International Journal of Humanities and Social Science Invention (IJHSSI)
ISSN (Online): 2319 – 7722, ISSN (Print): 2319 – 7714
www.ijhssi.org ||Volume 8 Issue 03 Ser. II || March. 2019 || PP.71-75

To Study the Functioning of Anganwadi workers in relation to health care services with the cooperation of ANM in the Anganwadi centers of Kolar Taluk Kolardistrict.

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ABSTRACT: *Government health service shall provide care under all systems of medicine. Existinghealth sub centers should be converted in to health and wellness centers not just in name but in sprit and practice. The goal of health and wellness centers would be to address the social determinants of health such as poverty, gender based inequalities, water and sanitation, child under nutrition and others, to seek convergence at the village level across all departments, rather than merely following an illness based approach*. ***Methods:*** *Study Setting: Anganwadi centers and Sub centers of Kolar Taluk.* ***Study population****: A.N.Ms appointed by the Government of Karnataka and A.W.Ws appointed under ICDS in Kolar Taluk.* ***Study Design:*** *Cross sectional Study. Duration: 6 months.* ***Sampling:*** *among 36 panchayats selected 20panchayaths, each panchayathconsist of 15villages randomly selected,* ***Sample Size:*** *30 ANMs and 295 A.W.Ws in Kolar Taluk. .*

KEY WORDS: *Integrated .Child Development Scheme, Auxiliary Nurse Midwife, Anganwadi worker, sub center.*

Date of Submission: 26-02-2019 Date of acceptance: 20-03-2019

I. INTRODUCTION

India is home to the largest population of malnourished and hunger stricken people and children leading to high infant and maternal mortality. Along with these issues are a deluge of problems ranging from diseases, lack of education, lack of hygiene, illness etc.The Anganwadi worker (AWW) is the community based voluntary frontline worker of the ICDS programme. Selected from the community, she assumes a pivotal role due to her close and continuous contact with the beneficiaries. Her educational level and knowledge of nutrition plays an important role related to her performance in Anganwadi centers[1]. The output of ICDS scheme to a great extent depends on the profile of the key functionary that is anganawadi worker, her qualification, experience, skills, attitude, training etc. Though government is spending lot of money on ICDS programme, impact is very ineffective. Most of the study concentrated on the nutritional and health status of the beneficiaries of ICDS. Less focus has been shown to assess the knowledge and awareness among AWW regarding recommended ICDS programmes, who are actually the main resource person. With this background the present study was planned to assess the knowledge of anganawadi workers and their problems in the urban and rural field practice area of Kolar[2, 3].

India is home to over-population, mal nutrition, poverty, unemployment, low literacy levels and more, was different to make healthcare accessible and affordable for everyone. Given the urgency of healthcare issues, child mortality, mal nutrition, etc., our country needs high number of medical and healthcare professionals to cater to the population that is now running into billions[4]. Faced with acute shortage of skilled professionals, the government's ICDS scheme is using the local population help to meet its grand goals. The Anganwadi worker hails from the village where she works and has her finger on the pulse of the health of the village, its people and children[5].

Apart for the healthcare knowledge that she possesses and gained over a period of time, the anganwadi worker is so entrenched in the general affairs of the household that she is in a better position to understand the real malady behind the healthcare issues. These latent problems of the household or community could range from relationship issues, daily hassles, sanitation, nutrition, social, peer pressure, and much more[6]. Given the definition of health – the physical, mental, social, spiritual wellbeing of an individual, the anganwadi worker perhaps has the best insight into the people's health of her region.

While educated doctors, learned nurses and seasoned professionals are excellent in their work and skills, they mostly lack the social skills and expertise which is more than necessary in interacting with the rural folk. An anganwadi worker is well versed in the ways of the village, knows the people by their names, interacts

with them on regular basis and may also has an personal relationship with the people. Anganwadi workers need to have good communication skills. They are usually adept in using the right language, metaphors and allusions for convincing people to act in a certain way. Religious customs and sentiments work best for them[7, 8]

Here is an interesting account of how the Anganwadi worker convinced the villagers from defecating on open land. From shaming the defecators, convincing the women of the house, to citing the sacred texts that emphasized cleanliness and took the sanitary hygiene of the village to much higher level than one can imagine. Such is the power of the anganwadi worker. Someanganwadi workers are very enterprising. Like the ones in south India, Karnataka, Tamil Nadu, Kerala.They have taken the initiative to help meet the nutritional needs and achieve the objectives of reducing mal nutrition of 0-6 year olds. So far 200 kitchen garden initiatives have been undertaken where anganwadi workers will be trained in laying the gardens and growing crops, among these 260 aw centers had toilets facilities,236own building,158other building, even though shortage of anganwadi workers anganwadi centers are functioning [9, 10,11...]

