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Research Article

Assessment

Assessment of the anganwadi centres in the Urban Field Practice Area of Father Muller Medical College, Mangalore

Kumar S.[1*], Prabhu S.[2], Acharya D.[3]

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[1*] Saurabh Kumar, Assistant Professor, Department of Community Medicine, Father Muller Medical College, Mangalore, Karnataka, India.

[2] Sudhir Prabhu, Assistant Professor, Department of Community Medicine, Father Muller Medical College, Mangalore, Karnataka, India.

[3] Das Acharya, Ex-Professor & Head, Department of Community Medicine, Father Muller Medical College, Mangalore, Karnataka, India.

Background: Anganwadi centers are the focal units for the implementation of the Integrated Child Development Services projects in each block. Anganwadi centres cater to the children up to the age of 6 years, pregnant and lactating mothers, adolescent girls and women in the reproductive age group. There are 32 anganwadi centres in the Mullerkad-Jyothinagar urban field practice area of Father Muller Medical College, Mangalore. Under the public private partnership model our institution provides immunization, health education, health check –up and referral services to these anganwadi centres. **Objective:** To assess the infrastructural facilities of the anganwadis and quality of services provided. **Methodology:** Study design: Cross Sectional; Study area: Field practice area of UTHC Mullerkad-Jyothinagar, Father Muller Medical College, Mangalore; Sample size: 24; Study duration: March 2013-June 2013; Data collection tool: Interview schedule cum observation checklist. **Results:** 9 of anganwadi workers were educated up to SSLC. Most of the anganwadi workers were residing within 15 minutes distance of the respective anganwadi centres. Registers were maintained properly and kept updated in all the anganwadis. 10 anganwadi were not having separate space of storage and 3 did not have even toilet facility available. Cooking area was separate in most of the anganwadis 14. **Conclusion**: Basic amenities like space for storage, kitchen and toilet and playing area for the children should be there in all the anganwadis. Pregnant and lactating mothers should be followed up to confirm whether they have been registered at any health centre and have received the requisite number of IFA and TT doses.

Keywords: Anganwadi, Assessment, Children, ICDS, Pregnant, Urban

Corresponding Author

Saurabh Kumar, Assistant Professor, Department of Community Medicine, Father Muller Medical College, Mangalore, Karnataka, India.
Email: docsaurabh777@gmail.com

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Introduction

Integrated child development services (ICDS) program continues to be the world's most unique early childhood development program, which is being satisfactorily operated since more than 3 decades of its existence[1].The Ministry of Women and Child Development (MWCD) of India established ICDS in 1975[2]. The roles of ICDS are providing pre-school education and primary healthcare for mothers and children to break "the vicious cycle of malnutrition, morbidity and reduced learning capacity and morality."ICDS has served as a flagship program for India's healthcare system, and has received financial and technical support from UNICEF and the World Bank. The ICDS scheme is a long term development program for community and all efforts should be continued to strengthen to make it more successful. It serves as an excellent platform for several development initiatives in India. The ICDS target population includes poor and malnourished people at risk for malnutrition and mortality, especially the vulnerable groups including children below six years old, pregnant and lactating mothers, and women in the age group between fifteen and forty five years of age[3]. The program includes a network of Anganwadi center (AWC) literally courtyard play center, provides integrated services comprising supplementary nutrition, immunization, health checkup, referral services to children below 6 years of age and expectant and nursing mothers. Non-formal PSE is imparted to children of the age group 3-6 years and health nutrition education to women in the age group 15-45 years. It delivers services right at the doorsteps of the beneficiaries to ensure their maximum participation [4].

The program is executed through dedicated cadre of female workers named Anganwadi workers (AWWs), who are chosen from the local community and given 4 months training in health, nutrition and child-care. She is in charge of an AWC and is supervised by a supervisor called Mukhyasevika. AWW is also assisted by helper who works with AWW and helps in executing routine activities at AWC. Statistical association was found between nutritional status and immunization status of <3 years age, with ICDS services[5-7] in some studiesbut some studies refuted the same[8,9]. According to National Family Health Survey-3, countrywide though 81.1% children under age 6 years were covered by AWCs, children who received any service from AWC were only 28.4% [10].

Overall various scientific studies have been conducted at evaluating its impact for nutritional status and child morbidity [5,11] but the status of these AWCs and their service constraints are not assessed much. The present study was done to assess the infrastructural facilities of the anganwadis and quality of services provided.

