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A STUDY ON ICDS PROJECTS OF INDIA

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ABSTRACT

Nutrition of the child is of paramount importance because the foundation for lifetime health, strength and intellectual vitality is laid down during this period. However, malnutrition – the silent killer, is India's major problem even today. Supplementary feeding program constitute the most promising and effective short term measures to overcome this problem among children and improve the quality of their performance in schools and the performance of these programs depends mainly on the performance of their functionaries.

Keywords: ICDS, Anganwadi, Malnutition,

I. INTRODUCTION

The Anganwadi worker is the community-based frontline worker of the ICDS program. Attainment of ICDS program goals depends heavily upon the effectiveness of the Anganwadi worker which in turn depends upon their knowledge, attitude and practice. In order to make presentation of this more clear and meaningful, the literature is reviewed under the following heads:

- Impact of ICDS on the beneficiaries.
- Impact of In-service training on the ICDS functionaries.
- Condition of Anganwadi centers.

Evaluation of knowledge and attitude of Anganwadi worker towards various components related to ICDS program. Survey of the related studies always adds to the knowledge of investigator and it not only saves the researcher from pit falls but also shows the shortest path to destination.

II. IMPACT OF ICDS ON THE BENEFICIARIES

ICDS is one of the few programs where evaluation was inbuilt right from the initial stages of the program development. A critical review of various research studies have been conducted in the past as to know about the proper functioning of the program, benefits to the target group, impact of the program on their health status and the holistic development is presented below:

A study to assess the nutritional status of ICDS and Non-ICDS children was conducted.[1] The study was done on 15 preschoolers from ICDS center and 15 from Non-ICDS centers of Resham Ghar Colony of Jammu city. The results revealed that ICDS centers were providing supplementary nutrition to children, pregnant women and nursing

mothers who are enrolled in the Anganwadi. Data showed that all the Anganwadi workers were assessing the nutritional status of children by taking their height and weight. All the respondents observed some changes in their children. It was found that children who attended Anganwadi center had good health or appearance as compared to their counterparts.

A study on 600 children (from 2 ICDS and 2 Non- ICDS slum units) was conducted in order to highlight the dynamics of changes in the nutritional status of children of ICDS and non ICDS area of Varanasi city.[2] The study revealed only marginal improvement in the nutritional status of ICDS children. It showed that enough emphasis was not given on growth monitoring of children in the ICDS area to detect disease, evidence of malnutrition, infection etc. and to provide them corrective measures immediately to improve their nutritional and health status. Thus the scheme could not check the rate of deterioration in the nutritional status of child beneficiaries.

The impact of ICDS on the health status of children who were about to be enrolled in the Anganwadi centers in the age group of 3-4 years was studied.[3] It was thus found that ICDS yielded the best result in improving the nutritional status of children, health status and performance of children along with improved attendance in the balwadies.

The impact of ICDS on maternal nutrition and birth weight was evaluated.[4] The study included 28 ICDS and 21 non ICDS village in 2 adjoining blocks of Varanasi. It was found that the ICDS supplemented mothers gained 100 gm more in pregnancy and birth weight was higher by 58 gm as compared to unsupplemented ICDS mothers. ICDS supplemented women had significantly smaller proportion of low birth weight babies (14.4%) compared to ICDS unsupplemented (20.4%) and non ICDS women (26.3%) and the corresponding prevalence of preterm births was 2.0%, 2.4% and 4.3% respectively. It was thus found that nutrition supplements to pregnant women in ICDS area improved weight gain in pregnancy and birth weight with reduction in preterm and low birth weight deliveries.

The impact of the program on the nutritional status of children aged 0 to <6 years and evaluation of the coverage of the scheme was carried out.[5] The results revealed a significant decrease in severely malnourished children from 21% in 1976 to 7% in 1990. The benefit of the program was evident in all sections of the society including Schedule caste, Schedule tribe, backward and minority communities. The nutritional service coverage of the children increased from 25% in 1976 to 53% in 1985 in ICDS blocks in comparison to 42% in non ICDS blocks while that for pregnant and lactating women increased from 17% and 14% in 1976 to 25% and 26% in 1985 respectively.

