is also informed by the nature of state and organisations, which critically impact policy implementation (Hill and Varone, 2017).

The literature on policy diffusion further touches upon four mechanisms through which policies may be transferred across contexts: learning from earlier adopters, economic competition, imitation and coercion. Learning is the process through which policy makers decide whether or not a policy has been deemed successful elsewhere and is implementable. Economic competition or the economic effects of adopting a policy are judged on the basis of positive and negative spill-overs. With more positive spill-overs, the chance of adopting a policy is more likely (Shipan and Volden, 2008).

While learning focuses on the action, imitation focuses on the actor, where the actions of another nation/state are followed in order to be perceived in a similar manner. Coercion is unlike the previous voluntary mechanisms, where trade practices or economic sanctions are imposed through international organisations (Shipan and Volden, 2008) . In practice, most often, policy-making uses a combination of imitation and learning, where the attempt is to borrow while also trying to learn in order to adapt policy to contextual specificities. This can perhaps be better captured through the notion of replication which combines the two approaches and allows one to examine how far the new policy differs from the older one. These mechanisms work in a temporal manner, where imitation is a short-lived process, while learning and economic competition are much longer processes. The current study draws on this vast body of knowledge on public policy analysis to frame its findings. Perspectives and theories from the field of policy analysis form the main analytical frame for the study.

There are several studies of public policy in India and various public policies have been extensively reviewed. Scholars have noted that Indian policies are characterised by a failure to anticipate needs, impacts and reactions(Agarwal & Somanathan, 2005). Further, the weak public policy structure has been attributed to fragmentation in thinking and action, overlaps between policy-making and implementation, lack of non-governmental inputs and informed discussions, dearth of systematic analysis and integration of policy-making (Agarwal & Somanathan, 2005). Fragmentation in policy-making has led to weaker coordination and integration, along with the separation of policy-making from implementation.

An important measure suggested to counter this is the solution of decentralisation of the implementing authority and improving flows of knowledge from external sources (Agarwal and Somanathan, 2005). The key benefits of decentralisation were seen to be those of better allocation of resources that centrally administered

bureaucracies could not ensure, as they lack “time and place knowledge”, that will help identifying the “real” needs of the people (Johnson, 2003). Further, it has also been seen as a measure to counter the lack of flexibility and reach of centralised administration, through the formation of institutions that cater more to local preferences and needs (Johnson, 2003).

Decentralisation was introduced through the 73rd and 74th Amendment and the Panchayats (Extension to Scheduled Areas) Act of 1996 (PESA), with the establishment of local self-governments in the form of the panchayati raj institutions (PRIs). However, it has not truly amounted to a locally responsive administration, as the state continued to hold more power over implementation aspects than the PRIs(Vaddiraju, 2015). Other issues with decentralisation remain the continued administrative and fiscal control in the hands of state governments, which in other cases has also led to a misappropriation of resources by local elites(Vaddiraju, 2015).

We draw on the following observations regarding public policy in general, and public policy in India specifically, and also on the functioning of schemes through local institutions, such as the PRIs, in our analysis of the MPS. The state's interest and commissioning of a study to review the pilot scheme suggests an attempt in some ways to address previous critiques of the policy-making process in India - that is, the failure of the state to pay attention to the impacts and reactions to policy. It also presents a case wherein the state has proactively attempted to adopt an approach of analysis for policy (i.e. to render policy qualitatively better). This is a significant move before the adoption of the scheme for the entire state by October 2017. It can perhaps also be said that the MPS in Karnataka seems to be leaning towards an approach of learning (where lessons learnt are drawn from a similar scheme implemented in Telangana and Maharashtra) but also through gathering data on the scheme's practice on the ground, through studies like the ones entrusted

to CBPS, allowing for further modifications and contextualisations before the state-wide roll-out.

In this context it is worth-mentioning that a study conducted by UNICEF (UNICEF Draft Report, 2017) of the Anna Amrutha Hastham in Andhra Pradesh and Arogya Lakshmi in Telangana which examined the implementation and uptake of the programmes, one year after their introduction in 2014, found that HCMs were better received by the beneficiaries as compared to THRs. As indicated by tables 3 and 4 below, the specific performance indicators of the programme, namely weight gain for women, birth weight of children, haemoglobin levels of women, etc. showed improvements in Andhra Pradesh and Telangana. In Andhra Pradesh, there has been a considerable improvement in the weight gain of women since the introduction of the scheme. The figures for 2014 indicate that 72.7% of women had a weight gain of less than 10 kgs. The 2015 figures show that 43.7 women had a weight gain of less than 10 kgs and 56.3% had a weight gain of less than or equal to 10 kgs. In Telangana, apart from birth weight of infants, most indicators have shown some degree of improvement.

Table 2: Programme performance indicators for Andhra Pradesh

Indicators, %	**Calendar Year 2014 (n=505)**	**Calendar Year 2015 (n=505)**
1. Weight gain (kg) during pregnancy (2nd to 9th month)		
n	44	71
<10 kgs	72.7	43.7
>=10 kgs	27.3	56.3

2. Birth weight		
n	450	458
LBW (<2.5 kgs)	4.0	3.3
Normal Birth Weight (>=2.5 kgs)	96.0	96.7
3. IFA tabletsreceived		
n	503	520
<100 tablets	18.5	34.2
≥100 tablets	81.5	65.8
4. Haemoglobin levels of pregnant women at registration (g/dl)		
n	452	448
Hb>=10 g/dl	17.3	18.3
5. Haemoglobin levels of pregnant women at last reading		
n	450	451
Hb>=10 g/dl	41.3	45.5

Source: One Full Meal Report, UNICEF Draft Report (2017).

Table 3: Programme performance indicators for Telangana

Indicators, %	**Calendar Year 2014 (n=500)**	**Calendar Year 2015 (n=500)**
1. Weight gain during pregnancy (2nd to 9th month) (kgs)		
N	65	74
<10 kg, %	63.1	50.0
>=10 kg, %	36.9	50.0
2. Birth weight (kgs)		
N	470	485

LBW (<2.5 kg) %	2.6	4.7
Normal Birth Weight (>=2.5 kg), %	97.4	95.3
3. IFA tabletsreceived, %		
N	520	519
<100 tablets %	49.4	24.6
>=100 tablets %	50.6	75.4
4. Haemoglobin levels of pregnant women at registration (g/dl)		
N	387	379
Hb>=10 g/dl	20.9	29.6
5. Haemoglobin levels of pregnant women at last reading (g/dl)		
N	441	417
Hb>=10 g/dl	51.5	52.5

Source: One Full Meal Report, UNICEF Draft Report (2017).

While the nutritional benefits of the scheme could not be reviewed in this study (due to the scheme being in its early phase), an examination of the implementation of the scheme revealed that there is a need to undertake informed discussions with district officials as well as local bodies regarding the scheme and conduct a systemic analysis before its roll-out in the entire state. Our observations on the field, and also discussions with beneficiaries in other states reporting positive experiences with the scheme(egs. Telangana and Maharashtra) show that social contexts may be very different in different parts of any state, including Karnataka.[6] Drawing on the

[6] Limited discussions with pregnant and lactating mothers in Rangareddy district of Telangana revealed that, unlike Karnataka, caste barriers, restrictions placed on women during pregnancy and lactation periods were not significant hurdles in the implementation of the scheme. However, another discussion held with a senior official of the government of Telangana who had been part of the administration that played an important part in introducing the scheme showed that within that state, the reception of the programme varied from one place to the other. In Maharashtra, in Gadchiroli district, it was observed that for working women, a solution in the form of tiffin boxes was being made available.

experiences of these other states without attention to local contexts and the appropriateness of the scheme for this context are likely to overtake the characteristics of learning, and in the process impact the process of successful replication adversely. While it is acknowledged that policy-making at the sub-national level, especially in a federal polity and a large country such India, is a complex and challenging task, it is also important that evidence from diverse sources inform the process. A more detailed analysis of this will be presented in Chapter 5, which presents an analysis of the programme.

2.2 Women's health and nutrition: The lifecycle approach of ICDS

Tinker et al. (1994, p.5-6) have argued that "Women's disadvantaged social position, which is often related to the economic value placed on familial roles, helps perpetuate poor health, inadequate diet, early and frequent pregnancy, and a continued cycle of poverty. Further, they point out that restrictions placed on girls'/women's mobility, and lesser investments made by parents on girls lead to lesser quantity and poorer quality of food and medical treatment received by them. Such concerns are corroborated by studies that have found protein-energy malnutrition higher among girls than boys in India (DasGupta, 1987, as cited in Tinker et al., 1994). It has also been noted that due to the various socio-cultural restrictions placed on women in rural India, poor nutrition amongst women has led to a higher prevalence of low birth weight infants and high MMR. Over 75% of pregnant women in India are anaemic and anaemia remains a major factor responsible for maternal morbidity, mortality and low birth weight (WCD, n.d.).

From a lifecycle perspective, research suggests the need to pay attention to women's health both during the pre- and post-reproductive ages. Such a perspective takes in to account the specific and cumulative effects of health and nutrition. Health problems that affect pregnant women, new-born infants, and even older women often start in childhood years of girls, especially during adolescence (Tinker et al.,

1994). Further, due to the gendered nature of certain nutritional deficiencies (e.g., iron-deficiency anaemia that is a result of menstruation (Tinker et al., 1994), it is critical that schemes and interventions focus on both lifecycle as well as gendered aspects of nutrition.

A woman healthy and well-nourished through her pregnancy is more likely to break the cycle of malnutrition and as a result can have a major impact on the child's ability to grow, learn and break out of poverty (1000 DAYS, 2011, as cited in Kindered, 2013). The inter-generational effects of nutritional deficits cannot be ignored. Research has shown that postnatal cognitive developments and problem-solving skills in seven month-olds were linked to maternal nutritional status with children of undernourished mothers performing poorer on these skills (Walker et al., 2011).

Studies by Gragnolati et al., 2006 (as cited in CBPS-UNICEF, 2017) and Gupta (2016) indicate that poor maternal nutrition has adverse effects on pregnancy as well as birth outcomes, particularly for women in rural communities. Improper nutrition or malnutrition often begins *in utero* and extends to adolescent and adult life. An undernourished mother produces a weak and low weight child (Gupta, 2016). Underweight mothers, who give birth to underweight children, have a low capacity to exclusively breastfeed for the first six months. A failure to exclusively breastfeed children during the first six months of life, along with a delayed introduction of semi-solid foods, is an important trigger of malnutrition (Gragnolati et al., 2006, as cited in CBPS-UNICEF, 2017). Studies indicate that the duo (mother and infant/child) and double (physiological state postpartum-cum-lactation coupled with meeting the demands of growing infant) calls for extra nutrients and calories (Catherin, 2015).

A number of factors contribute to poor maternal health during pregnancy leading to malnutrition. These studies indicate that ensuring greater maternal health is critical

to the development of the new born infant. ICDS, through its programmes, attempts to address these issues of poor maternal health.

2.3 Food and socio-cultural beliefs and practices

Public policies on nutrition and health, particularly those which relate to women's or girls' nutrition and health, have to primarily contend with social and cultural factors, particularly in the context of developing countries in Asia and Africa. The links between culture and food can throw light on how cultural, social and economic environments effect food practices and consumption patterns (Devadas, 1970; as cited in Kindered, 2013). Food has been found to bind people to their faiths via "powerful links between food and memory". Food becomes sacred simply by association with supernatural beings and processes (Mintz and DuBois, 2002). Certain rituals and beliefs surrounding food can act as powerful tools in reinforcing religious and ethnic boundaries. Income, gender, tradition, religion and knowledge constitute an individual's foodways. These have the ability to have positive or negative effects on the individual's food consumption. For example, in India, food practices and beliefs are deeply rooted in age-old traditions and customs. The food practices that arise, rather than emphasising the nutritive value of the food, are based on socio-cultural taboos and practices. These socio-cultural beliefs are passed on from generation to generation. Foodways can often have restrictive effects, and have also been found to affect dietary patterns of P&L women in rural communities. Gupta (2016) has argued that prohibitive practices and prescriptions in food habits during pregnancy are reflections of patriarchal practices and distinct gender roles in place within households and communities (Gupta, 2016). The following section looks at research studies on the various socio-cultural beliefs and practices that guide food consumption amongst P&L women.

Research evidence suggests strong links between maternal malnutrition and existing socio-cultural practices. In Bangladesh, prescribed cultural taboos and beliefs on

food have a significant impact on the consumption of food by pregnant women and in turn on their overall health (Kindered, 2013). Other studies (eg. Gupta, 2016) have noted practices such as reduction in consumption of food closer to the delivery period can be factors that lead to this condition. Practices known as 'eating down', where pregnant women eat less due to the belief that eating too much prior to delivery would obstruct the delivery of the child and cause complications, have been shown to contribute to a greater prevalence of anaemia, greater IMR, lower birth weight, and high incidence of night blindness.

A study conducted by Catherin et al. (2015) on feeding and eating practices amongst pregnant women in Karnataka found that pregnant mothers were not allowed to eat their meals with the rest of the family as they believed that an evil eye would be cast on the mother and the child, leading to a negative effect on their health. The study also revealed that some mothers would have to eat meals in isolation for up to three months post-delivery. The authors also noted that food considered nutritious for mothers and infants across the world is often denied to women due to existing socio-cultural norms that guide food consumption during pregnancy. Beliefs exist about food that can be eaten in relation to whether they are hot or cold or if the food will make the baby's skin fairer or darker. Hot food items are to be avoided during pregnancy (e.g., tea, ginger, butter, meat, etc.). Other foods (milk with saffron) were thought to make the child fairer while foods such as *ragi* (finger millets) or sesame (despite their nutritional value) had to be avoided for fear that the baby would become darker.

A different set of practices exist for lactating women that restrict the consumption of food post-delivery. Mothers who had just delivered were given only one glass of water and bland food in the first week. The restricted diet following the delivery of the child was stated to dry out the uterus and enhance the production of milk (Catherin et al, 2015).

In addition to cultural beliefs and taboos, public schemes around food and nutrition also have to take into account sociological considerations of purity and pollution. The notions of purity and pollution mark the still-continuing influence of caste divisions and hierarchies, which find expression through everyday phenomena such as consumption of food. Notions of purity and pollution are invoked not just as a way to prescribe what forms of food are exchangeable/acceptable for exchange, but also to maintain the caste hierarchy through a clear demarcation of foods consumed by different castes and through restrictions laid on who can accept food from whom. Such practices have continued to have their effects on public programmes such as the ICDS as well as the mid-day meals, where the issue of caste discrimination during meal distribution as well as hiring of cooks has been reported by Thorat and Lee (2005). For example, when lower caste cooks (Dalit cooks) were hired for the preparation of mid-day meals in schools, upper caste parents were found sending packed meals for their children. In some cases, children were asked by their parents to go back home for the meals. It was also found that local administration was pressured by parents/community members to change the cook (Thorat and Lee, 2005).

On the other hand, there are also examples where an intervention focusing on food has been deliberately and successfully used to break the caste barriers to some extent. For instance, the Mahila Samakhya in Bihar, a centrally sponsored programme for women's empowerment, had adopted a programme of training women's collectives, largely coming from Dalit families, in running catering services and they were often given jobs of serving food for large-scale teacher training workshops organised by the Bihar Education Project. A good majority of teachers came from upper castes and this process helped in breaking barriers. The fact remains that teachers in this case had no other choice. They were on official duty and therefore would have had to go hungry if they refused to eat. Also, it took them

years to use such means to make a dent in beliefs and practices.[7] The second example comes from common living and dining facilities in residential schools or centres run by organisations like MV Foundation and CARE. However, there too, a committed and well-trained cadre of staff engaged with these issues deeply and for long before they were resolved and that too not for ever in many cases.

A brief review of literature thus shows that the high incidence of continued malnutrition in India among women can be attributed to several factors - the limited impact of nutrition programmes on prevailing gender inequality, cultural norms and practices, as well as poor outcomes of public policies and programmes. There is a need to alter existing social and public health programmes to increase their effectiveness, reach and impact. A major lacuna within public programmes has been the sidelining of nutrition education and lack of transfer of critical nutrition-related information to parents and community (CBPS-UNICEF, 2017).In India, AWCs are the main focal point of the community where health and nutrition education are fostered. While the MPS can perhaps be seen as an effort to counter the lack of adequate nutrition received by P&L women at home, restrictions on food based on cultural taboos faced by P&L women and the lack of information on nutritious food, we use the tools of policy analysis to show what the significant hurdles to the efficient functioning of the scheme are in the chapters that follow.

