Role of Anganwadi in Improving Health Condition of Women and Children in India

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Abstract: *According to United Nation`s report, with a total of 356 million population aged between 10-24 years, India has the world's largest youth population despite having a smaller population than China. On one hand it is in possession of largest youth population, but on the other side It is being said that developing countries with large youth populations could see their economies soar, provided they invest heavily in young people's education and health and protect their rights (The Hindu, Nov 19,2014). Recently a survey was carried out globally on the health status of the countries, taking into consideration various parameters of health. This study conducted by an international collaboration on the Global Burden of Disease (GBD) analysed each country`s status in health services provided to the citizens of their respective nations and India stood at 143rd place out of 188 countries. India has been struggling with its rapidly growing population and lack of resources since it gained independence. It is often being seen as a result of lack of efficient implementation of various policies over the period of time including the field of health, which forces the nation to make at the bottom of the list. As majority of India`s population still resides in villages, which have a greater say in the overall development of the nation, but they are left untouched most of the times as either due to improper implementation of policies or hindrances in the whole chain of process for development. This paper is an attempt to highlight the major problems associated with health and the constructive and important role of Anganwadis in improving the health status of India especially at grass root level, focussing specially on women and children.*

Key Words: *Anganwadi, Integrated Child Development Scheme, Women health.*

1. INTRODUCTION:

Anganwadi had been in evolution since 1960s when Mid day meal programmes was started by some states which later was replaced with special nutrition programme in 1970s and on October 2nd, 1975 Integrated Child Development Services (ICDS) Programme was started covering only 33 blocks including 3 projects in Uttar Pradesh. The scheme of ICDS operated at state level and consists of multidimensional aims and targets in order to curb the problem of malnutrition among children and expectant mothers. Currently ICDS offers the following services:

- Health checkups and follow up of expectant mothers
- Referral services
- Supplementary nutrition
- Immunization
- Preschool and non formal education
- Nutrition and health education

Being a provider of these services it can be seen as a fully fledged package of initial development of children which includes the welfare services in the form of supplementary nutrition, immunization, health checkups, referral services, nutrition and health, education for both mother and children. ICDS is considered to be world`s largest child development programme providing care and services from conception till preschool age.

An ICDS programme is implemented through Anganwadi which is managed by the Anganwadi worker. She is a health worker chosen preferentially from the same community where Anganwadi is located. She is provided with the training pertaining to health, nutrition and child care for a period of 4 months. An Anganwadi covers an approximate population of 1000 and is in the charge of an Anganwadi worker. Further 20 to 25 Anganwadi workers are supervised by a supervisor which is known as Mukhyasevika. 4 Mukhyasevikas are headed by a child development project officer (CDPO). Anganwadi worker (AWW) is considered as a focal point in order to provide the services which are mentioned in ICDS scheme.

