Quality Day Care Services for the Young Child

Institute of Social Studies Trust, New Delhi

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Case studies Synthesis Report

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Introduction

The case for the provision of quality day-care services from the perspective of the needs of the young child and women as mothers, particularly those in the informal economy, has been made repeatedly over the decades.[1] A recent FORCES-CWDS needs assessment report from the perspective of working mothers clearly establishes an overarching need for day-care services for children under 6 years both to ease the burden on women working in the informal economy and to provide for the developmental needs of children (FORCES-CWDS 2012).

Numerous studies have critically evaluated existing regulations, policies and schemes on day-care provision in both the statutory and the non-statutory sector and have also located and analysed how day care is actually provided (Swaminathan 1985, 1993; Datta 1999; Datta and Konantambigi [eds] 2007). The policy focus on day-care provision for children has thus far been channelized either through laws regulating employer provision of day care in the organized sector or through limited interventions in the unorganized sector through schemes such as the Rajiv Gandhi National Creche Scheme for the Children of Working Mothers.[2] Another indirect modality of provision of day care has been through a wider policy focus on 'Early Childhood Care and Education' (ECCE) which has largely been routed through the central government's Integrated Child Development Services (ICDS), one of the world's largest schemes targeted at children under 6 years.

Even within this disjointed set of policies on day care, however, there has been very little policy attention given to the provision of day care focusing specifically on *children under 3 years*. One of the persistent critiques of the ICDS, for instance, has been of the inadequate attention given to children under 3 years (NAC, 2011). A restructured ICDS in mission mode is the primary modality through which the government envisages the public provisioning of childcare for children under 3 years in the coming years.[3] Under the 12th Five Year Plan as well as the Broad Framework for Implementation of ICDS Mission, a pilot project is envisaged where 5 per cent of anganwadi centres are to be converted into anganwadi--cum-crèches. There is, however, insufficient information on what constitutes quality day care for under threes, the models of provision of day care, as well as the effective delivery of such care.

The Institute of Social Studies Trust (ISST) project on Quality Day-Care Services for the Young Child supported by UNICEF,[4] seeks to fill the gap in the understanding of quality day-care services for children under 3 years by documenting a variety of models of provision of quality day-care services for children under 3 years and assessing what lessons may be learnt from them, in terms of models of delivery, components of quality care, and how it may be effectively delivered, particularly given the government's focus on the ICDS as the primary modality of public provisioning of childcare for young children. To this end, after a preliminary consultation and mapping exercise, six case studies were commissioned, three of them following on from the Suraksha series,[5] and three others being more recent interventions in the field of day-care provision for the young child. The studies involved a mix of models, including ICDS-NGO partnerships, solely NGO-based delivery, cooperatives, etc., and focusing on a range of ages of children as well as providing a range of services.

This report is based on a synthesis of the case study reports,[6] with the idea of drawing out what makes each model of delivery of childcare interesting and valuable and what lessons may be learnt from them. It draws on a matrix developed to identify commonalities in the case studies on various components of quality day-care provision, for instance, on the child-carer ratio, the times, location of the provision of day care (and how closely it takes into account the needs of the community), the levels of community involvement in the provision of day care, the components of health, nutrition, play, early learning, stimulation and care that each organization provides and what we may learn from them, the training that is provided to carers as well as monitoring and convergence. The report also draws on supplementary field visits, reports, discussions, project documents, and it is consolidated with feedback through a workshop with project partners.

This study is premised on the understanding that both familial and public provisioning (including the provisioning in the private sector, the role of employers, community, state and nongovernmental actors) of care should be enabled/regulated at every stage in the life cycle of an infant. In other words, there should exist for all children under 3 years of age a universal entitlement to quality day-care provision, which gives women as mothers flexibility and choice in the provision of care. In this sense, day-care services are a crucial component of the broader

provision of ECCE. The provision of day-care services is not a question of an either/or provision. It sits alongside a wide range of other components of ECCE, including universal maternity rights and entitlements, parental leave and pay, and the enablement of other forms of familial provision of care for instance through take home rations (THR) or home visits of ASHA and anganwadi workers for pregnant and lactating women and children under 3 years, or awareness-raising sessions through health and nutrition days.

The Case Studies

The small sample of case studies presents a range of modes of provision of day care/childcare, including government-run schemes, NGO-government collaborations (both management and facilitation models), NGO-run crèches with funding from a variety of sources including private donors, government, employers and parental contribution. Care is provided also in a range of varying contexts, both rural and urban – from the salt pans of Kutch, the construction sites of Delhi, the slums of Chennai, the forested areas of Bilaspur district in Chhattisgarh and the deserts of Bikaner district in Rajasthan. Moreover, the constituencies that are catered to in these various programmes range from the tribal and Dalit populations of Bilaspur district to women agricultural and tobacco workers of Gujarat, 'homemakers' in the various districts of Tamil Nadu, migrant populations of construction workers in Delhi and the seasonal migrant populations in the *dhanis* of Bikaner district and the salt pans of Kutch in Gujarat.

Table 1: Social Group-Region

Name of the organization	Region	Social Group
SEWA (Kheda Anand)	Kheda-Anand/Rural	Tobacco Workers/Landless agricultural workers mostly OBCs
SEWA (Ahmedabad)	Ahmedabad/Urban Slums	Home-based workers, vendors, service providers, producers, migrants, Muslims, OBCs, SCs
URMUL	Rajasthan/Rural/developed infrastructure	SC,OBC and General
JSS	Chhattisgarh/Rural/Tribal forested areas	ST (79%) OBC (19%) SC (2%)
Tamil Nadu ICDS	385 rural,47 urban,2 tribal ICDS projects	Na
Mobile Creches	New Delhi/Urban/Construction Site	Migrant workers; Primarily ST, SC, OBC

Below is a brief summary of each of the projects, including their history, their target groups and areas, as well as geographical reach.

I. Brief Background and History of Each Intervention

1. Mobile Creches

In 1969, as the story goes, Mobile Creches (MC) was born when Meena Mahadevan saw young children lying unattended in the heat and dust of a construction site in Delhi. She decided to pitch a tent the very next day and organized a childcare worker for the children (Venkateswaran, Mobile Creches report, 2012). With the first major relocation of unauthorized settlements to the outskirts of Delhi in the mid-1970s, MC spread its net to include children in Delhi's slums (MC Annual Report 2011–2012).

With this beginning, Mobile Creches has grown in the last forty-plus years to a pioneering early childcare and development services organization for children and an advocate for the rights of the young children in the country. The most direct form of action that MC engages in is field interventions. These focus on children belonging to the under-6 age group (with non-formal education for older children as well) in construction sites and in slums in Delhi and the National Capital Region (NCR). The crèches in the construction sites are targeted at the children of construction workers, who are mostly rural migrants. On construction sites, Mobile Creches install day-care facilities that are entirely run by them or facilitated/supported by them. The slum intervention is run by a community group that is trained by Mobile Creches (Venkateswaran, MC report, 2012).

Over the years, the interventions have grown in scale, depth and content with an evolving programme that has expanded beyond construction sites to slum settlements and has enhanced mobilization of stakeholders for shared responsibility, such as contractors/builders, members of the community and government (Venkateswaran, MC report, 2012).

MC has a presence on 20–25 construction sites in a year and 8–10 slums (MC website). In 2011–2012, MC reached out to 13,000 children in Delhi/NCR – 70 per cent at 50 construction sites and 30 per cent in 8 slum settlements (MC Annual Report 2011–2012).

Training is a key component of the services that MC provides. The training programme, which has been honed through many years of experience, is directed at mothers and families, childcare workers in anganwadis and neighbourhood crèches, government functionaries and NGO personnel, funding agencies and policymakers (MC website).