[7]Personal experience, Jyotsna Jha, part of the research team.

Chapter 3: Methodology

As stated earlier, the present study has adopted an ethnographic approach in order to get a holistic understanding of the scheme. Ethnography, as stated by Hammersly and Atkinson (2007), allows the researcher to "...study people's actions and accounts in everyday contexts in a fairly unstructured manner, over an extended period of time (Hammersly and Atkinson, 2007 as cited in Maithreyi, 2015).[8] This further allows for the possibility of examining the "empirical linkages among local settings of everyday life, organisations, and translocal processes of administration and governance" (DeVault and McCoy, 2006).

The ethnographic approach allowed us to understand social and cultural perspectives and local needs vis-a-vis the MPS, and make note of the claims, concerns and contestations around the newly launched scheme. Ethnographic analysis helped in identifying the gaps that exist in the policy framework of the scheme and also in its implementation process at the ground level. Moreover, as our research was primarily concerned with the evaluation of a scheme that deals with 'food', which has local and cultural connotations, an ethnographic approach seemed best suited for the purpose. Mintz and DuBois (2002) talk about how food has been explored in various ways through anthropological studies, where ethnographers have studied how humans connect to food rituals, symbols and belief systems.

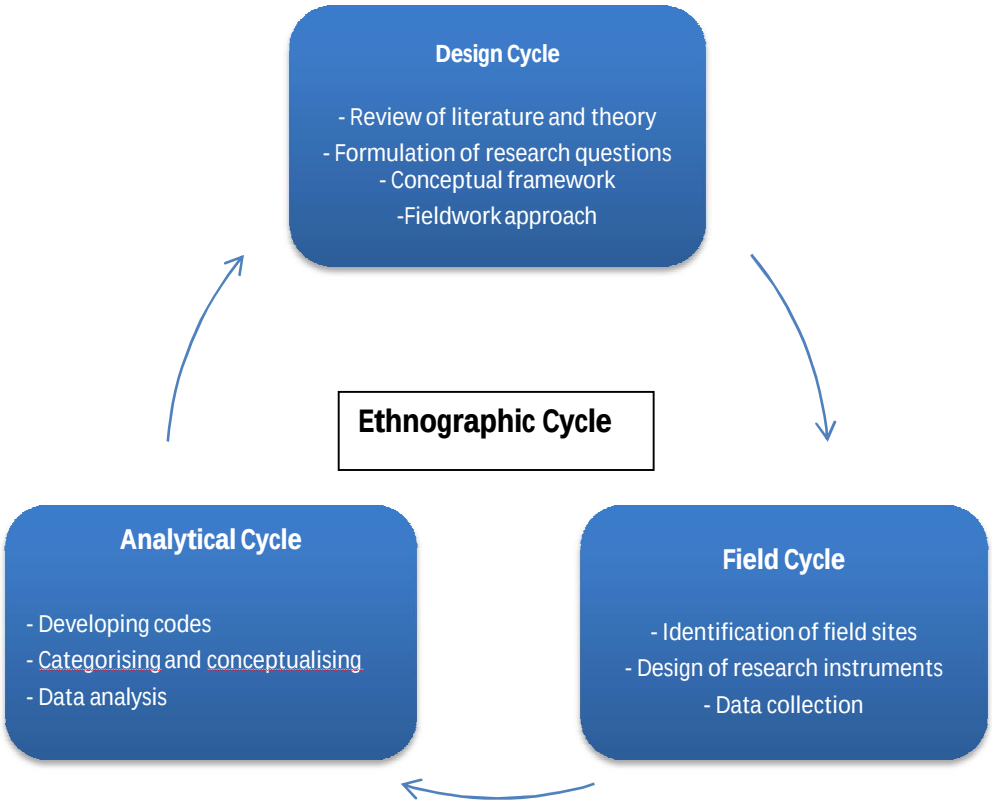
The study aimed at capturing the temporal impact of the intervention on a selected number of AWCs in two different blocks of two districts of Karnataka. This allowed us to understand the various issues associated with the scheme within diverse settings.

[8]By 'unstructured', Hammersly and Atkinson (2007) refer both to the flexibility allowed in research design, as well as in the categories used for interpretation of data, which can undergo a process of recursive and reflexive reformulation as the research proceeds.

3.1. Research cycle

The following diagram gives an illustration of the research cycle adopted for this study:

Figure 2: Research Cycle



1. Design cycle

The study began with a thorough reading of the policy documents (including the MPS document) and literature pertaining to maternal and child nutrition in the Indian as well as in the global contexts. Based on this, we formulated our research questions and the conceptual framework for the study (see Appendix for the list of questions identified for the study).

2. *Field cycle*

The programme districts for the pilot project of MPS were Bagalkote, Mysore, Tumkur and Raichur. Fieldwork was conducted in two blocks (Jamkhandi, Bagalkote district, representing North Karnataka and H.D. Kote, Mysore district, representing South Karnataka). Field visits and interactions with beneficiaries and community members at the block were carried out between February and June 2017.

Various qualitative data collection tools and methods like participant observation, unstructured interview guides and focus group discussions were used as part of the ethnographic approach.

From each of these blocks, one panchayat was selected keeping in mind issues of accessibility and proximity/distance from block headquarters. The issue of accessibility was taken into consideration for H.D. Kote in particular as it has large tracts of land under forest cover. Five AWCs were selected (in consultation with officials from the DWCD, GoK and UNICEF) based on issues of accessibility and convenience and representation of socio-religious categories. The criteria for selection of the AWCs were as follows:

a) the AWCs had a considerable/large number of beneficiaries (i.e. P&Lwomen)
b) the AWCs in each block consisted of a mix of AWCs classified as general, SC/ST, minority (according to ICDS classifications)
c) The AWCs comprised regular and mini AWCs.

Table 4:AWCs chosen in H.D. Kote[9]

HD Kote	Category	Size:Regular/Mini[10]
1. Tiger Block	ST	Regular
2. Annurhadi	ST	Regular
3. Chikkerhadi	ST	Mini
4. Hosahalli	General	Regular
5. Ganished	Minority	Mini

Table 5:AWCs chosen in Jamkhandi

Jamakhandi	Category	Size: Regular/Mini
1. RC Plot	General	Regular
2.SamudayaBhavan	SC	Regular
3.Primary School,Maigur	Jain	Regular
4. Ganiger Colony	General	Regular
5.Muddyarea, Shirguppe	SC	Regular

Two field researchers were employed in each of these two blocks. The field researchers were immersed in the field for three months. They visited each of the selected five AWCs on a rotational basis for five days in a week and maintained detailed field notes of their observations and interactions with the various stakeholders. Table 6 shows how regular field visits were planned on a rotational basis.

[9] In H.D. Kote, field investigators also visited two non-sample AWCs, Basavanagirihaddi and Shanthipura, as beneficiaries had stopped coming to all but one selected AWC for the MPS.

[10] A regular AWC is one in which a AWW and AWH are present, and is setup for a population of 800 persons; a mini-AWC is one in which only a worker is present and is set up for not more than a population of 400 persons.

Table 6: Daily plan for ethnographic fieldwork

DISTRICT 1								DISTRICT 2					
DAYS	M	T	W	TH	F	S		M	T	W	TH	F	S
Week1	A1	A2	A3	A4	A5	N		A1	A2	A3	A4	A5	NN
Week2	A2	A3	A4	A5	A1	N		A2	A3	A4	A5	A1	NN
Week3	A3	A4	A5	A1	A2	N		A3	A4	A5	A1	A2	N
Week4	A4	A5	A1	A2	A3	N		A4	A5	A1	A2	A3	NN
Week 5	A5	A1	A2	A3	A4	N		A5	A1	A2	A3	A4	NN
Week6	A1	A2	A3	A4	A5	N		A1	A2	A3	A4	A5	NN
Week7	A2	A3	A4	A5	A1	N		A2	A3	A4	A5	A1	NN
Week8	A3	A4	A5	A1	A2	N		A3	A4	A5	A1	A2	N
Week9	A4	A5	A1	A2	A3	N		A4	A5	A1	A2	A3	NN
Week10	A5	A1	A2	A3	A4	N		A5	A1	A2	A3	A4	NN
Week11	A1	A2	A3	A4	A5	N		A1	A2	A3	A4	A5	NN
Week12	A2	A3	A4	A5	A1	N		A2	A3	A4	A5	A1	NN

NOTE: A1-5 are the five selected AWCs for the each of the districts. N denotes writing fieldnotes and sharing it with the team.

Figure 3: Ethnographic process

The field work was carried out at three levels:

At the institutional level, the field team conducted interviews with state and block level officials and gram panchayat (GP) members who were responsible for the design and implementation of the scheme.

At the family and community level, the field investigators conducted regular home visits to the homes of pregnant/lactating women and interacted with the women as well as with their family members and other members of the community.

The AWC level was where the majority of field observations and interactions took place. The field investigators made daily visits to AWCs where they would interact

with AWC staff, P&L women and other members of the community visiting the centres. They conducted several FGDs with women at the centres in order to understand their perceptions of the scheme. They routinely gathered data on nutrition and mortality rates from the AWC registers. They also attended the monthly AWC meetings and any meeting pertaining to the MPS /ICDS.

In order to get 'embedded' in their respective fields, the field investigators underwent a short but rigorous training on the various techniques of ethnographic research methods at the Bangalore office from our research team. A four-member team from the Bangalore office visited each field site twice a month for two to three days to be able gain a first-hand view of the field leading to better understanding and interpretation of the field observations and field notes received from field-based researchers.

A reflexive workshop was conducted in the month of May 2017 to learn from the experiences of the various team members and map the specificities of the two districts. The field researchers from each district shared their findings with the group. The reflexive workshop was attended by the Principal Secretary, DWCD, GoK, and UNICEF officials. On the basis of discussions that took place at the workshop, future field plans were charted out.

3. Analytical cycle

Altheide (1987) talks about how several aspects of ethnographic research can be superimposed on content analysis to arrive at ethnographic content analysis. Although ethnographic content analysis has not been used popularly, various facets of it have been employed over time by historians, literary scholars and social scientists. An important use of ethnographic content analysis has been to exhaustively interpret how meaning is communicated and theoretical relationships built. It is a continuous reflection process through the steps of concept development,

sampling, data collection, coding, analysis and interpretation. Ethnographic content analysis is “embedded in constant discovery and constant comparison of relevant situations, settings, styles, images, meanings and nuances”(Glaser and Strauss, 1967, as cited in Altheide, 1987).

As with any ethnographic research, the process adopted for analysis for the current study was also a spiralling one, where categories, patterns and themes were developed through rigorous and critical reading and re-reading of the data generated throughout the entire course of the research. The data was then analysed using the qualitative method of ‘thematic analysis’ (Leininger, 1985, as cited in Aronsonm 1995, pp. 1-3) in which the process of identifying themes involves “bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone”. A block-specific analysis was conducted to highlight themes that emerged from each block. The themes were then collated to further develop a macro understanding of the scheme. The macroanalysis draws from the theoretical perspective of policy analysis and contextualises the observations and impressions developed from the 'field' within a framework of state action and intentions, and its interaction with beneficiary worldviews, contexts and needs.

Chapter 4: Details of the *Mathru Poorna scheme* (MPS)

4.1 Rationale of the scheme

As established through the introduction and review of literature, there is a need to provide adequate nutrition to women during the first 1000 days between their pregnancies and the child's second birthday to ensure the healthy growth and development of both woman and child (DWCD and UNICEF, 2016).

Keeping in mind the intergenerational effects of malnutrition, the supplementary nutrition component of the ICDS programme is a critical component. The supplementary nutrition component for P&L women which seeks to address nutritional needs has been active for several years. However, for a variety of reasons it has not proved successful. The two main reasons identified for this are: a) sharing of THRs with other members of the family and b)several malpractices that have been identified in the distribution of THRs leading to P&L women not consuming adequate quantities of nutritious food. Thus, the DWCD has proposed to place a major thrust on women's nutrition this year.

In order to tackle issues identified with THRs and address issues of anaemia, malnutrition and other health concerns for P&L women, the DWCD, GoK decided to launch the MPS or the One FullMeal scheme in 2017 in collaboration with the UNICEF. The scheme was piloted on a budget on Rs. 671.80 lakhs for 3.5 months in four districts of Karnataka. Proposing to revise the cost of SNP allotted for women, from Rs. 7 per beneficiary per day to Rs. 21 per beneficiary per day, an additional sum of Rs.447.87 lakhs has been planned for the SNP cost. Below, we present some of the details of the scheme and its operationalisation.

Table 7: Itemised cost and budget to implement the MPS

Sl.	Item	Quantity per day	Tentative cost per day (Rs.)	Nutritive value		
				Energy (kcal)	Protein (g)	Calcium (mg)
1	Rice @ Rs.5.00/kg PDS (Rs.3 + 2.00)	150 g	0.75	517.56	10.2	15
2	Dal (Toor dal) @ Rs.120/Kg	30 g	3.60	104.4	7.25	22.50
3	Oil @ Rs.81	16g	1.29	144	0	0
4	Transport		0.10	0	0	0
5	Cooking		0.50	0	0	0
6	Milk @Rs.292/kg (For 25 days)	200 ml	5.84	273	10.03	490
7	Egg	1	4.00	100.92	7.76	35
8	Vegetables	50 gm	1.92	52.5	1.8	16.06
9	Groundnut *chikki* (Sweet)		2.00			
9	Condiments		1.00	0	0	0
			21.00	**1192.38**	**37.04**	**578.56**

Source: DWCD (n.d)

4.2 Selection of districts

A pilot phase of the scheme has been launched in four districts and specifically in four blocks with higher incidence of anaemia amongst children and women in comparison to other regions in February 2017 (DWCD-UNICEF, n.d). The four blocks are H.D. Kote of Mysore district, Madhugiri of Tumkur district, Jamakhandi of Bagalkote district, and Manvi of Raichur district. Tables 6 and 7 provide a brief idea of rankings of these blocks in terms of human development and child

development indicators. MPS was launched as a central and state-sponsored scheme (DWCD, 2016).

Table 8:Human Development Index2011 and district/block-wise ranking

Human Development Index2011 and district/block-wise ranking									
District Name	Block	Standard of living Index		Health Index		Education Index		Human development Index	
		Value	Rank	Value	Rank	Value	Rank	Value	Rank
Raichur District		0.179	28	0.110	30	0.231	29	0.165	30
	Manvi	0.181	150	0.415	165	0.255	171	0.267	172
Mysore District		0.532	5	0.543	20	0.524	21	0.533	12
	H.D Kote	0.251	113	0.481	151	0.373	156	0.356	145
Tumkur District		0.330	17	0.649	13	0.489	24	0.471	17
	Madhugeri	0.245	116	0.473	153	0.200	175	0.285	167
Bagalkote District		0.191	25	0.490	23	0.605	15	0.384	24
	Jamkhandi	0.245	115	0.626	108	0.516	71	0.430	102

Source: Human Development Report 2014, DWCD, 2016

Table 9: Child Development Index2011 and block-wise ranking

Sl.No.	District Name	Block	Health Index		Nutrition Index		Education Index		Child development Index	
			Value	Rank	Value	Rank	Value	Rank	Value	Rank
1	Raichur district		0.000	30	0.185	30	0.555	17	0.231	30
		Manvi	0.217	164	0.456	169	0.414	123	0.386	172
2	Mysore district		0.516	21	0.483	22	0.667	13	0.537	20
		H.D Kote	0.193	167	0.636	122	0.887	21	0.588	123
3	Tumkur district		0.594	13	0.413	25	0.445	21	0.466	26
		Madhugeri	0.566	105	0.404	175	0.857	26	0.558	142
4	Bagalkote district		0.438	23	0.312	29	0.834	5	0.474	24
		Jamkhandi	0.590	101	0.731	86	1.000	1	0.763	31

Source: Human Development Report 2014, DWCD, 2016

Based on recommendations from the Nanjundappa Committee report on regional imbalances, NFHS-4 and the Human Development Index, the DWCD decided to select these four blocks from these four districts for the pilot implementation of the scheme (DWCD, 2016), andalso to extend the scheme to all districts by October 2017. The state-wide launch of the scheme has been planned to coincide with the celebration of AWC Day (i.e., 2 October, 2017).[11]

4.3 Objectives of the scheme

The expected outcomes of the scheme are as follows:

- reduction of IMR, MMR and anaemia amongst women
- reduction of incidence of low birth weight children
- reduction of stunting in children
- ensuring consumption of nutrition meals by P&L women
- administration of intake of IFA supplements and counselling of women
- optimal increase in weight of pregnant women and overall improvement in antenatal and postnatal care (DWCD, 2016).