A study to assess the impact of the ICDS program in South Arcot district of Tamil Nadu on the beneficiaries was conducted.[6] Out of 300 samples selected, 150 were the beneficiaries and other 150 were non beneficiaries of ICDS. The results indicated that the beneficiaries consumed more nutritious food and were much more aware than the non beneficiaries.

A study was done to determine whether the short term gains of ICDS continued or not.[7] The pediatrics department at RNT Medical College in Udaipur analyzed 1981 and 1991 survey data on 478 and 823 children under 6 years respectively, living in Garhi block, Rajasthan. The proportion of children with severe PEM declined from 14.64% to 11.3%. Immunization coverage of 12-24 month old children increased considerably for every vaccine. Thus it was

found that Anganwadi worker were able to successfully motivate parents to immunize their children but it also indicated a need to improve coordination between ICDS and health workers.

Assessment of mother's attitude towards her child's health, education and play in Dalmau (ICDS block) and Lalganj (Non ICDS) in India was done.[8] Results revealed a significant difference between the positive attitude towards child's health of mothers's of ICDS children (38.78%) and those of non ICDS (17.56%). It was found that more mothers in the ICDS block (24.76%) had a positive attitude towards child's education than those in the non ICDS block (16.59%). Most of the mothers did not realize the importance of play in child development, but play conditions were better in the ICDS block. Thus it was found that ICDS program had an impact on changing the attitudes of mothers.

Evaluation of the ICDS scheme in Garhi Block, Rajasthan was done in a study.[9] Protein Energy Malnutrition of grades I, II, III and IV at baseline survey was seen in 23.80%, 25.47%, 10.95% and 2.85% children respectively while it was 24.63%, 24.39%, 9.75% and 1.95% respectively after a year. At base line survey, 44.29% children received two primary doses of DPT whereas only 32.44% received at repeat survey. Thus, there was not much improvement in the status of nutrition and immunization in children less than 6 years due to this project.

Thus from the above given studies a clear positive impact of the program has been seen on the nutritional status of young children who actually participated regularly. These results suggest that at least some of the services that ICDS provides are of sufficient quality to positively influence child nutrition. Thus in order to have a measurable impact of ICDS on child malnutrition in the villages in which it is placed, strengthening measures need to be taken to encourage its beneficiaries to participate in the program regularly.

III. IMPACT OF IN-SERVICE TRAINING ON THE ICDS FUNCTIONARIES

The abilities and attitudes of the functionaries are of crucial importance for the efficacy and smooth running of ICDS program. So there should be adequate and proper training before recruitment and then in service training should form an essential and vital input to the program. Various studies have been done earlier in order to determine the impact of in service training on functionaries.

A Study was carried out to find out the effectiveness of training on the knowledge of vitamin A deficiency among Anganwadi workers in a rural area of North India.[10] 95 Anganwadi workers were trained, most of them knew that vitamin A deficiency leads to blindness and it can be identified by symptom of night blindness during pre test. Large number of them also knew that carrots and spinach are rich sources of vitamin A before conducting the teaching session. Their knowledge regarding causes of vitamin A deficiency, doses of vitamin A required for prophylaxis and treatment was less during pre test. But their knowledge improved significantly during post test. The study findings revealed the need for in service training of Anganwadi workers for updating their knowledge on vitamin A deficiency. It also suggested that training by using appropriate teaching methods is effective in increasing their knowledge for control of vitamin A deficiency.

A study was conducted to assess the practice and skills learnt by basic health workers for 4-8 weeks and one year after Integrated Management of Childhood Illness (IMCI) training and to identify the gaps in practice due to various constraints.[11] The Anganwadi workers and the supervisory staff were given 5 day IMCI training using WHO package in Panchkula, Haryana. The supervisors gave follow up visits to Anganwadi workers using standardized follow up forms adapted from WHO material. The supervisors gave follow up visit to first batch of Anganwadi workers one year after training in IMCI and a second visit was given 4-8 weeks after the first visit. The second batch of Anganwadi workers was followed up 4-8 weeks after training. The performance on correct treatment of cases by Anganwadi workers weeks were trained 4-6 weeks prior to follow up was better than group followed up one year after the completion of training. The performance on correct treatment showed significant improvement during the second follow up. The average number of cases seen by Anganwadi workers increased from 6.6 in first follow up to 9.3 during second follow up of the same Anganwadi workers.

