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A study on the awareness level of the Anganwadi workers about integrated child development services (ICDS) at urban health centres

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Abstract

Background: Integrated child development services (ICDS) are one of the largest early childhood development programmes in the world. The major goal of this programme is to respond to the developmental needs of children aged 0 to 6. The Anganwadi worker is an ICDS front-line volunteer who works in the community. Despite the fact that the government spends a lot of money on the ICDS programme, it is useless.

Objective: The aim of the study is to determine the level of awareness of integrated child development services among Anganwadi employees.

Methods: In the proposed investigation, 36 Anganwadi centers in the northeastern regions of the Patna district were visited, with Anganwadi respondents, purposively selected from five areas (Buddha colony, North Mandiri, South Mandiri, Kidwaipuri, and S.K Nagar). The self-created interview, schedules, and questionnaire method have been used in this.

Results: Anganwadi employees have (100%) aware has assessments of the services delivered by anganwadi workers.

Conclusion: The results of this study also indicated that anganwadi personnel performance and awareness of growth charts and growth monitoring were satisfactory. The AWWs had delivered the majority of the service and were reflecting on it at the time of the investigation. Anganwadi workers are the frontline workers who will promote ICDS best practices to improve the health and nutritional condition of mothers and children.

Keywords: Anganwadi center's, Anganwadi workers, knowledge assessment score

Introduction

In India, the Integrated Child Development Services (ICDS) programme provides healthy meals, preschool education, primary healthcare, immunization, health check-ups, and referral services to children under the age of six and their mothers. The project began in 1975, was terminated by Morarji Desai's government in 1978, and then re-launched by the Tenth Five.

According to a 2005 research, the ICDS programme was ineffective in reducing malnutrition, owing to operational issues as well as the fact that the poorest states received the least coverage and funds. Among other dietary, vaccination, and educational deficits among Indian children, the newborn death rate is 34%, the under-five mortality rate is 39%, and 25% of new born children are underweight. India's statistics are insufficient by developed-world standards. According to India's National Policy for Children, ICDS was established in 1975 (Ministry of women and child welfare 2019).

Supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-ups, and referral services are among the services provided by ICDS to fulfill its goals. One of the most significant variables in balancing the nutritional status of children is supplemental nourishment. This comprises supplemental feeding and growth monitoring, as well as protection against vitamin A deficiency and nutritional anemia control. To identify children under the age of six, pregnant and nursing moms, all families in the community are questioned. Anganwadi staff receive supplemental nutrition assistance for 300 days each year. Every child under the age of six receives 300 calories (eight to ten grams of protein) per day from the ICDS.

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Every day, adolescent girls should consume up to 500 calories and 25 grammas of protein.

Because its services primarily encompass the Anganwadi, Non-Formal Pre-School Education (NFPSE) is a part of the ICDS and is often referred to as its backbone. Its Anganwadi programme for children aged three to six years aims to provide and provide a natural, enjoyable, and motivating environment, with a focus on the necessary inputs for the best possible growth and development. The ICDS's early learning component makes an important contribution to laying a solid foundation for lifetime learning and development. It also contributes to the universalization of primary education by providing the essential preparation for primary school and providing alternate childcare for younger siblings, allowing older siblings, particularly girls, to attend school (Patel, N., *et al.* 2005) [4].

The Anganwadi worker's role includes nutrition, health, and education. The BCC (Behavior Change Communication) technique includes this. The long-term goal is to enhance the capacity of women, particularly those between the ages of 15 and 45, to care for their own health, nutrition, and development as well as that of their children and families. The community-based voluntary front line employees of the integrated child development services programme are known as Anganwadi workers (AWW). She is chosen from the community and plays a crucial role since she maintains constant contact with the beneficiaries. Her educational level and nutrition understanding are crucial factors in her Anganwadi centers performance.

The profile of the primary functionary, that is, anganwadi employees, her qualifications, experience, skill, attitude, and training, all influence the output of the integrated child development plan. An anganwadi is a community-based organisation that provides integrated child development services to children and their mothers. Immunization is critical in order to protect a youngster from health problems. Children are protected from six vaccine-preventable diseases, including tetanus, TB, and measles, when pregnant mothers and infants are immunized. These are significant preventable factors that aid in the reduction of child mortality, disability, illness, and malnutrition. Tetanus vaccination for pregnant women lowers the risk of maternal and newborn mortality (Jena, P., 2013) [5].

