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Contribution of marginalized women to Atma Nirbhar Bharat

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Background:

Atmanirbhar Bharat Abhiyaan or Self-reliant India campaign is the vision of new India envisaged by the Hon'ble Prime Minister Shri Narendra Modi. On 12 May 2020, The PM declared the policy of Atmanirbhar Bharat Abhiyaan (Self-reliant India campaign) and announced the Special economic and comprehensive package of rs. 20 lakh crores - equivalent to 10% of India's GDP – to fight COVID-19 pandemic in India.

The aim was to make the country and its citizens independent and self-reliant in all senses. He further outlined five pillars of Aatma Nirbhar Bharat – Economy, Infrastructure, System, Vibrant Demography and Demand.

(Source : https://www.investindia.gov.in/atmanirbhar-bharat-abhiyaan)

The roots of Atma nirbhar Bharat lie in the concept of , 'Swayampurna Gram ' i.e. Independent Villages. It was the dream of Father of the Nation Mahatma Gandhiji. Majority population of India used to live in villages, rural development being the key to development of the country; Gandhiji gave the slogan of independent villages . In other words, every village should be a self-contained republic. To end the problem of poverty and starvation in the rural areas the surplus at village level may be distributed among the poor people. Only this can help eradicating poverty and thus people can be happy and self-reliant. Agricultural sector alone cannot solve the problem of rural poverty and unemployment. That's why Gandhiji gave stress on the growth of the rural industries like khadi, handlooms, sericulture and handicrafts, small industries, local market, local distribution, employment to local population.. He further said that it would lead to development of Rural areas and a world where no conflicts between the classes and no problem of over crowded cities.(Swayampurna Gram) India has a long history and a typical system which was based on 'Balutedari.'

Every Village was depending and running its own administration and economy through 12 Balutes. It consisted- Carpenter, farmer, gold smith, tailor and so on…

Slowly the systems vanished and the result is; many areas such as education, public health, sanitization in villages and rural economy including farming are at stake.

The marginal population in India is the low profile population having no significant status, position. Women are supposed to be marginalized as they are at secondary position having secondary status.

Further, some women are marginalized on account of no / insignificant source of income, lower social status, lack of education, lack of exposure. However when the marginalized women are trained, given specific task; they contribute to a great extend to the development of Society, Country. This research article is an attempt to search the role of few categories of marginal women working at grass root level in bringing transformation in rural India.

Objective of the paper: To find out the contribution of Anganwadi Workers, ASHA workers and SHG members in making rural India 'Atma Nibhar'—self-reliant.

Introduction

Marginal means which is small or not very important. Marginal people are those who are not involved in the main events or developments in society because they are poor or have no power.

(Source: Collins dictionary)

In precise marginalized people are those who have less control on their lives, have limited sources and are vulnerable in many respect. They lack respect/ status in Society and often have to lose their self esteem due to meager resources and earnings. It adversely affects their life style, health and various aspects.

Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.

Marginalized communities are those excluded from mainstream social, economic, educational, and/or cultural life. Examples of marginalized populations include groups excluded due to race, gender identity, sexual orientation, age, physical ability, language, and/or immigration status. Marginalization occurs due to unequal power relationships between social groups

Marginalization, as we currently define it, is the act of pushing someone to an unimportant or powerless position. Creating a feeling that they are less important and negligible and very small.

The word , 'Economic Marginalization' is used to describe a group of people, or countries that are excluded from participating equally in the economic system. It is used today to refer to global capitalism, and free markets.

These definitions are applicable to women in Society. Women is one of the category that is called marginal population. However, there has been a category which is called marginal women those who are powerless, income less, unaware of their rights and vulnerable. Let us call them as Marginal Women.

Marginal women:

Women are called to be marginalized due to their secondary position in their personal and social/economic/ political life. Women are deprived of equal rights; including right to take birth.

Marginalized women are those who really are neglected, given least importance, paid a very meagre remuneration. Despite of all these constraints however the marginalized women can contribute to a great extent to make rural India physically, socially, financially self-sufficient.

The Anganwadi workers, ASHA workers, SHG members, who are low profile female folk found to be empowered on account of their unique position and status. Not only their personal status is improved however, they explore a golden opportunity to strengthen the economy and contribute to socio-economic development of the Country.

