STUDY OF AAGANWADI IN THE SINOR BLOCK

1.0 BACKGROUND

Health and education are the two most important factors for the development of a healthy society. No one can deny these factors. Major stake-holders of the society are children and women, which is why it is very important to create a healthy society. This can be accomplished by focusing more on malnourished children and maternal health. The role of a social institution is very important in addressing such issues. To fulfill the objective of 'HEALTHY MOTHER, HEALTHY CHILD',

1.1 MILLENNIUM DEVELOPMENT GOALS (**MDGS**) were the eight international development goals for the year 2015 that had been established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration. All 189 United Nations member states at that time, and at least 22 international organizations, committed to help achieve the following Millennium Development Goals by 2015:

1. To eradicate extreme poverty and hunger
2. To achieve universal primary education
3. To promote gender equality and empower women
4. To reduce child mortality
5. To improve maternal health
6. To combat HIV/AIDS, malaria, and other diseases
7. To ensure environmental sustainability
8. To develop a global partnership for development

Each goal had specific targets, and dates for achieving those targets. To accelerate progress, the G8 finance ministers agreed in June 2005 to provide enough funds to the World Bank, the International Monetary Fund (IMF) and the African Development Bank (AfDB) to cancel $40 to $55 billion in debt owed by members of the heavily

indebted poor countries (HIPC) to allow them to redirect resources to programs for improving health and education and for alleviating poverty.

Critics of the MDGs complained of a lack of analysis and justification behind the chosen objectives, and the difficulty or lack of measurements for some goals and uneven progress, among others. Although developed countries' aid for achieving the MDGs rose during the challenge period, more than half went for debt relief and much of the remainder going towards natural disaster relief and military aid, rather than further development.

As of 2013, progress towards the goals was uneven. Some countries achieved many goals, while others were not on track to realize any. A UN conference in September 2010 reviewed progress to date and adopted a global plan to achieve the eight goals by their target date. New commitments targeted women's and children's health, and new initiatives in the worldwide battle against poverty, hunger and disease.

Among the non-governmental organizations assisting were the United Nations Millennium Campaign, the Millennium Promise Alliance, Inc., the Global Poverty Project, the Micah Challenge, The Youth in Action EU Programme, "Cartoons in Action" video project and the 8 Visions of Hope global art project.

The Sustainable Development Goals (SDGs) replaced the MDGs in 2016.

1.2 ANGANWADI

The word **Anganwadi** means "courtyard shelter" in Indian languages. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.

A typical Anganwadi centre provides basic health care in Indian villages. 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.[1] The centres may be used as depots for oral rehydration salts, basic medicines and contraceptives.

As many as 13.3 lakh (a lakh is 100,000) Anganwadi and mini-Anganwadi centres (AWCs/mini-AWCs) are operational out of 13.7 lakh sanctioned AWCs/mini-AWCs, as of 31 January 2013. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services of which later three services are provided in convergence with public health systems.

India is a country suffering from overpopulation, malnourishment, poverty and high infant mortality rates. To counter the health and mortality issues there is a great need for medical and health care experts. Unfortunately India has a shortage of skilled professionals. Therefore, through the Anganwadi system, the country is trying to meet its goal of enhanced health facilities that are affordable and accessible for local populations.

In many ways an Anganwadi worker is better access than a physician in reaching out to the rural population. Since the worker lives with the people she is in a better position to identify the cause of health problems and hence counter them. She has a very good insight of the health status in her region. Secondly though Anganwadi workers are not as skilled or qualified as professionals they have better social skills thus making it easier to interact with the people. Moreover, since these workers are from the village, they are trusted which makes it easier for them to help the people. Last but not the least, Anganwadi workers are well aware of the ways of the people, are comfortable with the language, know the rural folk personally etc. This makes it very easy for them to figure out the problems being faced by the people and ensure that they are solved

Children are the future of the country and therefore, their growth and development have to be looked after by all the sections of community. However, it is noticed that many of the children face problem of under-nutrition or malnutrition. Globally, the malnutrition contributes to nearly 30 lakh (35%) deaths of children below five years of age which can only be prevented when policy, programme and budgetary actions are directed towards children during prenatal and their first few years of life. Any intervention at later stage of

their lives might not be very effective. Moreover, there is now evidence that rapid weight gain after first two years of age increases the risk of chronic diseases later. The National Family Health Survey (NFHS)-III revealed that 40.4% of children below the age of three years are underweight in India. In view of this, there is an urgent need to redress malnutrition in children. To accomplish this, the Integrated Child Development Services (ICDS) programme, is under implementation as the most important government intervention for reducing maternal and childhood malnutrition. It has emerged as the world's largest programme of its kind. This scheme has expanded remarkably in its scope and coverage providing a well-integrated package of services through a network of community level Anganwadi Centers (AWCs).

ICDS programme has expanded tremendously over the 30 years of its operation to cover almost all the development blocks in the country. It offers a wide range of health, nutrition and education related services to children, women and adolescent girls. ICDS is intended to target the needs of the poorest and the undernourished, as well as the age groups that represent a significant window of opportunity for nutrition investments (i.e. children under three years of age, pregnant and lactating mother). The services targeted at young children and mothers are immunization, regular health check-ups and supplementary feeding as well as nutrition and health education to improve the childcare and feeding practices. Preschool education is also provided to the children of age between three to six years. Realizing the impact and positive role of AWCs in solving the nutrition problems of children, the erstwhile Planning Commission felt a need to periodically update the data on child nutrition to assess the effectiveness of ICDS in delivering the intended services. Since the child nutrition data are routinely generated by the service delivery system, a quick test/check study to ascertain the reliability of data reported by ICDS's MIS was designed.

The ICDS programme today covers 8.4 crore children of age below 6 years and 1.91 crore pregnant and lactating mothers through 7,066 projects and 13.42 lakh operational AWCs. This is against a total number of 16.45 crore children in the age group 0-6 years (2011 Census). ICDS, therefore, reaches only around half of the children in this age group. While the families with better financial position do not send their children to

AWCs, there are still significant number of children from marginalized community groups and inaccessible habitations that have not been covered by ICDS. Therefore, ICDS data cannot adequately provide a full view of the nutrition status of all young children. Though ICDS-MIS does generate a large database on the weight for age of children under 6 years covered by ICDS, as recorded in the Child Growth Charts, it is confined to those participating in the programme. Other programs in operation at the Aanganwadi are presented below.

2.0 THROUGH ANGANWADI MANY GOVERNMENT SCHEMES ARE PROVIDED

There are various schemes listed below:

2.1 SUPPLEMENTARY NUTRITION PROGRAMME

The Supplementary Nutrition is one of the six services provided under the Integrated Child Development Services (ICDS) Scheme which is primarily designed to bridge the gap between the Recommended Dietary Allowance (FDA) and the Average Daily Intake (ADI). Supplementary Nutrition is given to the children (6 months – 6 years) and pregnant and lactating mothers under the ICDS Scheme.

The Government of India, on 24.2.2009, has issued revised guidelines on nutritional and feeding norms. States/UTs have been requested to provide supplementary nutrition to children below six years of age and pregnant and lactating mothers, in accordance with the guidelines which have been endorsed by the Hon'ble Supreme Court vide its Order dated 22.4.2009.

The provision of supplementary nutrition under ICDS Scheme prescribed for various categories of beneficiaries is as follows:

(i) Children in the age group of 6 months to 3 years: Food supplement of 500 calories of energy and 12-15 gms. of Protein per child per day as Take Home Ration (THR) in the form of Micronutrient Fortified Food and/or energy-dense food marked as 'ICDS Food Supplement'.

