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A VALIDATION STUDY FOR SERVICES PROVIDED BY AANGANWADI CENTERS IN RAIPUR CITY

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ABSTRACT

Introduction: It has been a focus of interest to expand ICDS scheme and provide adequate quality of services to the beneficiaries. Current study is an attempt to find out the coverage deficit in services provided by Aanganwadi centers to its eligible beneficiaries residing under urban project of Raipur district (I & II).

Objective: The study was conducted to validate the service provided to the eligible beneficiaries by the concerned Aanganwadi centre.

Materials and methods: Cross sectional observational study conducted at Raipur district in selected 30 Aanganwadi centers [by Systemic random sampling]. Selected centers were visited & their infrastructure, facility, beneficiaries registers were checked.10% of beneficiaries identified and interviewed to check adequacy of services.

Observations: 172/342(50 %) of the beneficiaries were not weighted when asked. 27/342(8 %) didn't know that what the frequency of growth monitoring at their centre was? Only 54/86(63%) received preschool education when interviewed. There was a deficit in record keeping in 15/30(50%) of Aanganwadi centre. Cause of partial immunization was the uncooperative nature of their AWW.

Conclusions: There was a gross deficit in the services provided by the Aanganwadi centers under ICDS scheme especially in record keeping when cross checked. This scheme is a social welfare scheme and a deficit like this is unacceptable. A thorough evaluation and supervision at the root level is required.

Key words: Service gap, ICDS, Aanganwadi center, AWW, Validation

INTRODUCTION

Integrated Child Development Services (ICDS) is the project run by the government which has a comprehensive approach for all-round development of child up to six years of age. Because the health and nutrition needs of a child cannot be addressed in isolation from those of his/her mother, the program also extends to adolescent girls, pregnant women and nursing mothers. The functional and grass route level worker of the scheme is an Aanganwadi centre. Each Aanganwadi is supposed to cover a population of 500-1500 persons in Rural & urban area & 300-1500 in tribal area & in Mini AWC cover a population of 150- 500 persons. [1] Work of an Aanganwadi worker is a key in the implementation of this scheme and she is supposed to carry over all the survey and services efficiently. However it has repeatedly been found that there is discrepancy of the expected verses actually delivered services. In order to decrease malnutrition, IMR, school

dropout it is essential to cover every beneficiary in the respective locality of AWC. [2]

This study is an attempt to find out the deficit in services provided by Aanganwadi centres to its eligible beneficiaries residing under urban project of Raipur district (Raipur I and II) the most accessible area where the work of the ICDS project is expected to be most up to date.

MATERIAL AND METHODS

This was a cross sectional observational study conducted at Raipur district in selected 30 aanganwadi centers distributed in urban project of Raipur I and Raipur II after approval from the institutional ethical committee. Eligible Beneficiaries catered by selected Aanganwadi centers of ICDS project I & II in Raipur city [children less than 6 yrs of age, Pregnant women, Lactating mother (only those with children of 0- 6 month)] were included. Adolescent girls were excluded from the study because the services to them were temporarily withheld by the ICDS at the time of survey. Whereas in the women in age group 15-45 only pregnant and lactating mothers were included because the records of the others were not available.

Systemic random sampling technique was used to select smaples. The total number of AWC in project I and II were 111 and 190 respectively. A total 30 AWC, 15 from each project were selected by systemic random sampling.

The selected Aanganwadi centres were visited & their infrastructure, facility, beneficiaries registers were checked to check for their adequacy with the permission from the AWW.

The coverage of services as per records were verified by visiting the population covered and interviewing randomly selected 10% of the registered beneficiaries using standard proformas after obtaining their consent.

RESULTS

With respect to the services provided

On visiting the Aanganwadi centre we could see that all the AWC were infrastructurally equipped for the purpose of growth monitoring and as per their records almost all the registered beneficiaries were monitored. However the actual fact obtained by inquiring from the beneficiaries was that 172/342(50 %) of the beneficiaries were not weighted when asked. To add to the surprise27/342(8 %) of the beneficiaries didn't know about the frequency of growth monitoring at their center.

