



International Journal of Home Science

ISSN: 2395-7476
IJHS 2017; 3(1): 213-217
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www.homesciencejournal.com
Received: 03-11-2016
Accepted: 04-12-2016

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Nutritional Services at anganwadi centre in Integrated Child Development Scheme: A continuing challenge in rural zone of Jammu district

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Abstract

The present research is an attempt to study the implementation of nutritional services in rural zone of Jammu district under ICDS project. A sample of 50 respondents (anganwadi worker) from 50 anganwadi centres was selected. The tool consisted of a self-devised interview schedule for assessment of implementation of nutritional services of ICDS. Random sampling technique was used for the study. Results of the study revealed that although majority (90 per cent) of anganwadi workers were trained and had work experience of around 10 years but in spite of that, the implementation part of nutritional services was not at satisfactory level. The study suggested for a strong and intense need of improving training quality to anganwadi workers in both extents, pre service as well as in service.

Keywords: Anganwadi worker, ICDS, awareness, health, nutrition, implementation

1. Introduction

The Integrated Child Development Services (ICDS) programme is a globally recognized community based early child care programme, which addresses the basic interrelated needs of young children, expectant and nursing mothers and adolescent girls across the life cycle, in a holistic manner. ICDS in India is a response to the challenge of breaking a vicious cycle of malnutrition, impaired development, morbidity and mortality in young children. The ICDS is perhaps one of the better concerned programmes, yet on travels around country one realises that there is a huge gap between what is expected of the programme and the ground situation. What is even more worrying is that even the existing centres do not function effectively and that corruption, mismanagement and callousness seem to permeate even the ICDS programme (Ramachandran 2005) [13]. A large number of monitoring studies indicate that the ICDS programme has many problems with implementation (NIPCCD 1992; Allen *et al* 2001; Bredenkamp *et al* 2004; Greiner *et al* 2000; NCAER 2001; Barman 2001; Forces, New Delhi 2007) [1, 1, 4, 9, 10, 3, 7]. One major implementation problem is that anganwadi workers are inadequately trained, supervised and supported, while their duties require considerable understanding of Nutrition, pre-school education, and Nutrition and health education (NHED) issues. These studies have indicated that implementation of services under ICDS are not up to satisfactory standards and still more efforts are needed for improving the quality of services for the successful achievement of expected targets. Thus, the present study has been taken up with the main objective of assessing the implementation of nutritional services provided to pre schoolers (3-6 years) at anganwadi centre.

2. Material and Methods

The present study was conducted in Jammu block of Jammu district during the year 2011-2012. 50 Anganwadi workers were selected as respondents. Multi stage sampling technique was adopted for sample selection. Samples were randomly selected for the purpose. A self-devised interview schedule and observation method was used as a tool for data collection with the various questions framed on the execution procedures required for different services and implementation of various services of ICDS at anganwadi centre. Data was collected by visits made to anganwadi centres. The data obtained was coded and tabulated. Analysis of the data was done qualitatively and quantitatively using simple numbers and percentage.

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3. Result and Discussion

3.1 Supplementary Nutrition: Nutrition knowledge and training apart from her education plays an important role in the performance of anganwadi worker '(Gopaldas *et al* 1990) [8]. The present study performed in the urban zone of Jammu district reflected a demographic profile of the anganwadi workers of the area. Table 1 showed that the majority (30 per cent) of anganwadi workers were qualified up to higher secondary, followed by 28 per cent graduates. Remaining anganwadi workers had qualification up to matric (20 per cent), post graduate (8 per cent), post graduates and above (6 per cent), under matric (4 per cent) and graduate and above (4 per cent). The table 1 also revealed the information regarding the work experience of anganwadi workers. Majority of anganwadi workers had experience of around 10 years (46 per cent) under job while 38 per cent anganwadi workers had experience between 20-30 yrs and remaining 16 per cent of anganwadi workers had experience between 10-20 years. As far as training status of anganwadi worker was concerned, it was found through the data of table 1 that majority of anganwadi workers (90 per cent) were trained. Only 10 per cent of anganwadi workers were found with untrained status. Supplementary nutrition has been one of the core activities of ICDS. The good quality of the services is an important determinant for acceptance of a programme in a community. It not only enhances the credibility of a worker at the ground level but also generates the demand for the services '(Davey *et al* 2005) [5]. A glance at table 2 indicates that execution of nutritional practices which were applicable at anganwadi centre was not satisfactory as the majority of anganwadi workers in urban (58 per cent) projects were using standard measure for distribution of raw food while only 8 per cent anganwadi workers in urban projects were using standard measure for distribution of cooked food. Follow up of menu was another unsatisfactory parameter. 64 per cent anganwadi workers were not following the official menu for making supplementary nutrition. Reasons further explored for not following the menu were found to be non-availability of ration at anganwadi centre. It was also found that anganwadi workers were not disciplined enough to follow guidelines for the execution of supplementary nutrition. A glance at the table 3 indicates that an irregularity among anganwadi workers was found regarding the use of standard measures to achieve fixed quantity of nutrition. In urban projects the study revealed that majority (52 per cent) of anganwadi workers were using standard measure only for raw food. The table 3 also highlights about a section (36 per cent) of anganwadi workers in urban projects who were completely ignoring the use of standard measures to achieve fixed quantity of nutrition. Only 2 per cent anganwadi workers in urban projects were using standard measure for the distribution of cooked food but not using the same for raw food. A small section (6 per cent) of anganwadi workers in urban projects were using standard measures for both, raw as well as cooked food and thus were implementing the nutritional guidelines of ICDS for the achievement of nutritional target. During the training an anganwadi worker learns about cooking, distribution and serving of supplementary food, skills of, 'on the spot feeding' for a child. It is evident from the table 4 that in urban projects majority (52 per cent) of anganwadi workers reported for partial consumption of supplementary nutrition by children at their respective anganwadi centres while 28 per cent stated that children tend to consume full meal at the anganwadi centre. Remaining 10 per cent anganwadi workers stated that children do not prefer eating at anganwadi centres