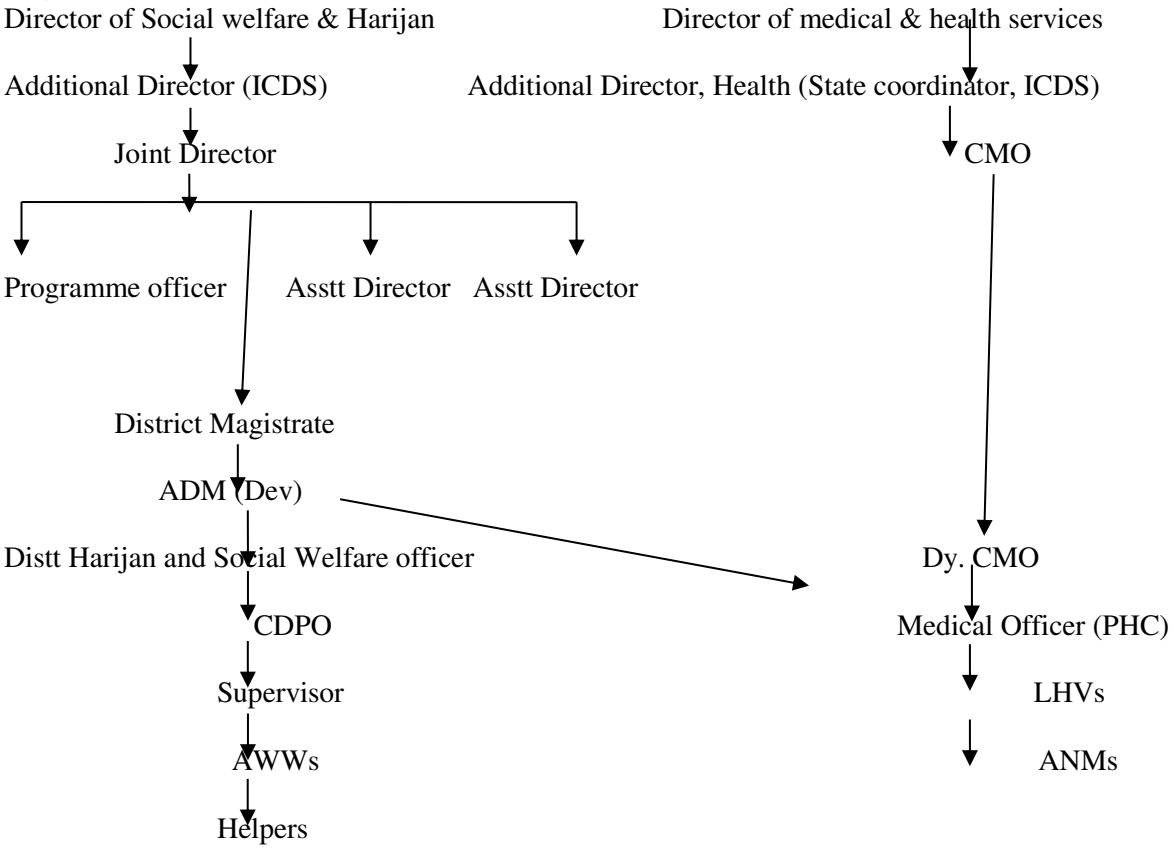
1.1. Team ICDS: Composition, Organisational structure and functions

ICDS is a programme which is managed and supervised at different levels and it comprises of group of people working together as a team. This team comprises mainly of:

- An Anganwadi worker and an Anganwadi helper which is present unit or village level.

- There is a supervisor and Child Development Project Officers (CDPO) at the sector and project level respectively.
- At district level, it is supervised by District Program Officers (DPOs).
- At state level, it is managed by Director, Additional Directors, Joint Directors, Deputy Directors, Research Officer, Additional Program Managers and Account Officers.

Organisational structure of ICDS



[Source: *Murthy, L. S. N. & Mathur, Sunita, NIPCCD,1995*]

All these officials work in coordination with each other for the proper implementation at different levels and they mainly function to curb the problem of under nutrition among children in the age group of 0-6 years, their immunization for various life threatening diseases and their prevention, Non formal education, supplementary nutrition, proper health care services to the expectant and new mothers.

1.2. Studies pertaining to Anganwadi and its related components:

Since its inception, various studies have been conducted assessing the knowledge of Anganwadi workers, beneficiaries etc. Available studies suggested that the knowledge of Anganwadi workers should be assessed at a regular interval so as to improve the quality of their work and hence improve the outcomes in achieving better results **(Sharma, 1987; Chattopadhayay, 1999).**In one such study **Manhas Shashi et.al (2012)** studied the awareness among Anganwadi workers regarding the knowledge of health and nutrition services for children in ICDS and it was found that despite being the training provided to 92.5% Anganwadi workers, only 55% were actually aware about the nutritional services but still they were not aware about the energy and protein requirements of children. In addition to that, 30% of Anganwadi workers who were assessing the nutritional status of children were not aware of the methods applicable for assessment. Some more studies have emphasised upon providing the workers with adequate knowledge and awareness as it was found to be missing or very low among them **(Kant et al. 1984; Gopaldas et al. 1990; Bhasin et al. 2001).** It is notable that provision of required and appropriate training to the workers can have a profound effect on the overall working of the Anganwadi and can provide better results in achieving the targets of healthy and happy growth of children as a study conducted by **Bamji Mehtab S. et.al (2004)** in non ICDS villages in which adequate training was provided pertaining to preventive and curative healthcare and after 3 years impact was assessed and it was found to have a remarkable impact on their health and the health of their family specially children. Studies also suggest that work overload is one such reason for the Anganwadi workers to not be able to give their best in ICDS. A study conducted by **Desai Gaurav et.al (2012)** in Vadodara district on 124 Anganwadi centres revealed that the Anganwadi workers were getting incentives for participation on National Health Programme and some other programmes not related to ICDS, surveys, tuberculosis programme etc due to which they were not giving ample time