Materials and Methods

The study was conducted in the Urban field practice area; Mullerkad and Jyothinagar of the Father Muller Medical College, Mangalore in From March 2013 to June 2013. It is located about 10 kms from the Medical College. The urban field practice area includes one notified slum of Municipal Corporation Mangalore.

This cross sectional study included 24(75%) anganwadis out of 32. The anganwadi worker was informed beforehand regarding the day of the visit.

The 24 anganwadis were selected randomly using lottery method.A pretested and validated interview schedule cum observational check list was used to collect the data. Information was gathered on all the staff, infrastructure and services with focus on the principal functions of the anganwadi centre i.e. Supplementary nutrition, Non formal preschool education, Nutrition and health education, Health check up and growth monitoring.

The data so collected was entered in Microsoft excel 2010 and imported in SPSS 23 and analysed. The results were expressed in terms of percentages and proportions.

The ethical clearance for the study was obtained from the institutional ethics committee. The informed consent was obtained from the participants before starting with interview.

Results

A total of 24 anganwadis out of 32 were visited during the study period in the Urban Field Practice Area of Father Muller Medical College, Mangalore.

Infrastructure and Staff: The present study reported 95.8% of the anganwadis having pucca type of building. Nearly 66.7% of the angwanwadis had own buildings (Table1). Most of the anganwadi workers were having the educational classification of SSLC 16. Only 2were found to be having a graduation degree and other were either PUC-I or PUC-II qualified.

Majority of the anganwadi workers were either from the same community or nearby area. They were able to reach in fifteen minutes to the respective anganwadi centres. Mean years of work experience was found to be 16.5. Record maintenance was found to be up to date in 22 anganwadis.

Table-1: Distribution of anganwadis by Infrastructural Details

Variable	Number
Type of Building	
Pucca	23
Semi-Pucca	1
Ownership	
Govt	16
Community	8
Sufficient space for PSE	
Yes	14
No	10
Separate Storage Space	
Yes	10
No	14
Separate Cooking room	
Yes	22
No	2

Health Check up & Referral Services: Health cards of the cards were maintained properly and kept updated in 16 anganwadis. After observing the immunization records it was found that all kids registered in the 23 anganwadis were immunized up to date. But one of the anganwadis, the records was not available on the day of the visit. Mean number of children examined in the previous health check up was found to be 34. Though pregnant women were registered with the anganwadi centres but none of them were coming for health check up to the anganwadi centre. Even all the pregnant women who were registered for supplementary nutrition were not receiving the IFA tablets. At 8 of the anganwadi centres only the pregnant women were being given the IFA tablets and further at only 14 anganwadis pregnant women had received the TT injections in the past 6 months. Again not all the pregnant women registered at the anganwadi centre were receiving the TT or IFA from the anganwadi centre. Only at 5 and 7 anganwadis adolescent girls were receiving IFA and deworming tablets respectively. All the kids were being examined by the doctors from our own institution on bimonthly basis and immunization was being conducted in the anganwadis on a monthly basis depending upon the beneficiaries.

In case the children were found to be severely ill, the anganwadi worker was being given referral card for diagnosis & treatment of the respective children.

Supplementary nutrition: Almost all the anganwadis had sufficient cooking utensils available for cooking the ready to eat food or rice and sambhar. All the anganwadi workers said there was no problem with respect to supplementary nutrition. There were no interruptions in the food supply from ICDS office in the past 3-4 months and hence no shortage of food was reported. On observation it was found that food was of good quality in all the anganwadi centres. It was found to be acceptable to the pregnant women as well as the children. Further it was found that 11 of the anganwadis had community support with respect to supplementary nutrition e.g. some of the areas they were providing eggs and milk on few days from the local community support. All the anganwadis visited were receiving the water from Municipal Corporation through taps. The water was being boiled before being used for drinking purposes on a daily basis.

Nutrition and Health education: All the 24 anganwadis were regularly conducting the nutritional education and health education sessions for the pregnant, lactating mothers, mahilamandals etc as observed in the registers. But adolescent girls were coming for health education only at 14 anganwadis.

Growth monitoring: 22 of the anganwadis were using Salter weighing scale for monthly weight measurements of the children. The remaining 2 anganwadis were using the adult weighing machines. All the anganwadi workers were found to be accurately recording the weight of the children in the growth charts. The age of children also was being determined accurately using the date of birth.All the anganwadi workers had organized the group counseling session on growth monitoring and its importance for the women in the respective areas.