(ii) Children in the age group of 3-6 years: Food supplement of 500 calories of energy and 12-15 gms of Protein per child per day. Since a child of this age group is not capable of consuming of meal of 500 calories in one sitting, the guidelines prescribed provision of morning snack in the form of milk/banana/seasonal fruits/Micronutrient Fortified Food etc. and a Hot Cooked Meal.

(iii) Severely underweight children: Food supplement of 800 calories of energy and 20-25 gms of Protein per child per day in the form of Micronutrient fortified and/or energy dense food as Take Home Ration.

(iv) Pregnant Women and Lactating Mothers: Food supplement of 600 calories of energy and 18-20 gms of Protein per day in the form of Micronutrient Fortified Food and/or energy dense food as Take Home Ration.

Sl. No.	Category	Revised feeding & nutritional norms (per beneficiary per day		Revised cost norms (per beneficiary per day)
		Calories (K Cal)	Protein (g)	
1.	Children (6-72 months)	500	12-15	Rs.4.00
2.	Severely malnourished children (6-72 months)	800	20-25	Rs.6.00
3.	Pregnant women and Nursing mothers	600	18-20	Rs.5.00

Under the Strengthened and Restructured ICDS, these rates have been revised to Rs.6.00, Rs.9.00 and Rs.7.00 per beneficiary per day for children (6-72 months), severely malnourished children (6-72 months) and pregnant women and Nursing mothers,

respectively. The revised rates are to follow the phased implementation over the 3 years of the Strengthened and Restructured ICDS on the existing cost sharing ratio of 50:50 between the Centre and the States other than NER where it will continue to be on 90:10 basis, as under:

(i) In 200 high burden districts in the first year (2012-13);
(ii) In additional 200 districts in second year (2013-14) (i.e. w.e.f. 1.4.2013) including districts from special category States and NER;
(iii) In remaining districts in third year (2014-15) (i.e. w.e.f. 1.4.2014).

India has the dubious distinction of having the highest number of malnourished children in the world. Successive national surveys have shown little change in nutritional levels among under-5 children. Given the close link between fetus and child under nutrition and increased morbidity and mortality among children, as well as impaired learning ability and long-lasting adverse health effects, the urgency of the need to address this issue cannot be overemphasized.

2.2 THE NUTRITION OPERATION PLAN (NOP)

In 2009, the Department of Women and Child Development decided to build on the gains in malnutrition reduction shown by the NFHS-3 as compared to NFHS-2, with a special focus on dephe rived sections of society. In this they were assisted by DFID for a system strengthening initiative called the Nutrition Operation Plan .This was developed after many consultations and review of other malnutrition reduction initiatives elsewhere, and buttressed by primary research of conditions within the state. The plan had a special focus on 15 high burden districts, and was based on the principles of targeting the most vulnerable, flexibility, evidence and outcome based participatory planning, stronger convergence, and strong monitoring and results based framework. Financial support was to the tune of GBP 35 million over a 5 year period (from 2010 – 2015).

The NOP provided for technical and financial assistance to achieve the following **goals**:

Statewide,

- to reduce the prevalence of moderate and severe malnutrition among under 2 children;
- to reduce the proportion of birth weights less than 2.5 kgs, and

 a reduction in nutritional anaemia among women and children.

The impact indicators between 2010 and 2015 are:

 Reduction in underweight children from 41% to 25%,

 Reduction in stunting from 45% to 35%, and

 Reduction in wasting from 20% to 10%.

The NOP is designed around eight strategies –

a. Institutional strengthening for improved access and utilization of ICDS services.

b. Strengthened institutional arrangements for improved access and utilization of ICDS services.

c. Decentralized planning identifying block priorities.

d. Ensuring community participation in planning, implementing and monitoring.

e. Strengthening service delivery for nutrition.

f. Results based Monitoring and Evaluation.

g. Early Childhood Education

h. Interdepartmental convergence

i. Integrated Behaviour Change Communication.

2.3 ANEMIA IN ADOLESCENT GIRLS

Girls' iron requirements increase dramatically during adolescent as a result of the expansion of the lean body mass, total blood volume and the onset of menstruation; these changes make adolescent girls more susceptible to anemia, which has lasting negative consequences for them and for the survival, growth, development of their children later in life. In India - home to nearly 113 million adolescent girls – the prevalence of anemia in adolescent girls is estimated at 56 per cent. In view of the scale of the problem, the Government of India and state governments with technical support by UNICEF and

partners have been implementing for over a decade the Adolescent Girls Anemia Control Programme. The main objective of the programme is to reduce the prevalence and severity of anemia in school-going adolescent girls using schools as the delivery channel and in out-of-school adolescent girls using the community *anganwadi* centre of India's Integrated Child Development Services (ICDS) programme as the delivery platform. The programme strategy for the initial phase was built around three essential interventions: 1) weekly iron and folic acid supplementation (WIFS) comprising 100 mg of elemental iron and 500 µg of folic acid; 2) bi-annual deworming prophylaxis (400 µg of albendazole) six months apart for the prevention of helminth infestations; and 3) information, counselling and support to adolescent girls on how to improve their diets and how to prevent anemia.

Lessons learnt: The genesis and expansion of the Adolescent Girls Anemia Control Programme in India demonstrate that appropriate leadership and programme action can successfully scale up evidence-based nutrition programmes for children and women. Several success factors and lessons learned have been identified in the decade that spans from the initial phase of the programme to end 2011:

Evidence-based advocacy using global and national evidence contributed to garner political support to pilot test (initial phase) the programme and assess its effectiveness;

- **Data on effectiveness and cost** was crucial to garner political commitment for the consolidation phase of the programme; particularly important was the evidence on the impact of the programme in reducing the prevalence and severity of anemia;
- **Synergy among state departments** and a clear segregation of roles and responsibilities among the departments at the national and state levels was key in the successful pilot testing and consolidation of the programme at scale with quality;

- **Involvement of stakeholders** at all levels of the programme, including girls, parents, community leaders, teachers, principals, district level programme managers, state level policy makers, and media is essential to ensure programme uptake, coverage and ownership;
- **Timely and quality communication** with adolescent girls and their families and communities about the benefits of the programme, the potential undesirable effects

of WIFS and deworming prophylaxis and how to mitigate them was essential to ensure girls' adherence to the programme;

- **Timely availability of supplies**, particularly iron and folic acid (IFA) supplements and deworming tablets, Information-Education-Communication (IEC) materials and monitoring tools in the schools and *anganwadi* centres is central to the girls' adherence to the programme and programme success;
- **An integrated package** of interventions including anaemia control services, counselling and support as well as other relevant components for adolescent's growth, development and empowerment is important; however, it is crucial to focus on a **limited number of evidence based interventions** and design the programme with a focus on large scale;

Use existing delivery platforms today while creating new policy and programme opportunities for tomorrow;

- **Girls are the best advocates** as they can be very articulate about the benefits of their programme; the "peer-to-peer/girl-to-girl" education and counseling approach increased girls' interest, enthusiasm and adherence to the programme. The lessons learned from this decade of programme experience suggest that the Adolescent Girls Anaemia Control Programme has the potential to become an important platform for intersectoral convergence among key government departments and UNICEF programmes to empower adolescent girls, reduce gender and social inequities, and break the inter-generational cycle of under nutrition and deprivation in India.