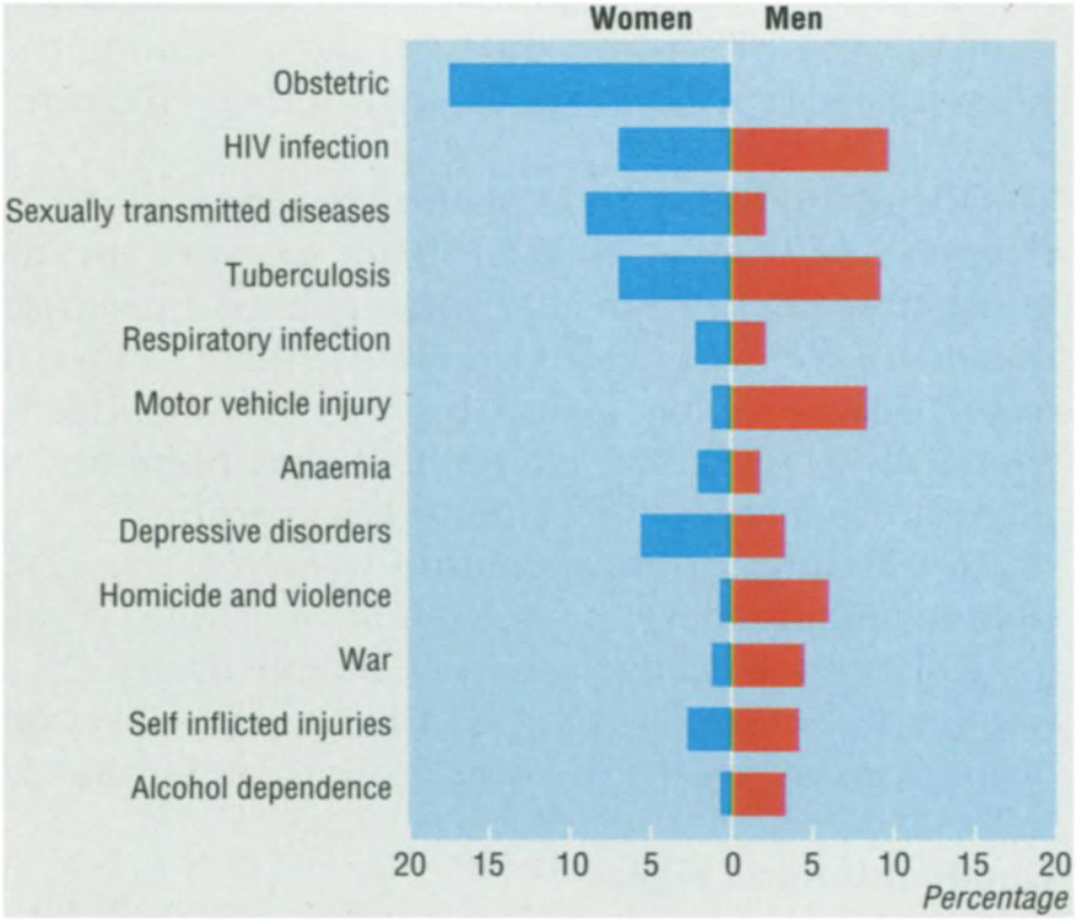
to run the centres and hence it was not able to achieve the required better outcomes. Another factor highlighted by some studies which was considered as an important one was the education level of Anganwadi workers as it was found that awareness about ICDS increases with increase in knowledge **(Thakare, 2011).** An Anganwadi worker`s education, being the focal point or a key person in the implementation carries the maximum importance in order to carry out the activities in a purposeful manner so that it provides the result in line with the expected outcome **(Das et al., 1990).** Overall, most of the studies points out certain shortcomings in the implementation part which creates a gap between the required knowledge and practices to perform their work and leads to inefficiency among Anganwadi workers **(Parikh, 2011).** These shortcomings can be rectified through some modifications in the implementation of the scheme and through the provision of adequate and required training to the Anganwadi workers in order to increase their efficiency and expected outcome **(Barman 2001; Forces New Delhi 2007).**