A study to assess the impact of nutrition education program on the nutritional and health status of the selected pre-school children was done.[12] The nutrition messages to the target group were disseminated by community nutrition worker in the center and in local meetings. Thus it was found that nutrition education plays a major role in improving the nutritional status of vulnerable groups in developing countries like India.

A study to know about the determinants of community health worker's performance in India was conducted.[13] 43 Anganwadi workers in Gujrat were interviewed to record their education level, evaluate their nutrition knowledge and collect information on the number of visits made by the ANM in the preceding 3 months and the activities she performed for the Anganwadi center. The study indicated that nutrition knowledge was the most powerful determinant of performance followed by guidance from the ANM and their education level. It is thus concluded that Anganwadi worker should receive nutrition health education and regular guidance from the ANM and their education level should be high school or above.

An evaluation study was conducted on the performance of the grass root workers i.e. Community Nutrition Workers, in the Tamil Nadu Integrated Nutrition Project (TINP) which indicated that the grass root level workers were well equipped to carry out their job function in the field and the program also made the village leaders understand the need for nutritional care of the pre school children.[14]

A study was conducted to find out the feasibility and impact of an in service training program in nutrition and health education on the knowledge and practices of the Balsevikas.[15] The study included 50 Balsevikas working under the ICCW, Chandigarh and program was conducted for about 4 weeks by two nutrition experts and a health expert. It was found that the magnitude of improvement was more for knowledge as compared to practices and such training will enable functionaries to discharge their responsibilities with knowledge, understanding and efficiency.

Thus from the above given studies we can conclude that in service training have shown a positive impact and have proved to be effective in the implementation in terms of beneficiaries leading to increased utilization of the services by the target group. But it has been seen that in some places still there is a need for in service training of these

workers for updating their knowledge and emphasis should be on the use of demonstration and practice classes to reinforce the theoretical knowledge imparted, also for sustaining the skills of Anganwadi worker follow up visits to the anganwadi centers should be suitably timed after the training and should not be delayed as delay leads to loss of skills.

IV. CONDITION OF ANGANWADI CENTER

The health of beneficiaries, their nutrition and hygienic conditions go hand in hand. Therefore, the AW buildings, its surroundings, design, lighting and ventilation all have important roles to play in behaviour and welfare of the beneficiaries and they thus add to the overall development of the target group. Various studies have been done to evaluate their infrastructure.

The functioning of Anganwadi center in the urban slums of Delhi was evaluated in order to asses the organization, available infrastructure and logistics at the center.[16] It was seen that 55% of Anganwadi centers were running in rented house and 40% in helper's house, 85% of Anganwadi centers had pucca building and were electrified. 60% of Anganwadi center had availability of fan for the children. Safe drinking water and food storing space in proper conditions was available in 75% of Anganwadi center. All the Anganwadi center had regular supply of adequate ration for their registered beneficiaries, 90% had registers for record keeping, 80% had functioning scale, 7.5% had nutrition and health education material and growth cards, but none of them had received medicine kit and iron folic acid tablets since the last four years.

A study was carried out about the social component of the ICDS scheme and found that Anganwadi center were located in unhygienic surroundings.[17]

There was deficiency in arrangements for supply of drinking water and in adequacy of teaching aids and play materials. Short falls in community participation and training of Anganwadi worker was seen.

A study conducted on 34 Anganwadi centers in Rajasthan found that 27 Anganwadi center among 34 were run in rented houses, 5 in school buildings and 2 in temple premises.[18] The building of 23 Anganwadi center were kutcha and only 11 AW were housed in pucca building. It has also been noted that majority of Anganwadi centers were situated in unhygienic surroundings which may effect the health of the children.

