The Functioning of Anganwadi Centres and Workers

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Abstract

The strategic method leading to the welfare of the children began in the First Five Year Plan when the Planning Commission decided to give primacy to the needs of children. There were launching of many child welfare programmes under the five year plans. These programs are related to the needs of the children in the areas of education, health, nutrition, welfare and recreation. Special programmes were initiated in order to meet the needs of antisocial, handicapped, impoverished and other groups of children. Some of these programmes were concerning the progress and development of the children, especially, belonging to the preschool age group of 0-6 years. However, such child care programmes with their insufficient reporting and inadequate efforts could not solve the problems of the children to a large extent. As all-inclusive and integrated early childhood services were regarded as investment in the forthcoming economic and social progress of the country, it was sensed that a model plan which would guarantee the provision of maximum benefits to the children within a long-term should be enhanced. Consequently, a scheme for integrated child care services was initiated for implementation in all states. The Anganwadi Programme, launched by the Government of India in 1975 as part of the Integrated Child Development Scheme (ICDS), is a grassroots programme that has an access to women in rural areas and urban slums, the main objective of this program is to educate them on matters such as, basic health and hygiene, nutrition, pre-natal and post-natal maternal and childcare and child rearing.

Keywords: Anganwadi Centres, Workers, Health, Nutrition, Education, Activities, Development

Introduction

The name anganwadi worker is derived from the Indian word, angan, which means the courtyard, it is a central area in and around the house where most of the societal and community activities are organized. In rural areas, the angan is referred to the open place where people meet to converse, greet the guests, and socialize. Traditional rural households have a small hut or a house with a periphery around where they keep their charpoys, cattle, feed, bicycle, and other materials. Sometimes food is also prepared in the angan. Sometimes, the members of the household also sleep outside in the open air, beneath the sky, in their

angans. There are many kinds of religious functions that are carried out in the angan, therefore, it is utilized for multiple purposes; this space has a versatile nature and is very useful. The public health workers who are employed in angans, and also makes visits to other people‘s angans, assist them in their healthcare issues and concerns, are known as the anganwadi workers (Anganawadi Workers: A Profile, n.d.).

The anganwadi system is primarily administered by the Anganwadi worker (AWW). She is a health worker selected from the society and is provided with four months of training in areas such as, health, nutrition and child-care. She is in charge of an anganwadi which includes a population of 1000. There are an estimated 10.53 lakh anganwadi centres employing 18 lakh workers, who are mostly females and helpers across the country. They provide outreach services to the disadvantaged families who are in need of immunization, healthy food, clean water, clean restrooms and a learning environment for infants, toddlers and pre-schoolers. They also make provision of services for expectant and nursing mothers. According to the government figures, anganwadis reach about 5.81 crore children and 1.02 crore pregnant or lactating women. Anganwadis are India's crucial areas against the problems of child malnourishment, infant mortality and restraining of preventable diseases such as polio (Anganawadi Workers: A Profile, n.d.).

Integrated Child Development Services

The Integrated Child Development Services (ICDS) with its network of anganwadis, that are covering more than 3000 community development blocks in the country, it is stated to be the largest women and child development program being implemented anywhere in the world. The Anganwadi worker (AWW) is the community based voluntary frontline worker of the ICDS programme. The AWW is chosen from the community, the role of these workers are considered imperative because of the creation of close and incessant communications with the beneficiaries. The productivity or the ICDS scheme is to a large extent dependant on the profile of the key functionary i,e. the AWW, educational qualifications, experience, skills, attitude., training and so forth (Thakare, Kuril, Doibale, & Goel, 2011).

This scheme is implemented in a uniform and a well-organized manner throughout the country. The main purpose of the ICDS scheme is to meet the health, nutritional and educational needs of the poverty stricken and disadvantaged infants, pre-school aged children, and women during their child-bearing time period. The six basic services that are offered have been classified as the following: (Seema, 2001).

Supplementary Nutrition – Supplementary nutrition is made available to the children who are below six years of age, nursing mothers and the expectant mothers who belong to low income families. The women and young children belonging to underprivileged and destitute families cannot afford healthy diet and experience problems in meeting their nutritional requirements, hence, they are supported by this scheme. These are in accordance with the guidelines for the purpose of the selection of the beneficiaries, this will be given for 300 days in a year.