S.No	Issue	Challenge(s)	Role of Anganwadi under ICDS
1	**Malnutrition**	Malnutrition is one of the biggest challenges because the chain of malnutrition which starts from birth of a female moves on to adolescence and passes on to another generation when she becomes a mother. The major challenge is to curb malnutrition to its lowest possible level.	1. ICDS activities should be focussed upon the most important aspects of malnutrition by enhancing disease control programmes and activities for prevention of disease. 2. Aware and educate masses to enhance domestic child care and feeding patterns and micronutrient supplementation. 3. Unite with health sector programmes like Reproductive and Child Health Programme(RCH)
2	**Focus on target group**	ICDS being a programme targeted on grass root level people is not efficient enough to achieve its target.	1. More focus should be targeted upon the most vulnerable group of children under 0-3 years and pregnant women. 2. Funds and new projects should be redirected towards the most affected in terms of malnutrition.
3	**Feeding activities**	Most of the beneficiaries lack supplementary nutrition which intensifies the problem of malnourishment.	Activities promoting supplementary nutrition should be targeted majorly towards the neediest and time to time monitoring activities related to growth and development should be conducted.
4	**People's participation**	Unawareness among the masses regarding health and its related components.	Community involvement is of utmost importance in implementation of ICDS programme in order to make them a part of the programme and help it in achieving its target.
5	**Monitoring and evaluation**	Absence of a well defined monitoring process decreases accountability and hence affects its final outcome.	1. Involvement of community in monitoring is important so that it improves the quality of service delivery system. 2. Proper monitoring and timely assessment is required in order to strengthen it and shift the focus from inputs to results.

1.3. Women health in India: Some issues & challenges:

Women`s health focuses on treatment and diagnosis of conditions and diseases concerning women`s physical and emotional well being in one way or the other. Health is an important factor in a human being's life as it contributes to the well being and economic growth. Women have profound impact on their health as nature has given them the responsibility of child bearing, it becomes important to focus more upon their health because their health directly or indirectly impacts the health of upcoming generations. In Indian context, women health is still at their lower stage in comparison to the development India has achieved so far in other fields. One of the major factor that constitute to ill health conditions is malnutrition among adolescent girls and women as National Family Health Survey (NFHS-3) indicates that approximately 35.6 percent of Indian women are chronically undernourished with a Body mass index (BMI) lesser than the cut off point of 18.5. Also, 5% of women are anaemic as compared to 24% of men. This cycle of malnourishment continues with the generations and lead to deprivation of nutrition among children. Another important factor which contributes to ill health and in some extreme cases, death of women, is lack of maternal health which could be due to early societal practices, cultural beliefs, lack of awareness about the future repercussions etc. Programmes like National Health Mission (NHM) and Family Welfare Program have been designed and implemented to cater to the issue of maternal health care needs of women across India but analysed that these are not up to the mark and are unable to serve the purpose fully.

Other issues which have a greater impact on women health but are not so focussed upon constitutes depression and anxiety among females which is increasing at an alarming rate due to lifestyle changes and increasing expectations from parents, peer pressure, work life balance etc. Discrimination among genders and domestic violence are some of the reasons that work as an addition in increasing depression among females. Reports of National Family Health Survey (NFHS-3) reveals that 31 percent of all women reported having been the victims of physical violence in a year. To mitigate these problems, Government had been implementing various policies and programmes since country gained independence but they fell short and could not achieve the estimated target because of certain reasons like corruption and improper coordination between the officials of the whole chain of implementation and many other reasons. World Development Report (1993) conducted a survey in the year 1990 to assess the burden of disease in adult men and women in the age group of 15-44 years in the developing countries. Report assessed obstetric issues to be the major burden which is associated with the females followed by HIV, tuberculosis and depressive disorders as some other issues that are the causes of deteriorating women health.



[Source: World Development Report 1993]

2. ISSUES AND CHALLENGES:

2.1. Strategies to improve the health of women and child through Anganwadi:

- **Community participation:** The most important part of any programme is the beneficiaries for which it is implemented. Sometimes it is a particular target group or it may be for whole community and those are responsible for its success. The key role in any programme`s success is played by community through awareness and proper education level to understand it.

Year	Literacy Rate			Gap in literacy
	Persons	Male	Female	
1981	43.6	56.4	29.8	26.6
1991	52.2	64.1	39.3	24.8
2001	64.8	75.3	53.7	21.6
2011	74.0	82.1	65.5	16.6

[Source: Govt of India, Census 2011]

As per the Census 2011, still there is a significant gap in literacy level among male and female which is of major concern as when it is talked about health of women, first of all it has to be female itself to be aware about her health and understand it well in order to provide solutions to her health problems.