These objectives have been planned to be addressed through the provision of nutritious meals consisting of rice, dal, green leafy vegetables/*sambar*, with boiled egg, peanut-jaggery *chikki* and 200ml milk for 25 days in a month at the AWCs, provision of IFA tablets, weight monitoring and through counselling for post-partum depression, delivery process andimmunisation. The one full meal is targeted at meeting 40-45% of the daily calorie and 40-45% of protein and calcium requirement per day for P&L women (DWCD, 2016).

Table 10: Proposed day-to-day variations in food menu by DWCD

[11]As was informed by the Principal Secretary during her discussions with CBPS on 2 May, 2017, at the reflective workshop on the MPS conducted by CBPS.

Day	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6
Day1	Rice	*Sambar* with vegetables	-	Egg Curry	Milk (200ml)	*Chikki*
Day 2	Rice	Dal	Green leafy vegetables	Egg	Milk (200ml)	*Chikki*
Day 3	Rice	Dal with leafy vegetables		Egg	Milk (200ml)	*Chikki*
Day 4	Rice	Sambar with vegetables		Egg Curry	Milk (200ml)	*Chikki*
Day 5	Rice	Dal	Green leafy vegetables	Egg	Milk (200ml)	*Chikki*
Day 6	Rice	Dal with leafy vegetables		Egg	Milk (200ml)	*Chikki*

Source: DWCD (n.d.)

The approach to the programme, as described by the DWCD in its scheme document, suggests that it aims to move away from an instrumental approach that focuses on just identification and enrolment of beneficiaries. The DWCD seek to adopt a holistic approach by engaging with family members of beneficiaries regarding the importance of nutritious food as well as directly making nutrients made available through provision of meals. This is to be ensured through regular home visits by AWC supervisors, anganwadi helpers (AWH) as well as accredited social health activists(ASHA workers) to ensure that families are also aware of the nutritional needs of P&L women (DWCD -UNICEF, 2016).

Interviews with DWCD officials suggest that the DWCD envisions the AWCs as vibrant, dynamic community centres where women can come out of their homes to eat and interact with other women. Thus, the vision seems to suggest an empowerment approach and scope offered for women to collectivise, specifically with respect to important life events related to child care and personal behaviour.

The AWCs have thus been conceived as spaces to also undertake prenatal care, counselling, and attitudinal/perceptual change.

4.4 Implementation of the scheme

Piloting this scheme involved 1852 AWCs with 36353 beneficiaries for which the DWCD, Department of Health (DoH) and the Rural Development and Panchayat Raj Department (RDPR) have collaborated to ensure that women get the meals at the AWCs. For monitoring purposes, the Bal Vikas Samiti (BVS) and GP are to be roped in at the community level to meet once a month on the first Village Health Nutrition and Sanitation Day (VHNSD) to create awareness of the programme (DWCD, 2016).

APPROACH TO IMPLEMENTATION OF MPS
* Sensitisation of state-level and district/block-level officials
* Joint capacity development of frontline service providers and community network
* Sensitisation of community and PRI members
* Engagement of thrift and credit women collectives
* Partnerships with community network, academic and research institutions and UNICEF
* Developing communication strategies and rolling the scheme out on the ground

4.5 Monitoring and evaluation of the scheme

With respect to monitoring of the scheme, state-level nodal officers, district deputy directors, block-level Child Development Project Officers (CDPOs)and supervisors are responsible. For monitoring and evaluation at the state and district level, the following plan has been drawn up at the state level, quarterly review meetings would be conducted by the Principal Secretary and the Director, DWCD. The nodal officers plan to inspect a minimum of five projects a month and prepare reports. At

the district level, Deputy Directors would be in charge of visiting at least three projects per month and conducting monthly review meetings. CDPOs have been given charge of inspecting a minimum of 20 AWCs to assess the programme. They are also to conduct bi-monthly review meetings. At the GP and community levels, MPS would be added to the agenda of the general body GP meetings and GP members along with the Panchayat Development Officer (PDO) should conduct review meetings and support the AWC staff in the implementation of the scheme.

A mid-term evaluation will be carried out by UNICEF in order to determine the current status of the scheme, level of achievement of objectives, impact, sustainability, etc. The evaluation would be conducted in two phases: mid-term evaluation and annual evaluation (DWCD, 2016).

The following chapter discusses the findings of the CBPS-UNICEF study on the pilot MPS implementation.

Chapter 5: Analysis of the MPS

The GoK launched the MPS or One Full Meal programme in February 2017 in four districts (Tumkur, Mysore, Bagalkot and Raichur) of Karnataka. (In each of these districts one block, namely Madhugiri, H.D. Kote, Jamkhandi and Manvi, was selected for implementation of the pilot programme). The pilot scheme aimed at providing one full HCM to all P&L women at the AWCs to ensure better health of the mother and the child. In addition, the provision of an HCM at the AWC was also seen as an avenue to collectivise and bring women together in order to provide them with opportunities to interact with peers, learn from each other with regard to pregnancy and child care-related information and, most importantly, to combat post-partum depression.

Based on the short ethnographic study, in this chapter we present the findings of the study. The analysis draws on a framework of public policy analysis, which in turn collate insights from a range of disciplines, including economics, sociology, political science and ethics (Dunn, 2016; Hill and Varone, 2017).

As discussed earlier, a significant contribution of ethnography is the examination of everyday people's lives in relation to larger, macrostructures, processes and variables that influence it. Our analysis begins with a description of the two blocks covered in the study, which are contextually and culturally different, located within diverse geographies as well as affected by differing relations with the state.

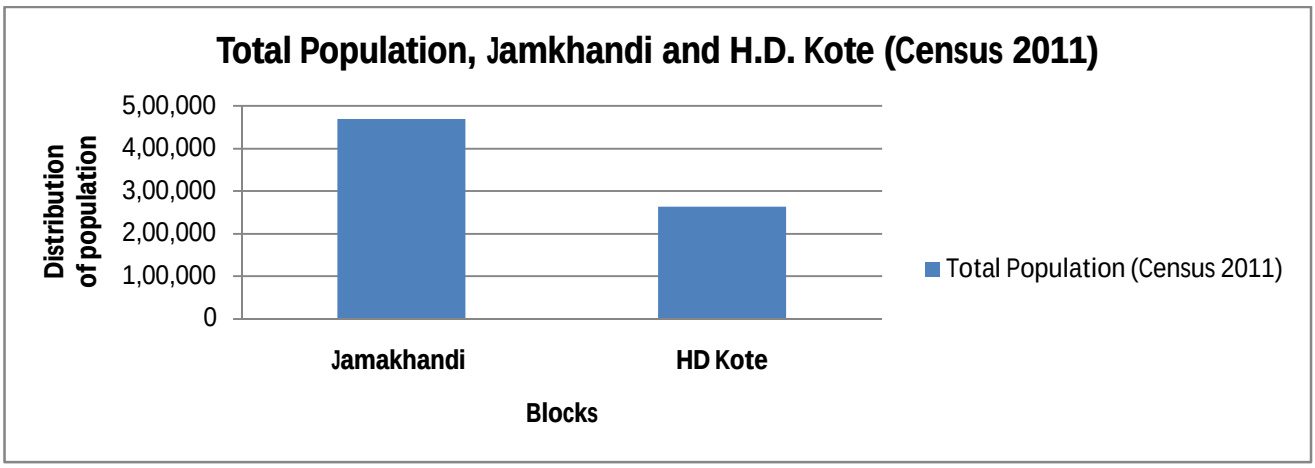
5.1 Descriptive account of the selected blocks – Jamkhandi and H.D. Kote

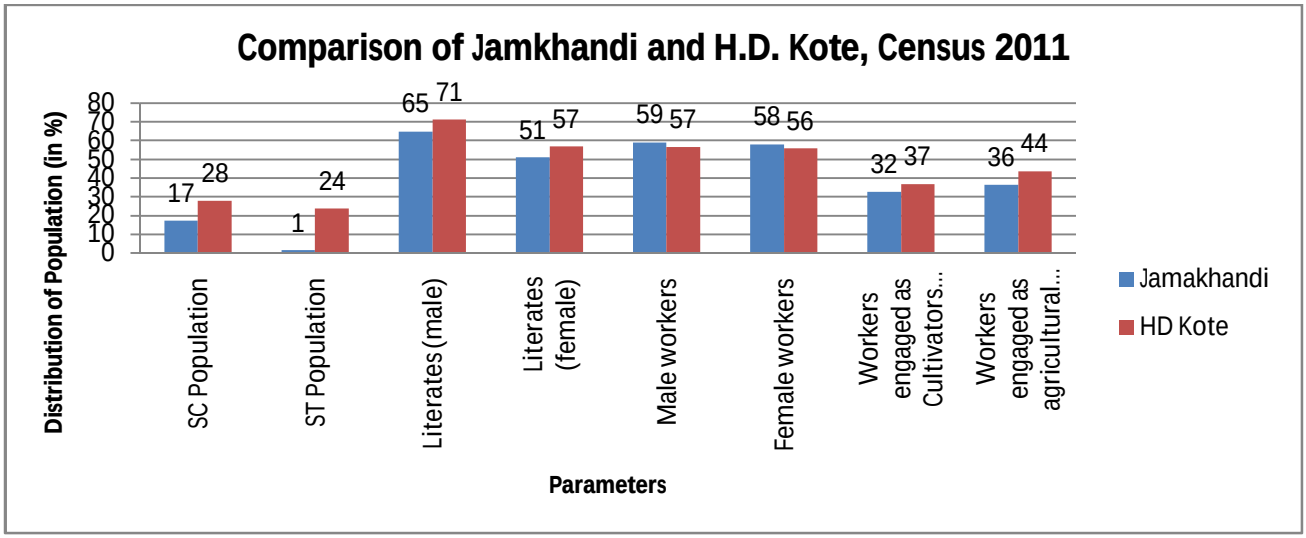
Bagalkote, a district in Northern Karnataka, has a total population of 18,89,752, with a sex ratio of 989 and total literacy rate of 58.92%. Jamkhandi is one of the nine blocks in Bagalkote district, with a total population of 4,70,176(Census 2011). Jamkhandi has a high SC population (17 per cent), and a comparatively lower ST population (1.2 percent). While the large majority are Hindus (82 per cent), there is

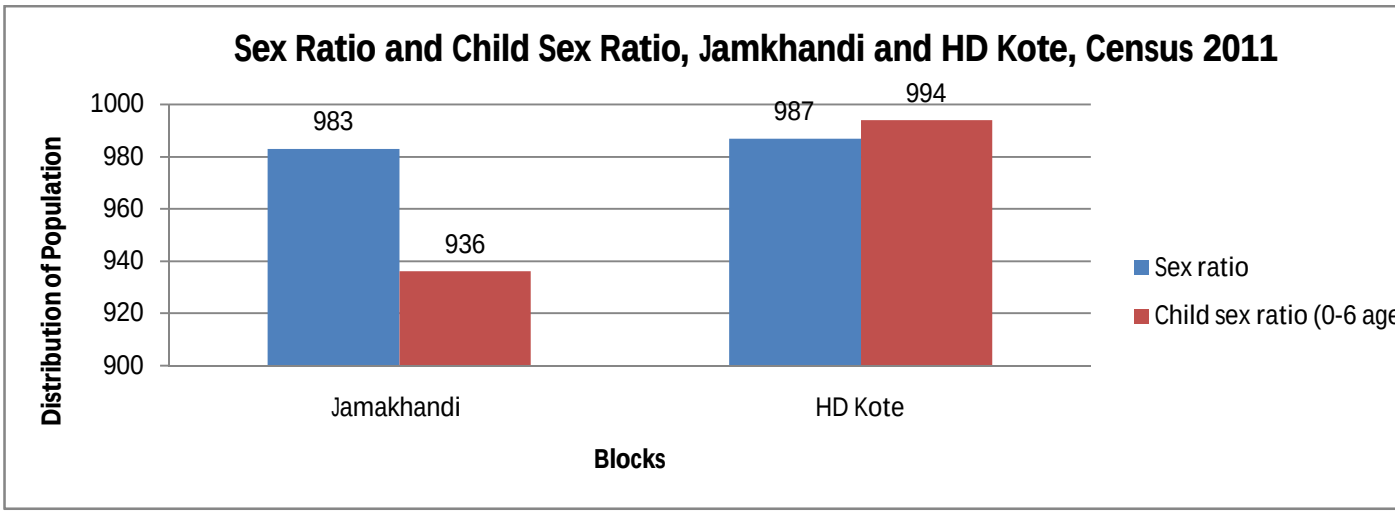
also a comparatively higher proportion of religious minorities such as Muslims (13.3 per cent) and Jains (5 per cent) (Census 2011). The average sex ratio for Jamkhandi is 983, higher than the state average (Census, 2011), but child sex ratio is much lower at 936. The child sex ratio is also lower than that for Karnataka (973) (Census 2011). During field visits, information about sex-selected abortions were informally shared by field informants which perhaps explains the extremely low child sex ratio. What this perhaps suggests is more recent setbacks and regression in social attitudes concerning girls and women. The literacy rate for Jamkhandi is 69per cent, with female literacy (51per cent) being way lower than that for males (65per cent) (Census 2011).

Mysore district in southern Karnataka has a total population of 30,01,127, with a sex ratio of 985 and a total literacy rate of 72.79%. H.D. Kote is one of the seven taluks in the Mysore district, with a total population of 2,63,706(Census, 2011), and large tracts of forest land. H.D. Kote has a large majority of SC population at 28 per cent, as well as a sizeable ST population at 24 per cent. The child sex ratio is 994.The literacy rate for H.D. Kote is 64per cent, with male and female literacy rate being 71 per cent and 57 per cent respectively (Census, 2011).

Figure 4: Demographic details for Jamkhandi and H.D. Kote







Source: Census 2011; Bagalkote District at a Glance 2012-2013

Table 11: Comparison of IMR and MMR rates in Jamkhandi and H.D. Kote

Districts*	IMR (2014)	MMR (2014)
Jamkhandi	36	223
Bagalkot	43	163
H.D. Kote	60	103
Mysore	39	155

Source: Human Development Report, Karnataka, 2014

The table above shows that or the year of 2014, IMR rates are much higher in H.D. Kote, while MMR rates are lower.

A comparison of the two blocks based on secondary data (obtained from census 2011) as well as primary fieldwork clearly indicated points of divergence. The data revealed intersectional effects that emerged from the nature and composition of the population, geographical conditions and socio-cultural traditions. Jamkhandi is a traditionally rich, well-irrigated area, with a higher population, while H.D. Kote with a higher concentration of forest land, lower population, and higher concentration of tribals has long been identified as a poor and less-developed block.

The presence of the Almatti dam in Bagalkot has been a factor that has contributed to the economic prosperity and profitability of agriculture in Bagalkot as a whole, as well as for Jamkhandi block. However, this has also led to certain negative effects, with the threat of floods looming large for the district and block as a whole. Realising this, the state administration has in fact made efforts to relocate the population, by creating a new township (with well-planned colonies, facilities such as hospitals). What field interactions and observations showed was that these plans for relocation have largely been unsuccessful even after sanctions have been issued by the state (i.e., in terms of withholding of services, such as refusing to provide gas cylinders to AWCs till they were relocated within state-demarcated areas that were safe from floods). In many cases, people left their land, houses, schools or AWCs only after they had been submerged. AWWs also reported that they were unable to move the AWCs as the AWC beneficiaries refused to relocate and thus had to continue operating from the older centres, despite being denied facilities by the state. The combined effects of the higher levels of affluence and withholding of state benefits have had an effect on women's attendance at the AWCs, which will be discussed in more detail below.