All AWC were providing preschool education up to maximum days (250-300 days per year) as per their records. Centers were well equipped with teaching material. But only 54/86(63%) actually received preschool education when interviewed during validation process.

All AWC were providing supplementary nutrition up to maximum days (250-300) days per year. All the AWC were infrastructurally well equipped to cook and store the supplementary nutrition. There was a deficit in record keeping in 15/30(50%) of Aanganwadi centre. On validation 324/448(72%) AWC provided supplementary nutrition up to maximum days (21-25days a month) and the amount of food concerned was >75% in 334/448(75%).

Total 51/270(19 %) of registered were completely immunized, 179/270(66%) were partially immunized and in 11% the records were inappropriate.

Table-1: Validation of services provided to 0-6 months children by mothers (n=34)

Services	Total (%)
Growth monitoring	
Children Weighted at AWC	34 (100)
Frequency of weighing	
Once in a month	13 (38)
Once in a two month	4 (12)
Any time	17 (50)
Immunization	
Place of Service Received	
AWC	22 (65)
Other	5 (15)
Both	7 (20)
Reason for partial/unimmunized /other source	
Not informed by AWW	6 (22)
Beneficiaries not willing to receive	10 (36)
AWW is non cooperative	12 (42)
Referral services	
Referred to higher center	
Yes	18 (52)
No	16 (48)
Reason for non referral	
Not needed	16 (100)

Notes- Response taken from mother of these children

With respect to the beneficiaries

All mothers mentioned that growth monitoring in the form of weight charting was done, there

was however a discrepancy in the frequency (table -1). When asked about immunization 22/34(65%) said that their child received immunization services from the AWC, a majority 12/34(42%) referred that partial immunization was due to the uncooperative nature of their AWW. (table-1)

Table-2 .Validation of services provided to 6 months -1 year children by mothers (n=35)

Services	Total (%)
Supplementary nutrition	
Received	30 (86)
Amount of food*	
>75%	29 (97)
<75%	1 (3)
6 days a week food received	30 (100)
Growth monitoring	
Weight taken at AWC	35 (100)
Frequency	
Once in a month	21 (60)
Once in 2 month	4 (12)
Once in 6 month	5 (14)
Any time	5 (14)
Immunization	
Full Immunized	7 (20)
Partial Immunized	28 (80)
Reason for partial/unimmunized	
Not informed by AWW	0 (0)
Beneficiaries not willing to receive	2 (7)
AWW is non cooperative	26 (93)
Place of Immunization	
AWC	25 (71)
Other (pvt/UFWC)	1 (3)
Both	9 (26)
Reason not availing serices at AWC	
Not informed by AWW	9 (90)
Beneficiaries not willing to receive	1 (10)
AWW is non cooperative	0 (0)
Referral services	
Referred to higher center for treatment	22 (63)
Not Referred to higher center	13 (37)
Reason for non referral	
Not needed	13 (100)

*Note - *as per Prescribed norms*

Validation of services provided to 6 months -1 year children by mothers: 30/35(86%) of children between 6 months to 1 years received the supplementary nutrition services from the AWC when interviewed, 5/35(14%) which were shown to be receiving supplementary nutrition from the AWC didn't actually got. All beneficiaries received growth monitoring but the frequency was not fixed (table 2) 28/35(80%) were partially immunized; this was due to the uncooperative nature of the AWW (Table-2).

Validation of services provided to 1-3year children by mothers: A total of 81/100(81%) received the supplementary nutrition services from the AWC. All received growth monitoring though the frequency was not fixed as per 40/100(40%) when interviewed. 81/100 (81%) were partially immunized due to the uncooperative nature of the AWW (Table 3).