2. SEWA

The Self Employed Women's Association (SEWA) was established in December 1971 in response to a call from textile workers in Ahmedabad to form themselves into a collective. The association grew from 1972, increasing its membership and including more occupations as well as geographical areas into its fold. Currently, it has over 17 lakh members spread over ten states in India, but the prioritization of the organization has remained the same – to organize women workers and ensure work and social security, including childcare for its members (Balakrishnan, SEWA report, 2012).

In 1980, a year after SEWA was registered as a trade union, a formal childcare programme for the children of unorganized workers was launched. In five years, the number of childcare centres had grown to 20, and the need for an organized democratic structure to deal with these centres eventually led to the registration of the first childcare cooperative, Shri Sangini Mahila Bal Seva Sahkari Mandli Ltd., in 1986 in Ahmedabad. It was in the same year that SEWA took the decision to partner with the ICDS, based on both exigency and a desire to influence the large and growing ICDS programme (Balakrishnan, SEWA report, 2012).

In the meantime, they had begun to organize women workers in other rural districts of Gujarat, for instance, in Kheda-Anand, with unorganized women tobacco workers. Recognizing the need for childcare provision for the under-3 children of the women workers, SEWA decided to set up a crèche with the support of the women, the panchayat, local leaders and tobacco factory owners.

This led to the creation of a second cooperative, Shaishav, in October 1989. Later, crèches were set up in 19 villages in the district (Pandit 1995, p. 5).

SEWA's partnership with ICDS grew from strength to strength until 2006. In 2006, at the peak of the partnership with ICDS, the SEWA childcare programme had a presence in five districts, and had 5,000 children attending its crèche facilities – six days a week from 9 a.m. to 6 p.m. in 185 Ghodiya Ghars (childcare centres). SEWA was also involved in the provision of childcare in the context of relief and rehabilitation following the earthquake and communal violence that shook Gujarat in 2001 and 2002. SEWA set up childcare centres in the relief camps and in Ahmedabad, catered to an additional 1,500 children (Balakrishnan, SEWA report, 2012).

However, in 2006, the long partnership with ICDS was to come to an end owing to a divergence in approach, particularly in its large earthquake relief and rehabilitation work in which it had been an early and long-standing partner of the Gujarat government. In 2004–2005, SEWA decided to withdraw from the partnership on rehabilitation and all such partnerships with the Gujarat government (Balakrishnan, SEWA report, 2012). All of the ICDS centres that SEWA was running were handed over to the government. By 2012, the Ghodiya Ghars were operational in only two districts, Ahmedabad and Kheda-Anand, all year round, and in Surendranagar, they functioned only during the time of the year when the salt pan workers move to the little Rann to support the migrant populations (Balakrishnan, SEWA report, 2012). Both 'Sangini'and 'Shaishav', the two childcare cooperatives that SEWA had set up earlier, survived the break with the ICDS. Currently, the Shri Sangini Mahila Bal Seva Sahkari Mandli Ltd provides full-time childcare for 900 children in 27 day-care centres or crèches in Ahmedabad city for the children of SEWA members (Sangini website).

3. Jan Swasthya Sahyog (JSS)

Jan Swasthya Sahyog is a not-for-profit organization that started working in rural Bilaspur district in Chhattisgarh in 2000. It provides low-cost, high-quality health care to a large number of rural poor and draws patients from all over Chhattisgarh and also from neighbouring districts of Madhya Pradesh. The base clinic is located at Ganiyari village, 18 km from Bilaspur. It caters to people from nearly 1,500 villages of the district. The outreach programme works in an area

with a tribal population of 78 per cent, a Dalit population of 11 per cent, a Muslim population of 2 per cent, and the rest being general caste or OBCs. It covers 53 forest and forest-fringe villages constituting a population of about 27,000 people and is currently being expanded (Atkuri, JSS report, 2012).

The JSS phulwari programme is probably the only crèche facility in the scattered forest and forest-fringe area with its unique challenges of access as well as one in an extremely poor region. In 2012, there were 78 crèches with 1,169 children in 35 villages covering half the children between 6 months and 3 years of age in the programme villages (Atkuri, JSS report, 2012).

The phulwaris were started by JSS in 2006 in the context of high levels of chronic poverty and malnutrition amongst both children and adults – 47 per cent of children are malnourished in Chhattisgarh and 16 per cent are severely malnourished (Atkuri, JSS report, 2012). The objectives of the phulwaris were to provide a safe, secure and stimulating environment for young children when their parents were at work, and particularly to prevent malnutrition among young children and to improve the nutritional status of those that were already malnourished. The further objectives of the phulwaris were to help older siblings who care for the younger child to return to school, and also to enable parents to go out to work to increase their income (Atkuri, JSS report, 2012).

Although the focus of the phulwaris has been on nutrition and health of the child, the phulwaris also provide age-appropriate toys to all crèches for the children to play with, and the crèche workers are also taught songs and games for the stimulation and learning of young children (Atkuri, JSS report, 2012). JSS plans to expand its early learning component in the phulwaris to provide more holistic day care for children under 3 years (Discussions, 13 Dec. 2013, ISST-UNICEFworkshop).

4. Urmul Seemant Samithi, Bikaner district, Rajasthan

Urmul Trust was established by members of the Uttari Rajasthan Milk Union Ltd (URMUL), a dairy cooperative based in Bikaner, initially with the mandate of providing primary health and educational services in the Kolayat block of Bikaner district in the 1980s (Mankodi 1995;

Balakrishnan 2012). In the late 1980s, the ICDS was started in the district, and in 1991, Urmul agreed to manage an entire ICDS project in Kolayat block. By 2012, Urmul was running ICDS centres in all 229 villages of Kolayat block, the single largest project in the state. In many of these villages there are multiple anganwadi centres functioning. At present, there are 190 Mukhya Anganwadi Kendras run by Urmul in Bikaner district out of a total of 302 ICDS centres in Bikaner district, and a total of 175 mini-anganwadi centres, of which 42 are run by Urmul (Balakrishnan, Urmul report, 2012).

5. Tamil Nadu Integrated Child Development Service (TN ICDS)

Tamil Nadu has a long history of nutrition-focused programmes. Over the years, the successive governments in TN have made serious attempts to combine provision of food under the Noon Meal Programme (NMP) with other services like health care, immunization, growth monitoring, prenatal and postnatal care for women, communication, and nutrition education. This has been done through two main nutrition and child development programmes: the Integrated Child Development Services Scheme (ICDS), which started as a small pilot in 1976, and the TN Integrated Nutrition Project (TINP), which started its phase I in 1980. As both these nutrition schemes expanded, they were integrated with the Noon Meal Programme infrastructure for preschoolers (see Shanmugavelayutham, TN ICDS report, 2012).

The second phase of the Tamil Nadu Integrated Nutrition Project (TINP) was introduced in 1989 on a pilot basis with financial assistance from the World Bank. Phase-I of TINP covered only ICDS areas, whereas phase-II was concentrated in non-ICDS areas. From 1998 onwards, the TIN Project was renamed the World Bank- ICDS-III, which covered 19,500 centres. Between the general ICDS and WB-ICDS III, all rural blocks in the state have in place integrated services for child development for children below 6 years , and most urban areas are also covered under ICDS (see Shanmugavelayutham, TN ICDS report, 2013).

ICDS in Tamil Nadu is currently implemented through 49,499 childcare centres (anganwadi centres) and 4,940 mini-centres, totalling 54,439 centres functioning under 434 ICDS projects. Out of 434 projects, 47 projects are in urban areas, 2 projects are in tribal areas and 385 projects

are in rural areas (Policy Note 2013–2014 Social Welfare and Nutritious Noon Meal Programme, Chennai, 2013). Fifty-nine per cent of the ICDS beneficiaries are children under 3 years.