Overall, these field observations suggest that there is a great prestige associated with land in Jamkhandi, also evident from other observations such as the large number of families who lived on their lands (i.e., away from the main village), educated youth who returned to agriculture, and the disregard for non-agricultural work. While the

Maigur panchayat (which was the locus of our study) in Jamkhandi had two factories - a sugar factory and a brick factory - the local population worked only in the sugar factory (which is an agriculture-based industry), and considered it below their status to work in the brick factory, which was mainly seen as occupation for migrants from outside the district.

However, data and fieldwork also showed that a higher proportion of the population in H.D. Kote were engaged in agriculture (44 per cent) compared to Jamkhandi (34.4 per cent), though H.D. Kote also had a higher proportion of agricultural labour (23.6 per cent) compared to Jamkhandi (17 per cent). The higher population in agriculture can perhaps be attributed partly also to the greater proportion of women's participation in the workforce in H.D. Kote (20 per cent compared to 15 per cent in Jamkhandi). The greater poverty in H.D. Kote was perhaps a reason for both the greater number of agricultural labourers seen there as well as greater participation of women in the labour force, while the greater affluence in Jamkhandi has contributed to the restriction of women's movements to within the home, affecting their participation in the workforce as well.

In Jamkhandi, affluence has intensified certain regressive patriarchal practices of control over women's bodies. Evidence of this is several cases of child marriage that became known to the field researchers during the course of three months of the study, sex-selective abortions, maternal deaths, disallowing women to participate in community activities (for example, visiting or spending time at the AWC). However, it seemed that affluence has also contributed to higher educational levels for women and the effects of this were also seen in the form of beneficiaries who challenged and questioned both certain patriarchal practices as well as government structures and policies, which will be further discussed below.

On the other hand, H.D. Kote, with its high levels of poverty showed stronger trends of migration, poor educational and nutritional levels of women (the number of

female literates in H.D. Kote is less than half of the population in Jamkhandi), and poor health awareness and practices. Due to its high tribal population and poverty, H.D. Kote has special schemes for the benefit of tribals such as additional household rations given under the Tribal Sub-Plan by the Department of Social and Tribal Welfare. However, it was largely reported that the ration provided to tribal families was sold in the market in order to have ready cash, due to the high levels of poverty (and was also often used for alcohol). Despite poverty, it was reported that food was not a primary problem for the tribal population as they received at least one meal as part of their contract as agricultural labour on tobacco, ginger, cotton and peanut farms. However, what was significantly absent was adequate health knowledge and belief in modern systems of medicine among the beneficiaries, particularly tribal, which led to poor availing of most government schemes. The tabular representation shows the differences emerging from the study, confirming the implications of the Census data for the two blocks.

Table 12: Comparison of the socio-economic profiles of Jamkhandi and H.D. Kote

Sl No	Indicator	Jamkhandi	H.D. Kote
1	Level of affluence and nature of employment	Indicators of relatively higher affluence levels: cattle, well built houses, metal industries, sugarcane factory point to availability of sources of employment	Lower level of affluence due to lack of own land, characterised by out migration for employment opportunities and predominance of hired labour for agriculture
2	Population composition	Majority of SC population, with low ST population	Higher number of STs than SCs
3	Health awareness	Traditional beliefs prevalent. Cooperation at beneficiary	Strong traditional beliefs and superstitions, leading to clear

		level was higher	rejection of the scheme
4	Community support	Community was supportive of the scheme and its benefits	Vested interests of some community members leading to low support from the community.
5	Specific contributing factors	The active participationof the community and GP members, good coordination between frontline workers and presence of institutional-building acted as catalysts to the scheme	Lack of awareness, and community support with strong belief in traditional customs, acted as obstacles for the scheme

Source: Fieldwork (March-June, 2017)

Against this context, the pilot implementation of the MPS has revealed certain mixed results. In discussions with state officials and functionaries of the ICDS, the MPS scheme was stated to be on track, having reached the expected targeted levels of 60 per cent enrolment.[12] The discussions also revealed that the programme had been positively received in Madhugiri and Manvi.[13] With respect to the two blocks covered as part of the study, Jamkhandi and H.D. Kote, it was observed that the scheme was better received in Jamkhandi, than in H.D. Kote. The table below shows the variation in attendance over two months in Jamkhandi and H.D. Kote.

[12]As discussed with the Principal Secretary during the CBPS-conducted reflective workshop on 2 May, 2017.

[13]Madhugiri and Manvi have not been covered through primary fieldwork for the current study.

Table 13:Enrolment and attendance of P&L women in the five selected sample AWCs in Jamkhandi

AWCs in Jamkhandi	Registered beneficiaries in April		Number of beneficiaries attending		Percentage of attendance in April		Registered Beneficiaries in in June[14]		Number of beneficiaries attending		Percentage of attendance in June	
	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women
RC Plot, Maigur	6	8	3	0	50	0	5	6	0	0	0	0
SamudayaBhavan, Maigur	10	5	4	1	40	20	4	3	3	1	75	33.3
Primary school, Maigur	10	5	4	1	40	20	8	5	2	0	25	0.0
Ganigeroni, Shiraguppe	10	6	8	4	80	67	6	7	3	4	50	57.1
Maddi Area-2,	7	18	6	11	86	61	6	11	6	6	100	54.5

Shiraguppe												

Source: Fieldwork (March-June, 2017)

Table 14:Enrolment and attendance of P&L women in the five selected sample AWCs in H.D. Kote

AWCs in HD Kote	Registered Beneficiaries in April		Number of beneficiaries attending		Percentage of attendance in April		Registered Beneficiaries in June		Number of beneficiaries attending		Percentage of attendance in June	
	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women	Pregnant women	Lactating women
Tiger block	5	8	0	0	0	0	9	5	3	2	33.3	40
Ganished	1	3	0	0	0	0	0	3	0	1	0	33.3
Annurhaddi	5	2	4	2	80	100	4	3	4	3	100	100
Hosahalli	3	7	0	0	0	0	4	6	0	0	0	0
Chikkerhaddi	3	3	0	0	0	0	2	1	2	1	100	100

Source: Fieldwork (March-June, 2017)

Table 15: Number of registered beneficiaries and number of beneficiaries availing the scheme in H.D. Kote, July 2017

Beneficiaries (July 2017)	No. of women registered for the scheme	Number of women attending the scheme	**Percentages**
Pregnant women	1754	353	20%
Lactating women	1730	290	17%
Total	3484	643	18%

Source: Data received from CDPO office, H.D. Kote

Of significance were the numbers of registered and attending beneficiaries in H.D. Kote in July 2017. The attendance points to a low uptake of the scheme, with the numbers stuck at 20% and 17% for P&L women respectively, with an average uptake of 18% for all beneficiaries, across a total of 403 AWCs in H.D. Kote.[15] This can be partly attributed to the limited observations made at H.D. Kote, due to delays in the implementation of the scheme. Below we further identify reasons for these differences as well as the hurdles for the scheme as a whole.

5.2 Observations from the field

Analysing the data collected, codes, categories and sub-themes are consolidated to have a comprehensive view of the information collected. These patterns are revisited along with the process of interpretation, to minimise gaps in themes and capture all nuances. The overarching themes identified are:

i. Administrative and planning processes

ii. Socio-cultural factors

[15] As collected from the CDPO office, HD Kote.

In this chapter, the findings are presented from the study across the two blocks, with respect to the MPS.

5.2i. Administrative and planning processes

In examining the operationalisation of the MPS, we first review the rationale, planning and administration of the scheme. As discussed earlier the MPS was launched as a pilot programme in four of the 39 most backward blocks identified by the Nanjundappa Committee Report. These four blocks were found to perform poorly in health and education related indicators, as well as have the lowest human development index.[16] While this presents a powerful rationale for intervention within these blocks, it also points to the fact that the likelihood of success in such a situation in a short period is also low. In this section, we point to some of the field-level issues in the implementation of the pilot programme.

We classify these issues as: a)lack of consensus-building b)implementation constraints faced c) responsibilisation of frontline workers. We discuss each of these in more detail below.

a. Lack of consensus-building

The policy literature puts a lot of emphasis on consensus-building, especially at lower levels, to be able to ensure uptake and implementation of a new scheme. This is even more critical in a political-economic situation where the introduction of the new policy is likely to face resistance from 'vested interests' both within and outside the system. An analysis of narratives of state officials did reveal efforts to learn from other states through visits, through discussions with academics and researchers and so on. However, it was also observed that all engagements with the lower levels of bureaucracy within the state (i.e., the district, block and community levels) were undertaken only in the form of trainings and orders issued regarding the operations

[16] As reported in the scheme document, titled *Focus on Mothers to Reduce Low Birth Weight – One Full Meal to Pregnant and Lactating Women Piloting in 4 Taluks of Karnataka,* DWCD.

of the scheme. The state accounts of the scheme were silent about discussions held at the local level - with district staff and communities before the launch of thepilot of the new scheme. Other discussions at the field level also showed this lack of effort made to build a consensus in the field. For example, during our visits to H.D. Kote, we were given to understand by district-level officials that the scheme of providing meals at the AWC had already been tried in Mysore district in the 1990s. However, due to the poor response by beneficiaries,[17] the state reverted to providing THRs. The apparent lack of adequate attention paid to these early lessons meant that the MPS came to a standstill in the H.D. Kote in the early stages of its implementation. It was observed that 2973of the 3484beneficiaries in H.D. Kote presented the district officials and AWWs with written letters refusing to cooperate with the scheme. They argued that they were only willing to avail THRs and would not come for the full HCM in the AWCs. Even among the five AWCs selected for our study, we observed that beneficiaries in four of the AWCs stopped coming for the meal in the first month itself. The scheme appeared to function well in only one of the five AWCs (which had several positive factors including good infrastructure, worker-beneficiary relations and the right caste composition of workers and beneficiaries). While refusal by some beneficiaries to come for the full HCM was observed in Jamkhandi too, this was a much smaller number and seemed mainly to be related to patriarchal reasons of families restricting the mobility of women.

[17] This information emerged during discussions with the District Programme Officer (DPO) on 22 March, 2017, as well as with the Deputy Director, Mysore on 25 May, 2017.

What makes Annurhaddi a pocket of success for the MPS?

Within HD Kote, the success of the scheme was the greatest in Annurhaddi. While exploring further the following reasons were identified as possible catalysts:

a. Majority of landless families, working on the fields of others. Hence, due to the low average level of affluence, the beneficiaries came regularly to the centres for the meals.
b. The AWW lived very close to the centre, and is perceived by the community as an insider. Thus, it was not very difficult for the AWW to convince the beneficiaries about the benefits of the scheme.
c. Strong community ties and support leading to the motivation of beneficiaries to exercise their right to the scheme.
d. Majority of the beneficiaries coming to the AWC reported staying at their maternal homes and having permission from their mothers/ elders to come for the meals

The poor rate of success, particularly for H.D. Kote, has largely been interpreted by the state as a case of a difficult block/district with lack of buy-in even among district officials. Further, the success of the programme in the three other districts has been used to argue that the non-performance of the district officials and frontline has led to the poor implementation of the scheme in H.D. Kote. State officials have pointed towards the political and vested interests in continuing the THRs scheme among district-level staff and community as reasons for the slow uptake of the scheme in this block. Issues of corruption, pilferage and misuse of THRs were not only provided by state department officials, but district-level accounts by officials and frontline workers also revealed that panchayat members were particularly vested in the THRs scheme. AWWs even reported being threatened by panchayat officials who would support the scheme publically but would later call the workers over phone and insist that they provide THRs. It is also important to be able to foresee such veiled opposition and have strategies to ensure proper implementation.

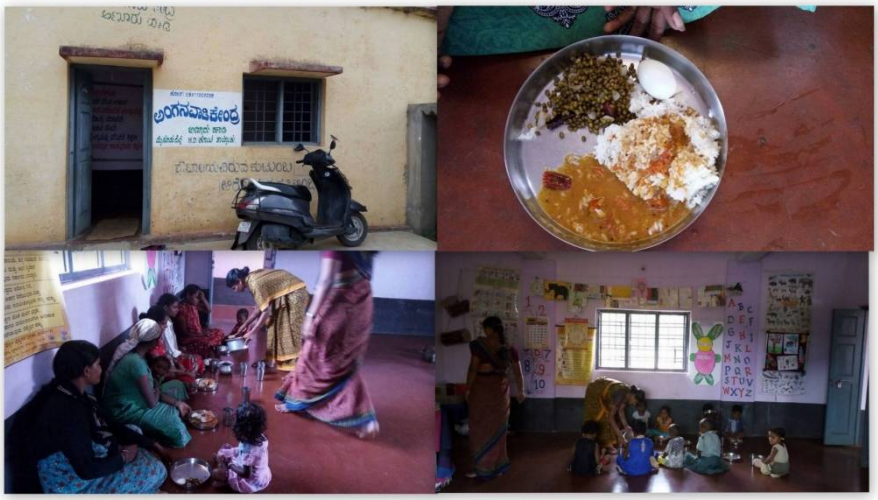


Figure 5: Annurhadi AWC, H.D. Kote

Pilferage and corruption in the distribution of THRs are significant issues and have also been identified by other studies (including the CBPS-UNICEF 2017 study; Saxena, 2016).Political interests over THR is also a real factor affecting the implementation of the MPS. It is important to address this through strategies of consensus-building. These efforts are important with both the frontline workers (in this case, AWWs) who have the real responsibility of implementing the scheme and whose lack of engagement can seriously affect the programme as well as among other stakeholders involved who can also derail the process. Greater attention to the real difficulties and challenges faced by AWWs and targeted actions to address those and also in creating a sense of ownership among them can go a long way in countering vested interests existing at local level.

A critical observation that emerged through the fieldwork was the need for greater attention to appropriate planning and implementation of the scheme. This was evident from other observations from the field that also showed that other factors – for example, distance, geography, migration and employment patterns, and, most importantly, culture, had not been adequately understood or represented within the

planning process of the pilot. For example, among the two field sites chosen for the study, the distance to the AWC was a real challenge for women in Jamkhandi, considering that a large number of families lived in the fields. With distances between the field and the AWCs (which were located in the main village) spanning almost three to four kilometres one way, beneficiaries argued that "We have to work in the fields and again walk so far for the meals. Even then, our families don't like us availing meals from the AWC. It is difficult for lactating mothers with infants to come out after delivery for meals. Thus, we prefer THRs."[18] In H.D. Kote, on the other hand, the planning process had also not taken the large quantum of migration into account, something that was brought to our notice by the AWW at Chikkerhaddi, where women and even children move out to plantations in Coorg for work.

b. Implementation constraints

Pilot programmes, though limited in scale, provide an opportunity to study the possible results of a programme before its full launch. In order that an evidence-based approach be used for policy formulation, and rigorous data on the strengths, weakness and opportunities of the programme be identified, it is important to ensure that all the basic elements of the programme are in place, without which it becomes difficult to assess the possible impacts. The choice of pilots in places where gaps exist in several forms – inadequate infrastructure, resource and financial planning, personnel, training and monitoring –prevent the research from examining the scheme in its entirety. On the other hand, if these are the realities of the field that the programme is likely to face in a majority of locations, it is important to view these as structural barriers to reaping the full potential of the programme unless addressed. Below we identify some of these gaps and how these impacted the functioning of the programme.

[18] As discussed with beneficiaries at R C Plot, during field visit dated 1 March, 2017.

Table 16: Infrastructural shortages at the selected AWCs

	Jamkhandi	Building	Details of amenities	HD KOTE	Building	Details of amenities
1	**RC Plot**	Available	Available	**Tiger block**	Available	No compound gate. No space for washing hands. No electricity.
2	**GanigerOni,Shirguppe**	Rented room	Metal sheet leading to heating up, lack of ventilation, no kitchen no store room	**Ganished**	Using the house of the AWW	Uses her own utensils along with what given to her by the ICDS
3	**Primary school**	Using old school building	Gas cylinder supply stalled due to allocation of land	**Annurhaddi**	Available. Earlier was a building in the Sericulture Department	Display of charts, provision of borewell for water, no toilet
4	**Samudaya Bhavan**	Construction still going on for new AWC	No kitchen or store room	**Hosahalli**	Available, adjoining the primary School	Lack of adequate space inside the centre,insufficient utensils
5	**Maddi area 2**	Available	Building and water facilities good	**Chikkerhaddi**	Available	Kitchen and store room available. No doors for toilets. Uneven flooring.