Non Formal Pre School Education: On an average 29 kids were registered for preschool education in the anganwadis. All the anganwadi workers were following the timetable given byICDS office for the same which was followed uniformly throughout the state. But in all the anganwadis the play materials were not in good condition. Most of the play materials were found to broken or damaged. It was observed that 14 of anganwadis only had sufficient space for preschool education.

14 of the anganwadi workers did not report any problems. Others reported problems varying from shortage of space, absence of helper and no water facilities in the toilet etc. The commonest problem reported was shortage of space either in kitchen or storage area or area for preschool education.

Discussion

Infrastructure and Staff: The present study reported 95.8% of the anganwadis having pucca type of building which was found in 50%, 63.6% and 81.8% in Gujarat[12], Tamil Nadu and Puducherry[14] indicating more developed infrastructure in this coastal city of Karnataka. Nearly 66.7% of the anganwadis had own buildings compared to that of 28% in Kerela[13]. Present study reported 16.5 years of mean experience of anganwadi workers which is on par with the study done in Gujarat [12]. This experience helps AWW to build a good rapport with their community and helps them to deliver better ICDS services.

Health checkup and Immunization: Present study reported the health checkup was being done at regular intervals for the anganwadi children and appropriate referral was also done. Additionally all the kids in the angawadis were immunized up to date. This is in stark contrast to the findings of other places Gujarat and Rajasthan.[12, 15].

Unfortunately the pregnant women were not receiving the health checkups in the anganwadi centres on the health check up days. This may be because of proximity of urban health and family welfare centres and a number of medical college in the city area. This is in contrast to the findings of NCAER 2004 [16] which observed 53% of health centres provided checkup for women. The study also reported that at 8 of the anganwadi centres only the pregnant women were being given the IFA tablets and further at only 14 anganwadis pregnant women had received the TT injections in the past 6 months.

The other anganwadi centres reported shortage of IFA tablets. This creates a problem of tracking the pregnant females regarding the antenatal services, which may have consequences with respect to MDG 4 related to maternal health. In the anganwadis in our field practice area, only 2 adolescent girls are getting the benefits of the ICDS services for six months whereas in Gujarat a very high percentage of adolescent girls were availing the services through anganwadis [12].

Supplementary nutrition: Beneficiaries were found to be satisfied with quality and distribution of food. There was no shortage also from the ICDS office similar to that of the findings of Community based Monitoring system: Dehradun ICDS unit[17] and NC et al Bhubneshwar[18]. Drinking water was being received from Municipal corporation which was used only afterboiling to ensure the safety aspects, contrary to the findings of IIM in Bangalore in (2006) which found out that clean drinking water was not available in many AWCs[19].

Nutrition and Health Education (NHE): Present study reported that all the anganwadis were celebrating NHE days in the anganwadicentres on a regular basis which is definitely a positive sign towards MCH care. The findings were better compared to that seen in the other surveys[12,14].

Growth monitoring: In our study it was found that all the anganwadi workers were found to be accurately recording the weight of the children in the growth charts. Additionally 91.7% of the anganwadis were using Salter weighing scale for weight measurement. This again was a very good sign of MCH care and findings were found to be better compared to some of the districts of Gujarat [20] and Jaipur[21].

Non formal preschool education: PSE has been envisaged in ICDS program as an essential component for children who are on the verge of going into formal education system. The importance of PSE recognized universally because it caters to those children who, during this phase of their life, undergo the most important educative process. In our study it was found that there was uniformity in the programme of non-formal preschool education contrary to the findings of Chudasama et al[19]where various timetables were found in different anganwadis But most of the anganwadis did not have functioning toys. Similar findings have been echoed by SobhaI[22] and Singh et al [23].

Conclusion

The performance of AWCs and maternal and child health services delivered by AWCs still needs improvement. The findings help in providing some insight into the existing infrastructural situation and quality of services. Basic amenities like space for storage, kitchen and toilet and playing area for the children should be there in all the anganwadis. Increased focus should be on providing services other than supplementary nutrition to adolescents.

Pregnant and lactating mothers should be followed up to confirm whether they have been registered at any health centre and have received the requisite number of IFA and TT doses. We need to look forward for a holistic approach involving various departments.

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