It can be thus concluded from the above given studies that existing ICDS program needs to improve its hygiene and sanitation facilities. So efforts should be made to coordinate with community in order to make Anganwadi center a healthy place for healthy development of children.

V. EVALUATION OF KNOWLEDGE AND ATTITUDE OF ANGANWADI WORKER TOWARDS VARIOUS COMPONENTS RELATED TO ICDS PROGRAM

Attainment of ICDS program goals depends heavily upon the effectiveness of the Anganwadi worker which in turn depends upon their knowledge, attitude and practice. Various studies have been done in order to assess their knowledge and skills.

Growth Monitoring: Growth monitoring and surveillance are two important activities in ICDS. Both are important for assessing the impact of the health and nutrition related services. Growth monitoring activities are hampered either by poor access to appropriate equipments such as weighing scale, growth charts or by inadequate training and skills of Anganwadi worker. Various studies have been done to evaluate the knowledge and skills of Anganwadi worker in this respect.

A study was conducted to find out the knowledge of Anganwadi worker in performing their jobs activities.[19] It was seen that 90% of them were able to interpret growth curve correctly. 75% were able to tell the significance of flattened, raising and falling growth lines. About 50% of Anganwadi worker knew about 3 colours (red, yellow and green) of mid upper arm circumference (MUAC) strip, whereas 35% were able to mention regarding the action to be taken according to interpreted colours.

A study was carried out to evaluate the status of growth monitoring activities in selected ICDS projects of Rajasthan.[20]A survey of 120 Anganwadi workers from ICDS projects in Jaipur, Ajmer, Udaipur, Bharatpur and Bikaner districts was conducted. It was found that growth charts were available to 83.3% of Anganwadi workers but 75% were unable to use weighing scales properly. Half of them plotted weight incorrectly on the chart and 57% were unable to interpret a flattened growth curve. 90% lacked knowledge of the sequence of steps involved in growth monitoring and only 33% conducted growth monitoring, primarily to identify malnourished children. It was also found that mother's participation in improving their child's nutritional status was not solicited. These findings suggest that the potential of growth monitoring activities in India is being impeded by inadequate knowledge and training on the part of Anganwadi workers faulty equipment and a lack of community participation.

In a study 100 Anganwadi workers were interviewed in an ICDS block, Alipur, Delhi to determine their knowledge on growth monitoring and to identify gaps in their knowledge.[21] It was found that 99% had adequate knowledge about the significance of the lines on the growth curve and 43% knew that they can begin growth monitoring for any child under age six.37% did not knew that assessment of correct age is not essential for growth monitoring. 90-91% had correct knowledge about weight of a child at one and three years. Yet only 17-30% knew the correct mid upper arm circumference for an optimally nourished child between 2 and 4 years.

A study conducted on 19 ICDS blocks of Gujrat and Maharashtra revealed that Anganwadi workers neither fill the growth charts in mother's presence nor try to involve them in the weighting or charting procedure.[22] Charts were not always maintained properly. Training of workers was also found to be inadequate with too much emphasis on

nutritional status and not enough hands on training. Thus there was need to give workers more relevant training through practical experience.

A study on 34 multipurpose workers (MPW) from a rural ICDS block of Rohtak district, Haryana was conducted in order to examine their knowledge and skills concerning growth monitoring and to identify knowledge gaps so that ICDS can design an active on the job training in growth monitoring.[23] The results indicated that all MPWs knew that a rising growth curve means improved nutritional status and the direction of the curve allows early detection of growth retardation. All MPWs agreed that the best method to monitor growth is serial periodic weighing of children. Further 82.3% MPWs were familiar with 2.5 kg being the cut off point for low birth weights. These results thus indicated high MPWs knowledge about anthropometry in determining nutritional status.