Source: Fieldwork data (March- June 2017)

Infrastructural, Resource and Financial Constraints

Observations on the field showed that the presence of an institutional building and government infrastructure aided the functioning of the MPS. In Jamkhandi, out of the five AWCs studied, two had their own buildings and all basic amenities, reflected in the number of beneficiaries coming for the meals. Two out of the five AWCs did not have kitchen utensils, store rooms or drinking water, resulting in unhygienic cooking conditions within which the meals were prepared. In fact, it was reported that at least at one of the AWC's - Samudaya Bhavan - beneficiaries had protested and stopped coming for the meals, after which the AWH was forced to start cooking the meals at her home. The Samudaya Bhavan AWC had no kitchen and just one long hall, and the AWH was earlier forced to cook outside the AWC. Along the same lines, the AWC studied in Tiger block, H.D. Kote, did not have a compound gate, no washing areas or utensils. Some places even lacked electricity.

Figure 6: SamudayaBhavan AWC, Jamkhandi

In other cases too, it was observed that the AWWs/AWHs were compelled to prepare the meals at their residences, due to the shortage of gas cylinders, utensils and adequate spices for the preparation of meals. Due to reallocation of land, the supply of the gas cylinder has been stalled in some AWCs in Jamkhandi. Hence, AWWs had to pay for the gas cylinders on their own as well as use personal utensils

for cooking, without having received compensation. A number of AWC staff spoke of delays in stocks, funds and fuel, making it difficult for them. In spite of this, a number of times they also reported being subjected to accusations of misappropriation of raw materials.

Issues were also raised about financial norms. For instance, field interactions in Jamkhandi and Bagalkot revealed that out of the Rs. 21 allocated per beneficiary/per meal, only one rupee has been allocated for spices, which is insufficient to suit the tastes of the local populace. AWC staff reported bringing their own spices or cooking meals at their homes to add additional spices, since beneficiaries would otherwise not come to the centre for such "tasteless meals".[19]What this suggests is the need for flexibility within defined boundaries at the decentralised level to accommodate and be responsive to context-specific needs and demands. In such circumstances, having a plan for consensus-building with AWWs where certain specific messages about flexibility within defined norms are clearly given, would be helpful.

The dearth of weighing machines acted as one of the impediments in monitoring the weight of the P&L women, and though collecting health data (such as weight and BP records) had been included as a component of our study, this could not be collected as this information had neither been updated in the health records at the AWCs, nor in the '*thayi* cards' issued to women at the primary health centres (PHCs). While lack or delay in procuring health-related resources was noted on the one hand, on the other, we also observed that IFA tablets that were to be supplied during every meal were absent in most AWCs. On enquiring, it was reported that this was because women were already receiving IFA tablets at the PHCs, and the tablets had been stopped at the AWCs following the advice of the chief medical officer. However, there was confusion among the AWC staff and district officials regarding the distribution of the tablets, indicating a lack of adequate coordination between

[19] As reported by a worker from Jamkhandi, during a field visit made on 27 March, 2017.

departments. Also, other health-related informational and educational (IEC) material to spread information about the scheme were also absent at the pilot AWCs.

In various meetings with government officials, it was found that due to a delay in deployment of funds from the state, district-level officials have been making use of the surplus funds available from previous schemes to keep the MPS running. An official in Jamkhandi mentioned, "We are adjusting with money from the previous budget where we had saved some amount due to interruption of feeding. This would cover us till April".[20] In the same way, in H.D. Kote, the government official spoke about how the funds from child marriage awareness sessions are being used for organising additional capacity-building sessions in the MPS. What such accounts seemed to suggest was an urgency on the part of the state in implementing the programme without fully laying the groundwork. This creates pressure on the lower levels, particularly on AWWs, to take on the onus of implementing the programme which suffers from several gaps.

Inadequate personnel and workload challenges

The heart of the ICDS programme is its personnel, particularly its field staff – that is the AWW, AWH and supervisor. Our observations in the field showed that there were several vacancies, which make the task of implementation challenging. For example, secondary data collected for H.D. Kote showed just three supervisors being present instead of 11. Further, we noted that at least two officials at the district level were suffering from prolonged medical conditions that have affected their full functioning. This has led to a scenario where an individual supervisor is burdened with monitoring over 75 AWCs. Discussion with district officials further revealed that while the state had extended full support to hire additional supervisors, in the last round of selection, more supervisors from the North Karnataka districts had been selected. Thus, they had completed their probation periods and returned to

[20]Personal interview dated 27 March, 2017.

their districts.[21]Even at Jamkhandi, there were only four supervisors and 13 posts, and it was noted that due to the increased burden on supervisors, AWW meetings were held once in three months.

While the shortage of supervisors is a concern at the district level, at the individual AWC level, the workload of the AWW also needs attention. While it was pointed out by state officials that the MPS does not actually affect the worker's workload, and it is the AWH that needs to be compensated for the double duty of cooking for women and children, field observations showed otherwise. Our study found that in addition to the regular duties of maintaining larger number of registers and conducting pre-school teaching on an everyday basis, workers were also required now to go to individual homes during lunch time to invite the beneficiaries for the meals. Just as in the case of children, who are expected to be individually collected by the AWWs each day, community expectations are also placed on the worker to invite the P&L woman for the meal, as this is considered giving her respect. Such additional expectations placed on the AWW disrupt pre-school teaching and this is more evident in mini-AWCs which do not have an AWH. In fact, due to the high burden on the AWW at a mini-centre at H.D. Kote, it was observed that the AWH had appointed a school drop-out to undertake the cooking in return for meals. In other cases, caste dynamics (further discussed below), have also made it necessary for the worker herself to prepare the meals. Maintaining records in the AWCs, a long standing issue for the ICDS, has become a further problem post-MPS. AWWs in Jamkhandi said, "We have to cook food and look after the children, after which food is prepared for P&L women. If we do not make house visits, the beneficiaries won't come and food will be wasted. Due to all this, it gets difficult to maintain records perfectly."[22]

[21] Data obtained from a discussion with an official in charge of women's welfare programmes in Mysore, on 25 May, 2017.

[22] As reported by an AWW at Jamkhandi, in a personal interview dated 1 March, 2017.

Even if some of these exist due to the 'newness' of the pilot and therefore can be termed 'teething issues', it is important to take note of them, as when the programme would be made universal these are likely to be witnessed in other places as well. If not resolved, teething problems become long-lasting impediments. Also important to note is the fact that though it is possible to overcome caste-related issues by questioning practices of purity and pollution, fieldwork indicates that it requires careful planning, strategising and perseverance to be able to reach that objective.

Among the factors that acted as catalysts, improved coordination and support from other frontline workers, such as ASHA workers, as well as participation from GP members have aided in better beneficiary attendance in the AWCs. This has even led to a lessening of the burden on the AWW as awareness created by ASHA workers and support shown for the scheme by GP members has resulted in beneficiaries coming to the centres by themselves. However, a critical issue that emerged here was the gap in both linking the scheme to ASHA workers' incentive-based compensations, as well as adequate training and awareness programmes conducted for panchayats. For example, during a district-level meeting with the Commissioner at H.D. Kote, the Deputy Director and CDPO requested the DoH officials to instruct the ASHA workers to lend support to the scheme. However, the DoH officials clearly stated that since ASHA workers were on incentive-based pay structures, the move to link the MPS to ASHA workers' workload had to be moved at the state level.[23]

Other issues with convergence and coordination noted were to do with women's movements between their natal and marital homes. This led to confusion about which AWCs the women would avail the scheme from, particularly if they move mid-way through their pregnancy. Women also return to their husband's homes after child birth, making it difficult for workers to monitor beneficiaries. The lack of

[23] The district-level meeting was held on 25 May, 2017.

communication between AWCs becomes a critical challenge here. In the post-pilot phase, the state may consider this as a desirable initiative to enable smooth implementation of the scheme.

Training/ Meetings

While personnel form the heart of the MPS, training becomes a key factor in ensuring that personnel are appropriately utilised and have the capacities to perform their roles. However, our fieldwork revealed that training was one of the weakest links in the implementation of the MPS in the pilot phase. As noted earlier, what was critically absent was a participatory approach to training that took into account local knowledge and challenges in building a shared body of knowledge for practice. Instead, training took on the form of lectures and information dissemination, along with the communication of strong expectations placed AWWs and others in charge of the scheme in ensuring its operationalisation.[24] The trainings and meetings observed by the CBPS team were mainly for frontline functionaries like AWWs, AWHs, ASHA workers and GP members.[25]The capacity-building exercises relied largely on the lecture mode, sessions were not very interactive and activities were used to have the workers repeat information about the scheme shared by the trainers. Some sessions however, had activities relating to the scheme and its implementation. For example, at a training[26] for AWWs attended by the CBPS team, the AWC supervisors organised a role play activity to train teachers on how to

[24] It should be noted that in at least one of the trainings observed, the CBPS team did note the use of games and role play. However, on clarifying with the supervisors, we found that the game (Chinese Whispers) was used as an activity to improve concentration and break the monotony of training, and the skit was organised with the expectation of workers to reproduce the information and knowledge given during the training. It is also important for activities during training to be structured as integral to the objectives of the training itself, and as avenues through which workers and other stakeholders can develop insights through their own processes of enquiry.

[25] The following trainings were observed: a) Training programme for AWWs and ASHA workers in H.D. Kote on 23 February, 2017 b) Training programme for ASHA workers, at H.D. Kote on 8 March, 2017c) Gram Sabha, with a discussion of the MPS on 28 February, 2017d) A block-level meeting to create district level awareness was attended at H.D. Kote on 18 March, 2017 e)An MPS re-training programme in H.D. Kote on 21 March, 2017.

[26]Training session held at H.D. Kote on 8March, 2017.

convince the pregnant/lactating women to come to the centres and the challenges involved in the process. The training for AWW and ASHA workers mainly focused on giving them additional information about maternal nutrition, maternal mortality, hygiene and cleanliness and provisions and responsibilities as part of the scheme. Field-level challenges and issues faced by workers that were raised during trainings, or even during circle meetings, were addressed by the supervisors. However, concrete solutions were not offered. To cite an example, in a training session[27] of AWWs attended by the CBPS team in H.D. Kote, it was found that when one of the participants, a middle-aged woman from one of the AWCs in Annur GP raised the issue of difficulty in running the scheme in mini AWCs, the trainer acknowledged the fact and said that the GoI needs to act on this urgently. Lack of interaction and a participative approach to the scheme is corroborated by the account of training given by an official at H.D. Kote, who noted that since the content of these sessions remained the same, it wouldn't matter if the workers missed a session or two.[28]

Training/meeting organised with GP members was mainly to elicit their cooperation in implementing the scheme.[29]Community support, as we noted through the study period, is an important catalyst in the working of the scheme. However, as a result of poor communication resulting in lack of information on trainings among GP members, and in the absence of more holistic and targeted training programmes thatbring about motivational and attitudinal changes in members by engaging them more critically with issues of maternal health and mortality, community support in implementation of the scheme remained unharnessed during the pilot phase. This should receive more attention and effort in the post-pilot phase of scheme implementation.

[27]Training session held at H.D. Kote on 23February, 2017.
[28]As reported by a district official during discussions regarding upcoming training sessions on child marriage and MPSon 13 June, 2017.
[29]As observed during a community training session held at Annur GP, H.D. Kote. (Field visit dated 22 March, 2017).

In fact, during our study period of three months, a second training had to be organised for H.D. Kote[30] due to the poor response to the scheme in the district. In the absence of more nuanced and participative approaches, these trainings remain routine exercises and avenues through which the final responsibility for the scheme can be transferred to the frontline workers.

We noted that the trainings are poor on informational content itself, as was evident from the confusion about the implementation schemes till present among the lower level functionaries and lack of sound knowledge on the functioning of the scheme among officials as well. For example, discussions with individual workers at Jamkhandi showed that they were unsure of issues such as whether the menu could be modified, how to dispose of extra food when beneficiaries do not come for the meals and how to manage the excess stock and budgets which do not get spent because beneficiaries do not avail the scheme. There also seemed to be a lack of adequate health-related information among workers, and it was seen that in some cases workers were unable to address beneficiaries' questions. For example, during a visit to an AWC in Jamkhandi, the AWW raised the issue of consuming an egg daily during pregnancy, with the field researcher. Stating that beneficiaries' felt that this would cause body heat, she and the beneficiaries looked to the researcher for answers.[31] Similarly, during a visit to a circle meeting in H.D. Kote, the supervisor and workers admitted to the field researcher that they were unable to convince beneficiaries who raised several questions about the scheme. Observing the field researcher's discussion with a beneficiary who had refused to come for the meals and challenged the field researcher to give guarantees about her health if she consumed the food given at the AWC rather than the meals recommended by her elders, the workers and supervisor stated that they were unable to address such

[30]Training for workers held on 14 June, 2017.
[31] Field visit dated 27 March, 2017.

beliefs among women.[32] This points to the need to foresee such questions and opposition, and equip AWWs with answers. This will also help in gaining consensus and building the confidence of the AWWs themselves.

c. Responsibilisation of the frontline worker

The final set of issues we observed with respect to the administration of the scheme was the phenomenon of responsibilisation of the last worker in the chain – the AWW. Despite several gaps observed in the pilot implementation, it was the AWW who was held responsible for the success/failure of the scheme. While the state laid pressure on the districts to ensure that the programme was implemented despite the delays in funds, and other resources, district-level officials laid responsibility on the workers. For example, senior district government officials spoke of how the scheme would be a success if the workers work with full dedication and use their time efficiently.[33] As mentioned above, these views were complemented by arguments such as the workers were not overburdened but lacked incentive to work. Incentive-driven payments, akin to those of ASHA workers were proposed as solutions to ensuring that the scheme was efficiently implemented, eliding over other issues such as cultural factors and the position of the workers in the community itself, within which they hardly enjoy any authority. In fact, officials spoke about the difficulties in motivating AWWs to take up additional responsibilities of the scheme, arguing that the workers have gotten comfortable with their job and salary at the end of the month. Therefore, it was important to make them feel insecure. They should have a target output and salary paid accordingly.[34]

While district officials pointed to similar issues regarding the delay in funds and provisions and the challenges of working with communities rooted in traditional mindsets and ideologies in discussions, this was never referenced in discussions with AWWs, or with field staff when discussing the workers' roles. In fact, as we

[32] Field visit dated 25 May, 2017.
[33] As reported by district officials at H.D. Kote during discussions on 12 June, 2017.
[34] Discussion with district officials, H.D. Kote on 12 June, 2017.

also noted above, during trainings and other meetings with AWWs, when issues such as community perceptions of the scheme, cultural and traditional practices related to pregnancy and lactation and the distance of the AWCs from beneficiaries' homes were brought up, the district officials brushed these concerns aside and instead transferred the onus of ensuring that the scheme functions in spite of all these challenges to the workers themselves. This has led not just to an increased workload for the frontline workers but also a greater responsibility to ensure that the scheme works at all costs.

Caught between the expectations of superior officials for better implementation and a politically charged community refusing to budge on certain principles such as caste differences and equally insistent on reinstating THRs, and lacking status and authority within the community who views them as one among them, AWWs are placed in a tight spot with respect to the implementation of the scheme. This point in fact came up in discussions with workers, especially in H.D. Kote where they stated that it was difficult to convince the women to eat outside their homes, as they did not have the same legitimising power as the teachers in government schools (who administer midday meals to children). Further, even in blocks such as Madhugiri and Manvi, where the scheme has been reported to be functioning well,[35] limited interactions with workers revealed that threats of withholding other ICDS services had to be used with the beneficiaries to ensure compliance, since they had to ensure that the scheme was functional and they had little other means of authority by which to ensure this.[36] In the long run, such measures may be detrimental to the absorption of the programme by the community and may create more distrust in the workers. If the scheme has to be successful, more intensive mobilising efforts with the communities are imperative. This gets clearer when one analyses the socio-cultural and personal issues.