The functioning of the ICDS in Tamil Nadu has come in for special praise over the last several years (Dreze 2006; Rajivan 2006). As an example of a state-implemented ICDS that goes beyond the basic provisioning, TN ICDS has been lauded for the longer hours that anganwadi centres remain open, the availability and provision of day-care facilities for children under 3 years, the decentralized training that is provided to anganwadi workers, the superior quality and variety of the nutrition that is provided to young children, and the additional state funding that has allowed for a better quality of ICDS services.

II. Models of Delivery: Financing and Management/Facilitation

In the proposed pilot of converting 5 per cent of anganwadis to anganwadi-cum-crèches, it is also proposed that this be done on a centre-state cost-sharing basis of 75:25 with flexibility to the states to explore the engagement of NGOs in implementing the model (see the Broad Framework for Implementation of ICDS Mission, MWCD, 2012). Given this policy context, it is important to understand the models of provision of day care for children under 3 years.

We have several models in the delivery of day-care services as exemplified by the case studies. There is the largely NGO-run crèche (the phulwaris in Chhattisgarh), the crèches that rely on employer-employee contributions as well as grants (SEWA, Mobile Creches), and there are the ICDS programmes, within which one has been an NGO-ICDS partnership offering ICDS plus plus services (SEWA), one that currently delivers childcare through an NGO-ICDS model (Urmul) (offering both management and facilitation services) and the third that is a solely government-run ICDS programme enhanced by state government involvement (TN ICDS).

Table 2: Models of Delivery

Name of the organization	Type of intervention				
	NGO		Cooperative	ICDS	
	NGO only	NGO facilitation / management / consultancy		ICDS-NGO partnership	ICDS-Enhanced State Govt involvement
SEWA			✓	✓	
URMUL				✓	
JSS	✓				
Tamil Nadu ICDS					✓
Mobile Creches		✓			

1. NGO model

The JSS model is the only model in the sample that is funded solely through individual contributions and donations (along with community contributions). Initial attempts were made to have small contributions from parents (a rupee or a handful of rice), but this resulted in the poorest families in the community not sending their children to the phulwari, as they could not afford to do so. Owing to this, contribution from parents was discontinued.

Further, JSS functions in a context where there is a void in the provision of services dealing with the nutritional well-being of children under 3 years. Although the ICDS functions in the region, it is out of range of hard-to-reach villages. Further, even where it functions, it focuses on the age group of 3–6 years, and for the under threes, it only provides take home rations . Even the THR that is provided once a week or fortnightly does not adequately address nutritional requirements. Further, MGNREGA crèches function in the region mostly in the breach. Although attempts were made to access the Rajiv Gandhi crèche scheme by JSS, it was found to be very difficult to access (Atkuri, JSS report, 2012).

JSS, as with some of the other organizations of this study, is stepping in where the state is failing to meet its obligations. Although the ICDS will now have a renewed focus on under threes,

whether this will adequately address the nutritional requirements of malnourished and severely malnourished children is unclear.

- NGO facilitation/management/consultant model

As in JSS, MC and SEWA, too, are stepping in where there is a vacuum created in the provision of care for children, in this case, where both employer's obligations are inadequately delineated by the law, and enforcement of the obligations that do exist is poor. Both of these organizations employ a complex model of financing involving the organization, employer, employee, user fees as well as donations.

In terms of the model of delivery of care, however, both of them have diverse models of delivery. While both organizations rely on community involvement in all the sites, the modality of delivery and the extent of MC involvement in the delivery of care vary across the variety of models it employs as well as the location in which it provides care.

Mobile Creches operates with three models of day care at the workplace: crèches operated and managed fully by MC and financed partly by the builder, crèches where personnel management and financial responsibility rests fully with the builder, but the initial set-up, training and other inputs are provided by MC, and crèches where the complete responsibility lies with the builder and where MC takes on the role of consulting (Venkateswaran, MC report, 2012).

The first model, where MC manages the crèches (with part financial support from the builder) is the one where MC has full control over the quality of the services delivered at the day-care centres. In the facilitation model, although all safeguards are in place to ensure supervision over the quality of provision of services, this is difficult to manage. The supervisor from MC, in sites that are supported and not run by MC, remains a critical part of the intervention. However, it has been noted that the absence of the supervisor can lead to various problems such as those relating to water and sanitation, which the centre staff are unable to address, as they are busy with the children. The builder is unwilling to pay the salary of the supervisor, and this creates a gap in regular supervision, which needs to be addressed if the model needs to scale up. For MC-run centres, the supervisor is responsible for 2–3 centres; for the MC-supported centres, one

supervisor is responsible for 5 centres. The builder can thus provide a supervisor only where there are 4–5 sites with centres (Venkateswaran, MC report, 2012).

While the facilitation model is critical for ensuring sustainability and scalability, the management model at MC clearly provides an example of how quality day care can be provided. Government support for carrying on with such flexible creative solutions should be enabled, alongside an overhaul of the maternity benefits legislation in the statutory sector and government provision of day-care services.

In the slums of Delhi where MC operates, it facilitates the provision of care through training community-based organizations (CBOs) to run their own crèches. However, the use of crèches is also influenced by finances. These crèches have a pay for use strategy, which, Venkateswaran argues, becomes self-selecting, as the poorer households cannot afford to the pay the Rs 150–200 per month charge for the centre. This, she notes, is especially so when there are cheaper options, as in New Seemapuri (Venkateswaran, MC report, 2012). Community involvement in the provision of day-care facilities is key, however, in the provision of childcare in both the construction sites (in order to sustain quality day care within a transient population) and the slums where MC facilitates delivery of quality day-care services.

2. Cooperative model

Community involvement is also at the heart of the SEWA model of delivery of childcare services, which is based on a democratic structure of governance. ‘Sangini’, the first cooperative on childcare in India, holds elections every year to an executive committee, which includes representation from all levels in the childcare structure: the bal sevikas, the supervisors, the Spearhead Team members, invitees from other teams of SEWA, representatives of home-based workers, vendors, daily wage labourers working on farms and construction sites, and self-employed producers of products such as salt, crafts and handlooms. Together the members elect a seven-member committee, who in turn elect a president and a vice-president (Balakrishnan, SEWA report, 2012). This committee is the main decision-making forum in the delivery of childcare in SEWA centres. The committee is therefore made of childcare workers themselves

and other key members. All childcare workers and staff report to the committee (Sangini website).

Ownership and collective responsibility in the provision of day care, along with the fact that the bal sevikas are drawn from the local community (see below) allow for working mothers/parents to trust their children to the day-care centres; trust is a crucial component in enabling women to leave their children to the centres. As the impact evaluation report of Sangini by the Association for Stimulating Knowhow noted, the 'women can go out to work in peace, knowing children are safe and cared for' (Sangini website 2011).

3. ICDS-NGO partnerships

When SEWA took on the ICDS partnership in 1986, SEWA was able to negotiate a partnership with ICDS, which allowed them flexibility in retaining some of the key elements of their provision of care prior to the partnership. This included an agreement that the Ghodiya Ghars would be open all day long (unlike the ICDS centres, which were meant to be open only for four hours), that the centres would retain its focus on day care for children under 3 years and that they would be able to charge their members for the extra hours (Balakrishnan, SEWA report, 2012). Balakrishnan notes in her report that 'this was an ICDS plus plus' that SEWA was keen to implement. This was by no means an easy process, as evidenced by the requirement of the ICDS on the qualifications of the bal sevikas. Bal sevikas that worked at SEWA did not meet the requirements of education, but had plenty of technical knowledge to take on the responsibilities of the anganwadi worker. Again, through negotiation, the bal sevikas were accepted on par with anganwadi workers.