Adolescence is a period of transition from childhood to adulthood. It is characterised by rapid physical, biological and hormonal changes resulting in psycho-social, behavioural and sexual maturation. Adolescence is a period of rapid growth: up to 45 per cent of skeletal growth takes Anemia during adolescence affects the growth and development of girls, diminishes their concentration in daily tasks, limits their learning ability, increases their vulnerability to dropping out of school, causes loss of appetite resulting in reduced food intake and irregular menstrual cycles, and reduces physical fitness and future work productivity. Moreover, anemia during adolescence influences women's entire life cycle since anemic girls will have lower pre-pregnancy iron stores. As pregnancy is too short a period to build the iron stores required to meet the needs of the growing fetus,

women who enter pregnancy anemic are at an increased risk of giving birth to children with a low birth weight (below 2,500 grams), delivering pre-term newborns, and/or dying while giving birth. Additionally, children born to anemic women are more likely to die before the age of one year and be sick, undernourished and anemic, thus perpetuating the intergenerational cycle of maternal and child under-nutrition. Hence, investing in preventing anemia during adolescence is critical for adolescent girls themselves as well as for the survival, growth and development of their children later in life.

India is home to nearly 113 million adolescent girls between the ages of 11 and 18 years, and 90 per cent of them (i.e. 104 million girls) live in the 15 largest states of the country. An estimated 56 per cent of adolescent girls in India are anemic, and this amounts to an average 64 million girls at any point in time. In view of the scale of the problem, Government of India, with technical support by UNICEF and partners has been implementing for over a decade the Adolescent Girls Anemia Control Programme. The main objective of the programme is to reduce the prevalence and severity of anemia in school-going adolescent girls using schools as delivery channel and in out-of-school adolescent girls using the community *anganwadi* centre of India's ICDS programme as the delivery platform. This publication reviews the initiation, consolidation and expansion of the Adolescent Girls Anemia Control Programme, its context, objectives, strategy and the key elements of its implementation, and the results and costs involved. It also describes UNICEF's evolving role in supporting the programme and summarises the lessons learned in the process to support the effective scale up of the programme in India**.**

Strategy:

Globally, a three-pronged strategy is recommended for the control of anemia at the population level. Such strategy comprises: 1) Dietary diversification and improvement; 2) Food fortification with iron and other essential micronutrients (vitamins and minerals); and 3) Regular consumption of IFA supplements. In India's current socio-economic situation, it is difficult for large segments of the population to consume a diversified iron-rich diet able to ensure optimal intake of iron, folic acid and other essential micronutrients as indicated by the high prevalence of anemia among adolescent girls and

women of reproductive age, showing the cumulative effects of nutritional deficiencies along the life cycle and across generations.

Therefore, the regular consumption of IFA supplements is essential for the prevention of iron deficiency and anemia in adolescent girls.

2.4 Fix Immunization Day

Immunization of infants and children against six vaccine-preventable diseases protect children from - poliomyelitis, diphtheria, pertusis, tetanus, tuberculosis and measles. These are major preventable causes of child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus reduces maternal and neonatal mortality. The fixed immunization day for our State is Wednesday . The AWW assists the health functionaries in coverage of the target population for immunization. She helps in the organization of fixed-day immunization sessions, maintains the immunization register and follows up to ensure full coverage.

Objectives

The objectives of Pustikar Divas are:

• To reduce the risk of death and disease amongst (0-5 yrs) children due to malnutrition.

• To prevent malnutrition in early childhood through the promotion of improved child feeding, care giving, and care seeking practices at the facility, family and community levels

• To strengthen the convergence between Health & ICDS in order to improve the nutritional status of (0-5 yrs.) children; and

• To strengthen the capacity of individuals, families, communities and the health systems to effectively manage and prevent malnutrition.

Implementation guidelines

Organization of the Day

• Information about the Pustikar Diwas will be prominently displayed in the AWC / SC/ PHC/ CHC / in the form of fixation of Board.

• Prior information to community to be given by ASHA, AWW with the help of PRI representatives & NGOs.

• AWW must be present on the day. BEE / LHV / ICDS Supervisor / MO /AYUSH MO/ CDPO/BPO as per the plan will participate and supervise the activities.

• All required logistic must be made available at the site. Those are: IEC Materials, weighing machines, History taking formats, registers for enrollment and money disbursement, referral slips.

Pre-Activity

• AWW will identify the malnourished children after measuring MUAC & weighing all the children in the VHND/AWC.

• AWW will fill-up the referral slip prior to 15th & handover to the parents. In case the AWW is not able to accompany the identified undernourished children to the Pustikar Diwas site, she will inform the ASHA to complete the task. She will give detail information of the child to the ASHA.

• The ASHA will meet the parents & take the full information of the child. She will also finalize the time & mode of journey from village to PHC/CHC.

• On 15th ASHA will accompany the child (in the event of AWW not able to accompany) with the referral slip and MAA O SISHU SURAKHYA card will be attached with the referral slip (this will be utilized as a monitoring tool).

• The AWW will maintain the referral register & follow-up register.

• The ASHA/AWW shall explain the entitlements to be received to the parents of the child.

• Availability of one Medical Officer in the PHC/CHC on the “Pustikar Diwas” is a mandatory requirement for effective check up and management of malnourished children.

• In case the child admitted in the hospital, necessary funds can be availed form block

2.5 Kishori Shakti Yojana

Kishori Shakti Yojana under the ambit of ICDS aims at the empowerment and holistic development of adolescent girls by improving their self perception and creating opportunities for realizing their full potential through Balika Mandals. The scheme

primarily aims at breaking the intergenerational life cycle of nutritional & gender disadvantage and providing a supportive environment for self development.

Objective:

i. To provide the required literacy and numeric skills through the non-formal stream of education.

ii. To stimulate a desire for more social exposure and knowledge and to help them improve their decision making capabilities.

iii. To improve the nutritional, health and development status of adolescent girls, promote awareness on health, hygiene, nutrition and family care,

iv. To link them to opportunities for learning life skills, to train and equip the adolescent girls to improve/upgrade home based and vocational skills.

v. To help them gain a better understanding of their social environment and take initiatives to become productive members of the society.

Target Group:

Adolescent Girls (11-18 yrs.) - both school going and out of school girls.

Coverage:

In all the 21 districts of the State except in the districts where the SABLA scheme is implemented.

2.6 Mamta Diwas

Under the programme, the primary clients are pregnant women, lactating mothers, children below five years and adolescent girls. Basic components of primary healthcare services, including early registration, deworming, counseling on early breastfeeding, identification and referral of high risk cases of children and pregnant women, as well as basic ANC and PNC care will be provided at community level in order to address the essential requirements of pregnancy, delivery, referral, childhood illnesses and adolescent health.

The programme would be organized once a month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM, AWW and ASHA. On an average, there are six to eight AWCs under the operational jurisdiction of one Sub Centre and thus there would be about eight

fixed days in a month per Sub Centre. There should be advanced fixation of the day with all AWCs for the entire month, so that the service providers and the community are aware of it much in advance. The main objectives of the programme are as follows:

Objectives

 To provide essential and comprehensive health & nutrition services to pregnant women, lactating mothers, children (0-5 yrs) and adolescent girls.

 To ensure early registration, identification and referral of high risk children and pregnant women.

To provide an effective platform for interaction of service providers and the community (through Gaon Kalyan Samiti or the mothers group)

 To provide information to families on care of mothers and children at the household and community level through discussion of various health topics (as envisaged in the Health Calendar); and

 To ensure establishment of linkage between health & ICDS as to promote maternal & child survival programmes.