Anganwadi workers are India's primary tool against the menace of child malnourishment, infant mortality, and lack of child education, community health problems and in curbing preventable diseases. They provide services to villagers, poor families and sick people across the country helping them access healthcare services, immunization, healthy food, hygiene, and provide healthy learning environment for infants, toddlers and children. Anganwadi workers are key informants of health care issues[12].

Integrated Child Development Services program (ICDS) is agovernment sponsored child-care and mother-care development program in India at village level**.** It caters to children in the 0-6 age group, pregnant mother, lactating mother and Adolescent girls. Anganwadi were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.[1, 13] An Anganwadi center provides basic health care facilities in Indian villages, and it is a part of the Indian public health-care system. Basic health-care activities include contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities. The centers may also be used as depots for oral re-hydration salts, basic medicines, contraceptives and child care.[14]

Table 1: Demographic Profile of Anganwadi workers.

Demographic Profile	Number (%)295
Age	
<25	15 (5.1)
26-35	50 (16.9)
36-45	101 (34.2)
46-55	98 (33.2)
>55	31 (10.5)
Marital status	
Married	279(94.6)
Unmarried	14(4.7)
Widow	2 (0.7)
Educational status	
10^{th}Std	196 (66.4)
PUC	74 (25.1)
Degree and others	25 (8.5)
Religion	
Hindu	204 (69.1)
Muslim	23 (7.8)
Christian	4 (1.4)
Not Disclosed	64 (21.6)

In the study majority of Anganwadi workers were in the age group 36 to 45 years (34.2%), followed by 46 to 55 years (33.2%), least number of ANMs were in the age group <25 years (5.1%). Majority 94.6% of Anganwadi workers were married, 4.7% were unmarried and 0.7% were widow. Out of 295 women 66.4% had educational background of 10^{th}Std, 25.1% studied till PUC and 8.5% studied degree and other courses. Hindus were majority in number (69%) and 21.6% did not disclose the religion status.

Table 2: Experience of Anganwadi Workers

Service		Frequency	Percent
Years of work	1 to 5	70	23.7
	6 to 10	58	19.7
	11 to 15	11	3.7
	16 to 20	41	13.9
	21 to 25	106	35.9
	> 25 years	9	3.1
	Total	295	100.0

Our study shows that the number of Anganwadi workers are 295 out of which 106 (35.9) serving in the Anganwadi center and majority of their age is21to 25years.

Table 3: Travel and Residential Status and Duration of Service of Anganwadi Worker

	Distance	N=295
1.Residing in the same village	--	138(46.8)
2.Travel distance from place of residence	<5km	129(43.7)
	5to10km	18(6.1)
	>10km	10(3.4)
3.Duration of service		
	<10yrs	110(37.2)
	11-20yrs	70(23.7)
	>20yrs	115(38.9)

With respect to travel distance from residence majority were residing in the same village (46.8%), 43.7% were travelling from <5km distance, 6.1% were travelling from a distance of 5 to 10 km and 3.4% were travelling from a distance >10 km. Majority of Anganwadi workers were working for >20 years (38.9%), 23.7% for a period of 11 to 20 years and 37.2% of them for a duration of <10 years. The number of years travelled.

Table 4: Frequency and Duration of Visit to Anganwadi center by ANMs in the previous month in Kolar

Duration of visit	Frequency of visit	N=295
ANM Visited AWC in last Month	Visited	204(69.2)
	Not Visited	91(30.8)
No of visit to Anganwadi center	1	110(37.2)
	2-3	74(25)
	>4	20(6.7)
Duration of stay at AWC	<5 min	95(32.2)
	10-30 min	72(24.4)
	>30 min	37(12.5)
Time spent by the ANM for each mother care	5-15 min	105(35.5)
	16-30 min	50(16.9)
	>30 min	49(16.1)

In the study (204)69.2% of ANM's visited AWC in the last month and (91)30.8% did not visit AWC during previous month and anganwadi workers express official reasons. Among those ANM's who visited AWC's 37.2% visited only once, 25% visited 2 – 3 times and 6.7% visited > 4 times in a month. Among those who visited anganwadi 32.2% stayed for of period of <5 min, 24.4% stayed for a period of 10 to 30 minutes and 16.1% stayed for a period >30 minutes. Similarly the time spent in mother care, it was observed that 35.5% spent only 5 to 15 minutes, 16.9% spent 16 to 30 minutes.

Table 5:Activities performedby the ANMs during their visit to AWC in Kolar.