It is interesting to note the role of certain marginal female workers in India contributing to self-reliant India in social/ economic/ health respect. The Anganwadi workers, ASHA workers, and members of Self Help Groups enjoy a typical status in Indian Society particularly in rural India.

ANGANWADI WORKERS

The word Anganwadi means "courtyard shelter" in Indian languages. They were started by the Indian government in 1975 as part of the Integrated Child Development Services (ICDS) program to combat child hunger and malnutrition. Anganwadi worker is a brain child of health and Nutrition Department.

Anganwadis are the crucial point for implementation of all the health, nutrition and early learning initiatives under ICDS.

The Anganwadi center provides basic health care in a village. It is a part of the Indian public health care system. It includes:

- Contraceptive counseling
- Supply, nutrition education and supplementation,
- Pre-school activities.
- The centers may be used as storehouses for oral rehydration salts, basic medicines and contraceptives.

The Ministry of Women Development and Child Welfare has laid down guidelines for the responsibilities of Anganwadi workers. These guidelines include:

- Showing community support
- Active participation in executing this program,
- Conducting regular quick surveys of all families,
- Organizing pre-school activities,
- Providing health and nutrition education to families, especially pregnant women,
- Motivating families to adopt family planning,
- Educating parents about child growth and development,
- Assisting in the implementation and execution of Kishori Shakti Yojana,
- Educating teenage girls and parents by organizing social awareness programs,
- Identifying disabilities in children.

Mechanism of Anganwadi centers:

- A Mukhya Sevika is appointed as a supervisor/ co-ordinator
- She supervises between 40 and 65 Anganwadi workers, --her role is to provide them with on-the-job training.
- Mukhya Sevikas' other duties are: keeping track of people of lower economic status benefiting from the program, in particular the malnourished; guiding the Anganwadi workers in assessing children's age and weight and plotting their weight; demonstrating effective methods of providing health and nutrition education to mothers; and maintaining statistics on Anganwadis and their workers to determine what can be improved.

- The Mukhya Sevikas report to the Child Development Projects.
- Anganwadi workers receive training to deal with health care requirements.
- They are preferred as they are living in the same rural area, which gives them insight into the state of health in the locality and assists in identifying the cause of problems and in countering them. They also have better social skills and can therefore more easily interact with the local people. As locals, they know and are comfortable with the local language and ways, are acquainted with the people, and are trusted.
- Anganwadi workers are paid around Rs 5000 a month .
- According to government data, the country has 13.77 lakh Anganwadies.
- Anganwadi workers played a magnificient role during pandemic, Covid-19.They created awareness about disease and how to fight against it. The strong network of Anganwadies made it possible to reach to villages and Padas effectively.
- Not only during pandemic but the devoted services of the Anganwadi Workers have helped to bring transformation in Rural India. Quick evaluation study of ICDS Anganwadi Centres by NITI Aayog showed that 76% of children in the sample were not malnourished. Also, over 75% of Anganwadi Centres were maintaining their records properly.
- That's why Anganwadis are said to be the backbone of India's grassroots social services platform for women and children

(NITI Ayog three year Agenda 2017-20)

Despite of admirable performance and role played by Anganwadi workers they face much difficult challenges. Those are enlisted below.

Challenges for Anganwadi workers:

The child and maternal mortality remain high despite of such a huge cadre of Anganwadi workers..

These centers play a key role in rural India but they need to play a much larger role in anchoring community development.

Nearly a fourth of centers lack drinking water facilities and 36 % do not have toilets.

ICDS beneficiaries do register for them but because the Anganwadis lack adequate facilities.

Anganwadi workers do not have any comprehensive manual on managing their roles. They are taught broad principles and it is left to their native wisdom to flesh out the details.

An Anganwadi Worker (AWW) is entrusted with many tasks such as preparing voter identity cards, conducting a census, employment or Swachh Bharat Mission (Clean India Mission) surveys and helming election booths — none of which is paid work except for election duty.

Sometimes the Anganwadi-serviced children fall sick or die; it becomes a big legal and social issue.

There are periodic reports of corruption and crimes against women in some Anganwadi centers.

Worker protests (by the All India Anganwadi Workers Federation) and public debates on this topic are ongoing.

Following are the suggestions given to improve the efficiency of Anganwadi workers.

Suggestions:

Anganwadis universally available to all eligible children and mothers who want their children there. This would require significant increases in budgetary allocation and a rise in the number of Anganwadis to over 16 lakh.