The VHND is to be organized once every month (preferably on Wednesdays, and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for intersectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

Keeping in view the significance of holding the VHND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the FHW and AWW should be well defined. The quality of the VHND needs to be improved, and hence the outcomes should be measured and monitored. This document will help AWWs and PRI members to understand their respective roles in providing their services effectively to the community during the monthly VHND and will also help in educating them on matters related to health. VHND if organized regularly and effectively can bring about the much needed

behavioural changes in the community, and can also induce health-seeking behaviour in the community leading to better health outcomes.
Programme managers at district/block level should ensure availability of necessary supplies and expendables in adequate quantities during the VHNDs. Similarly, supportive supervision by Programme Managers at different levels will result in improved quality of services.

On the appointed day, AWWs, and others including Village Health and Sanitation Committee will mobilize the villagers, especially women and children, to assemble at the nearest AWC. The FHW and other health personnel should be present on time; otherwise the villagers will be reluctant to attend the following monthly VHND. On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND will be held at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health services will be provided at their doorstep. The VHSC comprising the AWW, the FHW, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

3.1 Process of Data Collection

In our 10 days of rural camp we covered 24 villages and their Anganwadi of each village. As we were supposed to take the details mentioned in the forms regarding the working of Anganwadi we were asked to meet Anganwadi worker. Anganwadi is preschool contracted for rural children from age 3-6 where they are taught how to sit patiently at one place, how to play with others and also share their toys with others, there children are provided with games which can help children develop their motor skills. Walls of Anganwadi contains bright colors and pictures of various animals, fruits. Many Anganwadi even have posters of flowers with their names and even posters of vegetable and fruits which is the need of children of this age group so that they can get a basics of education which can further help them in their studies.

At the time of enrollment and every month , the Anganwadi workers record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the sub centres/PHC etc., and maintain child cards for children below 6 years and produce these cards before visiting medical and paramedical personnel. AWW's also carry out survey across the village every year just to see what all facilities are provided to children and expecting mothers in their respected area of work. In case they identify the disability among children during her home visits they refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre. As they are close to their community people they also motivate women to practice family planning and also provide awareness in the form of health and nutrition education and counselling on breast feeding/infant & young feeding practices to mothers. So that heath of both mother and child can be preserved. Mid-day meals are also provided to children present in the preschool and also to the other children who are enrolled in Anganwadi but are too small to visit school, the food is delivered to their home. Nutritional supplements are also provided to expectant and nursing mothers by planning the menu based on locally available food and local recipes. The food is prepared according to WHO guidelines and is prepared in Anganwadi itself. Parameters for healthy child are also displayed on the walls of many anganwadi's.

Apart from nutritional supplements, various non-formal activities are also organized in Anganwadi for children of the age 3-6 years and help in designing and making of toys and play equipment of indigenous origin for use in Anganwadi is also provided to them. Various awareness programs are also carried out by AWW's to make people aware about correct way of nurturing their children and also make expecting women and lactating women aware of aspects which they need to keep in mind which can help them keep themselves healthy and also their children. Records for numbers of birth and deaths in village is also kept in Anganwadi and further the data is provided to panchayat every month and complete records are kept. In Anganwadi we also asked AWW's to show us all the records just to see whether they are keeping it updated or not. They even had attendance registers of how many children are enrolled in Anganwadi. The attendance was taken on regular basis just to keep a check over the presence of children. If in case any child remains absent without informing the AWW's , then AWW herself visit the child's home and ask their parents to send their children to school. Apart from these every 6 months, one health

checkup campaign is organized for adolescent girls and for expecting and lactating mothers to check their hemoglobin level and basic health test are also taken. Record of the reports are also kept in Anganwadi through which the number of women or girls who are malnourished or are anemic can be estimated. So in this case medicines are also provided to such females. AWW's assist in implementation of Kishori Shakti Yojana (KSY) and SABLA and motivate and educate the adolescent girls and their parents and community in general by organizing social awareness programmes/campaigns etc.

A) SERVICES TO BE PROVIDED:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services

  are to be provided to them.
- All eligible children below one year are to be given vaccines against six
- Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered, to children.

- All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children

3.2 ISSUES TO BE DISCUSSED WITH THE COMMUNITY

- Danger signs during pregnancy
- Importance of institutional delivery and where to go for delivery
- Importance of seeking post-natal care
- Counselling on ENBC
- Registration for the JSY
- Counselling for better nutrition
- Exclusive Breastfeeding
- Weaning and complementary feeding
- Care during diarrhoea and home management
- Care during acute respiratory infections
- Prevention of malaria, TB, and other communicable diseases
- Prevention of HIV/AIDS
- Prevention of STIs
- Importance of safe drinking water
- Personal hygiene
- Household sanitation
- Education of children
- Dangers of sex selection
- Age at marriage
- Information on RTIs, STIs, HIV and AIDS
- Disease outbreak
- Disaster management
- Rashtriya Swasthya Bima Yojna (RSBY)

3.3 IDENTIFICATION OF CASES THAT NEED SPECIAL ATTENTION

- Identify children with disabilities.
- Identify children with Grade III and Grade IV malnutrition for referral
- Identify severe cases of anemia.
- Identify pregnant women who need hospitalization.
- Identify cases of malaria, TB, leprosy, and Kala Azar.
- Identify problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society.

3.4 STUDY OBJECTIVES

The objectives of the study are to:-

- Verify and examine the enrollment and other records maintained by AWCs.
- Examine the accuracy of weighing instruments provided to AWCs.
- Assess the availability and adequacy of infrastructures at AWCs.

3.5 Evaluation Issues:

The quick study was designed to reflect on the following issues:

- Proper maintenance of records / registers by the AWCs.
- Enrolment of children both boys and girls in the AWCs.
- Correctness of the weight measurement machines available at the AWCs.
- Correctness of the health registers maintained by the AWC workers.
- Proper procedure of health checkup done by the AWCs.
- Correctness of the health reports prepared by the AWCs.
- Availability of infrastructures in the AWCs.

4.0 Data Analysis:

For Analyzing data raw data has been put in tables and for two sets of responses bar graphs have been used.

1. **Schemes**

Table 1 Shows schemes presented through Anganwadi

Sr. No.	Details	No. of Villages
1.	SNP(supplementary nutrition Program) Morning Snacks, Hot Cook Meal, Take Home Ration	12
2.	Mamata Diwas	12
3.	Village Health and Nutrition Day (VHND)	9
4.	Pustikar Diwas referral	5
5.	Fix Immunization Day	8
6.	Adolescent Anaemia Control Program (AACP)	9
7.	Sabla / Kishori Shakti Yojana (KSY)	10

In the 12 surveyed villages, all 12 villages had Supplementary nutrition program, Mamta Diwas was also celebrated in all the surveyed villages. Village health and nutrition day was celebrated once in a month in all the anganwadi. Pustikar Diwas that is nutrition referral for under nourished children (AACP). Ten villages out of 12 villages have Kishori Shakti or KSY program.

2. **Committees**

Table 2: Indicating formation of various committee that help anganwadi

Sr.No.	Details	No. of Villages
1.	Jaanch Committee	5
2.	Mothers Committee	9
3.	Self Help Groups	7
4.	Gaon Kalyan Samiti	6

Out of 12 villages 5 villages had Jaanch Samiti which looks into the food distribution. Mothers committee was there in 9 villages. Seven out of 12 villages had Self help groups. Gaon Kalyan Samiti was also found in 50% villages.

3. Sanitation & Hygiene of Children

Table:3 Table indicating Sanitation and hygiene in the surveyed villages.

Sr.No.	Details	Yes	No
1.	Availability of Soap	12	0
2.	Nails Cut	11	1
3.	Hair Combed	11	1
4.	Face Cleaned	11	1

Table 3 indicates in all the surveyed villages there is availability of soap. That is 100% of villages have availability of soap, nails are cut, hair are combed and face cleaned.