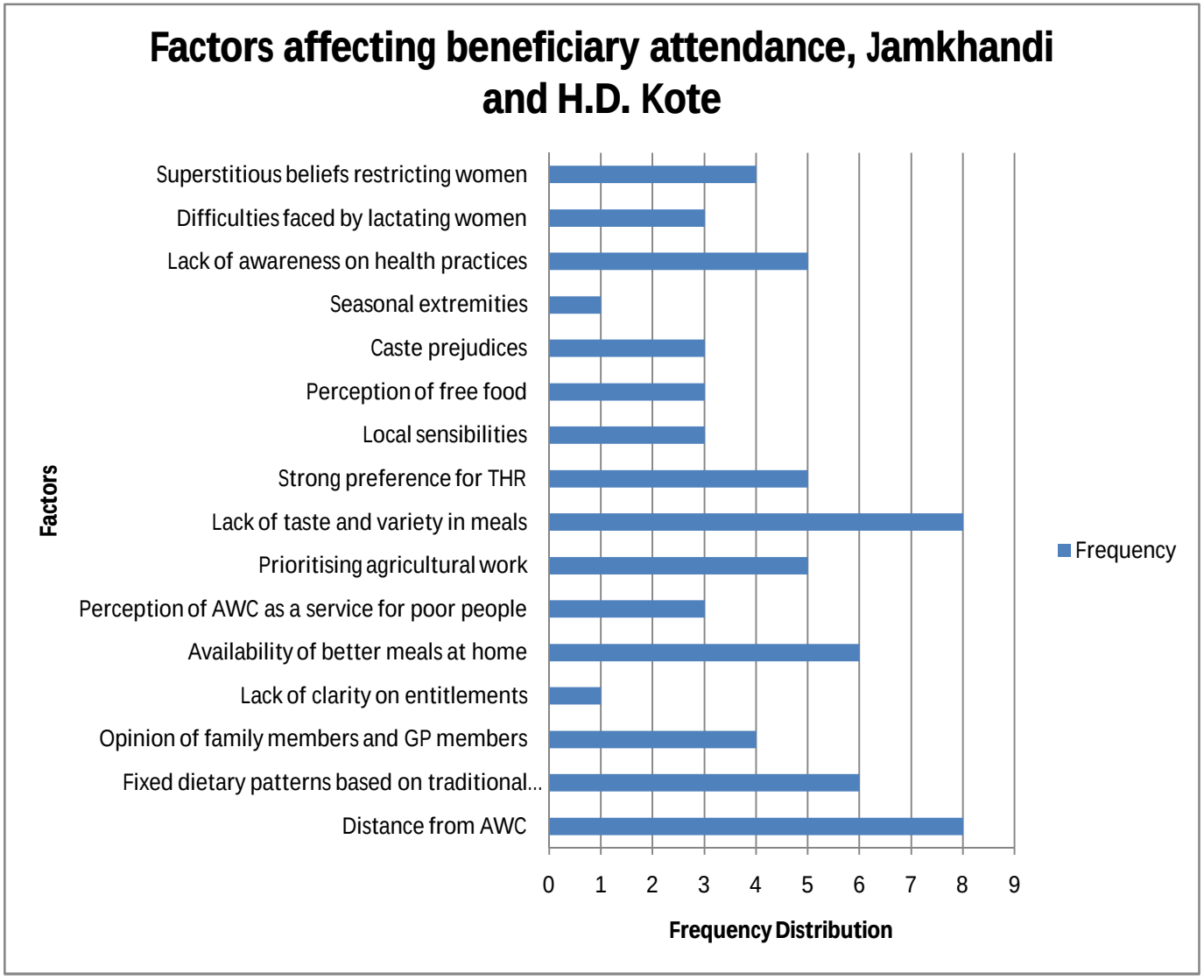
[35] As reported during discussions with the Principal Secretary on 2 May, 2017.

[36] As reported by two workers during an informal conversation on 22 June, 2017, when attending a workshop organised by DWCD on "Training state-level officers on the Mathru Poorna scheme".

5.2ii. Socio-cultural and political constraints

Having discussed the administrative hurdles to the implementation of the scheme, we now present the strong socio-cultural factors that have contributed to the low uptake of the scheme in certain areas during the pilot phase. The table below presents the beneficiaries' own accounts of reasons for not availing the MPS.

Figure 7: Reasons stated by beneficiaries for not attending the MPS[37]



Source: Field data (March-June 2017)

[37]Based on data from field notes collected from Jamkhandi and H.D. Kote between February-June, 2017.

The common reasons being cited for not wanting to come for meals include distance to AWC, dislike of the taste of the meals being prepared, menu being served for lunch, fixed timings, availability of better meals at home, discouragement from elders in the family and community. Distance, as we have discussed earlier, was a challenge specifically in Jamkhandi where many families stayed in their fields. As one AWW at Jamkhandi reported to us "Only 4-5 women come to eat, as the rest of them live in the interiors and do not come. They have agreed to come when the temperature drops and gets cooler, during monsoons. Also, they do not consume eggs as the beneficiaries belong to the Lingayat caste."[38]

Visibility of women coming to the AWCs was another issue that was brought up and many beneficiaries reported that they were subjected to ridicule and snide remarks, which ranged from comments made regarding their desire to consume eggs (associated with their lower caste status) to immaturity in availing such a scheme. Some beneficiaries also spoke of how the provision of eggs was leading to community discouragement. Often the beneficiaries would eat the egg but not admit to have consumed eggs at the AWC. In other cases, women even stated that "I want to come to the AWC, but my husband does not allow me to come and would say things like 'Why are you going to eat at the anganwadi like a child?'"[39]

Beneficiaries responses suggested that such comments directly brought into question the reputation of their families or themselves. Household economic status and poverty became the subjects of discussion within the community as a result of their visit for the meals and the perception of women's infantile attitudes and lack of maturity/responsibility all seem to be linked up with these visits.

These observations revealed the continued perception of AWCs as resources for poor families. In Jamkhandi, households with higher levels of affluence did not want

[38] As reported by an AWH in Jamkhandi, during field visits dated 27 March, 2017.
[39] As reported by a 20 year old pregnant Lingayat woman expecting her first child at an AWC in Jamkhandi (field visit dated 27 March, 2017).

to associate themselves with institutions that provide services for the poorer sections of the society. It was considered demeaning in the society if a woman went to the AWC, which was not the case for children. The general perception of free food is associated with vulnerable groups, children, elderly and disabled. Discussions with AWWs revealed that with minimum levels of food security present for the poorest tribal families from H.D. Kote as well, cooked meals at AWCs were looked down upon, and women did not consider it worthwhile to leave their work/chores to get one meal at the AWC. Further perceptions and quality of the AWC food vis-à-vis food received at home became another barrier for the uptake of the scheme. AWC food was seen as tasteless and lacking variety. Women complained that it was the same meal of *anna-sambar* every day and they also questioned why they must go to the AWC to avail food options that they had at home itself. This was especially true in the case of Jamkhandi, where women were articulate about the variety of dishes they prepared for one meal at home. They argued that their meals at home consisted of *rotis*, salads, chutneys, pickles, different kinds of vegetables, curd and ghee. Women pointed out to the field researchers that they prepared this full meal for their family members to enjoy and were being forced to come to eat an unappetising meal at the AWC which consisted of rice and *sambar* daily, with the latter consisting of no more than one tiny portion of tomato or one small piece of drumstick and a few curry leaves. Thus, beneficiaries questioned the field researchers stating "Why should we come so far for just cooked rice and sambar? It is available at our homes too".[40]Even discussion with a GP member from Jamkhandi revealed the same, as she pointed out that "Everyone in this village is able to afford food. The SCs have sufficient food at home as well as access to good dairy products."[41]Further, a number of beneficiaries also complained of the smell of powdered milk and boiled rice and stated that this induced nausea. AWWs in H.D. Kote also pointed out to the field researchers that women do not come to the AWC stating that they were providing

[40] Field visit dated 28 March, 2017.
[41] Field visit dated 28 March, 2017.

inferior quality 'society rice' compared to the highly quality, nutritive rice that was purchased for them at home.[42]Further, in H.D. Kote, when it was pointed out to one of the AWWsthat the powdered milk had passed its expiry date, she responded by saying, "No one consumes the milk as they have access to dairy products and hence it is getting wasted[43]."Similarly, in Jamkhandi which is a well-irrigated area with plenty of dairy products, milk powder is not utilised as women get fresh dairy products at home. Instead, there was a request to replace milk with fruits, and a sweet item (a suggestion that was also made by a district official in H.D. Kote, who noted that it would be a good way to attract beneficiaries for the meals, as well as ensure that the milk gets consumed[44]). Thus flexibility in planning the food menu seems central to improving the uptake of the scheme. While discussions at the state level with higher officials revealed that this has been provided for, perhaps this needs to be better communicated at the grassroots level so that workers are also aware of the possibility of customising the meal.

Food practices were further tightly connected with traditional cultural beliefs regarding pregnancy and lactation. Anthropological studies of food have shown how eating practices, rituals and superstitions help people connect with their ethnicity. While the MPS supposedly has adopted a meal (constructed by nutrition experts), that constitutes 40 % of their RDA for P&L mothers, to improve health of the infant and the mother, field observations actually revealed that food practices, beliefs and superstitions varied across the two taluks studied, based on the composition of the population in each of the areas. For example, there are taboos and prescriptions related to what kinds of foods can be consumed by whom and this is particularly strong for P&L women. The dietary patterns observed during our field visits ranged from eating boiled rice, ghee and pepper (in Jamkhandi) after child birth to eating meat (in H.D. Kote) during pregnancy. There also seemed to be some

[42] As discussed during a circle meeting at H.D. Kote on 25 May, 2017.
[43]As reported by an AWW at Basavanagirihaddi AWC, H.D. Kote. (Field visit dated 14 June, 2017).
[44] As discussed with the Deputy Director, Mysore district on 25 May, 2017.

distinction with regards to the consumption of eggs among the different castes. In Jamkhandi, the beneficiaries spoke about how they did not consume egg, (mostly Lingayat), and also coming to the centre for "a simple meal of *sambar* and rice" seemed pointless to them. In H.D. Kote, culturally egg is not given at home to lactating mothers in Shanthipura (a village consisting of mixed population), while in Annurhaddi a strict diet of rice, pepper and ghee is followed. Some beneficiaries questioned the need to come to theAWC for an egg, when they could have meat products at home, for example, in villages such as Basavanhaddi (a village with a dominant tribal population), where mutton is prescribed as part of the diet. Hence, there is geographical variation in customs and norms followed by P&L mothers.

Fieldwork also revealed restrictions placed on water following the birth of the child, with women allowed to only consume half a glass of hot water for about 1-3 months. Further, in Jamkhandi, where beneficiaries are primarily Jain, it was also reported that they do not believe in consuming food outside their homes.

Food practices are also tightly connected with notions of 'purity' and 'pollution' which also determines who can receive cooked food from whom. Such cultural taboos about food created issues in centres where the AWH who cooks the meals was of a lower caste than the beneficiaries. Significantly, 'purity' and 'pollution' seemed to operate even if the AWH belonged to one of the upper castes but was considered to be of lower caste status than the beneficiaries. For example, at an AWC in Maigur, it was observed that the worker (who belonged to the Jain community that all beneficiaries themselves came from) had to prepare meals by herself to ensure the attendance of beneficiaries since they would not eat the meal cooked by the Lingayat worker. In order to manage this additional load, the worker explained to us that she boiled the pulses for the sambar at home and only added the seasoning and masala at the AWC. She also added that due to added responsibilities, she was finding it difficult to concentrate on pre-school education and maintenance of records. These cases represent not just the additional burden on the worker but also

indicate how they are responsibilised to take on the onus to make sure the programme functions. Although the AWH provides support to the worker, the beneficiaries refuse to eat meals cooked by a lower caste AWH, increasing the burden on the worker.

The layers of caste hierarchies further became evident in other instances as well. We observed that lower caste women discriminate against migrant workers, refusing to share space with them for a meal, just as beneficiaries from a higher caste would not share space with lower caste women during meals. This was observed in H.D. Kote, while in Jamkhandi, we also observed that a worker from an upper caste herself would not enter the houses of lower caste women while making household visits to call the beneficiaries for the meals. We found that while in certain cases AWWs and frontline staff have to contend with deep-rooted socio-cultural practices and norms of community engagement, in others, they themselves were limited in their abilities to run the scheme effectively due to the same mindsets and communities that they came from. This suggests that stronger training is needed not just in content awareness for workers but also through additional strategies to counter mindsets of both workers and communities.

While these personal cultural factors seemed to have a strong impact on the functioning of the programme, not all respondents rejected the meals. The data seems to however suggest the role of family size and structure as critical in influencing positive responses to the scheme. For example, a beneficiary in her eighth month of pregnancy at an AWC at Jamkhandi was asked her opinion on the scheme and said, “It is convenient for me to come to the AWC as my house is close and there’s no one at home throughout the day. My husband goes to work in the morning and there are no in-laws living with us. As it is difficult for me to cook for myself during the day, I prefer coming to the anganwadi for the meals. Although it is difficult to walk in the sun, I prefer this over THRs. The food cooked at the anganwadi is tastier than what I cook at home. If tiffin system was started, then I

won't end up eating on time and would continue with household work. But I must admit that I find it convenient as I live only with my husband, while this might not be the case for other women who are usually asked a number of questions if they leave their homes to go eat at the anganwadi."[45]

Similarly, it was also noticed that in all but one AWC visited at H.D. Kote, women were refusing to come for the meals. On probing further, beneficiaries at Annurhaddi, where women were availing the meals stated that since elders in their homes were supportive of this, they were coming for the meals. They also reported that the day their elders felt that they should not go for the meals as it was not good for them, they would stop coming for the meals.[46] This seemed to be a prominent trend in H.D. Kote, where family ratification of meals at AWCs was also linked to strong, traditional health-related beliefs. While communities seemed to lack modern knowledge of medicine and health and were also reported to have poor childcare practices (e.g. workers reported

Collectivisation of beneficiaries:

An interesting form of collectivisation was encountered in Jamkhandi. Although there were a number of prejudices barring the beneficiaries' mobility, the beneficiaries were vociferous about their right to entitlements. They were unwilling to give up their entitlement to food, irrespective of the shift from THRs to HCMs. It seemed that there was a collectivisation emerging, where women were coming together to articulate their demand for food. This collectivisation is different from that envisioned when formulating the scheme.

Women were willing to stand in favour of the scheme if it benefitted marginalised women in other areas.

Thus a sense of sisterhood was observed among the beneficiaries as one of the positive impacts of the scheme.

[45] Field visit dated 27 March, 2017.
[46] Field visit dated 26 May, 2017.

that mothers used to drink and abandon their children)[47] staunch beliefs in traditional health practices passed down from one generation to another were adhered to strongly. Most beneficiaries spoke about the health benefits of diets prescribed by the elders in their homes, which they considered beneficial and properly suited to their health as well.

This was also linked with other practices such as restriction of mobility for lactating women, with the result that in most AWCs (even in those where women came during their pregnancies), the numbers of lactating women attending the meal was close to nil. Strong traditional beliefs regarding confining women to a single room during the first three months in Jamkhandi and at least for a month in H.D. Kote were responsible for this poor attendance of lactating women. The restriction period for lactating women varied from place to place. For instance, in Basavanhaddi, beneficiaries did not leave their houses for a year after delivery, while in Shanthipura, the period was of two months and in Annurhaddi, it was 45 days. Further discussions with the community showed that there were traditional beliefs regarding women being possessed by spirits, or catching 'dust' (signifying perhaps that they may be susceptible to falling ill due to exposure to the elements), because of which families disallowed their women from going out during the early months after childbirth. Oddly enough, these mobility taboos did not apply to the same beneficiaries when they went for medical check-ups. In Shirguppe, during a household visit to a lactating mother staying at her native place, her mother spoke about how her daughter will not be let outside the home for five months after delivery, which is when she would be going back to her husband's house. She spoke about the hazards of venturing outside the domestic space where her daughter might be inflicted by the devil or the evil spirit, fall sick due to the dust and would probably not even like the taste of the meals.[48]Another beneficiary reported about

[47] As discussed at a circle meeting at H.D. Kote on 25 May, 2017.
[48] Field visit dated 28 March, 2017.

how her temple rules of worshipping the Shani Mahatma mandated that she not step out of her home for the next three years.[49]

Other beneficiaries spoke about their difficulty in coming as they worked in their fields. A significant number of the beneficiaries interviewed prioritised agricultural work during pregnancy over going to AWCs for a free meal. While conversing with a GP member on the overall functioning of the scheme in Ganiger Oni, where the scheme was functioning relatively well, she argued that, "People in the village are fighting with me to reinstate the THRs. They would fight with the CDPO and supervisors during their visits to the village, as they find it difficult to walk three to four kms to eat the meals. The women become hungry by the time they get back. What is the rationale behind this scheme without making additional considerations of transporting the meals to the beneficiaries? The pregnant women work in the fields, and they are tired by the time it is afternoon. It is not possible to come and eat the meals after that. Due to this, the responsibility falls on the AWW, who is already overburdened with work."[50]

Due to the prioritisation of work over women's health and nutrition, women even reported that they would not come for meals even if the food was better than what is consumed at their homes. They also added that they can come to talk, if required. Perhaps this implies stricter consumption taboos but flexible mobility taboos and also the need to couple the nutrition-related services with empowerment programmes (not just information and awareness), to ensure that women also pay attention to their own health[51].