The officers and their helpers who staff Anganwadis are typically women from poor families. The workers need to have permanent jobs with comprehensive retirement benefits like other government staff.

The administration of Anganwadi workers need to be more regulated, transparent.

A written manual will help to regulate the Anganwadies all over India.

The another important element that makes the public health of India stronger is Asha worker. Following discussion ia an attempt to overview Asha workers in India.

ASHA WORKERS

An Accredited Social Health Activist is a community health worker instituted by the government of India's Ministry of Health and Family Welfare as a part of the National Rural Health Mission. The mission began in 2005; full implementation was targeted for 2012.

Health of rural population more specifically of the women and children has remained a serious issue despite of various efforts for rural public health including Anganwadi Workers.

Non accessibility of the health facilities at the villages, tribal areas, hilly and remote places make the issues more crucial. The Government of India decided to launch a National Rural Health Mission (NRHM) to address the health needs of rural population, especially the vulnerable sections of society. The Sub-center is the most peripheral level of contact with the community under the public health infrastructure. This caters to a population norm of 5000, but is effectively serving much larger population at the Sub-center level, especially in Empowered Action Group States.

ASHA is an initiative by the Central Government for assuring rural health. ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

ASHA is the grass root level worker promoting good health practices. It is the front level female force providing access to rural population mainly women and children.

The Government has set the guidelines for working ASHAs those are as follows.

The Guidelines for / role and responsibilities of ASHA:

- ASHA would take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
- She would counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

- ASHA is expected to mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She needs to work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan.
- She would arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre-identified health facility i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).
- ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.
- Fulfillment of all these roles by ASHA is envisaged through continuous training and upgradation of her skills, spread over two years or more.

There are certain norms for selection of ASHA workers those are as follows:

SELECTION OF ASHA:

- The general norm will be 'One ASHA per 1000 population'. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.
- The States will also need to work out the district and block-wise coverage/phasing for selection of ASHAs.
- It is envisaged that the selection and training process of ASHA will be given due attention by the concerned State to ensure that at least 40 percent of the envisaged 3 ASHAs in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year. Criteria for Selection
- ASHA must be primarily a woman resident of the village - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available.

- Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

At present there are more than 9 lakh ASHA workers in the Country. They have played a key role in managing rural health and more specifically during Pandemic Covid 2019. A single ASHA worker looks after more than one thousand families in an administrative unit.

ASHAs are appointed from local and largely rural communities, They go door-to-door educating people about maternal and child health, contraception, immunisation, and sanitation, as well as enrolling them in health programmes and monitoring the results. They also ensure immunization, give first aid, and administer antimalarial and anti-tubercular drugs and oral rehydration solutions (ORS). They are semi literate females generally reached/ passed out 5th std.

An ASHA is the first port of call for any health-related demands of the deprived sections of the rural population, especially women and children. ASHAs also perform several other duties that make their role roving.

Challenges for ASHAs:

- ASHAS are neither paid regular salaries, nor given full time assignments.
- ASHAs earning is based on incentives; they receive Rs 75 for each full immunization, Rs 40 for reporting child death, Rs 300 for accompanying a woman to a hospital for childbirth, and Rs 1000 for administering TB treatment over 6-7 months. They are being paid an additional Rs1,000 for COVID-19 interventions.
- They are overburdened many times requiring to travel a long distance without much transport facilities.

Following steps would enhance the effectiveness of working of ASHAs:

Challenges during Pandemic To Ashas And Anganvadi Workers

- On March 1 2021, India launched the world's biggest vaccination drive to halt the surging virus. The Union health ministry has set the target of vaccinating 500 million people by July. The rural sector would be dependent entirely on ASHA workers and PHCs for this to happen. As frontline health workers, they were already part of the vaccination drive last month and were administered the first doses.
- ASHA workers take high risk e.g. during pandemic they worked for testing of people for to locate Corona patients however, they were not given PPE kits always, e.g. at Delhi
- ASHA workers with Anganwadi workers are performing additional duties **which included assisting deliveries, immunisation drives, sterilisation camps and staffing the PHCs during the pandemic situation.**
- Many of them died at various states however their dependents are not paid any compensation under any insurance plan.
- ASHA workers are not been vaccinated at many palces.
- The latest news as on 6th April 2021 is that the ASHA workers and Anganwadi workers refused to take jobs because of the scare of children getting infected, high BP, high sugar.