When Urmul took on the partnership with the ICDS all those many years ago in 1991, they too negotiated to retain what was creative and innovative about how they worked with communities in Kolayat block of Bikaner district. They managed to negotiate complete freedom to select staff; for local procurement of supplementary nutrition; for development of an alternative training module; to have a ratio of one supervisor to every ten anganwadi workers (instead of 1:20) owing to the terrain; to put stress on preschool education instead of only nutrition through an interesting and educative environment within the centres by equipping them with toys and

learning materials; to have community involvement in selection of anganwadi locations and workers and in their maintenance; to integrate the scheme with other activities of the Urmul trust; and to target it at the lower strata of village society (Mankodi 1995, pp.10–11). At the time that Mankodi wrote of Urmul in 1995, there was a sense of Urmul's experiment with the ICDS being bogged down by the bureaucratic nature of the ICDS, by 'terminal targetitis' as Mankodi termed it, with quality falling behind because of the quantity of anganwadi centres that were required to be set up every year, the vast numbers of forms to be filled by anganwadi workers and supervisors, with the training falling behind the setting up of anganwadi centres (Mankodi 1995).

When the State Institute of Health and Family Welfare assessed the work of Urmul in 2010, however, they found that the overall quality of service delivery was better in Kolayat when compared with government-run ICDS centres in the rest of the district as well as in comparison with other NGO-run projects. The team particularly highlighted the effectiveness of reach, ECE activities, supplementary feeding and community involvement. Among the distinct differences between the government and NGO-run centres, was the anganwadi worker. A higher proportion of Urmul anganwadi workers had been found to be locally resident in the villages, which meant a greater chance of the centre being open every day and greater commitment to assuring quality services (Balakrishnan, Urmul report, 2012).

Balakrishnan also found that Urmul continues to innovate with the training it provides and has retained its emphasis on caring, of solidarity and on the overarching value of social transformation as the project goal (Balakrishnan, Urmul report, 2012). The sequence of local innovation and a possible systemic acceptance (which Urmul experienced with training and also with the construction of buildings) was now being experienced with play and learning materials for children, with innovations being made based on local requirements (Balakrishnan, Urmul report, 2012). However, problems do persist and the concerns that had existed when the work had started in Kolayat, Balakrishnan notes, continue to hamper Urmul's ability to deliver quality services. The distances make supervision more expensive than ICDS provision. It is difficult to find qualified staff to work in the *dhanis* when families migrate there during the agricultural season. The team accepts that 'with growth from the 100 centres 15 years ago to the 225

operational centres in 2012, the sheer scale of operations that ensues has meant that the in-depth engagement, the quality of relationships that we would like, it's difficult to ensure' (Balakrishnan, Urmul report, 2012).

Urmul's engagement with ICDS has been through two models (as with Mobile Creches with the builders). One is the implementation model (in Kolayat block) and the other is a facilitation model (in Lunkaransar, and also in neighbouring districts). In the implementation model, Urmul is part of the system, and they see this as advantageous in pushing for a particular value-based development model. In the facilitation model, they provide external facilitative support to government-run ICDS projects, such as training and supply of educational toys and games to the centres. The management team sees the facilitative model as useful for the distance it provides from the actual administration and for a strategic engagement with the community of care providers (Balakrishnan, Urmul report, 2012). However, it is clear that Urmul has more flexibility in the implementation model, where it is able to go the extra mile, such as, when they were able to buy better quality growth monitoring machines on a no profit no loss basis.

While it is clear that Urmul's involvement in the delivery of ICDS in Kolayat block has been key to the relative success of the ICDS in the area and warrants the use and duplication of the implementing model, the question of sustainability and scale, as with the management /facilitation models of MC, make the facilitation model a tantalizing one for shifting the responsibility of the delivery of provision of childcare back to the state and to the builder in whom legal obligations rest. However, when both the ICDS and the childcare obligations under the statutory provisions are inadequate in their conceptualization of care for young children, the facilitation model seems likely to be consistently constrained by systemic problems.

4. ICDS with enhanced state government involvement

What is interesting about the Tamil Nadu model of ICDS provision is the enhanced involvement of the state government in the delivery of integrated childcare services. This enhanced involvement has played a significant part in Tamil Nadu being assessed as one of the better performing states in the delivery of ICDS. For instance, the state government has increased the number of hours that anganwadi workers (AWWs) work and has been adding to the monthly

compensation paid to the AWWs by the Government of India. In addition, AWWs are entitled by the state government to a range of other benefits including old-age pension, monthly medical reimbursements of Rs 100, the state-run medical insurance scheme and bonuses during Pongal and other festivals (NAC recommendations June 2011).

Further, against an estimated requirement of Rs 89 crore, the state allocated more than Rs 150 crore for supplementary nutrition, and the allocation per beneficiary, per day, is also the highest for all states (Shanumugavelayutham, TN ICDS report, 2013). Although there are many challenges in the implementation of the ICDS in Tamil Nadu, it is clear that when there are certain conditions, including the 'sandwich approach' that Rajivan (2006) talks of, viz. – both pressure from the bottom and political will from the top allows for a better provisioning of ICDS for the young child.

III. Target Group

1. Age of the child

Although all the case studies focus on children under 3 years, the focus for every organization is not on only children of this age group. For instance, SEWA, along with TN ICDS and Urmul, focuses on children under 6 years of age, with the difference being that SEWA started their childcare facilities specifically for children under 3 years, and this focus on the under threes has been retained. Mobile Creches focuses on three age groups– under 3s, 3–6 and 6–12 years of age. JSS specifically targets services for children in the under-3 age group, from 6 months – 3 years.

Since Urmul is in partnership with ICDS, the services that it offers for under threes are very limited. For a start, the centres do not function as day-care centres for under threes and do so only in a very limited fashion for the age group of 3–6 years, who are the focus of the ICDS intervention. However, during the ISST field visit (Bikaner dist, 29 May to 1 June 2013), it was clear that the siblings (who are under 3 years) of children over 3years who use the centres are also sometimes given 'custodial care' (Balakrishnan 2012). By custodial care is meant a limited understanding of day care where children are kept in the centre for 'safekeeping' rather than for the fuller range of care provisions.

In contrast to the ICDS in Rajasthan, the Tamil Nadu ICDS does provide more than just custodial care, along with nutrition and health checks for children under 3 years. This marks it as being different from other states in catering to under-3 children (NAC Recommendations on ICDS 2011, Shanmugavelayutham, TN ICDS report, 2012).

Table 3: Day-care provision by age group

Name of the organization	Age Group		
	0–3years	3–6 years	6–12 years
SEWA	✓	✓	X
URMUL	X (sometimes custodial care)	✓ (day care but in limited fashion)	X
JSS	✓	X	X
Tamil Nadu ICDS	✓	✓	X
Mobile Creches	✓	✓	✓

- Disaggregating the age group, 0–3.

There is insufficient information in the reports on how young the children are when they are enrolled in the day-care centres. When numbers of children are disaggregated by age, there are interesting insights. In SEWA childcare centres, 34 per cent of the total children fall in the 0–2 years age group and the remaining in the 2–6 years category (email communication, Susan Thomas, SEWA, 14 June 2013). Similarly, writing in 1995 for the Suraksha series, Margaret Khalakdina noted that the age-wise monthly average of children on the rolls in 1993–1994 showed that 34 per cent of children in Mobile Creches (Delhi) were in the below-2 years age group, and 46 per cent of children were in the age group 3–5 years (Khalakdina 1995, p. 4). In relation to the ICDS, Dr Shanmugavelyutham notes in his report that what is unique about the Tamil Nadu ICDS is that it provides day-care facilities for children under 3 years, but, further, that this is particularly geared towards children between the ages of 2–3 years. Although there are a few infants too that receive day care in anganwadi centres in Tamil Nadu (ISST field visit in Chennai, 22 June 2013), in relation to under threes, largely the day-care provision is directed at the age group of 2–3 year old children.