4. Functional Weighing Machine

Table: 4 Indicating presence and functionality of Weighing Scale

Sr.No.	Details	Yes	No
1.	Salter (hanging for Children)	12	0
2.	Adult (Floor based)	12	0

Table 4 shows 100% of anganwadi's have Salter hanging weighing scale for infants. 100% of villages had the floor based weighing scale in functioning conditions.

5. Feeding

Table: 5 Indicating Provision of meals in anganwadi

Sr.No.	Details	Yes	No
1.	Hot Cooked Meal and Morning Snacks given as per weekly menu chart.	7	5
2.	Attendance (Head Count) during spot feeding on the day of visit	9	3
3.	No. of days Hot Cooked Meal not given	8	4

Table no. 5 Indicates hot cooked meal was there on chart but only 7 out of 12 villages followed the weekly menu chart. Attendance during the food service was taken in 9 villages only. Only four villages did not provide for hot food in the anganwadi.

6. Maintenance of Registers

Table 6 Indicating the Registers maintained by Anganwadi

Sr.No.	Details	Yes	No
1.	Survey Register	12	0
2.	Pregnancy Register	12	0
3.	Immunization Register	12	0
4.	Pre School Attendance Register	12	0
5.			
6.	S.N.P Hot Cooked Meal Attendance Register	12	0
7.	Growth Monitoring Register	12	0

Table 6 indicated the registers maintained by anganwadi in the surveyed villages. It can be observed from the table that 100% of registered in every category were maintained by anganwadi. Survey registers were maintained by anganwadi.

Pregnancy register of pregnant villages was maintained in the anganwadi surveyed.

Immunization of young children is also managed by the surveyed anganwadi

Supplementary nutritional Program was also provided to children, pregnant women and lactating mothers.

Pre school attendance registers were also monitored on a regular basis.

Growth of young children was also managed in the form of register in the surveyed villages.

7. Sanitation & Hygiene of Children

Table 7 Indicating sanitation and hygiene of children in surveyed anganwadi

Sr. No.	Details	Yes	No
i.	Availability of Soap	10	2
ii.	Nail Cutter	10	2
iii.	Hair Combed	12	0
iv.	Face Cleaned	12	0
v.	Dish washing Detergent	10	2
vi.	Foot Wear for Toilet	3	9
vii.	Towel	11	1
viii.	Dustbin	11	1
ix.	Clean room	11	1
x.	Toilet	11	1

Table no. 7 indicates certain checks on maintenance of sanitation and hygiene. In the table given above 10 parameters are given. Parameter like hair combed face cleaned show 100% result that is in every anganwadi it was observed that children had combed hair and clean faces.

In 4 villages it was observed that there were facilities of towel, dustbin, clean rooms and toilets. Out of 12 village anganwadi 10 had a dish wash bar to clean utensils.

Availability of soap was there in 10 out of 12 villages. Nail cutter was also available in 10 0ut of 12 villages. Availability of foot wear for toilets was found to be lacking in 9 out of 12 anganwadi's.

Table:8 Indicates Preschool amenities available at Anganwadi

Pre school	Criteria	V-1	V-2	V-3	V-4	V-5	V-6	V-7	V-8	V-9	V-10	V-11	V-12
i.	No. of Children enrolled in School	40	116	40	41	11	17	54	55	27	53	30	14
ii.	No. of Children present in School	35	25	40	14	0	19	16	14	5	53	7	14
iii.	No. of PWD children	0	1	0	0	0	6	0	0	10	0	0	1
iv.	Whether pre school kit is available	y	y	y	y	N	y	y	y	y	y	y	y
v.	Whether parents and teachers meeting is held.	y	y	y	y	Y	y	y	y	y	y	y	y

Table 8 shows five parameters, No. of children enrolled in school, No. of children present in school, No. of children with people with disability (pwd), availability of pre-school kit. Lastly whether parents and teachers meeting is held.

With regards to first criteria it can be seen that the range of enrollment is from 11 to 116. With regards to second criteria regarding attendance it can be noticed that only in three villages same enrollment and attendance can be seen, that is village 3, 10 and village 12. With regards to children with physical disability village 2 reported one case, village 6 reported 6 cases, village 9 reported 10 cases and village 12 showed one case of pwd..

Regarding availability of pre school kit except for village 5 all other anganwadi had pre school kit.

Regarding Parents teachers meeting all the anganwadi had regular meetings.

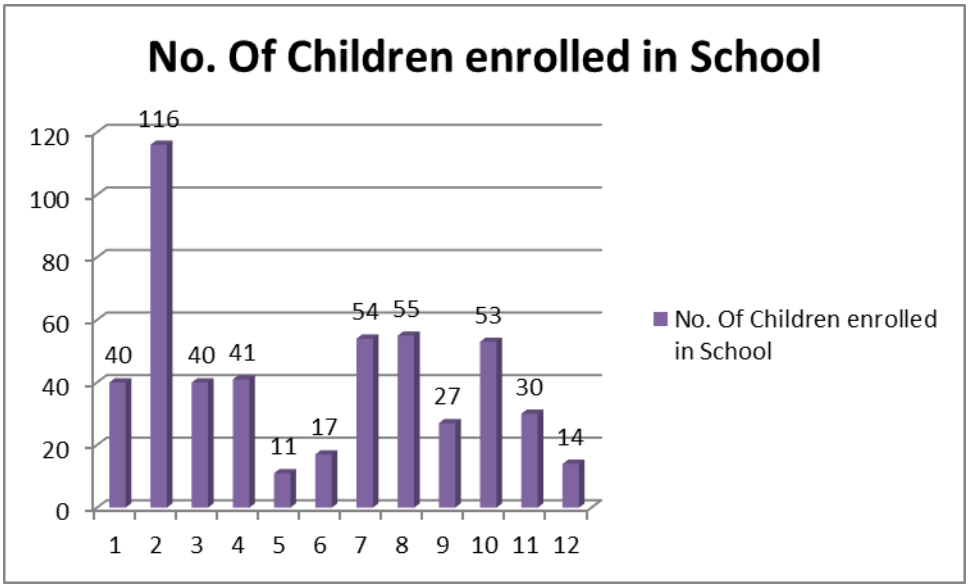

Figure No. 1. Showing number of preschool Children enrolled in anganwadi of Sampled Villages

Figure 1 shows number of children enrolled in preschool. Highest no. of students were enrolled in village 2 and lowest number of students were enrolled in village 5.

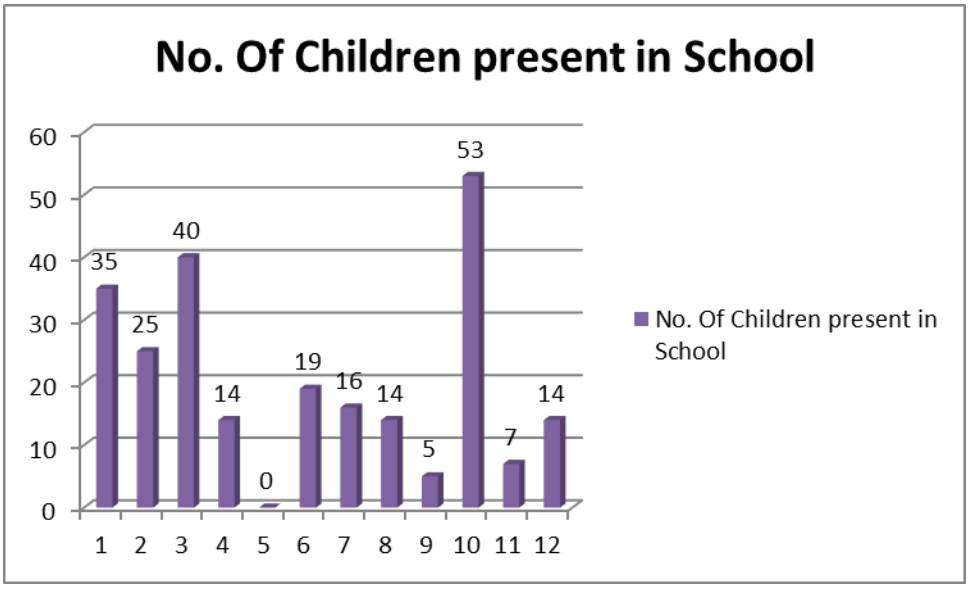

Figure No. 2. Showing number of preschool Children enrolled in anganwadi of Sampled Villages

From figure 2 it can be seen that attendance in village 10 was highest and in village five attendance was 0 perhaps some kind of holiday may have been declared on that particular day.