Children under the age of six, prenatal care for women, and postnatal care for nursing moms are all included in the health checkup. Regular health check-ups, weight recording,

immunization, management of malnutrition, treatment of diarrhea, and provision of simple medicines are among the several health services offered by Anganwadi workers for those children and Primary Health Centre (PHC) staff. Malnourished children are sent to the Primary Health Centre (PHC) or its sub-center during health check-ups and receive timely medical attention. The Anganwadi personnel has also been taught that small children are incapable. She keeps track of all such cases in a separate file and reports them to the PHC's medical officer.

Objective

To determine the level of awareness of integrated child development services among Anganwadi employees.

Hypothesis

H₀: The level of awareness of Anganwadi workers about integrated child development programmes is satisfactory.

Materials and Methods

The present study entitled "A study on the Awareness level of the anganwadi worker's about integrated child development services at urban health centers" was conducted by using the following methods based on the Awareness level of Anganwadi workers' problems and its objectives. It has been discussed in the following sub-heads.

Research design

The current study used a descriptive cross-sectional research design. When the goal of the study is to discover characteristics, frequency, trends, and classifications, a descriptive research design is the best option. The goal of research under an explanatory design, on the other hand, is to improve the researcher's understanding of a topic.

Area of the study

The study region was chosen in the Patna district's northeastern corner. The study included Anganwadi personnel. Following the pilot research, areas were chosen.

Sample size

Because of the researcher's easy accessibility, the Patna area of Bihar was chosen specifically for this study. Anganwadi respondents from five localities (Buddha colony, North Mandiri, South Mandiri, Kidwaipuri, and S.K Nagar) were purposefully selected for this study.



Fig 1: Patna District Map of a Specified Area

Selection of the respondents

The sample procedures were chosen in accordance with the study's goal. The sample size estimations purposefully picked 36 anganwadi workers as respondents.

Tools and techniques of data collection

Data was collected using a self-designed interview schedule and questionnaire. Personal visits to anganwadi centers were used to gather information.

Data analysis

For data analysis, tabulation and frequency distribution methods were used.

Statistical analysis

The respondent's orientation was used to calculate percentages.

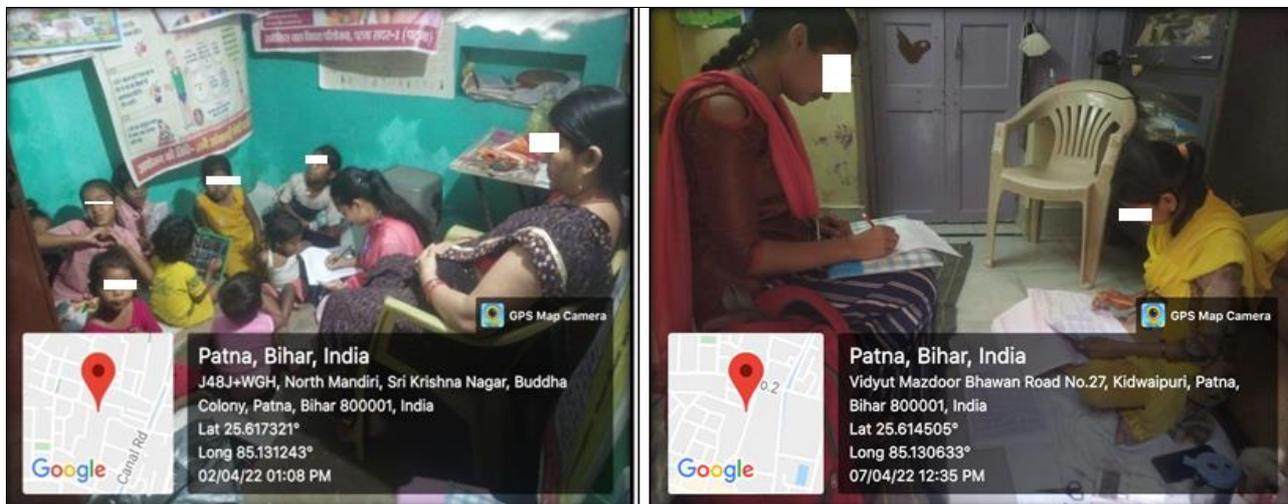


Fig 2: Collecting information from the respondents

Result and Discussions

Table 1: Assessments of the services delivered by Anganwadi workers (AWWs)

| Variables | Frequency (N=36) | Percentage (%) |
|--|------------------|----------------|
| Do you maintain records of immunization, health check-up etc in AWCs | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you assist hospital staff in immunization, Health check –up in AWCs | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you provides referral services in AWCs | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you provides health and nutritional education to adolescent girls, women & the community in AWCs | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you provides services to mothers/children/lactating mother& adult girls in AWCs | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do community supports you | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you provide prophylaxis against blindness and anaemia in AWCs | | |
| Yes | 36 | 100% |
| No | 0% | 0% |