Similarly disaggregated statistics in all of the organizations (particularly noting what the average age of the child is when the parents first bring them to the day-care centres) will give more information about the difficulties in providing public provisioning for children, particularly for children under the age of 2 years. A SEWA study written by S. Anandlakshmy and Mirai Chatterjee in 2009, for instance, notes that most of the children in SEWA's childcare centres are normally admitted when they are toddlers – between 18 and 24 months of age (Anandlakshmy and Chatterjee 2009, p. 39).

The FORCES-CWDS study on the need for crèches and childcare services makes amply clear that 97.8 per cent of working women (with children under the age of 6 years) would use a crèche facility if it was made available to them (2012, p. 40). However, the study does not examine the age (of the child) at which the women would prefer to use the crèche facilities. This can be discerned somewhat from the study in analysing the existing childcare patterns for children in the age group of 0–6 months, 6 months–3 years, and 3–6 years. Although these patterns are not indicative of the women's preferences, it is suggestive of the extent of the need for childcare. If we take one category of workers, for instance, brick kiln workers, 56.3 per cent of mothers are the sole caregivers for children in the age group 0–6 months (viz., 43.7 per cent rely on family and extended kin networks to provide care) (2012, p. 34). On the question of whether the mothers were able to give exclusive time for childcare, the study noted that 66.3 per cent of brick kiln workers said they could not provide time (2012, p. 38). Although this second statistic is not disaggregated by the age of the child, it can be surmised that there is a need for public provisioning of childcare for this group too.

The JSS study too makes amply clear the need for day-care services for improving the nutritional status of all children in the age group of 6 months to 3 years of age. There is an important case to be made for the public provisioning of day-care services for children under 3 years, and not just for the blanket group of children under 6 years. As the many decades of ICDS provisioning has shown, not targeting the age group of under-3 children specifically means this group tends to be neglected. Further, there continues to be presumptions made about where and who should be providing day care for children under 3 years. Sundar Kompalli's report on the Nutrition cum Day Care Centres (NDCCs) provided through the Indira Kranti Patham (IKP)in Andhra Pradesh

(2013) notes the lack of use of the NDCCs as *day-care centres* (also see endnote 6). The predominant reason given for this lack of use was the lack of need for the provision of day-care centres for this category of the young child, with wide-ranging perceptions that the responsibility for the care of children of this age belonged to the family, particularly the mothers (Kompalli 2013). While this argument is belied by the use of balabadis (which are directed at children in the age group 3–5 years) by children in the age group of 2–3 years for custodial care, the ideology that care is a familial and female responsibility continues to dominate in the provision of care, particularly when it comes to the provision of care for infants and toddlers (see *Report of the Status of the Young Child* 2009).

2. Children of women workers

Apart from the TN ICDS and Urmul, each of the other three organizations gears their services towards the children of working mothers/parents (though this is not exclusively so for MC and JSS). The working women that are targeted by these interventions are particularly vulnerable, live in conditions of acute poverty, lack social security and form a part of disadvantaged groups such as Dalits, tribals communities, the urban poor living in slums and migrant labour. Providing *inclusive* and specifically targeted services is done through *flexibility* in the provision of care and by being sensitive to location of provision and timing of provision. Some of these issues are brought out in the next section.

The benefits for both the child and the working mothers when they are able to access *quality* day-care facilities are immense, as indicated in a 2011 study conducted on SEWA's Sangini cooperative (see SEWA website, also see UNICEF-ISST report, 2009 and Chatterjee 2006). The study noted that 88 per cent of the worker-mothers surveyed who send their children to SEWA crèches feel that they can go for work without worrying about the children, viz., quality day care facilitates women's entry and continuance in paid employment. Moreover, as the study noted, worker-mothers feel that they are able to take better care of themselves, take rest when required and pay more attention to their own diet and medication, and that they feel much more energetic and stress free. Thus, quality day-care facilitates enhances women's health and quality of life. Further, the impact on women's earnings was found to be immense, particularly when full day care was provided, with an increase in women's earnings by at least 50 per cent, which thereby

enabled women to be more self-sufficient. The benefits for children with the provision of quality day care were similarly palpable. Improvement of health and nutrition, a 100 per cent enrolment in primary school as well as enabling older siblings to go to school (as much as 70 per cent of older siblings, particularly girls, according to the study, were freed from childcare responsibilities).

In this context, it is also interesting to note the reverse, viz., what happens when an intervention is not targeted at working mothers. When a provision is made universally available as it is with the ICDS, there are interesting observations to be made. In the survey conducted on the Tamil Nadu ICDS, where centres stay open for about seven and a half hours every day, it was found that most children used the service for four hours. The majority of the women surveyed who were mothers who used the ICDS were 'homemakers' and not necessarily workers (Shanmugavelayutham, TN ICDS report, 2012). While this self-evaluation on who constitutes a worker maybe questioned, it is interesting to note that even with 'homemakers', there is a significant uptake of ICDS services. While the uptake of children of working mothers may have been more (as indicated by the Needs Assessment, FORCES-CWDS 2012), nevertheless, there is a need for quality day care from the perspective of 'non-worker' mothers too.

SEWA's intervention in the provision of day-care facilities is also interesting in the focus it provides on parental involvement in the care of their children. SEWA conducts regular monthly meetings with mothers to brief them about the children's growth and progress issues, if any. Further, SEWA has also initiated meetings with the fathers to update them on their child's growth and development. Emphasis is given in encouraging the fathers to spend more time with their children and share the responsibilities with the mothers in their development and upbringing (email communication with Susan Thomas, SEWA).

However, the ideology that care is a familial and female responsibility continues to pose a significant challenge to the provision of quality day-care centres, as Sandhya Venkateswaran's report demonstrates. She notes in her study of MC that the users of MC centres are mothers who have no one else to keep an eye on the children. This is especially so in the construction sites, where extended families are not common, unlike in urban slums. At construction sites, it is those

mothers who do not go to work that invariably do not send their children to the crèche (Venkateswaran, MC report, 2012).

Therefore, while targeted interventions at working mothers clearly have benefits for both workers who are mothers and children, it is also clear that making day-care provision that is universally available (as in TN ICDS) and including fathers in the discussions on childcare are important means of making dents into the ideology that care is a familial and female responsibility.

IV. Holistic Quality Day Care for under threes

The understanding that Mobile Creches brings to childcare, as evidenced by the other organizations as well, is one of holistic development of the child, including components of nutrition and health, education, training, dealing with stakeholders and community communication. Some of the key elements of providing such care are in terms of,

a) *accessibility* in terms of timings and location;
b) *flexibility* in terms of responding to specific needs;
c) *inclusiveness* in regard to children with different abilities; and
d) a *rights-based approach* (Mobile Creches presentation, ISST Design Workshop, 2012)

If we add to this the elements that Mina Swaminthan has argued that we should hold as central to providing *care*, viz., the process of taking care of the child, the focus is then on the caregiver or the anganwadi worker – the modes with which the anganwadi worker is selected, her ties to the community, her conditions of work, her training, etc.

In this section, the focus is on what may be learnt about these elements from the case studies in the provision of day care in relation to nutrition and health, play and early learning, process of giving care, community involvement and, monitoring and supervision.