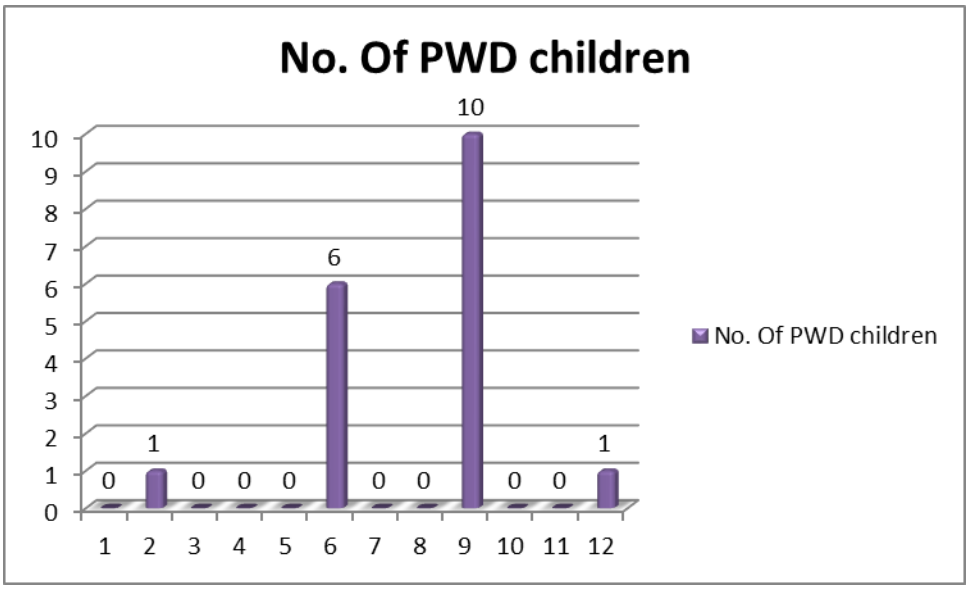

Figure No. 3. Showing number of People with Disability served by anganwadi of Sampled Villages.

From figure 3 it can be observed that no. of pwd children were found in village 1 and village 12 (1 child). Whereas in village 6 there are 6 children with disability and in village 9 there are 10 children with disability. These are serious concerns which need attention.

Table No. 9. Beneficiaries of Anganwadi

Bene-ficiary details	Criteria	V-1	V-2	V-3	V-4	V-5	V-6	V-7	V-8	V-9	V-10	V-11	V-12
i.	No. Of pregnant women	10	15	1	5	3	1	4	2	5	4	3	4
ii.	No. Of lactating mother	7	17	7	2	0	5	4	4	10	0	5	4
iii.	No of children below 2 years	7	12	11	5	0	8	20	10	5	37	14	15
iv.	No. Of severely underweight children	0	0	7	0	1	1	2	1	10	1	9	2
v.	No. Of adolescent girls (11-18)	16	40	20	39	10	12	15	10	5	29	13	15
vi.	No. Of out of school adolescent girls	16	19	10	17	0	12	4	0	5	13	3	6
vii.	No. Of adolescent girls (11-18) anemic	20	0	0	13	0	0	0	29	0	6	15	0

Table 9 deals with the beneficiaries of Anganwadi. It has seven criteria. The criteria are as follows; pregnant women, lactating mothers, no. of children below two years, severely underweight children, no. of adolescent girls, no. of out of school adolescent girls and no of anemic girls.

With regards to pregnant women served range was from 1 to 15.

With regards to lactating mothers 0 to 17 mothers were served by the anganwadi's

With regards to no. of children below 2 years range was 1 to 10 children.

With regards to no. of severely underweight children range was1 to 10. Underweight children are a cause of concern. Perhaps they also indicate health of mother as well.

With regards to adolescent girls range was from 5 to 40.

With regards to out of school girls there are 3 to 19 is a cause of concern. Girls have to be educated as their education is important for family and the country.

With regards to adolescent anemic girls 6 to 29. Anemia of adolescent girls can not be left unattended as these girls will be future mothers.

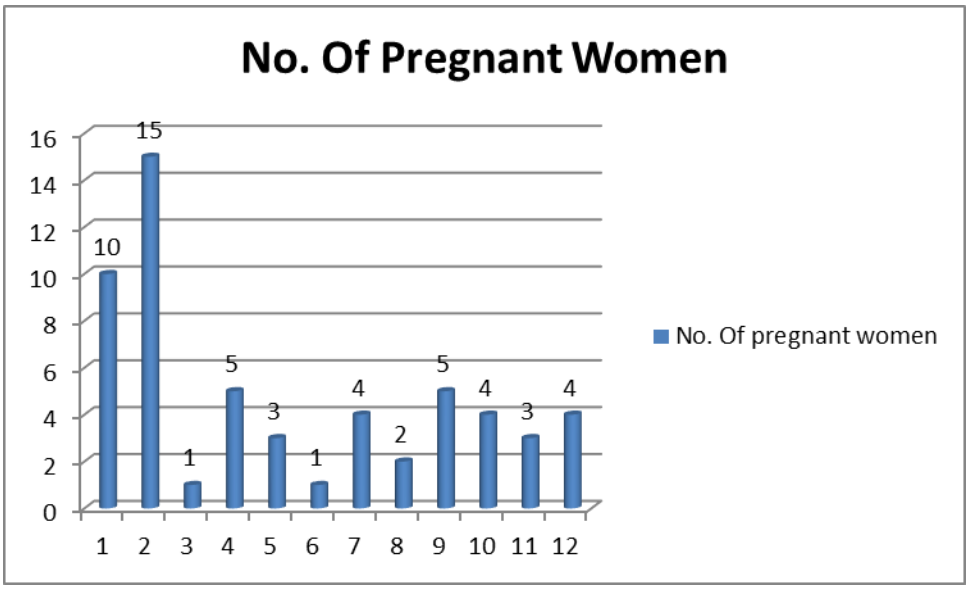

Figure No. 4 Showing number of Pregnant Women served by Aanganwadi of the Sampled Villages.

Figure 4 showing no. of pregnant women village 2 had highest number of pregnant women and village 3 and village 6 had minimum no. of pregnant women.