and thus take their ration home for consumption. During the study, it was observed that children were either taking their ration home along with them or were partially consuming the food for the sake of demonstration in presence of outside visitor. It was also observed that majority of children in urban projects were bringing their own Tiffin meals and were consuming it at anganwadi centres. When served the supplementary food by anganwadi workers, they tend to reject eating and preferred to take their ration home because of the satiety feeling of the Tiffin meal they already had around 11-12 pm. Anganwadi workers were also not keeping a track of consumption of food by children who were taking the ration home.

Both anganwadi workers and anganwadi helpers were found not making efforts for feeding the child or motivating him/her to consume the meal. It was also found to be a general practice among anganwadi workers to serve the child twice in his/her Tiffin box: once for partial eating at anganwadi centre and secondly when the child is about to leave for home. There was no criterion found for how much to be served to a child under supplementary nutrition. She was found to be practising her own choice and intellect and avoiding the fixed guidelines of ICDS for supplementary nutrition.

3.2 Growth Monitoring

Growth monitoring is one of the prominent tool designs of ICDS programme in controlling the existing prevalence rate of child malnutrition. However, a finding of the study conducted by 'Ray (2005) [14]' depicted that Growth monitoring Services in the ICDS scheme meant only weight recording and was not at all satisfactory. Even the majority of the Anganwadi workers (AWW) under study stated that it meant monthly weight recording of children while only few knew it is in addition plotting these on growth charts and advising mothers if growth was not proper.

The table 5 highlighted that majority (82 per cent) of anganwadi workers in urban projects had Salter scale for weighing of children while 18 per cent anganwadi workers did not had any type of weighing scale. This clearly indicated that in the centres where there is no Salter machine, no growth monitoring would have been done for the children aged 3-6 years. The reasons observed for the non-availability of weighing scales were non functionality of the apparatus or no supply of apparatus by the authorities.

The glance at table 6 indicated that in urban projects, majority (60 per cent) of anganwadi workers had accuracy in proper use of weighing scale at anganwadi centre but the accuracy in plotting weight on growth chart was found to be average as, only 52 per cent anganwadi workers from urban projects were executing it properly. The record maintenance (48 per cent) was found to be unsatisfactory among urban anganwadi workers.

It was seen from table 7 that the majority of anganwadi workers in urban (38 per cent) projects were trained for accurate execution skills of growth monitoring for a child. These workers performed well when studied against accuracy in plotting weight on growth chart as well as accuracy in proper use of weighing scale. In urban projects there was a prominent section of anganwadi workers (26 per cent) who did not have the accuracy in either of the skills required for execution of growth monitoring. Table 7 also revealed that 12 per cent of anganwadi workers in urban projects had accuracy in plotting weight on growth chart but they were not trained and also not accurate for using weighing scale in proper manner. Similarly 20 per cent of anganwadi workers in urban

projects had accuracy in using weighing scales but were found to be inaccurate for the use of growth chart. The national evaluation of ICDS by ‘NIPCCD (1992) [11]’ also showed that about 36.3 per cent anganwadi workers were not able to monitor the growth of children. The main reason that was pointed out was the lack of skills among anganwadi workers in filling up growth charts.

3.3 Nutrition and Health Education (NHED)

Nutrition and health education is given to all women in the age group 15-45 years. Priority is given to nursing and expectant mothers. A special follow-up is made of mothers whose children suffer from malnutrition or from frequent illness. The methods of carrying the message of health and nutrition education are by the use of mass media and other forms of publicity, special campaign at suitable intervals, home visits by Anganwadi workers. A study done in past revealed that 37 per cent Anganwadi Workers reported non-availability of materials/aids for Nutrition and Health Education ‘(NIPCCD 2006) [12].