In conversation with district-level officials, it was noticed that they were aware of the lack of health awareness prevalent in the community. They mentioned how

[49] As reported by a 26 year-old lactating mother at Basavanagirihaddi, H.D. Kote. (Field visited dated 14 June, 2017).
[50] Field visit dated 28 March, 2017.
[51] As reported by a group of beneficiaries at Basavanagirihaddi AWC, H.D. Kote. (Field visit dated 14 June, 2017).

women are largely unaware of health and hygiene concerns, where eating is guided by traditional norms and since people are not aware of the importance of including certain nutrients in their meals during pregnancy and after delivery, they are reluctant to eat at the centres.

While the issues raised above remain a big challenge for the MPS, we conclude our field observations with the roadmap identified by the DWCD itself in addressing some of these concerns. One important solution raised by a senior official was with regards to changing the perception of the AWC as a centre for cognitive development of mother and the child.[52]The official argued that the centre should be envisioned as a space catering to education, health and the cognitive development of the child. While this would be an important step in the right direction, it is also important that resourcing and personnel constraints, along with issues of local-level engagement and participative planning and the convergence of scheme with other departments and stakeholders be addressed in order to ensure the full functioning of the scheme.

[52] As discussed with the Principal Secretary during the reflective workshop organised on 2 May, 2017, at CBPS.

Chapter 6: Conclusion

In the light of continued high MMR and IMR rates and poor health and nutrition indicators for women and children in the state, the GoK launching the MPS is commendable. Drawing on lessons learnt elsewhere, the scheme has aimed at ensuring that at least 40 percent of the required nutritional input P&L women was made available to them and in addition has also sought to ensure that this nutrition was consumed by the women themselves through daily monitoring at the AWCs. The scheme further has sought to go beyond an instrumental approach of viewing 'women as wombs' and also sought to provide opportunities for women to come together, discuss important issues related to their well-being and children's growth and development, and also combat problems of post-partum depression, by conceiving of the AWC and the meal-time as a space for women to come together and receive support from workers and peers.

While the rationale with which the scheme has been adopted needs to be applauded, there are several practical challenges in its implementation. Problems identified through this study range from the lack of adequate consensus built at the community level through participatory learning approaches, involving community and workers at the grassroots to compulsion becoming the means to ensure participation in the absence of other options available with the worker to encourage participation. Both of these may prove detrimental to the long term outcomes of the programme, as they may lead to disgruntled beneficiaries and stakeholders rather than those appreciative of the state's services.

What is important for long-term impact and sustenance of the programme are critical attitudinal and behavioural changes amongst women and community members, viewing women's nutrition and health as of intrinsic importance as well as contributing to the community's well-being as a whole. Critical behavioural change requires deeper empowerment-related education for women and other stakeholders

within the community who need to be able to perceive of the scheme as more than a women's issue or benefits for women, and instead view it as a community concern, in order to counter the patriarchal attitudes to, and backlash against, the scheme. Pushing the scheme on to the community without involving everyone has negative effects for women's participation and place in the community itself and may lead to further strengthening of certain patriarchal values and expectations placed on women.

It should be recognised that long-standing problems of caste and gender discrimination, patriarchal attitudes and traditional beliefs and superstitions cannot be redressed overnight. Such changes require constant, long-term engagement with the community and a truly participative approach wherein knowledge is co-created and social change co-facilitated. Such deep-rooted changes, which require long-term sustenance also require community buy-in which cannot be obtained in the absence of efforts made to engage community leaders and other frontline workers. Thus inter-departmental convergences and joint efforts and attempts to harness the panchayat in mobilisation and training-related activities is essential, rather than just viewing them as receivers of benefits or training.

These changes also need to be preceded by changes brought to the functioning of the AWC and the status of the worker. With the AWC still largely being viewed as a service centre for the poor, beneficiaries hesitate to come to it for food. Thus there is a need to re-position the AWC as a community centre through additional activities undertaken to convert it into a learning centre for mothers and children. Further, the role of the AWW itself needs to be strengthened, not just through training, but through a re-positioning of her role as that of a trained childcare professional. With little authority and status within the community, which perceives her to be one among them, as well as someone with little health knowledge (unlike medical doctors and auxiliary nurses/midwives (ANMs) and knowledge of children's

education (unlike government school teachers), the worker commands little respect and is thus unlikely to be able to influence her community.

Further, observations in the field showed delays in reception of funds and material for implementation of the programme. Efficient implementation requires appropriate planning and also assurance of availability of adequate resources to ensure that the scheme is smoothly rolled out, without any kind of interruption. Rather than implementing the scheme in an urgency, it would be advisable to plan well for it in advance and unroll the scheme once all infrastructure, personnel and funds are in place. Field observations did show certain factors critical to the success of the scheme. These included adequate availability of own building, full strength of staff and adequate support from panchayat members. It is important to ensure that these considerations are met on a priority basis in order to increase the uptake of the scheme.

As indicated in the data collected from H.D. Kote, the number of beneficiaries availing the scheme seems to have increased in June 2017. This is perhaps an indication that with time and continuous engagement with the beneficiaries, initial operational issues and concerns can be ironed out and there may be a further increase in the number of beneficiaries attending.

Finally, sensitivity in engaging with community-level differences – in food patterns, geographical conditions, patriarchal practices, caste practices and employment conditions go a long way in contextualising the programme to make it more effective. Appropriate targeting of the community with specific messages through IEC would not only generate awareness of the scheme but also ensure changes in critical attitudes. Well-designed mass media messages play an enabling role given the penetration of radio-TV in rural areas. But it would be important to recognise that in order to be effective, this must address different audiences including the elders in the family and the larger community. It is clear that the woman alone is not

deciding for herself – the whole family is. Initial targeting of all through mass media followed by more intimate strategies of collectivising women through this programme and empowering them about their own rights and potential may bring change but it would require a clearly articulated policy framework and implementation pathway to be able to reach there.

ROAD MAP FOR IMPROVED SCHEME IMPLEMENTATION
• Build greater consensus within the community with respect to the scheme through more district level consultations and meetings with important local level stakeholders • Address the variations at the district level with specific messages, IEC campaigns (mass media for all and more targeting individual ones for women themselves) and flexibility given to district staff in planning • Repositioning and rebranding of the AWC as a community centre and the AWW as a 'childcare professional'. Positioning the AWC as a space for the community to use and to contribute to • Address critical issues of responsibilisation of frontline workers and overburdening – mentoring and support, and adoption specific strategies / tasks by other members of the district team to ensure smooth functioning of the scheme • Inter-departmental convergence essential – important to develop support and authority for frontline worker • Approach to be combined with an empowerment approach that also enables women to challenge structures of patriarchy, demand for their rights and entitlements • Attention to training important and reconceptualization of training as a participatory process essential

References

Agarwal, O. P., & Somanathan, T. V. (2005). Public Policy Making in India: Issues and Remedies. Retrieved from: http://www1.ximb.ac.in/users/fac/shambu/sprasad.nsf/0/e78490ff090249d06525730c0030abf9/$FILE/Public_Policy_Making_in_India_TV_SOMANATHAN.pdf

Altheide, D. L. (1987). Ethnographic Content Analysis. *Qualitative Sociology*. *Human Sciences Press.* 10,1. 65-68.

Aronson, J. (1995). A Pragmatic View of Thematic Analysis. *The Qualitative Report*, 2,I. 1-3. Retrieved from: http://nsuworks.nova.edu/tqr/vol2/iss1/3

Bradshaw, S. (2015).Gendered Rights in the Post-2015 Development and Disasters Agenda. IDS Bulletin, 46,4,59-65. Retrieved from https://opendocs.ids.ac.uk /opendocs /bitstream/ handle/123456789/7734/IDSB_46_4_10.1111-1759-5436.12158.pdf?sequence=1&isAllowed=y

Bhutta, Z.A., Das, J.K., Rizvi, A., Gaffey, M.F., Walker, N., Horton, S.Black, R.E. (2013). Evidence-based Interventions for Improvement of Maternal and Child Nutrition: What Can be Done and at What Cost? *Lancet*, 382, 452-477.

Catherin, N., B, R., V, Roger.,Ankita,C., G, A., P, D., Shanbag, D., BR, G. (2015). Beliefs and practices regarding nutrition during pregnancy and lactation in a rural area in Karnataka, India: a qualitative study. *International Journal of Community Medicine and Public Health*. 2, 2, 116-120.

CBPS-UNICEF.(2017). *A Review of Expenditure and Services of ICDS in Karnataka*. Hyderabad: UNICEF.

CBPS-UNICEF (2017). Draft Report on Nutrition in Karnataka, Hyderabad: UNICEF.

Census.(2011). District Census Handbook.Directorate of Census Operations.Government of India. Karnataka

Dahiya, S., and Viswanathan, B. (2014). Women's Malnutrition in India: The Role of Economic and Social Status. *Madras School of Economics Working Paper* No. 93, 1-33, Retrieved from http://www.mse.ac.in/wp-content/uploads/2016/09/working-paper-93.pdf, accessed on 23rd July, 2017.

DWCD-UNICEF (n.d.).Focus on Mothers to Reduce Low Birth Weight: One Full Meal to Pregnant and Lactating Women-Piloting in 4 Taluks of Karnataka, Government of Karnataka, Department of Women and Child Development.

DWCD -UNICEF. (2016). *Brief Report on Training of Trainers (TOT) to Initiate MathruPoorna Scheme*. Department of Women and Child Development.

DWCD-UNICEF.(2016). MathruPoorna Scheme.Manual of Nutritious and Hot Lunch to Pregnant Women and Lactating Mothers Programme.Government of Karnataka. Department of Women and Child Development.

Dunn, W. N. (2016). Public Policy Analysis.(5th Edition). Oxon: Routledge.

Government of India.District at a Glance- Bagalkot 2012-2013.National Informatics Centre. Retrieved from: http://www.bagalkot.nic.in/index-en.html

Gupta, P. (2016). Understanding Food and Diet Pattern during Pregnancy among the Chamar Women in Rural Uttar Pradesh: Perceptions and Practices. *Journal of the Anthropological Survey of India*, 65,1, 23-37.

Hammersly, M., and Atkinson, P. (2007).*Ethnography. Principles in Practice*(3rd ed.). Taylor & Francis e-library.

Hill, M. and Varone, F. (2017).*The Public Policy Process*.(7th Edition). Oxon: Routledge.

Jose, S. and Navaneetham, K. (2008).A Factsheet on Women's Malnutrition in India.*Economic and Political Weekly*, 43,33, 61-67.

Kabeer, N. (1999). Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment. *Development and Change*, 30, 435-464.

Kaliamoorthi, M. (2013).Poverty and Malnutrition.*Language in India*, 13,4, 67-78. Retrieved from http://languageinindia.com/april2013/kaliamurthi.pdf.

Kilpatrick, D. (2000). Definitions of Public Policy and the Law. Retrieved from https://mainweb-v.musc.edu/vawprevention/policy/definition.shtml

Lasania,Y. (2014, November 30). Hot Meals in the Offing for Women, Children.*The Hindu*. Retrieved from: http://www.thehindu.com/todays-paper/tp-national/tp-andhrapradesh/hot-meals-in-the-offing-for-women-children/article6647990.ece

Lee, J., Thorat, S. (2005). Caste Discrimination and Food Security Programmes.*Economic and Political Weekly*. 40,49. 4198-4201.

Lokshin, M., Gupta, M.D., Gragnolati, M., and Ivaschenko, O. (2005). Improving Child Nutrition? The Integrated Child Development Services in India. *Development and Change,* 36,4, 613–640.

Maithreyi, R., Padmanabhan, S., Jha, J. and Menon, N. (2016).Skills Development, Social Mobility and Educational Change: A Sociological Analysis of the Effects of the National Policy on Skills Development in India.(Unpublished Report).

Mason, J, Bailes, A., Beda-Andourou, M., Copeland, N., Curtis, T., Deitchler, M. and Vance, G. (2005). Recent Trends in Malnutrition in Developing Regions: Vitamin A Deficiency, Anaemia, Iodine Deficiency, and Child Underweight. *Food and Nutrition Bulletin*, 26, 1, 59-16

Mintz, SW., Du Bois, C. (2002). The Anthropology of Food and Eating.*Annual Review of Anthropology* . 31, 99-119.

Moss, N. (2002). Gender Equity and Socioeconomic Inequality: A Framework for the Patterning of Women's Health. *Social Science and Medicine*, 54, 649-661.

Munshi, V., Yamey, G., and Verguet, S. (2016). Trends in State-Level Child Mortality, Maternal Mortality, and Fertility Rates in India.*Health Affairs,* 35, 10, 759-1763. Retrieved from http://globalhealth2035.org/sites/default/files/journal-articles/trends-state-level-child-mortality-india.pdf

Nayar, N., Kapil, U., Saxena, N. (1998). Nutrient Intake and Consumption of Supplementary Nutrition by Pregnant Mothers in ICDS and Non-ICDS Areas - A Pilot Study**.***Indian Pediatrics*, 35,287-289.

NIPCCD. (undated). Monitoring and Supervision of ICDS: A Concurrent Evaluation. *National Institute of Public Cooperation and Child Development*. New Delhi.

Paul, V.P., Sachdev, H.S., Mavalankar, D., Ramachandran, P., Sankar, M., Bhandari, N., Kirkwood, B. (2011). Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge. Lancet, 377, 332-349. doi: 10.1016/S01406736(10)61492-4

Planning, Programme, Monitoring and Statistics Department, Government of Karnataka. (2014). Human Development Report 2014.Government of Karnataka.

Press Information Bureau. (2014). Supplementary Nutrition Programe.*Ministry of Women and Child Development*, *Government of India.* Retrieved from: http://pib.nic.in/newsite/PrintRelease.aspx?relid=104046

Rajan,P., Gangbar,J., Gayithri, K. (2015). Integrated Child Development Services in Karnataka'.*The Institute for Social and Economic Change Working Paper* No. 333, Bangalore.

Ramakrishna, U. (2004). Nutrition and Low Birth Weight: From Research to Practice. American *Journal of Clinical Nutrition*, 79,1, 17-21.

Rao, N., Pradhan M., and Roy, D. (2017). Gender Justice and Food Security in India: A Review. *International Food Policy Research Institute (IFPRI) Discussion Paper* No. 01600,

1-26. Retrieved from http://www.ifpri.org/publication/gender-justice-and-food-security-india-review, accessed on 20th July, 2017.

Registrar General of India.(2012). *SRS Bulletin*.Registrar General, Government of India.

Registrar General of India. (2013).*SRS Bulletin*.Registrar General, Government of India.

Saxena, N.C. (2016). Governance Challenges to reducing hunger and malnutrition in India. In Sonali Desai, Lawrence Haddad, Deepta Chopra and AmitThorat (Eds.), *Undernutrition and Public Policy in India: Investing in the Future*. New Delhi: Routledge

Sethuraman, K., and Duvvury, N. (2007). The Nexus of Gender Discrimination with Malnutrition: An Introduction. *Economic and Political Weekly*, 42, 44, 49-53.

Shipan, C. R., & Volden, C. (2008). The Mechanisms of Policy Diffusion. *American Journal of Political Science,* 52,4. 840-841.

Tinker, A., Daly, P., Green, C., Saxenian, H., Lakshminarayan, R., and Gill, K. (1994). Women's Health and Nutrition: Making a Difference. *World Bank Discussion Papers (256)*. Washington: The International Bank for Reconstruction and Development/The World Bank.

UNICEF.(2017). One Full Meal Draft Report.UNICEF.(Unpublished report).