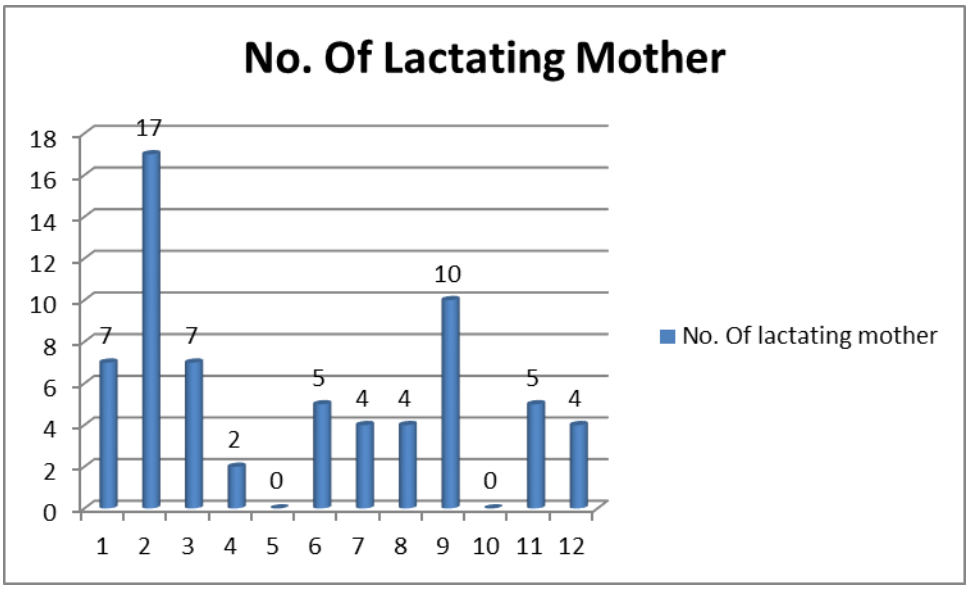

Figure No. 5 Showing Number of Lactating mothers served by Anganwadi of the Sampled Villages

Village no.2 is showing highest number of lactating mothers. Lactating mothers and the health of infant need utmost attention as health of mother and the child are important for proper growth and development of child.

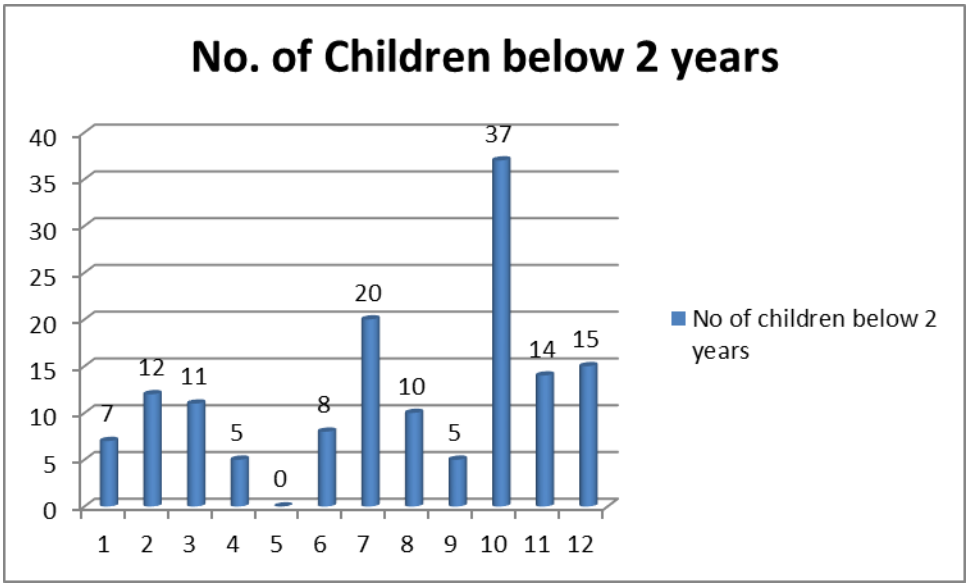

Figure No. 6 Showing number of children below two years served by anganwadi of the Sampled Villages.

Figure 6 shows that village 10 had highest number of children below two years. Children below two years are highly vulnerable to diseases their immunization is most important.

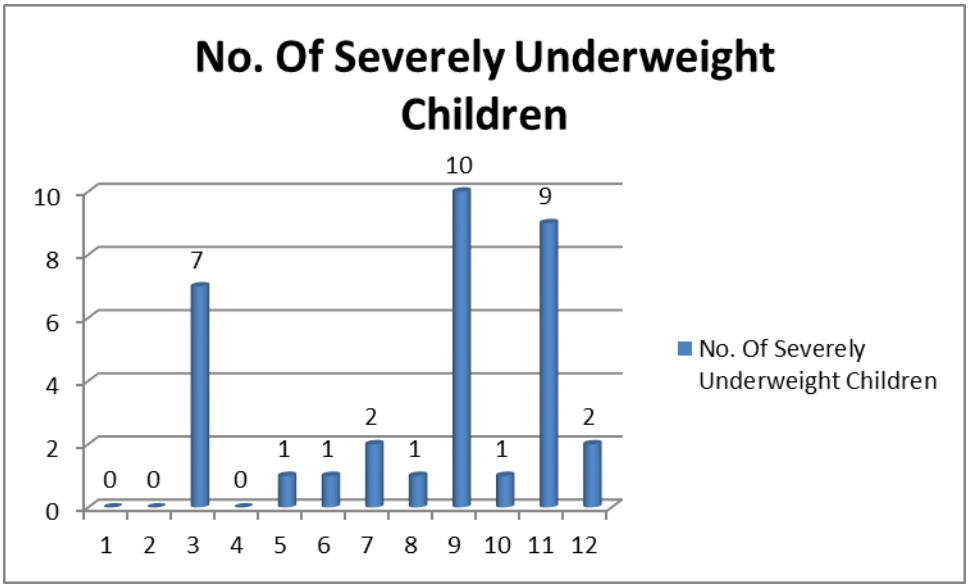

Figure No. 7 Showing number of Severely underweight children below two years served by anganwadi of the Sampled Villages.

Figure above shows children severely underweight. Underweight children can we observed in 9 villages out of 12 villages. Underweight children is a concern as these children are undernourished and have high chances of getting sick as their immunity is low they are susceptible to disease.

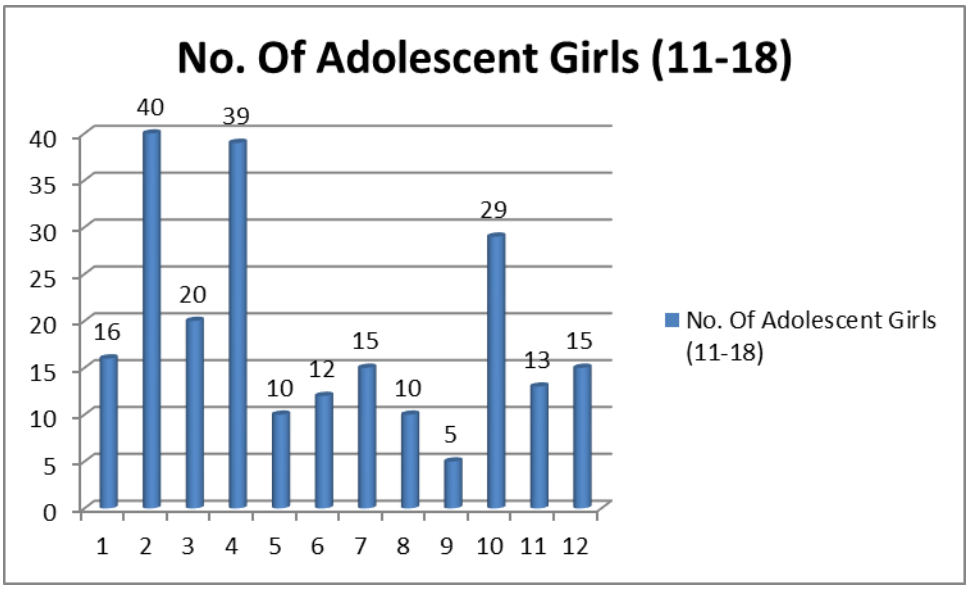

Figure No. 8. Showing number of Adolescent Girls (11-18) served by anganwadi of the Sampled Villages

There were large no. of adolescent girls in the surveyed villages. Most of them had stopped going to school after onset of puberty. They did work in the Sabla group.