The glance at table 8 indicated that majority of anganwadi workers in urban (56 per cent) were organizing independent NHED counselling sessions at anganwadi centres while 32 per cent anganwadi workers were conducting NHED sessions with Mahila Mandal meeting and reporting the same session for both registers i.e Mahila Mandal and Nutrition and health education. Under these mixed sessions, anganwadi workers were discussing general topics which used to be out of context with Nutrition and health education guidelines. Also during these mixed sessions, anganwadi workers were found to be ignorant towards the required strength of community attending the meeting. It was observed that meetings, whether independent or mixed with Mahila Mandal, were used to be

unorganised and unstructured. No pre-planning for the conduction of Nutrition and health education counselling by anganwadi workers was found. It was also seen in table 8 that 12 per cent anganwadi workers in urban projects were found not conducting Nutrition and health education sessions at anganwadi centres. At some centres although record entries for Nutrition and health education sessions were found but when enquired spontaneously for the topic of last Nutrition and health education session held at anganwadi centre, anganwadi workers were not capable of answering the query or answered it incorrectly. Thus it was observed that fake entries were made on Nutrition and health education registers.

The Table 8 also highlighted that majority of anganwadi workers in urban (92 per cent) were organising *Nutrition and health education* session for once a month. Remaining anganwadi workers in urban (8 per cent) projects were organising *Nutrition and health education* session twice a month. The various topics discussed during sessions were deficiency diseases, balanced diet, adolescence health and hygiene practices during menstruation, child and mother health, diet during pregnancy and lactation. Few other topics like jam preparation and methods of food preservation were also discussed during these sessions.

During the study it was observed that many of the anganwadi workers were even not aware of mandatory guidelines of organizing two independent session of *Nutrition and health education* in a month. It was also observed that anganwadi workers were not confident and motivated enough for personating themselves as a nutrition and health educator for these sessions. They also reported the non-co-operation of community for these sessions and thus found themselves helpless enough to conduct the sessions with in the schedule.

Table 1: Demographic profile of Anganwadi Worker

Parameter	Frequency	Percentage
Qualification		
Under matric	02	04 %
Matric	10	20 %
Higher secondary	15	30 %
Graduate	14	28 %
Graduate and above	02	04%
Post graduate	04	08 %
Post graduate and above	03	06 %
TOTAL	N=50	100%
Work Experience		
0-10	23	46 %
10-20	08	16 %
20-30	19	38 %
TOTAL	N=50	100%
Training Status		
Trained	45	90 %
Untrained	05	10 %
TOTAL	N=50	100%

Table 2: Execution of Supplementary Nutritional Practices at Anganwadi Centre

Parameters	Response (yes)		Response (no)	
	Frequency	Percentage	Frequency	Percentage
Follow up of menu	18	36 %	32	64 %
Use of standard measure for weighing of raw food	29	58 %	21	42 %
Use of standard measure for distribution of cooked food	04	08 %	46	92 %
Total	N=50	100 %	N=50	100 %

Table 3: Implementation of Supplementary Nutritional Target at Anganwadi Centre

Activity	Frequency	Percentage
Use of standard measures to achieve fixed quantity of nutrition		
Raw but not for cooked	26	52 %
Cooked but not for raw	01	02 %
Both (raw + cooked)	03	06 %
None	18	36 %
Total	N=50	100 %

Multiple responses

Table 4: Consumption of Supplementary Nutrition by Children at Anganwadi Centre

Consumption of food	Frequency	Percentage
Full	14	28 %
Partial	31	62 %
Nil	05	10 %
Total	N=50	100 %

Table 5: Availability of weighing scale at Anganwadi Centre

Parameters	Frequency	Percentage
Type of scale		
Salter scale	41	82 %
Any other scale	-	-
None	09	18 %
Total	N=50	100 %

Table 6: Implementation of Services under Growth Monitoring

Parameters	Response (yes)		Response (no)	
	Frequency	Percentage	Frequency	Percentage
Record maintenance at AWC	24	48 %	26	52%
Accuracy in plotting weight on growth chart	26	52 %	24	48 %
Accuracy in proper use of weighing scale at AWC	30	60 %	20	40 %
Total	N=50	100 %	N=50	100 %

Table 7: Execution Skills of AWW under Growth Monitoring

Activity	Frequency	Percentage
Accuracy in plotting weight on growth chart but no proper use of weight scale	06	12 %
Accuracy in proper use of weighing scale but not for growth chart	10	20 %
Accuracy in both activities	19	38 %
None	13	26 %

Multiple responses

Table 8: Nutrition and Health Education (NHED) at Anganwadi Centre

Parameters	Frequency	Percentage
NHED Counselling at AWC		
Independent NHED session	28	56 %
NHED Session With Mahila Mandal Meeting	16	32 %
None	06	12 %
Total	N=50	100 %
Rotation of NHED session		
Once a Month	46	92 %
Twice a Month	04	08 %
Total	N=50	100%

4. Conclusion

The study concluded that although majority (90 per cent) of anganwadi workers were trained and had work experience of around 10 years but in spite of that the implementation part of nutritional services was not at satisfactory level. A evaluation study done in past '(NCAER, 1996-2001)' also reported that though about 84 per cent of the functionaries reported to have received training, the training was largely pre-service training. In-service training remained largely neglected. Thus there is a strong and intense need of improving training quality to

anganwadi workers in both extents pre service as well as in service. Frequent interactions among anganwadi workers and supervisor should be introduced for upgraded information and awareness.

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