Table-3: Validation of services provided to 1-3year children by mothers (n=100)

Services	Total (%)
Supplementary nutrition	
Received	81 (81)
Not received	19 (19)
Amount of food*	
>75%	80 (99)
<75%	1 (1)
6 Days a week food received*	81 (100)
Growth monitoring	
Weight taken at AWC by salter weighing machine	100(100)
Frequency of weighing	
Once in a month	59 (59)
Once in a two month	1 (1)
Any time	40 (40)
Immunization	
Full immunized	19 (19)
Partial immunized	81 (81)
Reason for partial/ unimmunized	
Not informed by AWW	40 (49)
Uncooperative AWW	41 (51)
Place of Immunization	
AWC	79 (79)
Other(pvt./UFWC)	2 (2)
Both	19 (19)
Reason for not availing services of AWC	
Beneficiaries not willing to receive	11 (51)
Uncooperative AWW	10 (49)
Referral services	
Referred to higher center for treatment	59 (59)
Not referred to higher center	41 (41)
Reason for non referral	
Not needed	41 (100)

**As per norm/prescribed*

Validation of services provided to 3-6 year children by mothers: When interviewed 83/107(77%) received the supplementary nutrition services from the AWC, all received growth monitoring though the frequency was not fixed. 85/107 (79%) were partially immunized as the AWW was uncooperative to them (table -4).

Table-4: Validation of services provided to 3-6 year children by mothers (n=107)

Services	Total (%)
Supplementary nutrition	
Received	83 (77)
Not received	24 (23)
Amount of food*	
>75%	82 (99)
<75%	1 (1)
6 Days a week food received*	83 (100)
Growth monitoring	
Weight taken at AWC	107 (100)
Frequency of weighing	
Once in a month	59 (55)
Once in a two month	4 (4)
Any time	44 (41)
Immunization	
Full immunized	22 (21)
Partial immunized	85 (79)
Reason for partial/ unimmunized	
Not informed by AWW	42 (49)
Uncooperative AWW	43 (51)
Place of Immunization	
AWC	95 (89)
Other(pvt./UFWC)	3 (3)
Both	9 (8)
Reason for not availing services at AWC	
Beneficiaries not willing to receive	3 (25)
Uncooperative AWW	9 (75)
HCU – at AWC	107 (100)
Referral services	
Referred to higher center for treatment	67 (62)
Not referred to higher center	40 (38)
Reason for non referral	
Not needed	40 (100)
Preschool education	
Received Yes	104 (97)
Not Received	3 (3)

**As per norm/prescribed*

Validation of services provided to pregnant women -18/20(90%) of the pregnant women on interview confirmed that they received the supplementary nutrition services from the AWC and the amount of food was sufficient for all of them. All of them received immunization, health checkups, nutrition and health education.

Validation of services provided to Lactating women -These were most satisfied all of them said that they received supplementary nutrition, health check up, nutritional and health education.

DISCUSSION

Providing the desired services to the beneficiaries is what is expected from an aanganwadi center, the benefit of the beneficiary lies in the proper functioning of the aanganwadi center. Unfortunately integrated child development scheme (ICDS) has failed to achieve the noble goal for which it was established. Various studies done time to time such as those by Seema TN et al[3], Nayar D at el[4] and Sharma at el [5] attributed lack of infrastructural facilities as the major culprit in this failure which unfortunately was not the case in our study. We found that all the aanganwadi centers surveyed were well equipped with the infrastructural facilities for providing their services.

Most of the studies done in this field have concentrated their survey on the nutritional status of the beneficiaries and the adequacy of supplementary nutrition among the beneficiaries. Ahmed E at el [6] in their study on utilization of ICDS services in 1-5 year children found that the coverage of supplementary nutrition was only 24.30%, however Nayar D et al [4] showed this to be 20 to 48% in their study. Sharma at el [5] also assessed the deficiency in supplementary nutrition and found a significant lag. They all attributed this to the inadequate infrastructure. Tandon B.N [7, 8] -In his study observed that for the management of Severely Malnourished Children by Village Worker in Integrated Child Development Services in India. four thousand two hundred and ninety –two children with children with severe protein calorie malnutrition were managed by village level workers at village centers, treatment included provision of 700 to 900 calories and 15-20 g protein as supplement to the breast milk and weaning food being received at home and simple drug therapy for associated diseases .85 percent children improved, 6.3 percent had no change, 3.6 percent deterioted, 3.0 percent died and 2.1 percent were lost to follow up. In our study we found that all the beneficiaries registered received supplementary nutrition for maximum number of days though there was a gross lag in record keeping in 50 % of the centers. On validating with respect to the beneficiaries we found the coverage to be 86%, 81%, 77% and 100% for 6month- 1 year, 1-3 year, 3-6 year and pregnant ladies respectively. Overall coverage was thus better than that observed in previous studies. This can be due to the presence of adequate supply of ration to the centers. This small gap could yet be improved by adequate supervision by the higher authorities.