A study published in Indian Pediatrics included a survey of 48 Child Development Project Officers (CDPO) in order to assess their knowledge and skills about growth monitoring through interview technique.[24] Majority (94%) of subjects had correct knowledge that growth monitoring helps in early detection of growth retardation while about 83% felt that a flattened growth curve indicates no weight gain. 83, 71 and 50% of CDPOs were respectively able to interpret and read correctly about what ascending, descending and flattened growth curves indicated. The researchers thus concluded that these knowledge gaps among CDPOs would negatively affect subordinates. Thus in service training of CDPOs should address these gaps to improve their knowledge of growth monitoring activities.

A survey of 52 Anganwadi community workers and 156 mothers of ICDS beneficiary children in Nelamangala, Bangalore was conducted.[25] The results of the survey showed that 96.16% of Anganwadi workers had education upto high school level. 69.2% weighed children correctly and 53.84% plotted growth charts satisfactorily, 94% of Anganwadi workers weighed all the children every month and only 5.7% plotted the growth chart immediately after weighing, 86.92% correctly identified a flattened curve as an indicator of growth failure. 71.15% were aware that additional feeding was needed, 17.30% suggested treatment with tonics and 3.84% suggested treatment for worm infestations. These results were used in improving health education and developing appropriate and effective communication about nutrition and health between Anganwadi worker and the mothers.

A study was conducted to assess the knowledge and skills about growth monitoring amongst Medical Officers (MO), CDPOs and MPWs.[26] This included 48 CDPOs, 24 MOs and 34 MPWs and all had to have some measure of in service or course training. It was found that all MOs and MPWs knew that adequate nutrition was necessary for an ascending growth curve and only 81% of CDPOs had this knowledge. Majority of MOs, MPWs and CDPOs knew that inadequate food intake over a prolonged period of time leads to a depressed growth curve. About 96% of MOs, 83% CDPOs and 100% MPWs interpreted that descending growth curves could be used to identify at risk children and no weight gain children by most personnel.

It can be concluded that not all Anganwadi workers are adequately knowledgeable in weighing and recording the weight on growth charts and interpreting it. The level of education of many is not sufficient for this activity. As growth monitoring activities are used as community tools to educate and encourage mothers to adopt behaviour that

promote the growth of their children. Thus training of Anganwadi workers and its application by them needs to be paid urgent attention in order to ensure that Anganwadi workers are competent and effective in growth monitoring and promotion activities.

Infant feeding: Failure to exclusive breast feeding of children during the first six months of life along with delayed introduction of semisolid foods is an important trigger of malnutrition. Anganwadi workers are the first level health workers who are responsible for promotion of maternity and child health care. Various studies have been done in order to assess the knowledge and attitude of these Anganwadi workers towards breastfeeding/infant feeding.

Evaluation of the knowledge of Anganwadi workers in performing their activities was done in urban slums of Delhi.[27] It was seen that regarding the age of weaning of infants, 60% of Anganwadi workers mentioned as 4-6 months, whereas 15% of the Anganwadi workers said after the age of 6 months and 25% said as even before 4 months.

A study on 130 Anganwadi workers in Orissa was conducted in order to assess the knowledge and attitude of these Anganwadi workers towards breast feeding.[28] The study included questions about initiation, continuation, benefits and cost, reasons of failure and attitude of Anganwadi workers towards breast feeding. It was thus found that Anganwadi workers had less information about the causes of breast feeding failure and their attitude showed a low score towards breast feeding practices.

A study was carried on 100 Anganwadi workers in an ICDS block, Alipur, Delhi to determine their knowledge and attitude about infant feeding.[29] It was seen that 98.7% Anganwadi workers had the correct knowledge that breast feeding should be started immediately after birth and 92.7% knew that colostrum should be given to the child. However, only 56.6% knew that top milk should not be diluted. 48.2% Anganwadi workers had wrong knowledge that breast feeding should be stopped if the mother had fever or tuberculosis. More than a quarter of Anganwadi workers had the wrong perception regarding breast feeding and social consideration.

A study was conducted to determine their knowledge and attitude about breast feeding in Rural Delhi.[30] It was found that all the respondents had correct knowledge about age of initiating breast feeding, feeding of colostrum and superiority of breast milk over commercial milk preparations. But still there is need for continuing education of peripheral health functionaries for updating their knowledge.