2.2. Catering to the issues of the Anganwadi workers:

A study was conducted on "Knowledge of Anganwadi Worker about Integrated Child Development Services (ICDS)" (Prasanti Jena, 2013), the problems faced by the Anganwadi workers were highlighted which resulted in lower efficiency of working.

Types of problem	Number of AWWs with the problem
Inadequate salary	17 (56.7%)
Infrastructure related	15 (50.0%)
Logistic supply related	5 (16.7%)
Work overload	13 (43.3%)
Excessive record maintenance	12 (40.0%)
Total (N)	**30**

[Source: Prasanti Jena, 2013]

It is evident from the study that Anganwadi workers are somewhat dissatisfied with the facilities and remuneration they are getting, and it leads to not so better outcomes in reference to what is expected. Therefore, it is highly required from the policy makers to take such issues into considerations and amend as per the requirement and availability of resources so that these issues do not come up again and do not hinder the pace of workers.

2.3. NGOs and civil society`s participation:

Non Governmental Organisations are those entities which work as a bridge to mend the gap between policies and its grass root level beneficiaries as they have a better understanding and rapport with the community. National Health Policy lists partnerships with NGOs as a viable and an important part for better results of the policies and programmes. Government should think about partnering with civil society on certain issues like:

- Policy formulation and suggested changes in existing policies.
- Planning of well structured new policies.
- Ways to properly implement policies.
- Monitoring and evaluation of workers as well as the programmes.
- Training and research on the required areas in the programme.

2.4. Integration with programmes of national and international repute:

Currently the administrative expenditure of ICDS is borne by Government of India and processing and transportation expenditure is borne by state governments. Since ICDS is a world`s largest child development programme, it has attracted number of bilateral and multilateral funding agencies for support which are:

- International Development Association.
- United Nations Children`s emergency Fund.
- United States Agency for International Development.
- Swedish International Development Agency.
- Norwegian Agency for Development Cooperation.
- World Health Organisation.

In addition to that UNICEF also provides technical assistance to ICDS programmes at central as well as state level. Since, quite a good number of agencies have assisted and some of them are still assisting, it is required to pursue some more agencies for funding and support especially for the areas which are worse in terms of women and child health care services and are not able to provide required support.

3. CONCLUSION:

There is a quote by Mahatma Gandhi which says "*Educate one man, you educate one person, but educate a woman and you educate a whole civilisation*". The most important tool in one`s life to succeed is education which brings awareness and reduces the problems to a lower level. In the developing country like India, the utilisation of basic health services specially among women is quite poor which is due to increase in public private partnership expenditure in advanced healthcare, the reason of which seems to be the low household incomes, higher rates of illiteracy, unawareness and various other factors. On one hand, the governmental efforts and investments in healthcare are unable to give required results, and on the other hand some gaps like over emphasis on secondary and tertiary hospital care, inequitable distribution of health care services which are favouring urban (Nayler et al., 1999) and gender discrimination in access to health care are all pervasive (Shariff, 1999). Certain studies have raised concern about the design and implementation of ICDS. These studies take into consideration the type of services delivered by ICDS; Characteristics of beneficiaries that are persuaded by ICDS and the geographic areas that it targets. Studies concluded that even though the structuring of ICDS focuses on multidimensional determinants of malnutrition, little focus is upon improving child care behaviours among the families and education of parents to understand it well. Another factor is the divergence of ICDS from children specially under the age group of 3 years and belonging to lower castes mostly girl child. There is an urgent need to mend the gap between ICDS and its intentions to curb malnourishment and provide better healthcare services to women and children. As ICDS is designed to address multidimensional causes of malnutrition, it should work upon other aspects of it as well by not adhering just to a limited number of factors. The key roles can be played by community in its better outcomes, they should be involved and made aware about it and their suggestions should be taken into consideration for any modification, if required. Another important aspect is the role of Anganwadi workers as they have multiple issues and problems, so it should be rectified time to time in order to make it more efficient. NGO`s and civil societies can work as a bridge in providing better outcomes. As all the smaller looking problems, when taken together, proves to be a bigger threat for the overall healthcare of women and child and is deteriorating for countries' economy as well. It is high time to think over rectifying the issues emerging in its implementation because ICDS running under Anganwadi is able to provide better upliftment to the healthcare system of India as it covers the ground level population of our country.

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