The above information was taken by the anganwadi workers (AWWs). Table 1 shows that the assessment of services provided by anganwadi workers and the first vaccination action report were completed (100%) by anganwadi centres, and the second support hospitals staff in immunisation was completed (100%) by anganwadi centres. Anganwadi workers provide all government programmes and services for children/pregnant women/lactating women/adolescent girls,

and anganwadi workers provide (100%) health and nutritional education to girls, women, and the community in anganwadi facilities. However, anganwadi staff in urban regions claim that these initiatives are not totally successful in urban settings. In this anganwadi centre, the neighbourhood has been completely supportive. And all vaccines, including as protection against blindness and anaemia, were (100%) available in AWCs.

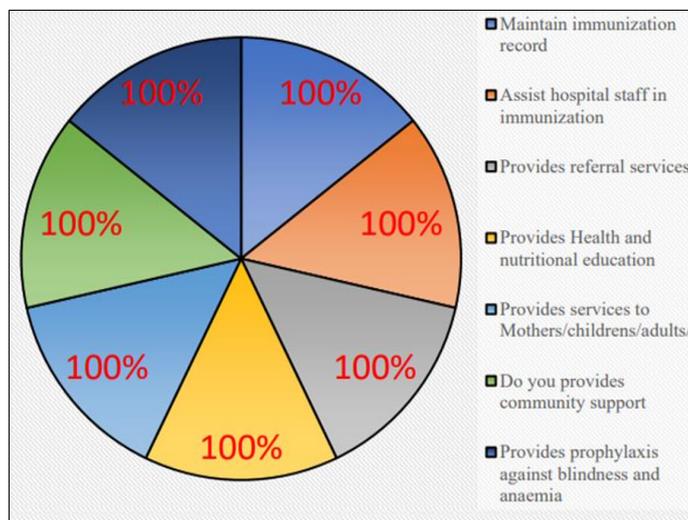


Fig 3: Assessment of the services delivered by (AWCs)

Table 2: Yojana and programmes conducted by anganwadi Centers (AWCs)

| Variables | Frequency (N=36) | Percentage (%) |
|---|------------------|----------------|
| Indira Gandhi Matritva Sahyog Yojana (INMSY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| “SABLA” Rajiv Gandhi Kishori Yojana (RGKY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Kisori Shakti Yojana (KSY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Mukhya Mantri Poshan Yojana (MPY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Dular se Muskan Yojana (DMY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Janani Surksha yojana (JSY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |
| Purakposhan yojana (PPY) | | |
| Yes | 36 | 100% |
| No | 0 | 0% |

anganwadis, although the Indira Gandhi Matritva Sahyog Yojana (INMSY), Rajiv Gandhi Kishori Yojana (RGKY), and Kishori Shakti Yojana (KSY) do not provide full benefits, for example, if ten people's names are given, only two persons will receive funding. Anganwadi staff confront numerous challenges.

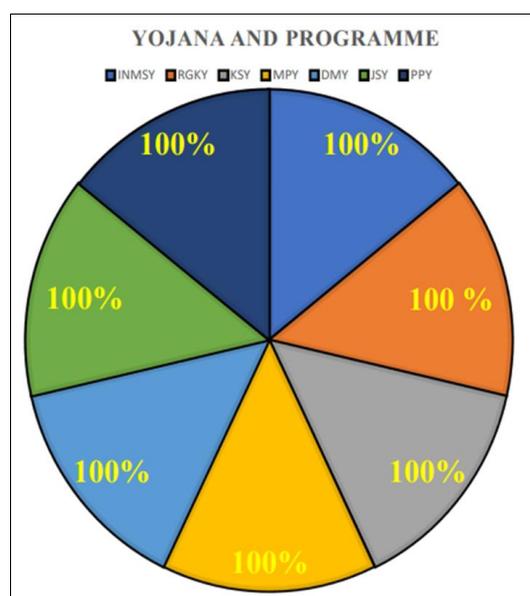


Fig 4: Yojana and programme of (AWCs)

The above information was taken by the anganwadi workers (AWWs). Table 2 shows that the Yojana and programmes run by anganwadi staff are already operating, according to the report. All of these plans and programmes are administered by