Table 1: Holistic quality day care for under threes

Name of the organization	SEWA	URMUL	JSS	Tamil Nadu ICDS	Mobile Creches
Health	✓	✓	✓	✓	✓

Nutrition	✓	✓	✓	✓	✓
Play and Early Learning	✓	✓		✓	✓
Process of giving care					
a)Child–carer ratio	1:15	1:25 *	01:10	1:25 (and 1:15mini AWC)	1:10
b)Flexibility and accessibility in timings, location	✓		✓	✓	✓
c)Training of crèche /AWW	✓	✓	✓	✓	✓
Community involvement	✓	✓	✓		✓
Monitoring and Supervision	✓	✓	✓	✓	✓

*(ICDS requirement but owing to demand constraints, unable to maintain this ratio)

1. Nutrition

All of the organizations have nutrition as a key component of the provision of ECCD in their day-care centres. Nutrition (through either two or three meals) and varying supplementary nutrition are provided for under threes by nearly all the organizations. The nutritional status is monitored through growth monitoring in all of the organizations.

What is interesting to note is that JSS makes a strong case for the existence of day-care centres *in order to* address the nutritional requirements of children in a safe and hygienic environment. The understanding that JSS brings is that the nutritional requirements of children are better served *through* day-care facilities that provide a safe and secure environment where these needs can be attended to holistically and not through a tokenistic THR; this is especially so in a context where there is acute poverty and malnutrition and where both parents work.

The TN ICDS deserves special mention, given the history and continuing links of the ICDS with the wider nutritional policy in the state. The variety of food provided across the state has come on the back of civil society pressure for the provision of nutritious food through the ICDS (Shanmugavelayutham, TN ICDS report, 2012, as well as workshop presentation). However,

just as with the other organizations, food is a potent marker of cultural differences, and each of the organizations makes a concerted effort to ensure that markers such as caste do not either infringe on the provision of a basic necessity or reinforce social prejudices,;for instance, Urmul has resisted the requests to remove a Dalit angwanwadi worker (see Balakrishnan, Urmul report, 2012). However, instances of prejudice with dominant caste children bringing their own plates to the anganwadi centres or refusing to eat at the centres (field work in Urmul and Chennai) indicate how difficult it is to deal with pervasive differences.

Another means through which SEWA enables the nutritional intake of the infants and toddlers is by encouraging the mothers to visit the centre to feed the infants or take them home as per need. Being located close to the worksites enable agricultural workers and other working women to come to the centres to feed their babies during recess between their two shifts of working in the fields (email communication, Susan Thomas).

2. Health

Immunization is a key component of ECCE, and each of the organizations includes health provision through a system of monitoring, supervision and referrals as a component of their day-care provision for under threes. In SEWA, for instance, the bal sevikas coordinate with the nearby urban health centres to organize monthly health check-ups and immunization for children and pregnant women. A SEWA doctor visits the centres once a month to monitor growth and health of the children via growth charts. She also provides counselling to the parents in addition to providing referral services to both government and private hospitals for the children or mothers who need further treatment. There are similarly robust systems of monitoring and supervision in both MC and JSS.

In the Tamil Nadu ICDS, however, the convergence of services between the NRHM and other health services poses an issue. While the anganwadi centre refers the mothers and children to the closest private or public health care centre, the referral services as well as the convergence between the various schemes of the government are not as robust as they could be to ensure the health requirements of the young child are taken care of in an emergency (field work, anganwadi centre, Chennai, 22 June 2013).

3. Play and early learning

Play and early learning, based on age-specific needs, are catered to by some of the organizations, particularly MC and SEWA. Mobile Creches believes that learning starts at birth and continues through preschool and formal schooling to equip the child for life. MC organizes its day-care centres into age-specific groups, with the crèche catering to under twos, who are taught through colourful mobiles, songs, cuddling, and interactive play. While the issue of *what* method of teaching/play best facilitates the early learning of children under 3 years (see Balakrishnan's report on SEWA), it is clear that for the two organizations, this element is a key component of the provision of early childhood development.

The element of early childhood care and development is not necessarily given the focus it deserves by all the organizations, particularly for the age group under discussion. As field work in Tamil Nadu established, the training for anganwadi workers, which is well thought through in terms of the content of the early education that is provided for the age group of 3–6 years, is not geared towards anganwadi workers who deal with children under 3 years (interview with Usha Raghavan, Principal Training Centre, Indian Council for Child Welfare, Chennai, 22 June 2013).

4. Process of giving care

The process of giving care encapsulates the flexibility and inclusiveness with which care is provided, while focusing on the integral component of early childhood care and development – *care*. At the heart of care is a carer and a caring relationship, along with caregiving activities. The quality of such care is enhanced by not just parameters, such as child to carer ratio, but also the selection process and training provided to the carer and her working conditions.

- Child to carer ratio

It is quite clear across most of the case studies that good quality care for children under 3 years requires a lower child to carer ratio. JSS tries to keep to a 1:10 ratio for children under 3 years, and owing to the remoteness of the areas in which it operates, going so far as to provide a crèche, with a carer and a helper, for even a minimum of five children under 3 years. MC norms

for staff to children ratio are typically in the range of 1:10–12. However, this varies depending on the particular model: the norm is followed strictly within the MC-run centres, but varies in other centres. In the centres run by community-based organizations, in the slums for instance, while the aim is to have the same norms as MC-run centres, in practice, the tendency to increase the number of children per group is high, in order to increase financial collection (Venkateswaran, MC report, 2012).

The ICDS centres in TN and in Rajasthan are not able to comply with such a low child–carer ratio, with both of them basing their child–carer ratio on the ICDS requirement of 1:25. While the TN ICDS strictly enforces this limit of children to an anganwadi centre, Urmul is unable to do so, owing to demand and constraints in provision (field work, Urmul, 29 May–1 June 2013).

With SEWA, initially the centres were run with 1: 8–10 ratio of teachers to children under 3 years. However, the strong demand from the community to accommodate older children (3–6 years) was accepted, resulting in an increase in the number of children per centre. The teacher–child ratio in each centre was then upgraded to 2–3 teachers per 25–30 children (email communication, Susan Thomas, SEWA).

- Flexibility, accessibility in timings, location

In each of the case studies, if there is one attribute that exemplifies quality day-care provision, it is the *flexibility* with which organizations cater to the needs of the population for whom they provide care. The timings, extent of time provided, the location, are, in most instances, not standard, but flexible, which allows for *inclusive* and *targeted* provision of care.

MC is a classic example of a flexible provisioning of day care in terms of location following the migrant construction workers to their sites of work. Similarly, SEWA's flexibility in terms of both where and when the day-care centres operate is best exemplified by their setting up temporary mobile day-care centres during the seasonal migration of the salt pan workers to the little Rann. JSS too illustrates flexibility in the provision of day-care services, starting the crèche service at 3.30 a.m. for children of families engaged in MGNREGA employment, which starts at 4 a.m.

For Urmul, too, the location of the centre is key, as early on, they had taken the decision that they would open and run crèches as far as possible in the vicinity of the cluster where the most socially marginalized caste of each village lived. This allows for breaking down of barriers as well as ensuring inclusion of disadvantaged communities. The Tamil Nadu ICDS also displays flexibility by extending the hours of the day-care centres from the usual requirement of four hours to seven and a half hours.

What is interesting in this narrative of flexibility and localized provision as key components in the provision of quality day care is the standardized care that TN ICDS provides. While this uniformity has allowed for scalability and easier monitoring in the provision of day-care services, the standardization of services across anganwadi centres does not allow for variations in day-care services to suit the local context. For instance, although the food provided in TN anganwadi centres is varied and highly nutritious, it still does not cater to the diversity of food cultures of the state, and it provides vegetarian food (with the exception of eggs) across diverse populations (field work, Chennai, 22 June 2013). Similarly, while the anganwadi centres may display flexibility in timings, such as being open between 8 a.m. to 3.30 p.m. or 8.30 a.m. to 3 p.m., it does not have a provision to stay open longer or with variable opening and closing timings as JSS does.