Next important service provided by the aanganwadi center is the growths monitoring unfortunately most of the available studies have not touched this aspect. We found that all the centers were well equipped with infrastructure required for growth monitoring. Unfortunately 50% of the children were not weighed at the center when asked and 8% of the beneficiaries didn't even know about the frequency of growth monitoring in their center. Growth monitoring is what on which supplementary nutrition is based and there was such a deficit in the same. Unfortunately when you have not monitored the growth how can you provide adequate nutrition to the beneficiary? This gross deficit may be because the supervisors of the concerned centers never dared to check the registers. This was a gross deficit and needs serious addressal.

As far as preschool education was concerned all the centers were infrastructurally well equipped and provided it for maximum number of days but on validation we found that only 63% beneficiaries received this service. Balsekar A et al [9] attempted to assess the functioning of the ICDS (Aanganwadi) at the grassroots level in selected villages of Kerala with respect to preschool education and the nutritional status of the beneficiaries. Their study included ten Aanganwadi centers. Five Aanganwadi centers were selected from each of two blocks, based on the grades given to them by the ICDS office. They found that services of aanganwadi centers were directly dependent on the community participation and the grade of an aanganwadi centre could not completely explain the nutritional status of the children enrolled. Arora S et al [10] **o**bserved that non-formal preschool education was provided to the children at the AWC. Most of the parents were satisfied with the non formal education provided at the aanganwadi centre but few weren't as they felt that aanganwadi worker laid more emphasis on nutrition. In our study we found that this service was provided by the aanganwadi centers to all the beneficiaries as per their records but on validation only 63% of beneficiaries actually received it, when asked from them about this it was found that the beneficiaries were not satisfied with the quality of education provided at the centers and many else were not motivated to receive education. The whole purpose of the visit to the center was to receive supplementary nutrition, these were those cases which could be motivated and recruited for preschool education, authors tried to motivate them regarding the importance of the same while on survey and many of them assured that they will attend the preschool education program.

Immunization services are also the work of aanganwadi center in association with the ANM, Tandon B.N et al [11] - studied the impact of ICDS on immunization coverage of children aged 12-24 months and of mothers of infants in projects that had been operational for more than 5 years. Complete coverage with BCG, diphtheria-pertusis- tetanus (DPT) and poliomyelitis vaccines was recorded for 65%, 63% and 64% of children. TT coverage was 68% in pregnant mothers. Coverage was greater in urban and lower in the tribal projects. When we reviewed the records we found that only 19% were completely immunized as per records, in 11% cases records were incomplete, majority were partially immunized. When we tried to find out the cause for the same during validation majority of beneficiaries attributed this to the uncooperative nature of the aanganwadi worker, as per them the aanganwadi worker was least interested in the same and used to consider it an additional unrelated workload on her. This was a serious issue and this difference needs to be addressed. The aanganwadi worker needs motivation that this is not an additional work but one of the work and this can be done by the supervisors and the medical officer because unless she considers it as one of her works she won't do it sincerely.

CONCLUSIONS

It could be thus concluded that there was a gross deficit on the part of the services provided by the Aanganwadi centres under ICDS scheme especially when cross checked. Aanganwadi worker's nature and her relation with the covered population is an important predictor of the service. There was also a gross deficit in record keeping. This scheme is a social welfare scheme and a deficit like this is unacceptable. A thorough evaluation at the root level is required to identify the causes. A lack of supervisory activity and adequate supervision of the CDPO is required what is felt by the authors.

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