Table 3: Knowledge of anganwadi workers (AWWS) regarding supplementary nutrition

| Variables | Frequency (N=36) | Percentage (%) |
|--|------------------|----------------|
| What amount of calories & protein's given of each child in AWCs | | |
| 200 kcal & 5 gm protein | 0 | 0% |
| 300 kcal & 10 gm protein | 12 | 33.34% |
| 500 kcal & 15 gm protein | 24 | 66.66% |
| 600 kcal & 20 gm protein | 0 | 0% |
| Calories & protein's given of each pregnant women in AWCs | | |
| 200 kcal & 5 gm protein | 0 | 0% |
| 300 kcal & 10 gm protein | 9 | 25% |
| 500 kcal & 15 gm protein | 27 | 75% |
| 600 kcal & 20 gm protein | 0 | 0% |
| Calories & protein's given of each lactating mother's in AWCs | | |
| 200 kcal & 5 gm protein | 0 | 0% |
| 300 kcal & 10 gm protein | 6 | 16.66% |
| 500 kcal & 15 gm protein | 30 | 83.34% |
| 600 kcal & 20 gm protein | 0 | 0% |

Table 3 summarizes knowledge of anganwadi workers (AWWS) regarding different aspects of health services provides. The above information was taken by the Anganwadi workers' (AWWs). Table 3 shows that the anganwadi workers' understanding of supplementary nutrition was not entirely satisfied since they were unaware of the amount of calories and protein provided by the government. According to her response, children are given 300 kcal calories and 10 gm protein per day in anganwadi centres (33.34 percent),

whereas children are given 500 kcal calories and 15 gm protein (66.66 percent). And (25%) of responders supply 500 calories and 20 grammes of protein per day for pregnant women, whereas (75%) of anganwadi workers provide 600 calories and 15 grammes of protein per day. And an overwhelming majority of Anganwadi personnel (83.34 percent) were aware of the calories and protein that breastfeeding mothers supply.

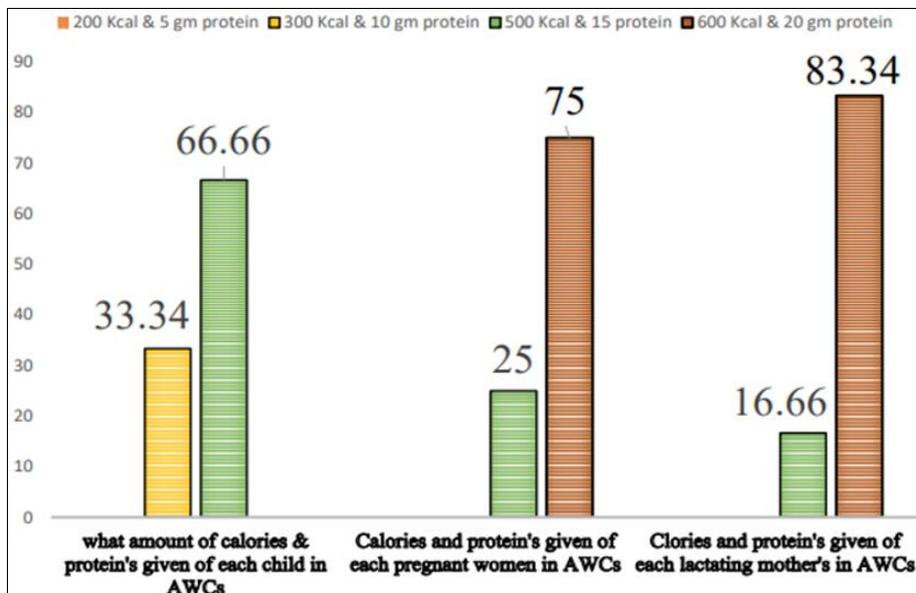


Fig 5: Supplementary Nutrition

Table 4: Knowledge of anganwadi workers (AWWS) regarding immunization

| Do you have a register iron, & folic acid & Vitamin A supplementation | | |
|---|----|--------|
| Yes | 36 | 100% |
| No | 0 | 0% |
| Measles vaccine given at what age | | |
| 6 months | 5 | 13.88% |
| 9 months | 31 | 86.12% |
| 11 months | 0 | 0% |
| 1 years | 0 | 0% |
| What types of vaccines given at 5 years age | | |
| DTP | 36 | 100% |
| DT | 0 | 0% |
| TT | 0 | 0% |

Table 2.3.2 shows that the immunization report of 36 anganwadi centres had (100%) registers maintained by iron/folic acid/vitamin A supplementation, and (100%) AWWs had answers indicating DTP vaccines were provided

to children aged 5 years old. However, the measles vaccination offers what ages are provided (13.88%) are replies had 6 months, while (86.12%) AWWs react were answers 9 months.