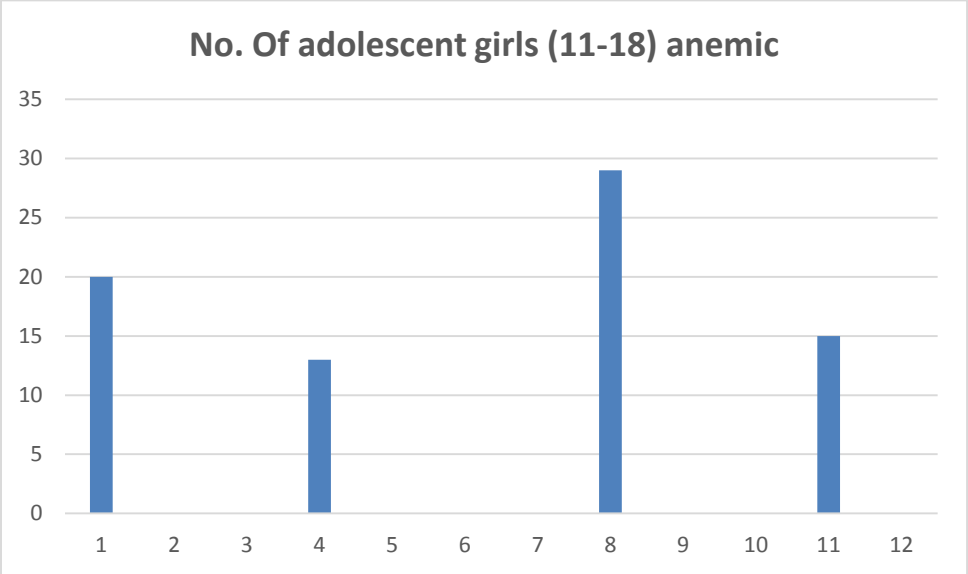

Figure 9 Figure No. 7. Showing number of anemic girls served by the anganwadi of Sampled Villages.

Above figure shows anemic girls registered in various anganwadi's Anganwadi's of village 1, village 4, village 8 and village 11 are serious concerns. As these girls will be future mothers.

4.1 Findings

- It was found that there were many children who were malnourished and underweight.
- It was found that all 12 villages had Supplementary nutrition program, Mamta Diwas was also celebrated in all the surveyed villages.
- It was also found that out of 12 villages 5 villages had jaanch samiti, 9 villages had Mothers committee, 7 villages had Self Help Group and 50% villages had Gaon Kalyan Samiti.
- It was found that all the villages had availability of soap and good standard of sanitation and hygiene.

- It was found that all the anganwadis in all the villages had weighing machine for children.
- It was observed that only 7 villages followed weekly menu chart out of which only 4 villages provided hot food and 9 villages had attendance during food service.
- It was observed that 100% of registers in every category were maintained by anganwadi of all the villages.
- It was found that all children had combed hair and clean faces, anganwadi of 4 villages had towel, dustbin, clean rooms and toilets. Anganwadi of 10 villages had soaps, nail cutters, and anganwadi of 9 villages had separate foot wears for toilets.
- It was observed that range of enrollment was from 11 to 116 in 3 villages. Village 2 had one case, village 6 had 6 cases and village 9 had 10 cases of physical disability and village 12 showed 1 case of Person with Disability.
- Except one village all other villages had pre-school kit in anganwadi.
- Anganwadi of village 2 had highest number of children enrolment and anganwadi of village 5 had the lowest.
- It was found that anganwadi of village 2 had highest number of pregnant women and anganwadi of village 3 and village 6 had minimum no. of pregnant women.
- It was observed that anganwadi of village 2 was showing the highest number of lactating mothers and anganwadi of village 10 had the highest number of children below two years.
- Some anganwadi did not have proper lightings and fan facilities.
- Some anganwadi have toilets and kitchen side by side which is at the same time very unhygienic.
- Walls of anganwadi were also not clean and painted properly.
- Anganwadi workers who were assigned to call children were also not doing their work properly.
- Gas stoves were kept on the floor which is dangerous for children.

4.2 Recommendations

- It is recommended that the roof of anganwadi should be made up of either terracotta tiles (Nadiya) or ceiling.
- It is recommended that the anganwadi worker and children ratio should be in proportion. Number of Anganwadi helpers should also be increased.
- It is also recommended that kitchen and toilet should not be side by side as it's very unhygienic for younger children.
- It is also suggested that the food cooked in anganwadi has to be cooked under clean area.
- It is also recommended that the nuisance of flies and mosquitoes should be reduced.

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Appendix 1

Department of Social Work
Navrachana University, Vadodara

Checklist for Swachh Bharat Mission

Date of Visit:
Name of AWC:

1. Please check whether the following schemes are being implemented properly

a. SNP(supplementary nutrition Program) Morning Snacks, Hot Cook Meal, Take Home Ration
b. Mamata Diwas
c. Village Health and Nutrition Day (VHND)
d. Pustikar Diwas referral
e. Fix Immunization Day
f. Adolescent Anaemia Control Program (AACP)
g. Sabla / Kishori Shakti Yojana (KSY)

2. Whether the following Committees are functional, if possible please interact.

a. Jaanch Committee
b. Mothers Committee
c. Self Help Groups
d. Gaon Kalyan Samiti

3. Sanitation & Hygiene of Children:

a. Availability of Soap: (Please ask children if they wash hands before eating, you should also inspect their hands).
b. Nails Cut Y N
c. Hair Combed Y N
d. Face Cleaned Y N

5 Functional Weighing Machine:

a. Salter (hanging for Children) Y N
b. Adult (Floor based) Y N

6 Feeding:

a. Hot Cooked Meal and Morning Snacks given as per weekly menu chart. Y N
b. Attendance (Head Count) during spot feeding on the day of visit.
c. No. of days Hot Cooked Meal not given last month. Why? (Check sign of Jaanch Committee Members)

7. Maintenance of Registers:

a. Survey Register Y N
b. Pregnancy Register Y N
c. Immunization Register Y N
d. Pre School Attendance Register Y N
e. S.N.P Hot Cooked Meal Attendance Register Y N

f. Growth Monitoring Register Y N

8. Sanitation & Hygiene of Children:
   a. Availability of Soap: (Please ask children if they wash hands before eating, you should also inspect their hands).
   b. Nail Cutter Y N
   c. Hair Combed Y N
   d. Face Cleaned Y N
   e. Dish washing Detergent Y N
   f. Foot Wear for Toilet Y N
   g. Towel Y N
   h. Dustbin Y N
   i. Whether keeping the room clean Y N
   j. Whether Toilet is available Y N

9. Beneficiary Details:
   a. Number of Pregnant Women
   b. Number of Lactating Mothers
   c. Number of Children below 2 years
   d. Number of severely Underweight Children
   e. Number of Adolescent Girls (11-18 years)
   f. Number of out of school Adolescent Girls (11-18 years)
   g. Number of Adolescent Girls anaemic (After Test) (Counsel AWW on deworming, BB Test, BMI and IFA)

10. Preschool:
   a. Number of Children enrolled in preschool.
   b. Number of Children present in preschool.
   c. Number of PWD Children attending preschool.
   d. Whether preschool kit (toys, materials) available and being used? Y N
   e. Was Parent-Teacher Meeting held last quarter? Y N