5. The crèche/anganwadi worker

The crèche/ anganwadi worker is at the heart of the provision of day care, and the process of selection of the carer, her training, her level of involvement in community, the trust that the community reposes in her are all crucial in determining the extent and quality of care provided in the centre. This is seen as a critical component in nearly all the case studies. SEWA's insistence on having childcare workers from similar socio-economic circumstances to the women whose children attend the centres is key to their method of building trust in the childcare worker (Balakrishnan 2012; Pandit 1995).

- Training

Each of the organizations takes the provision of training to their carers very seriously. MC has been a pioneer in this regard and has honed the training to be provided to the carer, assessing whether she has the necessary attributes to care for young children. The training, in MC's experience, can also be a self-selecting exercise, with many trainees dropping out before the end of the course (Venkateswaran, MC report, 2012; MC website). Moreover, the training is tailored towards the varying needs of the child based on age. MC also provides training to other organizations including SEWA and Urmul for their child carers.

Urmul's training programmes retain the flavor of its vision by emphasizing the larger goals of social transformation along with the immediate objectives of providing good quality childcare at the anganwadi centre (Balakrishanan, Urmul, 2012). Here, it is not just a question of the components of training that a trainer requires, but the broader context in which care is provided.

The training of JSS staff, given its particular history, is geared largely towards monitoring nutrition and health. The early learning component of ECCE is something that the organization is keen to implement to provide more holistic quality care, for which purpose training will need to be provided.

Given the scale of its operations, Tamil Nadu has a unique decentralized pattern of training for its anganwadi workers, which percolates from block / project level to the grass-root level. Every project/block has a trainer; the training at block level is conducted by a team of trainers, that is, a Block Training Team (BTT) comprising the ICDS trainer (Gr. I Supervisor), Block E E (BEE), Block H S (BHS) and Child Health Nurse from Health and Family Welfare Department (Shanmugavelyutham, 2013). Apart from regular job training, refresher training is also conducted. Some of the key areas in which the anganwadi workers are trained include community-based strategy for prevention of malnutrition; gender sensitization and women's empowerment; Infant and Young Child Feeding; and the integrated management of neo-natal and childhood illness.

- Recruitment

The recruitment of childcare workers is a key method through which parents may repose trust in the carer, which is an essential requirement for a functioning day-care centre. SEWA's decision to recruit bal sevikas from the same socio-economic milieu as the women workers themselves was crucial to ensuring the trust of the community in the bal sevika. Moreover, community involvement in the recruitment of the carer in both SEWA and JSS are key means by which the bal sevika/phulwari worker is recruited. With JSS, the community was responsible for selecting a woman from among themselves whom they could trust with their children and also to provide a room for the crèche (Atkuri, JSS report, 2012).

The ICDS requirements (which periodically change) of educational qualifications, etc., were found to be inflexible at first in the recruitment of anganwadi workers in ICDS-NGO collaborations, as both the SEWA and Urmul reports demonstrate (Balakrishnan's reports on both, 2012). The experiences of these organizations show that the training provided, the experience gained by the bal sevika/anganwadi worker as well as local familiarity and knowledge of the bal sevika/worker and the trust that parents reposed in her are more important for the provision of quality day care than whether a woman had passed Class 8 or Class 10.

6. Community involvement

As mentioned previously, community involvement in the provision of day care is an important means through which trust can be engendered within the community for enabling the provision of day-care services. The engagement of JSS with the local community in assessing whether, and if so where, to start the phulwaris has been crucial for the functioning of the day-care centres. Similarly, for MC, the involvement of CBOs has been a crucial component of ensuring the sustainability of their work with the children of migrant workers as well as in the slums (Venkateswaran, MC report, 2012).

For SEWA too, the childcare centres are a focal point for the community. Moreover, SEWA's cooperative model, their engagement of the parents in the provision of care for their children, and selecting the bal sevika from within the community are all key means through which SEWA enables ownership and investment of the community in the day-care centres.

While community involvement is no easy process and is ridden with difficulties particularly in relation to questions of inclusion and ethics (see Renu Khanna and COPASAH 2013), it is an important means through which trust and ownership are engendered, and these in turn are crucial for sustainability.

7. Monitoring and supervision

Most of the organizations have clearly delineated systems of monitoring and supervision of the day-care centres. This is provided through crèche supervisors, spearhead and technical teams as well as community-based monitoring. The Spearhead Team at SEWA, for instance, is entrusted with overseeing the functioning of the activities of the centres and access to referral services and to provide monthly supervision (Balakrishnan 2012). The supervisor in MC-supported and MC-run centres plays multiple roles – she oversees the centre's functions and also deals with any operational problem such as water problem, clogging of drains, sanitation, electricity, etc. Other than the work in the centre, she plays key roles in outreach to the community- – making household visits, mobilizing mothers to send their children to the centres, facilitating weighing and immunization for children who do not come to the centre, organizing camps on relevant issues, etc. (Venkateswaran, MC report, 2012). The supervisor thus plays an extremely critical role, ranging from practical input to guidance and motivation of the staff at the centres, playing an ongoing capacitating role, apart from a supervision and monitoring function (Venkateswaran, MC report, 2012).

JSS has a system of monitoring that includes community monitoring (through meetings at villages which ensures accountability in the provision of services) as well as a supervisor- and health-worker-based system of monitoring. The crèche supervisors who are deputed to oversee a 'cluster' of crèches based on the size of the cluster, visit each centre twice a week to provide them with eggs and also to monitor and supervise the provision of food and supplementary nutrition for the malnourished children. Further, a village health worker also visits the crèche once a week, and the senior health workers visit each crèche once a month to monitor the health of the children as well as the functioning of the crèches.

While the system of monitoring and supervision varies across the interventions, it also varies within an organization. For instance, supervision by MC, in sites that are supported and not run by MC, remains a critical part of the intervention. However, while for MC-run centres, the supervisor is responsible for 2–3 centres, for the MC-supported centres, one supervisor is responsible for 5 centres.

Policy implications

I. ICDS and/or NGO/Partnerships

Given that ICDS is to be the key modality for the provision of ECCE and given the very limited piloting of AWC-cum-creche centres that has been planned (5 per cent of anganwadis are to function as such), it is essential to understand what we can learn from these case studies about how future care may be provisioned. Amongst the case studies, there is one that is an entirely government-run ICDS programme (Tamil Nadu), a second is an NGO-run ICDS programme (Urmul) and a third partnered with the ICDS for several years (SEWA). Each of these organizations clearly go beyond the basic ICDS provisioning that is envisaged in terms of the six interventions (now more). While both SEWA and Urmul employed the implementation models, it is in fact the facilitation model that is the principal method by which the voluntary sector has engaged with the ICDS nationwide. In the facilitation model, the ICDS is run directly by the state government and voluntary agencies such as Urmul support the programme through ancillary efforts, particularly capacity building of staff and encouraging community participation in the functioning and monitoring of ICDS in every village.

It is clear from Urmul and SEWA's experiences that although it is difficult to retain creativity and localized provision in a partnership with ICDS, it is the implementation model that provides the possibility of more flexibility in provision. This would warrant a duplication of the implementation model, but only where the NGO is able to clearly negotiate flexibility in the localized provision of care.

On the question of sustainability and scale, as with the management /facilitation models of MC, the facilitation model is a tantalizing one for shifting the responsibility of the delivery of

provision of childcare back to the state and to the builder in whom legal obligations rest. However, when both the ICDS and the childcare obligations under the statutory provisions are inadequate in their conceptualization of care for young children, the facilitation model seems likely to be consistently constrained by systemic problems.