Nutrition and Health Education – Nutrition and health education is provided to women who are in the age group of 15 to 45 years. The individuals who belong to underprivileged and marginalized communities need to possess adequate knowledge about diet and nutrition and maintenance of good health conditions. This applies mainly to expectant and nursing mothers; this information will help them in the implementation of child rearing in a better way.

Immunisation – Immunisation is required for all children less than six years of age, in the project against diphtheria, tetanus, cough, typhoid and tuberculosis. Immunisation against tetanus is required for all the expectant mothers. It is to be made sure that all the infants staying within the anganwadi centres should be administered vaccination against BCG, DPT, Polio and Measles before they reach one year of age.

Health Check-Up – Health check-up on a regular basis is important for young children as well as for expectant and nursing mothers. This includes antenatal care of expectant mothers, post-natal care of the nursing mothers, care of infants and of all the children who are below six years of age.

Referral Services – The problem of malnutrition is prevalent amongst young children, therefore, referral services are required in the case of the problem of malnutrition. Children who are suffering from third or fourth degree of malnutrition or illnesses are taken to the hospitals, progressed PHCs, community health services or district hospitals.

Non-Formal Pre-school Education – The provision of non-formal education is made to the children who are within the age group of three to five years through anganwadis. The major emphasis is laid upon play, resourceful and creative activities that have the main objective of leading to psychological, intellectual and physical growth and development of the children.

Roles and Responsibilities of Anganwadi Workers

The roles and responsibilities of the Anganwadi Workers (AWW) under the ICDS scheme have been stated as follows: (Sandhyarani, & Rao, 2013).

1. To produce community support and participation in operating the program.
2. To analyse the weight of each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers and children to the sub-centres, PHC and so forth, and preserve child cards for children below six years of age and produce these cards before visiting medical and para-medical personnel.
3. To conduct the survey of the mothers and children belonging to all the families, especially within the respective working area, once a year.
4. To organize non-formal pre-school education for the children within the age group of three to five years, in order to get them acquainted with the play and creative activities that are required for their growth and development.
5. To organize supplementary nutrition feeding for the children within the age group of 0-6 years and for expectant and nursing mothers on locally available food and also the adequate food preparation methods.
6. To provide health and nutrition education to the expectant and nursing mothers. Married women are also counselled on areas such as family planning and birth control measures.
7. AWW share all the information relating to births with the Panchayat secretary, or Gram Sabha Sevak, whoever has been notified as the Registrar or the Sub-Registrar in the village.
8. To make home visits to educate the parents in order to enable them to contribute towards effective growth and development of their children, with main emphasis put upon infants.
9. To maintain records, files and registers in an appropriate manner.
10. To assist the PHC staff in the implementation of health components of the program, i.e. immunisation, health check-up, ante-natal and post natal check etc.
11. To support ANM in the administration of IFA and Vitamin A by maintaining stock of the two medicines in the centre without the maintenance of the stock register as it would add to the administrative work which would affect the primary tasks under the scheme.

12. To share the information collected under the ICDS with the ANM.
13. If any work is required in the village, particularly if the work is relating to co-ordination of procedures with the different departments, then it has to be brought to the attention of the supervisors.
14. To maintain liaison with the other institutions and involve women school workers and girls of the primary and middle schools in the village which give recognition to the significance of their tasks.
15. To guide Accredited Social Health Activists (ASHA) involved under the National Rural Health Mission in the delivery of health care services and maintenance of the records under the ICDS scheme.
16. To contribute in the operation of the Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls, their parents and the community by the organization of the social awareness programs and campaigns.
17. AWW would also contribute in the implementation of Nutrition Program for Adolescent Girls (NPAG), this is in accordance to the guidelines of the scheme and it is vital to maintain such records as recommended under NPAG.
18. Anganwadi Workers can perform their job duties as depot holder for RCH Kit, contraceptives and disposable delivery kits. However, the concrete distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.
19. To identify disabilities amongst the children during home visits and referring the case to the nearby PHC or District Disability Rehabilitation Centre.
20. To assist in the organization of Pulse Polio Immunization (PPI) Drives.
21. To notify the ANM in case of any health problems or illnesses such as, diahorrea, cholera etc.