A similar study was conducted on the CDPOs working in ICDS scheme.[31] It was found that majority of respondents had correct knowledge about feeding of colostrums, age of initiation of breast milk and introduction of semi-solid foods. Majority of CDPOs had the knowledge that consumption of dry fruits, milk and desi ghee would increase breast milk secretion. The percentage of subjects who were aware that breast feeding should be discontinued if mother is suffering from serious illness were 48% in case of breast cancer, 57% in case of Tuberculosis, 67% in malaria and 84% suffering from diarrhoea.

It can be thus concluded from the above given studies that Anganwadi workers no doubt have adequate knowledge about colostrum feeding, initiation of breast feeding, weaning foods etc, but still their knowledge is inadequate like about causes of breast feeding failure. Thus there is an urgent need of in service continuing education of peripheral health functionaries for updating their knowledge with recent advances in the field of nutrition and pediatrics.

Immunization: It is an important cost effective strategy for child survival. Health workers are grass root agencies in immunization for rural as well as urban population. Inadequate management of cold chain, incorrect administration and dose may reduce the potency of vaccine and can lead to adverse effects. In order to assess the knowledge, attitude and practice regarding immunization previously various studies have been done on Anganwadi workers, an attempt to present few of them is made here.

A study was done on 366 workers of Nagaur district in Rajasthan in order to asses their knowledge, attitude and practice regarding immunization.[32]

Information was collected about the place of storage of vaccines, methods of storing vaccine in the refrigerator, method of carrying vaccines in the field, dose of vaccine, route of administration and age of vaccination. It was evident from the results that knowledge of health workers increase with higher basic qualification. It was found that proper intermittent re-orientation training and periodic reassessment for all health workers is necessary for successful immunization.

A study was carried out in order to find out the knowledge of Anganwadi workers in performing their job activities in Anganwadi centers of urban slums of Delhi.[33] Regarding the knowledge of disease prevented through vaccination, all of them knew about polio, followed by measles, diphtheria, pertussis, tetanus and TB through DPT and BCG. 60% of Anganwadi workers knew that night blindness can be prevented by administering vitamin A syrup to the children.

Thus, it can be concluded that there is a need of targeted efforts to deliver immunization services to children to reduce early childhood mortality and morbidity. Regular capacity building and reinforcement of knowledge of health workers should be conducted and if possible better qualified workers should be enrolled.

Supplementary Nutrition: It is considered to be the core of the program and a great deal of time of Anganwadi worker is spent on the various activities concerned with this like recording, storing, cooking, distribution etc., with the objective of improving the nutritional status of children. Various studies have been done in order to evaluate the nutritional services provided in the Anganwadi centers.

A study was conducted to evaluate the ICDS centers in Fathua, Bikram and Masaurthi blocks of Patna district.[34] It was observed that supply of nutritious food was irregular under the scheme. As the allocation of funds for purchase of foods were much delayed in the centers, So Anganwadi centers went without food for months and feeding program also remained suspended. Anganwadi centers were located in unsuitable premises. Majority of them did not

have open space. Pre school education was minimal. Anganwadi centers were seldom selected and used for launching the immunization program. There were large number of children in the Anganwadi centers who were not immunized. There was lack of coordination between health officers and ICDS staff.

A study was conducted to examine the position of Anganwadi centers, its main functionary and to ascertain the socio geographical factors that hinder the delivery of package of services, in 34 Anganwadi centers in Garti district Banswana, Rajasthan.[35] The results revealed that place for storage of raw food was available in 24 Anganwadi centers. In 23 Anganwadi centers, there was provision to organize cooking and distribution of supplementary nutrition whereas in 11 Anganwadi centers neither there was place for cooking nor for the distribution of cooked food. The arrangement of cooking was made else where and the beneficiaries were allowed to take supplementary nutrition to their homes.

A study was done to see the impact of special nutrition under the ICDS scheme on the nutritional status of children in urban slums of Rohtak district and found that children got 8-10 gm proteins and 200 kcal of energy per day.[36] The incidence of malnutrition was also lowered in those children.