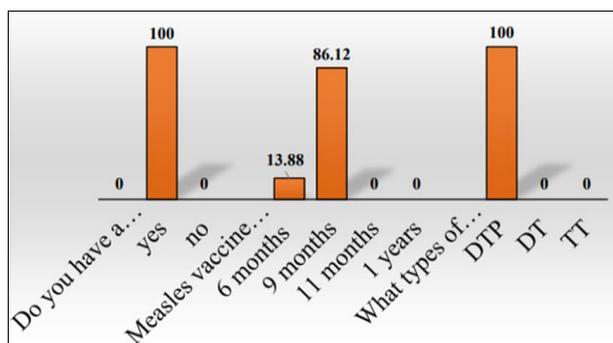


Fig 6: Immunization

Table 5: Knowledge of anganwadi workers (AWWS) regarding health -UP

| Do you have medicine distribution register in AWCs | | |
|--|----|------|
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you have how to identify children "at risk" | | |
| Yes | 36 | 100% |
| No | 0 | 0% |

Table 2.3.3 shows that 36 anganwadi employees provided health check-up reports, and (100%) of successfully means medicine distribution record and identify children "at risk" were provided in anganwadi centres.

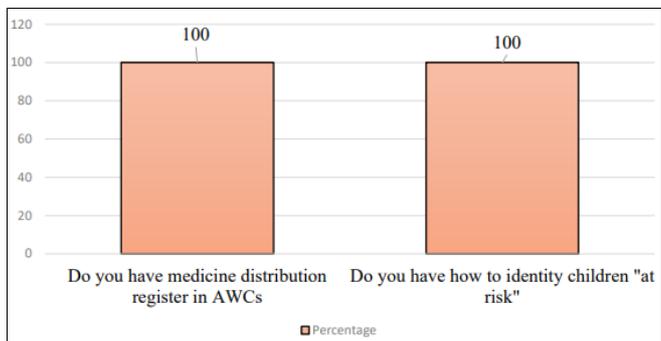


Fig 7: Health Check-up

Table 6: Knowledge of anganwadi workers (AWWS) regarding pre-school education

| Do you have pre – school education register | | |
|---|----|--------|
| Yes | 36 | 100% |
| No | 0 | 0% |
| Do you have black board | | |
| Yes | 32 | 88.87% |
| No | 4 | 11.11% |

Table 2.3.4 shows that, In the anganwadi centres, there was a (100%) pre-school education registry. In addition, anganwadi facilities have (88.87%) black boards, while pre-school education has (11.11%) no black boards.

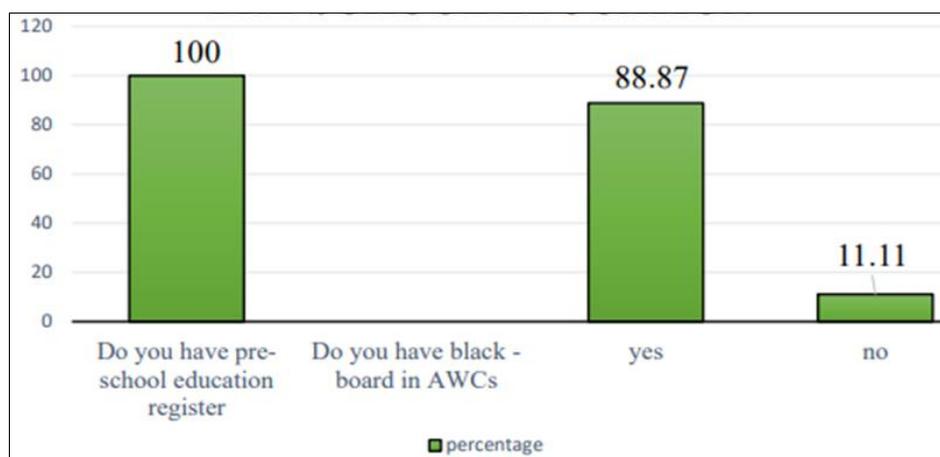


Fig 8: Pre-school Education

Table 7: Knowledge of anganwadi workers (Awws) regarding referral services

| Mention any four high risk pregnancies which need referral | | |
|--|----|--------|
| Could mention all correctly | 25 | 69.45% |
| Only 3 | 10 | 27.77% |
| Only 2 | 1 | 2.77% |
| And none | 0 | 0% |
| Children who need referral (any four) | | |
| Could mention all correctly | 28 | 77.78% |
| Only 3 | 8 | 22.22% |
| Only 2 | 0 | 0% |
| And none | 0 | 0% |

Table 2.3.5 shows that, in our research, we discovered that high-risk pregnancies such as anaemia, pre-eclampsia, and oligohydraminios are all accurately mentioned by (69.45 percent) AWWs, whereas (27.77 percent) AWWs responded just 3 and (2.77 percent) AWWs responded only 2 replies. And children who require referral services such as immunization, injection, or supplements (77.78 percent) AWWs could properly name all of them, but (22.22 percent) AWWs could only name two types of referral services for children.