On this, the Tamil Nadu ICDS is instructive. Where the vision for the policy is not limited, then it is possible to provide a relatively better standard of care, as TN ICDS clearly demonstrates, particularly for children of the ages 2–3 years. This, however, has to be understood within a background of what Rajivan terms the 'sandwich approach'– pressure from both bottom and top in Tamil Nadu, allowing for a relatively more successful implementation of ICDS. Moreover, the investment that the Tamil Nadu state has made, particularly in nutrition and infrastructure, clearly outstrips the contributions that other states make.

There is definitely a need for a continued presence of organizations such as JSS, which are creatively engaging the community and providing a vital service, particularly to those that the state for whatever reason does not reach. The government should not disrupt existing programmes such as these that are run by the voluntary sector where these are well run. The effort should be to try and strengthen and sustain these existing multiple models. This is true of MC and SEWA as well.

II. Targeting Vulnerable Populations

Each of the case studies exemplifies the provision of care to children of vulnerable populations: rural migrants to cities (Mobile Creches), seasonal migrants (salt pans in Kutch, dhanis in Bikaner), Dalit and tribal populations in remote forested areas (JSS), urban poor (MC). Moreover, three of the organizations also provide targeted day care for the children of working mothers.

From each of the case studies, it is important to reiterate that most of the organizations (apart from TN ICDS) step in where the state has failed in its obligations either to provide childcare or to regulate its provision (at worksites) to vulnerable populations. While the ICDS mandates

universal provision of childcare for children under 6 years, in order to reach vulnerable populations, attempts have been made to also target populations, such as Scheduled Castes/Scheduled Tribes, and to include migrants (MC has struggled to get this particularly vulnerable population covered by anganwadi centres in Delhi with instances of success – see MC website). The importance of having these organizations continue with their provision of day care to vulnerable populations that remain either unreached by the state or underserved cannot be emphasized enough. This is a key means through which vulnerable populations continue to be reached. State support for these interventions (as with SEWA in Ahmedabad, which receives partial support from the State Welfare Board) is essential in ensuring that childcare is provided to vulnerable populations.

III. Quality Day-Care Provision

As each of the case studies illustrate, *quality* day-care provision lies in the flexibility, sensitivity, and localized nature of the provision of care, which has at its heart the needs of the local community, particularly the parents and the child. *Care* is an essential component of *quality* day-care provision, with not just the content of care, but also the process of care central to the provision of quality day-care services. What this means is that the carer, the processes of her recruitment, her involvement in the local community, the content and quality of her training, her conditions of work are all essential components in the provision of quality day-care services.

Each of our models illustrates ways in which each of these components can be creatively provided, whether it be by opening the phulwaris at 3.30 a.m., or locating day-care facilities in the salt pans of Surendranagar or the construction sites of Delhi, or recruiting women from the local community as carers, or training carers to understand age-specific needs of children, or providing quality nutritious and varied food to children under 3 years.

Each of the case studies also illustrate some of the difficulties that are attendant upon efforts to provide quality day care – for instance, the continued perceptions of day-care facilities as merely 'baby-sitting facilities' (JSS), the difficulty of catering to migrant populations (Urmul, when parents migrate to work in the dhanis), or sustaining the work with migrant children (MC). A

significant barrier to the provision of day-care facilities is the ideology that care is a familial and female responsibility.

The need for day-care facilities for children under 3 years from the perspective of both women (working as well as non-working mothers) and children has been clearly and consistently made through the case studies. However, the government draft policy on ECCE falls far short of recognizing the importance of universal, free, accessible day-care facilities for children under 3 years. Moreover, the ideology that care is a familial and female responsibility and a lack of awareness of the importance of quality childcare in the development of children, particularly when they are under 3 years, continue to plague the provision of childcare for under-3 children . Recognition by the state of the universal public provisioning of day-care facilities for children under 3 years as a right will go some way in ensuring the rights of children as well as women.

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Endnotes

[1] See the Shram Shakti report by the National Commission of Self Employed Women and Women in the Informal Sector (1989); Swaminathan (1985); FORCES-CWDS (2012); Datta and Konantambigi (eds) (2007). The Forum for Creches and Child Care Services (FORCES), an advocacy network committed to the survival and development of the young child and women working in the informal sector, was formed in 1989 following the recommendations of the Shram Shakti Report brought out by the National Commission of Self Employed Women and Women in the Informal Sector. This network has several regional chapters, many of which are actively engaged on the issue of childcare. Similarly, a more recent network, the Alliance for Rights to Early Childhood Care and Development has been mobilized by Mobile Creches to intervene on the draft National Policy on Early Childhood Care and Education.

[2] Statutory interventions are largely directed at the organized sector and include the Maternity Benefits Act, Factories Act, Mines Act, etc. (see Swaminathan 1993 and Vrinda Dutta 1999). A statutory intervention directed at the unorganized sector is MGNREGA, which mandates the provision of crèches at worksites. Evaluations of the implementation of MGNREGA have pointed to the lack of provision of crèches at worksites (IAMR, 1999). Another scheme directed at the unorganized sector is the Rajiv Gandhi Creche Scheme which is targeted at children under 6 years. It is specifically geared to families of working mothers with a monthly income of less than Rs 12,000. However, as the Need Assessment study for Creches (2012,p. 11) notes, this scheme is woefully inadequate, 'only 22,599 creches are functional even though the requirement is much higher'. The second draft Policy on ECCE (2013) recognizes a higher figure, noting that there are 23,785 crèches which are operational.

[3] See the 12th Five Year Plan, the Broad Framework for Implementation of ICDS, Ministry of Women and Child Development (2012), as well as the second Draft of the National Policy on Early Childhood Care and Education, 2013.

[4] The project on 'Quality Day Care Services for the Young Child' came out of an earlier partnership between UNICEF and the Institute of Social Studies Trust (ISST), where the organizations collaborated to organize an international workshop, , 'Who Cares for the Child? Gender and the Care Regime in India',from 8–9 December 2009. The current project (March 2012—une2013) builds on the findings and recommendations of this workshop.

[5] Published in 1995 by the M.S. Swaminathan Research Foundation, the Suraksha series documents a variety of models of provision of day care in a series of contexts.

[6] Although six studies form the basis of this report, one of the case studies on the Indira Kranti Pratham (IKP) run by the Society for the Elimination of Rural Poverty (SERP) in Andhra Pradesh is only used in a limited fashion in the report. This is because although IKP runs Nutrition cum Day Care Centres (NDCCs) in the state, these function more as health and nutrition centres for pregnant and lactating women and children under 3 years, rather than as *day care* centres (see Sundar Kompalli's report on IKP, 2012). As Ms Lakshmi Durga Chava, Director of the Community Managed Health and Nutrition (CMHN) programme of IKP, under which NDCCs are run, said, the aim of the CMHN programme was always on the reduction of malnutrition for both pregnant and lactating women and for infants (Interview, 12 June 2013, SERP office, Hyderabad). In the larger scheme of ECCE, the IKP plays a crucial role in a key component of ECCE – the reduction of malnutrition among pregnant and lactating women and in infants in rural Andhra Pradesh. However, in relation to the provision of day-care facilities for under-3 children, it is the Community Managed Education Services (CMES), also under the aegis of the IKP run by SERP, that focuses on the age group of 3–5 years, dovetailing with the ICDS in rural Andhra that also takes in children in their balabadis (Interview with Ms Mrudula Vemulapati, Director, CMES, 12 June 2013). Although not geared towards under threes, the balabadis also take in children between 2–3, whose siblings visit the early learning centres. However, we were unable to study the functioning of the balabadis.