Role of Anganwadi Workers in Pre-school Education

The individuals employed in the anganwadi centres do perform their job duties in a pioneering way making use of the best devices in a creative and practical manner. The main purpose of the individuals is to influence the development of the children so that they learn to make use of their life skills. The resourcefulness of having tribal language translations of preschool educational methods in Orissa is a constructive indication that preschool education devices are continuously being appraised for their prospective utilization in different backgrounds, languages and areas. The teachers in anganwadi centres, analyse the needs of

the students and find out what are their main weaknesses that are required to get improved upon. They are required to possess the awareness of the individual's strengths and weaknesses and what kinds of measures need to be implemented in order to contribute towards their growth and development (The Anganwadi Programme, n.d.).

In anganwadi centres, a variety of learning experiences are organized for the children, they are organized through appealing to all senses such as, visual, auditory and physical. Interaction is considered to be one of the most effective areas that are required for the development of young children; it is organized in individual, partnered, small group and large group settings, the children are also taught how to get involved into group discussions. In the case of the early childhood programs, assessment takes place by the observation of the children in daily activities and taking into account their skills, understandings, interests, vocabulary and approaches towards various tasks. The needs and the requirements of the children are assessed by getting involved into communication with the family members. Boys and girls have equal opportunities to participate in the range of activities that are organized such as, musical, artistic, sports and play activities, with the main purpose to generate the development of these skills amongst the children (The Anganwadi Programme, n.d.).

Role of Anganwadis within the Society

India is a country that is experiencing certain problems such as, overpopulation, malnourishment, poverty and high infant mortality rates. In order to take into account, the health and mortality issues enthralling the country, there is a requirement for a large number of medical and healthcare professionals. Inappropriately, India is experiencing from a scarcity of skilled professionals. Therefore, through the anganwadi system, the country is making an effort to meet its objective of improved health care facilities that are reasonable and accessible to the local population. In many ways, an anganwadi worker is better prepared than the professional doctors in reaching out to the rural population. Firstly, since the worker lives with the people, in this way they are able to identify the reasons of various health problems and hence adequately deal with them. AWW have a very good understanding of the health status within the region. Secondly, though anganwadi workers are not as accomplished or competent as professionals, still they have improved social skills, thus making it manageable to communicate with the people. Moreover, since these workers are from the village itself they are reliable, which makes it easier for them to make provision of help to the people. Last but not the least, anganwadi workers are well acquainted with the ways of the people, are contented with the language, know the rural people personally and so forth, these

points makes it very easy for them to figure out the problems being experienced by the people and to make sure that those problems are solved (Anganawadi Workers: A Profile, n.d.).

India is a country that is experiencing problems such as, over-population, mal-nutrition, poverty, unemployment, low literacy levels, homelessness and more, with an objective to make healthcare accessible and reasonable for even those individuals belonging to marginalized and underprivileged families. To solve the problems of healthcare issues, child mortality, malnutrition, educational levels, the country requires a high number of medical and healthcare professionals to cater to the population that is in the present existence representing large numbers. There has been a scarcity of experts and with also shortage of skilled professionals, the Government‘s ICDS scheme is using the local population to help meet its major objectives. The aim of the anganwadi workers is to bring about physical, psychological, intellectual, societal, and spiritual wellbeing of the individuals. They also participate in the general affairs of the household in order to acquire a better understanding of various issues and problems (Anganawadi Workers: A Profile, n.d.).

Service Delivery and Monitoring in Anganwadis

The anganwadi centres function for four hours from 8 AM until 12 PM. Each centre has about 40 students who are taught various educational concepts, such as, reciting of rhymes, counting and learning the alphabets, numbers, drawing and so forth. The Sevika and Sahayika are the helpers that provide snacks in the morning and nutritious meals every day. Apart from teaching, these centres also seek to improve the nutrition levels of the children. Children with malnutrition are provided special assistance. Children who are in grade three and grade four levels of malnutrition are sent to clinics, where they are taken care of for a month along with their mothers. These pre-school centres also place emphasis on hygiene and sanitation. The centres inspire the students to enrol in a primary school after their pre-school education and maintain records of students who have later enrolled in schools and those who have dropped out. However, many centres do not function in an adequate manner and are a far call from a model pre-school (Katticaran, 2012).