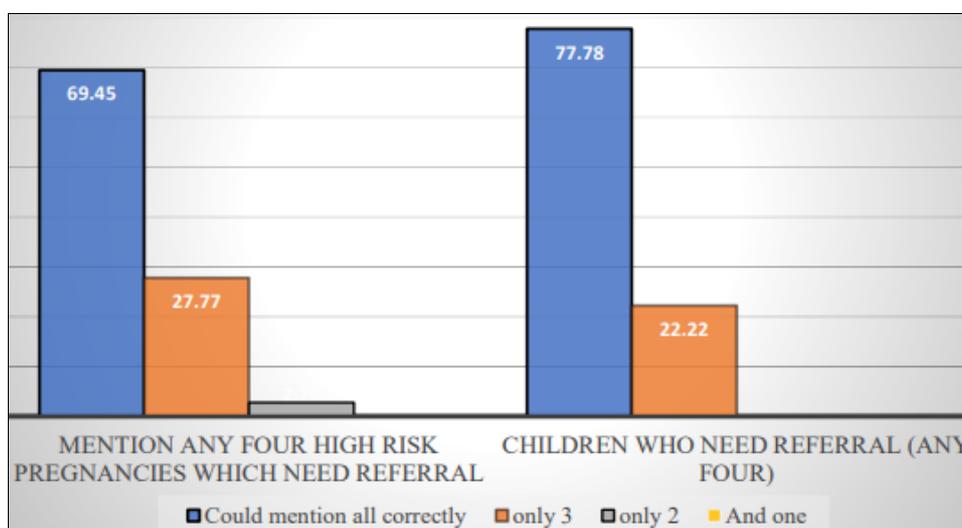


Fig 9: Referral Services

Table 8: Knowledge of Anganwadi workers (awws) regarding nutrition and health education

| Nutrition & health education especially in what age group of | | |
|--|----|---------|
| 15 to 25 | 0 | 0% |
| 15 to 35 | 9 | 25% |
| 15 to 45 | 27 | 75% |
| 15 to 55 | 0 | 0% |
| Other (specify) | | |
| What kind of diet that should be given during Diarrhoea | | |
| Only liquids | 31 | 86.12% |
| Light and nutritious diet | 5 | 13.88% |
| Diet should withheld | 0 | 0% |
| The sources of Vitamin A | | |
| Pulses | 2 | 5.55% |
| Rice | 0 | 0% |
| Fruits | 34 | 94.45% |
| The sources of Protein | | |
| Egg | 32 | 88.89% |
| Vegetables | 4 | 11.11% |
| The sources of Iron | | |
| Pulses | 0 | 0% |
| Beans | 30 | 83.34 % |
| Vegetables | 6 | 16.66% |
| Following are high risk pregnancies | | |
| Win pregnancy | 0 | 0% |
| Anaemia | 32 | 88.89% |
| pre-eclampsia | 4 | 11.11% |
| Oligohydramnios | 0 | 0% |

Table 2.3.6 shows that, Nutrition and health education were particularly important in this study, with 75% of respondents in the 15 to 45 age group and 25% in the 15 to 35 age group. &in the case of diarrhoea, 86.12% of AWWs claimed they merely give drink, but 13.88 percent indicated they should give a light and balanced diet. Pulse had a 5.55 percent source

of vitamin A, and AWWs had a 94.45 percent source of vitamin A fruits. Egg is also a good source of protein (88.89%). Beans have 83.34 percent iron, while vegetables contain 16.66 percent. Anemia (88.89%) and pre-eclampsia (11.11%) are also common in high-risk pregnancies.