  (Ref. Deccan Chronical, News Line published on 6th April 2021)
- As well at Delhi the ASHA workers protested as no payment done on time during the period of vaccination and no Insurance cover for them.

Suggestions:

- ASHAs are the backbone of rural India and need to be supported with sufficient remuneration for her working.
- She should be taken care of in respect of her working hours and stress of work.
- They need to be covered under group insurance when they bear high risk such as testing for Covid -19., or has to travel without any proper protection to save the patients under emergency.
- The third element that empowers rural women not only economically but also socially, personally and leads to foster the growth of Rural economy is Self help Group.

Self Help Groups :

Self Help Groups are **groups** of 10-20 people in a locality formed for any social or economic purpose. Most of the **SHGs** are formed for the purpose of better financial security among its members. **SHGs** can exist with or without registration.

The roots of SHGs in India can be traced in the past around 1950's of India such as;

In 1954, the Textile Labour Association (TLA) of Ahmedabad formed its women's wing in order to train the women belonging to families of mill workers in skills such as sewing, knitting, etc. As well as Establishment of the Self-Employed Women's Association (SEWA) in 1972 by Ela Bhatt

In 1972 however, NABARD, formed the SHG Bank Linkage Project, which is today the world's largest microfinance project. From 1993 onwards, NABARD, along with the Reserve Bank of India, allowed SHGs to open savings bank accounts in banks. The Swarn Jayanti Gram Swarozgar Yojana was introduced in 1999 by Government of india with the intention of promoting self-employment in rural areas through formation and skilling of such groups. This evolved into the National Rural Livelihoods Mission (NRLM) in 2011.

Micro Finance is provided through SHG is a model that has become extremely successful in India. It has lead to developing habit of savings among rural poor women enabling her to be financially self sufficient through SHG. It has led to alleviate poverty and empower rural people, particularly rural women SHGs.

SHGs have not only made rural women self sufficient but proved her to be an agent of Rural transformation the small enterprises run by the SHGs have made a considerable contribution in the socio-economic and cultural development of rural poor in the society. It has definitely help to improve std. of living of rural poor particularly of poor females. It has created employment opportunities , source of Income for rural poor population and proved to be a magic wand for them. The objectives of Five Year plans of Inclusive growth are not attainable without counting SHGs and Micro Finance.

During pandemic situation arouse due to Covid -19 ; SHGs found out the means of their survival by marketing of masks, sanitizer and phenol and other dis infectants.

As on 31 March 2018, the total number of WSHGs promoted and credit linked are 2.05 Lakh and 1.20 Lakh respectively- all over the country.

(NABARD official website)

Despite of a grand success the SHG movement in India faces many challenges those are as follows.

Challenges to SHGs:

- SHGs do not sustain for a long time. Very few SHGs run their activities for morethan 10 years.
- Due to its flexible nature its contribution can not be ascertained exctly.
- The poorest of the poor need to participate in SHGs.
- Very few SHGs run business activities.

The SHG movement in India can be strengthened with some improvements. The recommendations are discussed below.

- Recommendations;
- Different types of SHGs are required for different types of people, depending on their particular socioeconomic backgrounds.
- More focused programmes are needed with a target of specific needs of poor people.
- The rural women should be empowered with the help of specific esteem building , confidence building programmes.

Conclusion

Recently the Internationally renowned magazine , 'Forbes' has included the name of a ASHA worker Ms. Matilda Kulu from Odisa in the list of most influential women in world. Last 15 years she has been creating awareness against the black magic in the region.

Thus, Anganwadi Workers, ASHA workers and SHG members are from the category of marginalized population in rural India.

All the three elements are women. Catering to the needs of different aspects of rural India.

Anganwadi workers cater to the need of rural health, hygine, pre school education.

They have played a fabulous role during Pandemic when the medical care giver could not attain the patients other than affected by 'Corona' at villages.

ASHA workers mainly deal with health issues and emergencies at the remote and difficult geographical areas. They have a very appreciable role of conducting tests to locate Corona patients. Their role in reducing MMR has always remained significant.

The SHGs of women are most trusted Unit for empowering rural women through savings, creating a source of income for themselves and also run small entrprises; either jointly or individually and thereby transforming the villages in India.

All the three are unique, flexible to adapt to the local situations, working at the Grass root level and proved magical under difficult situations like Pandemic due to Covid -19 virus; when medium and big businesses are found to get collapsed.

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