Thus, it can be concluded that supplementary nutrition can be improved in terms of variety and quality like low cost recipes can be developed provided to the beneficiaries. Thus an initiative should be taken on part of the Anganwadi workers as well as Government to make sure that these facilities are available in each Anganwadi centers in good quantity and quality routinely.

Nutritional Knowledge: The knowledge and skills of Anganwadi workers in respect to different components of their sphere of activity ranges from fair to good to excellent. Various studies have been done to check the nutritional knowledge of Anganwadi workers.

A study was conducted to assess the knowledge of the MPW on the topics of nutrition included in their training curriculum.[37] MPWs working in PHCs of 3 different districts of Hyderabad were interviewed. The results thus showed that, in general the knowledge of nutrition was poor among the workers. The effect of age, sex and institutional input on knowledge scores was not significant and thus there was need for improvement among MPWs .

A study on 106 Anganwadi workers in the Inderpuri project of ICDS scheme was conducted in West Delhi.[38] It was found that 92.7% Anganwadi workers could not tell full form of ICDS and only 9.38% of Anganwadi workers could enumerate all the 6 components of the package of services being provided by ICDS and 45.83% could not even name one, the remaining 44.79% gave incomplete answers. None of the respondents could enumerate all the functions of Anganwadi worker and 40.62% could only name a few and rest 59.38% did not knew any.

A study was carried out to know about the knowledge, attitude and practices regarding dental health of Anganwadi worker from rural and urban areas of Manglore, Karnataka.[39] Even though oral health is not considered to be of sufficient importance by them now, an awareness of dental health among most of the Anganwadi worker itself could

be a beginning. 42% respondents reported that teeth cannot be retained over a life time. 60% of subject in the rural and 73% in the urban centre reported to have had dental problems, predominant being cavities. About 50% of both urban and rural respondents had mentioned that tooth extraction causes problems. The findings of the study suggested that education on preventive and certain curative aspects of dental diseases and maintenance of dental health may need to be incorporated.

A study was done to evaluate the role of Anganwadi workers in detection and prevention of disability in children below 6 yrs of age in ICDS project of Gorakhpur.[40] The trained Anganwadi workers identified disabilities and instituted preventive measures like immunization and supplementary nutrition with the simultaneous independent verification by pediatricians and a repeat survey after 6 months of follow up. It was seen that amongst 1545 children, Anganwadi workers identified disability in 126 subjects which were verified in 118 cases by pediatricians. Thus it was concluded that Anganwadi workers can help in early detection and appropriate management of incipient and preventable childhood disabilities.

A study was done in order to assess the coordination of Anganwadi worker with ANM on activities related to health and nutrition.[41] In order to assess the coordination of activities, 75 Anganwadi workers selected from 3 rural ICDS project of Agra district were interviewed. About 84, 65, 54 and 53% of Anganwadi workers respectively reported coordination with ANM on activities related to immunization, iron folic acid tablet distribution, vitamin A and oral re-hydration solution. But only 6.6% Anganwadi workers reported coordination in activity related to growth monitoring. The results indicated that certain areas require strengthening in order to achieve the objective laid down by the ICDS.

VI. CONCLUSION

A survey of 34 Anganwadi workers in West Bengal was done in order to assess their knowledge and skills.[42] It was found that 11.8% Anganwadi workers could define fever, 17.6% knew the age group for exclusive breast feeding and 32.4% knew the eligibility criterion for iron prophylaxis in children. No Anganwadi worker weighed a child twice to take the average and none recorded the weights in growth charts. No Anganwadi worker properly counted the beneficiaries for supplementary nutrition. Only 25% weigh corn soya blend and 20% got the utensils cleaned by acceptable water.

Thus it has been observed that ICDS program has positive impact on its beneficiaries, but its working mainly depends on its functionaries i.e., the Anganwadi workers and which in turn depends on their knowledge about various components of ICDS and their skills on how they apply their theoretical knowledge in practice.

So it can be concluded from the above studies that though the knowledge of Anganwadi workers regarding major activities is mostly adequate still their knowledge and skills in many key areas need improvement for successful implementation of the program.

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