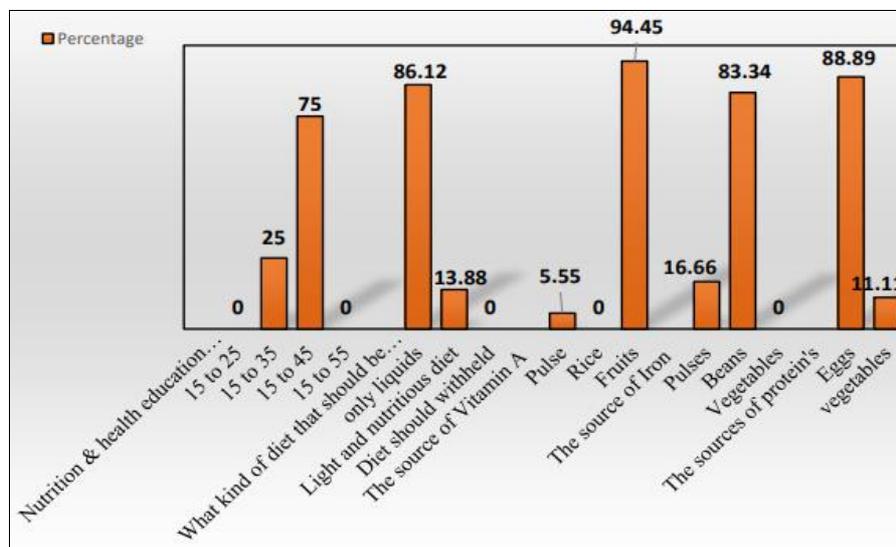


Fig 10: Nutrition and Health Education

Table 9a: Knowledge assessment score of anganwadi worker's (AWWS) related to her educational status

| Characterictis | Variable | Frequency (n=36) | | | Percentage (%) |
|---|-----------|------------------|--------------|-----------|----------------|
| | | <25 (N= %) | 26-28 (N= %) | >28 (N=%) | |
| Educational Status of Anganwadi Workers | Primary | 3(18.75) | 5(31.25) | 8(50) | 16(44.45) |
| | Secondary | 4(28.57) | 3(21.42) | 7(50) | 14(38.88) |
| | Graduated | 0(0) | 3(50) | 3(50) | 6(16.67) |
| | Total | 7(20) | 11(30) | 18(50) | 36(100) |

<1 quartile (<25):- poor knowledge.

1-3rd quartile (26-28):- average knowledge.

>3rd quartile (>28):- good knowledge.

Table 9b: Knowledge assessment score of anganwadi worker’s (AWWS) related to her working experience

| Characteristic | Variable | Frequency (N=36) | | | Percentage (%) |
|---|-------------|------------------|--------------|------------|----------------|
| | | <25 (N=%) | 26-28 (N= %) | >28 (N= %) | Total (N=%) |
| Working Experience of Anganwadi Workers | 0-5 years | 5 (45.45) | 2 (18.19) | 4 (36.36) | 11 (30.56) |
| | 6-10 years | 1 (7.15) | 5 (35.71) | 8 (57.14) | 14 (38.88) |
| | 11-15 years | 0 (0) | 2 (22.23) | 7 (77.77) | 9 (25) |
| | >16 years | 0 (0) | 1 (50) | 1 (50) | 2 (5.56) |
| | Total | 6 (16.67) | 10 (27.78) | 20 (55.55) | 36 (100) |

<1 quartile (<25):- poor knowledge, 1-3rd quartile (26-28):- average knowledge, >3rd quartile (>28):- good knowledge

Table 2.4 summarizes the knowledge assessment score of anganwadi worker’s (awws) related to her educational status and working experience for the study. Median and quartile were selected for knowledge assessment in anganwadi workers because the majority of the distribution of variables was skewed. According to the table 2.4.1 7(20%) of anganwadi staff had a limited understanding of primary education. Furthermore, 10 (27.77%) of anganwadi workers had an average understanding of higher secondary education,

while 18 (50%) had good knowledge of graduated anganwadi workers. Table 2.4.2 shows that 4 (36.36) percent of 11 anganwadi employees with work experience of 0-5 years and 8 (57.14) percent of 14 anganwadi workers with work experience of 6-10 years had good knowledge, while 9 anganwadi workers with work experience of 11-15 years had high knowledge. 7 (77.77%) of them had good knowledge, and 1 (50%) of two anganwadi workers with more than 16 years of experience had good knowledge.