The implementation of tasks and functions in a proper manner requires monitoring at the anganwadis, and these are located at varying distances from the CDPO office. Monitoring of the anganwadis is not an easy task and requires thorough investigation and inquiry. Monitoring is also considered to be a difficult task, because as many of these centres are located in areas which are not easily reachable and do not have proper roads leading to them. The information technology systems and surveillance technology are not available in these

centres. It is therefore unmanageable for the CDPO officer to monitor the functioning of the centres on a daily basis and to ensure their consistent workings. The problems that follow from the lack of monitoring are widespread across the centres. The anganwadi centres experience various kinds of problems and irregularities, these are, the rate of absenteeism of the anganwadi workers and helpers is high, the rate of absenteeism amongst the children is high, inadequate availability of resources and in some instances food does not get prepared for the afternoon meals, avoidance of the attendance registers, and take-home rations are not distributed (Katticaran, 2012).

Conclusion

The anganwadi system in one village or area is administered by a single anganwadi worker, who is chosen from the community and has been trained for four months in the areas of health, nutrition and childcare. Each anganwadi worker covers a population of about 1000 people. It is a positive point to know that there are more than a million anganwadi centers in India, employing more than two million workers, who are mostly females and intuitive to the health needs of the region. For a country, where the problems of illness, child mortality, illiteracy and poverty are present, in case of these problems, the roles and job duties of anganwadi workers carry meaning and significance. The six basic services that are offered by the ICDS scheme are, supplementary nutrition, nutrition and health education, immunisation, health check-up, referral services, and non-formal pre-school education.

The anganwadis are involved in making provision of the services to the areas, which are, immunisation of all children less than six years of age, immunisation against tetanus for all the expectant mothers, supplementary nutrition to children below six years of age, the expecting and nursing mothers who belong to underprivileged and low income groups are provided with supplementary nutrition, nutrition, health education and health check-ups are provided to women within the age group of 15 to 45 years, antenatal care of expectant mothers, postnatal care of nursing mothers, caring for infants, caring for all the children who are under six years of age, and referral of serious cases of malnutrition and illnesses to the hospitals, upgraded PHCs, community health services or district hospitals.

The anganwadi workers also make available pre-school education to the children who are below six years of age. These children are familiarized with the concepts and play that would contribute in leading to their effective growth and development. The anganwadi centres play an imperative role not only in the wellbeing of women and children, but also the society as a whole; healthcare services, education and welfare of the individuals are the major

objectives that these centres contribute in achieving. The efficient implementation of tasks and functions in these centres require monitoring and evaluation, the major objective of monitoring and evaluation is to identify the inconsistencies and implementation of measures in order to achieve the formulated goals.

Bibliography

Anganawadi Workers: A Profile. (n.d.). Retrieved June 07, 2017 from http://shodhganga.inflibnet.ac.in/bitstream/10603/37010/11/10_chapter%203.pdf

Katticaran, J. (2012). Improving Services of Anganwadi Centres & Increasing its Reach. Retrieved June 07, 2017 from http://www.icdsbih.gov.in/admin/UploadFile/ICDS%20Internship%20report%20Jovie.pdf

Sandhyarani, M.C., & Rao, C.U. (2013). Role and Responsibilities of Anganwadi Workers with Special Reference to Mysore District. *International Journal of Science, Environment and Technology, 2(6),* 1277-1296. Retrieved June 08, 2017 from http://www.ijset.net/journal/205.pdf

Seema, T.N. (2001). Performance of Anganwadi Centres in Kerala: An Evaluation and Experiment to develop a model centre with Community Participation. Retrieved June 08, 2017 from http://www.cds.ac.in/krpcds/seema.pdf

Thakare, M.M., Kuril, B.M., Doibale, M.K., & Goel, N.K. (2011). Knowledge of Anganwadi Workers and their Problems in an Urban ICDS Blocks. *Journal of Medical College, Chandigarh, 1(1),* 15-19. Retrieved June 07, 2017 from http://gmch.nic.in/journalgmch/Archives/6%20Original%20article-Anganwadi%20worker.pdf

The Anganwadi Programme. (n.d.). Retrieved June 08, 2017 from http://www.chinh.in/2013%20CIKFF/WCD%20Research%20for%20WEB%20UPLOAD%202013/Anganwadis%20Report%20Part%201.pdf