UN Women.(n.d.)*Women and Sustainable Development Goals*. Nairobi: UN Women Eastern and Southern Africa Regional Office. Retrieved from https://sustainabledevelopment.un.org/ content/documents/2322UN%20Women%20Analysis%20on%20Women%20and%20SDGs.pdf.

Unnamed. (undated). *Nutrition in Pregnancy and Lactation.*

Vaddiraju, A. K. (2015). Two steps forward one step back: Decentralisation as a policy process in India. *Journal of Social and Economic Development*, Institute for Social and Economic Change, 2-3.

Walker, S. P., Wachs, T. D., Grantham-McGregor, S., Black, M. M., Nelson, C.A., Huffman, S. L., & Gardner, J. M. M.(2011). Inequality in early childhood: risk and protective factors for early child development. *The Lancet, 378*(9799), 1325-1338.

Appendix

Appendix A: Fieldwork tools

Interview Guide

(A) For AWWs/AWHs

1a. Background and demographic characteristics of the village / AWC / pregnant and lactating women

b. explore questions of caste, income, occupation, age, education levels

c. Find out about the functioning of the village- how often does the GP meet? Are members active and aware about the roles and functions? How often do other committees like SMCs meet? How active and aware are they about their roles and functions? Have any of these committees been playing a role in ensuring nutrition/ health for pregnant and lactating women? Have they impacted the present scheme on HCM for pregnant and lactating women in any way?

d. Have there been any other government or non-government interventions that have also been working towards pregnant and lactating women's health and nutrition or women's empowerment (e.g., Mahilasamakhya)? How have these programmes impacted the functioning of the present scheme on HCMs for pregnant and lactating women under review?

2. Their understanding of the details/provisions of the MPS:

a.its goals and rationale

b.target population

c. services provided under the scheme

d. food menu-what are the items cooked and given in the meal?

e.infrastructure required/provided for implementation of the scheme- cooking gas; utensils (for cooking, storage and serving); water supply; storage of raw materials; proper kitchen etc.

f.procurement related issues-raw materials for cooking, IFA tablets etc., their role and responsibilities for this

g.issues of partnerships and convergences-with whom and in what ways?- with whom (the various other departmental functionaries as well as functionaries from their own department-WCD) and the ways in which they have to collaborate for delivery of services to pregnant and lactating women

h.how different is the scheme from the previous supplementary nutrition programme for women and lactating women?

i.capacity-building training workshops-whether attended; for how many days; how many times; issues discussed; who were the resource persons; their overall impressions on the programme

j.their role and responsibilities as mentioned in the scheme-services required from them (weight and health monitoring, immunisation, nutrition-related information, health or cleanliness related information, other specific tasks)

k.explore the roles / responsibilities / challenges that get thrown up by the new SNP format in relation to their overall workload and duties.

l.what is the role of the supervisors, CDPOs, other block and district-level staff in relation to this scheme?

3. Challenges faced by them with regard to:

a.infrastructure-issues of space constraint as the scheme involves spot feeding; presence of proper kitchen and its size; availability of cooking gas; sufficient utensils for cooking, serving, storage; abundance of water as cooking has to be done for even a larger population (because of the inclusion of the pregnant and lactating women) and for cleaning of utensils; storage of raw materials and IFA tablets etc.

b.procurement-delays in supply; quality issues and pilferage; bringing raw materials to the AWCs; availability of transportation for this purpose etc.

c.workload- How has the new scheme affected their workload? How do they split their time among their various tasks and also attend capacity-building workshops, meetings for various schemes- their coping mechanisms and strategies, if any?

d. understand the strengths, challenges and limitations of the earlier format and current formats comparatively (explore the AWWs/AWHs opinions, feelings, burdens related to the old and changed formats? According to them, does the new format address certain specific lacunae not addressed in the previous format? Does it create new challenges? Their personal opinions about how successful the uptake of this strategy will be, understanding the village or community dynamics.)

e. dealing with the beneficiaries (pregnant and lactating women) - Questions here must mainly explore the challenges and negotiations that have to be made with families and communities regardingspot-feeding for pregnant and lactating women. Do all pregnant and lactating women come or there is a caste/class dynamics in that as well? Whether these pregnant and lactating women are largely daughters or daughters in law or both?Examine how AWWs/AWHs undertake this especially in a context where women in a large number of rural communities are not allowed to come out of home at the advanced stage of pregnancy and for few months post-delivery-how do they ensure that the scheme reachesthose women?

f. Also explore and understand other dynamics such as how the loss of additional ration to the family kitty affects family's perceptions and compliance with the scheme

g. Explore gender and patriarchal relations that generally govern Indian/traditional families - for example in the context of literature and common knowledge that suggests that women eat the last at home; women usually eat leftovers saving most of the food for their families.

h. Ask questions about other aspects related to pregnancy/post-pregnancy - egs. postpartum depression, anxiety of new mothers, other problems related to health, relations between workload and pregnancy, anxieties or pressures related to having a boy/girl child that women bring with them when they visit the AWC. How do the AWWs/AWHs address these issues? Do women who come together for the HCMs have discussions around these issues? What are the outcomes?

i.How does the AWW/AWH address any of these issues (e.g., providescounselling for postpartum depression, shares information about managing pregnancy, post-pregnancy, new born children, about local traditions related to any of these) - try to probe how much of this may be in an official capacity and how much is informal; how much of this knowledge comes from formal training and how much is based on personal experience?

j.Seeking local support- what kinds of support are required? Who are the key stakeholders from whom support for the operationalisation of the scheme is required? Who are the key stakeholders from whom support for the success of the programmes is required?

k. Does this result is issues of coordination with any of the key stakeholders (e.g. GPs, BVSs, local SHGs or other critical stakeholders, etc.) Are there specific problems faced in relation to this?

l. Capacity-building workshops-time to attend; place where this is conducted; comprehension of the scheme; difference between what is taught and what is practiced (issue of pedagogy vs. practice) etc.

4.a. What techniques do they use to sensitise pregnant women and lactating mothers, including their families, about this scheme?-the ways for motivating them for spot-feeding in the AWCs?

b.Do they undertake house visits for this? What do they do in the case that women don't come to the AWCs for the HCM? Or families do not allow this? - Do they have a protocol for escalation in relation to this? What is the role of supervisors, CDPOs, and other block and district-level staff in addressing the issue/taking the programme forward?

5. Any other challenges?

6. Have they observed any effects of the programme on the women/ community (e.g., changes in weight or health status; changes in women's position or community dynamics, etc)

7. Their suggestions for betterment of the schemein terms of its scope and implementation

(B) Pregnant andlactating women

1a. Personal details: name, age, caste / religion, education level, marital status (to check if separated/widowed); household occupation / spouse's occupation; no. of years of marriage,no. of children, family type (joint, extended, nuclear); position in the family (e.g., eldestdaughter-in-law, etc); whether she is a daughter or a daughter-in-law of the household?

b. If pregnant, enquire about whether she is working and how long will she be working. If has stopped working, find out till which month she worked. If lactating,find out till which month she worked and when will she resume work. What kind of work is she involved in? Reasons for continuing work till end of pregnancy or immediately after child birth.

c. If lactating, find out about breast feeding practices. Ask pregnant women also about potential breast feeding practices.

d. Find out about how these practices were informed (e.g., working, breastfeeding, any other pregnancy and child care-related practices)

e. If they have other children, find out the kinds of services and care that was available to them for the earlier pregnancy and post-pregnancy period

f. If pregnant and lactating women also have their other children enrolled in the AWC?

2. What are the activities undertaken in the AWC for pregnant and lactating women? Are they satisfied with the services? Do they have any specific problems with the services?

3. New scheme on HCM for pregnant and lactating women?

a. How did they come to know about the scheme?

b. How do they find this spot-feeding? Is it convenient for them to come-distance and timings; carrying their new-born child etc.

c. Food: menu-whether they like the food, any suggestions on the menu and its quality, cooking (taste), hygiene etc; do they get the IFA tablets regularly?

4. Comparison of the two SNP formats - Which one is better- THRs (if yes, then why;if no, then why not) or the new HCM scheme (if yes, then why; if no, why not)?

5. Do they also get counselling or other forms of emotional support when they visit the AWC for the HCM? What kinds of support; do they find it useful/effective ((if yes, then why; if no, then also why so)?

6. Have they noted any changes (in weight, health, mood, etc) since the start of the HCM services for pregnant and lactating women? If yes, what do they attribute this to? (may be after a month of availing of the scheme by the respective woman)

(C) ANMs:

1. Personal details - qualification, age, years of service, place of residence, caste, religion

2. Their role and responsibilities under the scheme, as understood by them

3.a. Specific knowledge and services/duties related to pregnant and lactating women. Their understanding of the pregnant and lactating women in the village (how aware they are about pregnancy/ post-pregnancy/child care-related issues; family dynamics and how women are able to negotiate needs and issues related to pregnancy and child birth; specific local traditions or knowledge that guides their approach and strategies; gender related issues in care for child)

b. What specific services do they offer pregnant and lactating women? How effective are these? What challenges do they face in relation to these?

c. Are they aware of the new HCM programme for pregnant and lactating women? What is their opinion of this? How effective do they think the uptake of the programme will be? What might be challenges to the uptake of the programme? Have they observed any effects of the programme on women / community?

3. Challenges faced by them and how do they overcome them and carry forward the scheme-workload; infrastructure; procurement; seeking support from other stakeholders

4. Whether training provided to them for capacity building under this scheme is enough?

5. Their suggestions for the betterment of the scheme (ICDS and the HCM for pregnant and lactating women)

(D) ASHAs:

1. Personal details - qualification, age, years of service, place of residence, caste, religion

2. Their role and responsibilities under the scheme, as understood by them

3. a. Specific knowledge and services / duties related to pregnant and lactating women. Their understanding of the pregnant and lactating women in the village (how aware they are about pregnancy/ post-pregnancy/child care-related issues; family dynamics and how women are able to negotiate needs and issues related to pregnancy and child birth; specific local traditions/knowledges that guide their approach and strategies; gender-related issues in infant care)
b. What specific services do they offer pregnant and lactating women? How effective are these? What challenges do they face in relation to these?
c. Are they aware of the new HCM programme for pregnant and lactating women? What is their opinion of this? How effective will the uptake of the programme be? What might be challenges to the uptake of the programme? Have they observed any effects of the programme on women / community?

3. Challenges faced by them and how do they overcome them and carry forward the scheme-workload; infrastructure; procurement; seeking support from other stakeholders
4. Whether training provided to them for capacity-building under this scheme is enough?
5. Their suggestions for the betterment of the scheme (ICDS and the HCM for pregnant and lactating women)

(E) Focus Group Discussions
a.BVS members:
(Points to observe when conducting the FGD - who dominates the discussion? Who remains quiet?)
1) Background details about members - caste, age, religion, education level, whether they are members of other committees / or important people in the village
2) Members understanding of role of the BVS as envisaged under the ICDS as well as HCM scheme.

3) Their (BVS members) idea about the effectiveness/ineffectiveness of both ICDS and HCM scheme and suggestions for betterment of both the schemes - are they also aware of the new programme on HCM for pregnant and lactating women? How did they come to know of this? What is their opinion on this? How will it be received by the community? Is the scheme in line with local beliefs and traditions about care and nutrition for pregnant and lactating women?

4) Issues brought before them by the various frontline service delivery stakeholders like the AWWs, AWHs, ASHAs and ANMs about both the schemes (ICDS and HCM) and how do they address them

5) Perception of members of the Samitis regarding the various challenges faced by the various frontline service delivery stakeholders, especially the AWWs

b. Members of the local GP:

(Points to observe when conducting the FGD - who dominates the discussion? Who remains quiet?)

1) Background details about members - caste, age, religion, education level, whether they are members of other committees / or important people in the village

2) Members understanding of role of the local GP. Do they have linkages / intervene with respect to the ICDS programme?

3) Their (GP members) idea about the effectiveness/ineffectiveness of the scheme and suggestions for betterment of the scheme - are they also aware of the new HCM programme for pregnant and lactating women? How did they come to know of this? What is their opinion on this? How will it be received by the community? Is the scheme in line with local beliefs and traditions about care and nutrition for pregnant and lactating women?

4) Issues brought before them by the various like the AWWs, AWHs, ASHAs and ANMs about both the schemes frontline service delivery stakeholders about the scheme and how do they address them

5) Perception ofGPmembers regarding the various challenges faced by the various frontline service delivery stakeholders, especially the AWWs

C) Local Women SHGs:

1) their idea of what is the scheme about (if they are aware at all)?

2) are they involved or their support is being sought by the various stakeholders, especially AWWs? If yes, then in what ways?

3) their perceptions of problem with the scheme

4) their suggestions for the betterment of the scheme

Observations

1. AWC-related - AWC size, appearance, cleanliness, how it is decorated or organised, what facilities are available at the AWC, functioning of the various provisions such as water and toilets.

- AWC staff - timings, regularity, knowledge and performance of their work, workload, daily routines, problems faced, help and support received from community or other sources

- Functioning of the HCM scheme for pregnant and lactating women - timings (when cooking is done, when meals are served, how this is adjusted with other services), quality of food grains, cleanliness maintained

- satisfaction among beneficiaries with respect to the scheme - regularity of coming to the AWCs; other arrangements made to collect the food; who comes with women (do they come alone or accompanied with family members - find out why if possible); do women have discussions when they come for the HCMs? What do they discuss? Are there group dynamics/nepotism /favouritism?

2. Village and community dynamics - observe (if possible and however possible), spatial organisation of the village, landscape, cleanliness and sanitation issues, drainage patterns, water sources, nature of houses etc.

- observe which families access the AWCs (their caste, socio-economic status, religious beliefs, education levels)

- observe if possible traditions / rituals / celebrations that may be associated with pregnancy / birth

-observe (if possible) attitudes towards girl / boy child

- observe (if possible) gatekeepers of the village / who controls opinions / decisions, facilitates the progress of new schemes like the HCM scheme for pregnant and lactating women

- observe (if possible the) what is the general uptake of government schemes or non-governmental interventions in the village

- observe (if possible) the functioning of schools, PHCs, GPs, and other government institutions in the village

3. Family and home dynamics (for selected pregnant and lactating beneficiaries, after sufficient rapport is built) - socio-economic conditions of the house (type of house, amenities at home, how the house has been kept, number of family members, number of children); religious symbols and other objects or resources present in the house that can be an indicator of the households beliefs or responses towards the HCM scheme for pregnant and lactating women.

- inter-personal dynamics - who is the authority figure/decision maker in the house? Status of the pregnant and lactating women in the house? How do these interpersonal relations determine the take-up of the new scheme?

- Education level of the household and key members in the household - and how this has bearing on how the HCM scheme for pregnant and lactating women is taken up

Appendix B. DEMOGRAPHIC TABLES

1. Demographic details of Jamkhandi and H.D. Kotedistricts

Demographic details of Jamkhandi and HD Koteat the block level

SL NO.	Parameter	Jamakhandi	HD Kote	Percentages	
1	Total population (Census 2011)	4,70,176	263706	Jamakhandi	HD Kote
2	SC population	80138	73263	17	28
3	ST population	5866	62254	1	24
4	Literacy rate (male)	153901	84021	65	71
5	Literacy rate (female)	118296	66085	51	57
7	Workers (male)	237086	132748	59	57
8	Workers (female)	233090	130958	58	56
9	Workers engaged as cultivators (main and marginal)	53515	49328	32	37
10	Workers engaged as agricultural labourers(main and marginal)	60055	58425	36	44

11	Sex ratio	983	987
12	Child sex ratio (0-6 age group)	936	994

2. Demographic details of Bagalkote and Mysore at the district level

Demographic details of Bagalkote and Mysoredistricts			
SL NO.	**Parameter**	**Bagalkote**	**Mysore**
1	Total population (Census 2011)	1889752	3001127
2	Sex ratio	989	985
3	Total literacy rate	68.82	72.79
4	Literacy rate (male)	79.20%	78.50%
5	Literacy rate (female)	58.40%	67.10%
7	ST population	5.10%	11.10%
8	Work participation rate (male)	53.80%	61%
9	Work participation rate (female)	32.60%	26.30%

10	Percentage of people engaged as cultivators	24%	26.60%
11	Percentage of people engaged in agricultural labour	37.10%	23.70%
12	Other workers	33.50%	47.60%
13	Workers engaged in HHindustry	5.50%	2.10%