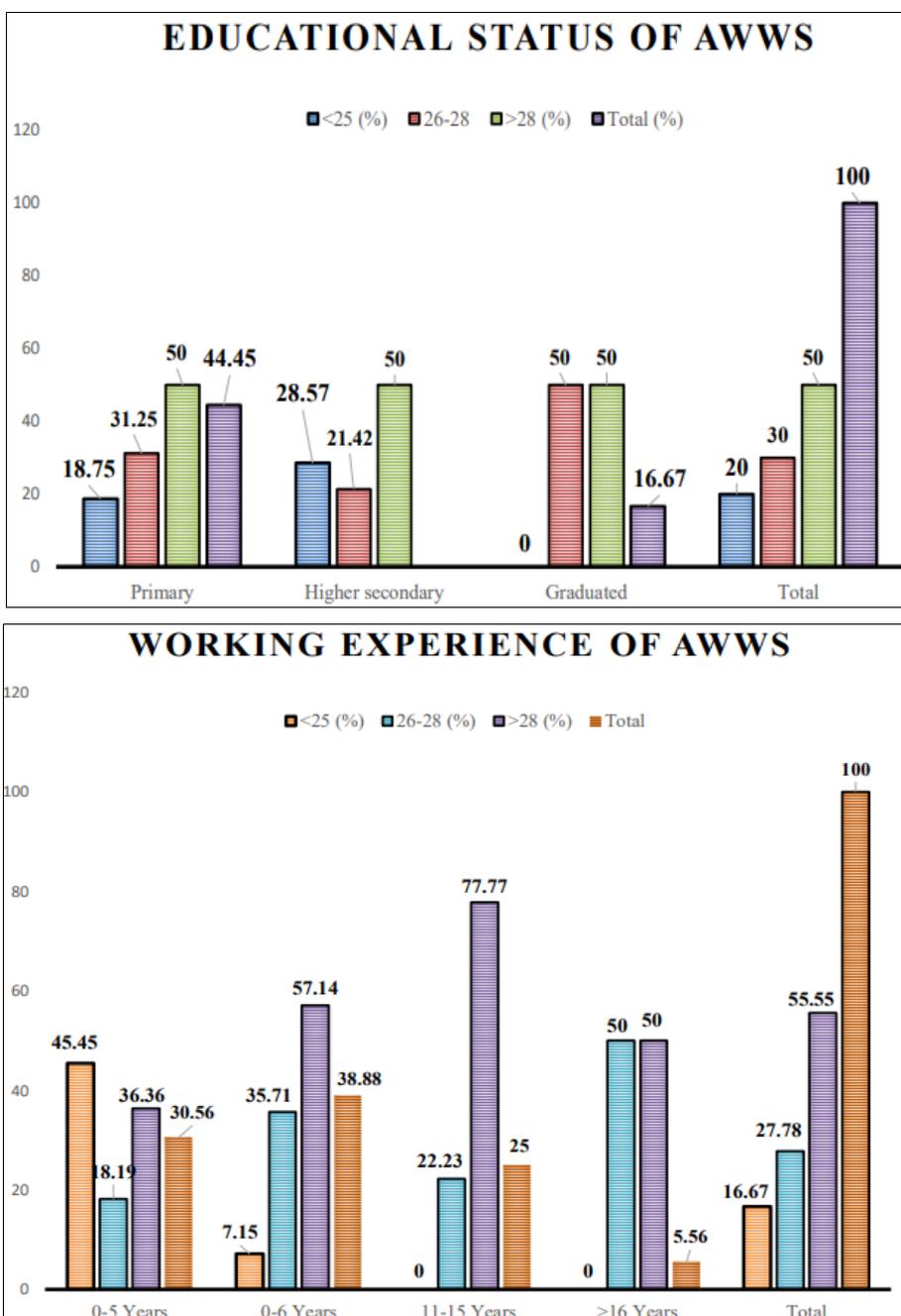


Fig 11: Knowledge assessment score of anganwadi workers related to her educational status and working experience of (AWWS)

Conclusion

According to the findings of this study, anganwadi workers are aware of integrated child development services. As we all know, ICDS is one of the world's most important early childhood development programmes. Anganwadi workers' education and nutrition abilities are vital to their success because they are the most important people in the programme. Growth monitoring training, in addition to anganwadi personnel education, has been found to be crucial for enhancing their performance. Anganwadi personnel helps people get ICDS services.

Then, based on all of the activities offered by the Anganwadi, we determined the level of awareness among Anganwadi personnel, and discovered that everyone was aware of the programme. The AWWs had delivered the majority of the service and were reflecting on it at the time of the investigation. Orientation classes would keep them up to date on the latest information. Anganwadi workers are the frontline workers who will promote ICDS best practices to improve the health and nutritional condition of mothers and children.

Limitation

Given the vast number of anganwadi centres (AWCs), the sample size of this study was modest; therefore, future studies should include a bigger sample size in order to generalise the findings and draw acceptable conclusions.

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