Activities performed by ANM during last visit at AWC	N=295
ANM studied the records of children	180(61.0)
ANM noted down the information in the records	188(63.7)
ANM Discussed the information recorded into in her observation book	162(54.9)
ANM went through the drugs stock in the Anganwadi center.	159(53.8)
ANM undertake visit to households of ANC,PNC & Underweight children in village	167(56.6)
ANM invited antenatal, postnatal mothers to the AWC	185(62.7)
AN M talked with mother about their health	185(62.7)
ANM distributed Iron folic tablets to the mothers	70(23.7)
ANM physically examined the mother	122(41.3)
ANM recorded the information to the mother card	122(41.3)
ANM observed/examined children in the Anganwadi center	120(40.6)
ANM distributed medicines to the identified sick children	125(42.3)
ANM referred sick children to the PHC	75(25.4)
ANM gave advice to mother about the children's healthy feeding	60(20.3)
ANM discussed about growth of the children with the mother.	70(23.7)
ANM noted down the details of the child examined in her	89(30.1)

II. DISCUSSION:

The table5 express that 61 percent of ANMs are studied the children's records,and noted down the information. ANM are went through the drugs stock in the center. She went around the village to look after the underweight children.41.3percent of ANMs physically examined the mother. Few ANMs says that there is no stock of common drugs.

Regarding ANMs findings are the present study says that ANMs did not conduct home visits regularly and had poor communication skills, some of the ANMs were found to be performing well. Study reveals that dissatisfaction among ANMs regarding workload and personal satisfaction, plausible reasons for poor progress of health indicators, the insufficient number of Auxiliary Nurse Midwives to serve in rural and remote areas. Work related stress[9], in charge of more than one sub center, experienced by nurses has been associated with lower job satisfaction, lower organizational commitment and increased physical and mental health symptoms and also age factor, several policy level interventions, inadequacy and inequitable distribution of ANMs especially in rural areas such efforts have focused on addressing shortage with the introduction of various human resources. Work related stress is a global issue, however nurses are particularly vulnerable to work related stress as today the health system and nursing work force limited resources and increasing demands on their service[13].

The AWWs: have to carry out heavy reporting work. As mentioned by them, there are at least 14 registers of different programmes and activity, to be maintained by them on monthly basis. The ICDS supervisors pay visits and check whether registers are being maintained by the AWWs. Many of them have found report writing as a time consuming and tedious job to do[14].

The inter-sectorial coordination taking place between ICDS and the Health machinery. Out of the six specified objectives under ICDS, three objectives (Health check-up, immunization, and referral services) are fulfilled in close coordination with the Health Services System. The AWWs and ICDS supervisors, coordinate with the PHC-MOs and ANMs for Village Child Development Committee planning, immunization sessions, health check-up of AWC children, distribution of Vitamin A, referral of pregnant and sick children, weight monitoring etc. They also share data about Sever acute malnutrition, moderate acute malnutrition children and pregnant women with the ANMs in every month. At the ground level ASHAs coordinate with AWWs on VHNDs (Village Health and Nutrition Day) for immunization sessions and health education sessions with the women[15].

Some factors at the system level affecting the implementation and causing hindrance in the implementation of ICDS activities.(a)Low attendance of anganwadi center because of the baby sickness, long distance to be covered, needed to be at home to work , rainy season, migration, noverity in supplementary food at AWC.(b)Difficulty of identifying SAM/MAM childrenwhen new method the anthropometric measurement was introduced, most of the AWW lost the confidence of applying the method correctly because of their age factor,(c)Problem with take home ration,(d)Lack of infrastructure staff and resources,(e)The role of ICDS supervisor due to time constraints and long distance most of the ICDS Supervisors do not get to visit all the AWCs.(f)Low morale of AWW most of the AWWs are from the local communities and lack of exposure to the outside world majority of them are educated only 10^{th} standard and the younger ones joined in the last 5-10years are little more educated.(g)Children go there for weighing and immunization when ANMs coming to the Anganwadi center, some of the respondents reported that they did not get help from the community for health checkup and immunization, majority of the Anganwadi did not have proper cooking place and safe storage facilities for raw materials.[16]

III. CONCLUSION:

Women with rural background may be preferred in recruitment given the fact that they are more likely to reside in the villages. Transfers, career path: It also emerged from the study that ANMs have varying needs at different periods of time during their career. Absence of a well-defined transfer policy means that while some of them continue to be posted in remote and difficult areas for long durations, others manage to remain at comfortable postings closer to town from where it is easier to commute daily. A transfer policy that takes into consideration increasing personal responsibilities and needs of ANMs over time by posting them into progressively bigger villages or towns after defined periods of time will be helpful in this regard. Meeting their needs: While fulfilling some of the needs such as schooling of the children requires larger inputs, responsive supervisors who are provided with requisite means can meet others. For the latter, policy should emphasize making supervision more responsive and humane and provide mechanisms for ensuring the same.

Conflict of interest: No
Funding agency: No

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