# Study on Assessment of Anganwadi Centers in Supaul District of Bihar

***By***

*Nitesh Kumar Mishra*

*Dissertation submitted in partial fulfillment of the requirements of the degree*

*MBA Hospital and Health Management*

*Academic year, 2017-2019*

**The IIHMR University, Jaipur**

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

# Study on Assessment of Anganwadi Centers in Supaul District of Bihar


***By***

*Nitesh Kumar Mishra*


*Dissertation submitted in partial fulfillment of award of*

*MBA Hospital and Health Management*

*Academic year, 2017-2019*

*The India Nutrition Initiative (TINI), TATA Trusts, Bihar*


**The IIHMR University, Jaipur**

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

**TO WHOMSOEVER MAY CONCERN**

This is to certify that **Nitesh Kumar Mishra** student of MBA Health and Hospital Management from The IIHMR University, Jaipur has undergone internship training at **TATA Trust** from **2nd February 2019 to 2nd May, 2019.**

The Candidate has successfully carried out the study on '**A study on Assessment of Anganwadi centers in Supaul district of Bihar'** designated to him during internship training and his approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

(Col) Dr. Ashok Kaushik
Dean, Academic and Student Affairs
The IIHMR University, Jaipur

17 May 2019

Dr. Neetu Purohit
Associate Professor, Guide
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

# WOMEN AND CHILD DEVELOPMENT DEPARTMENT

# DISTRICT SUPAUL (BIHAR)

A joint initiative of
TATA TRUSTS
&
Towards a new dawn
Ministry of Women and Child Development

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

## Certification of completion of Dissertation

The certificate is awarded to

**Nitesh Kumar Mishra**

In recognition of having successfully completed his internship in the department of

**Women and Child Development**

And has successfully completed his project on

**Assessment of Anganwadi centres in Supaul District of Bihar**

**Date-** 11th February to 11th May, 2019

**Organization-** TINI (The India Nutrition Initiative) TATA TRUST

He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning.

I wish him all the best for future endeavours

11.05.19

**District Programme Officer**
**Women and Child Development**
**District Supaul (Bihar)**

## CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Assessment of Anganwadi Centers in Supaul district of Bihar"** and submitted by **Nitesh Kumar Mishra,** Enrollment No. **IIHMR/MBAHM/2017-19/ 0615** under the supervision of **Dr. Neetu Purohit** for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from 11th February 2019 to 10th May 2019 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Signature

## ACKNOWLEDGEMENT

I feel honored in expressing my kindest gratitude to **Mr. Mahendra Kumar (IAS), District Magistrate, Suapul, Bihar,** under whose able guidance and supervision this study was conducted. The keen attention he evinced throughout this period and the graciousness with which he gave his valuable advice was his exclusive acumen.

I also feel privileged in expressing my thanks to **Mrs. Rakhi kumari (DPO, WCD Suapul )** whose guidance and sustenance was always there for me.

I express my deepest thanks **Mrs. Manu Jha (DTO outreach and nutrition, CARE)** for taking part in useful decision & giving necessary advices and guidance. I choose this moment to acknowledge his contribution gratefully.

I would be failing in my duties if I miss to acknowledge and thank all those co-operating people who formed the subject of this study. These include the entire team of **Women and Child Development Department, Supaul, Bihar**. They extended their wholehearted co-operation in different phases of my project.

In the end I thank all those fellows and colleagues who have helped me in making this project a success and my apologies to anyone whose name I would have inadvertently forgotten to mention here.

Nitesh Mishra

## Contents

**ABBREVATIONS**

ANM- Auxiliary Nurse Midwife
ASHA- Accredited Social Health Activist
AWC- Anganwadi Centre
AWW- Anganwadi Worker
AG- Adolescent Girl
BCC- Behavior Change Communication
BRG- Block Resource Group
CBE- Community Based Events
CDPO- Child Development Project Officer
CPMU- Central Program Management Unit DC District Collector
DM- District Magistrate
DPO- District Programme Officer
DRG- District Resource Group
ECCE- Early Childhood Care and Education
HBNC- Home Based Newborn Care
HBYC- Home Based Care for Young Child
ICDS- Integrated Child Development Services
CAS- Common Application Software
IEC- Information, Education and Communication
IFA- Iron and Folic Acid
ILA- Incremental Learning Approach
IMR- Infant Mortality Rate
IYCF- Infant and Young Child Feeding
JSY- Janani Suraksha Yojana
LM- Lactating Mother
LS Lady- Supervisor
LBW- Low Birth Weight
MDM- Mid Day Meal
MIS- Management Information System
MMR- Maternal Mortality Ratio
MoH&FW- Ministry of Health and Family Welfare

MoW&CD- Ministry of Women and Child Development

NNM- National Nutrition Mission

NNRC- National Nutrition Resource Centre

POSHAN- PM's Overarching Scheme for Holistic Nourishment

PRI- Panchayati Raj Institution

RCH- Reproductive and Child Health

SHG- Self Help Group

SPMU- State Project Monitoring Unit

SN- Supplementary Nutrition

TINI- The India Nutrition Initiative

THR- Take Home Ration

VHSND- Village Health, Sanitation and Nutrition Day

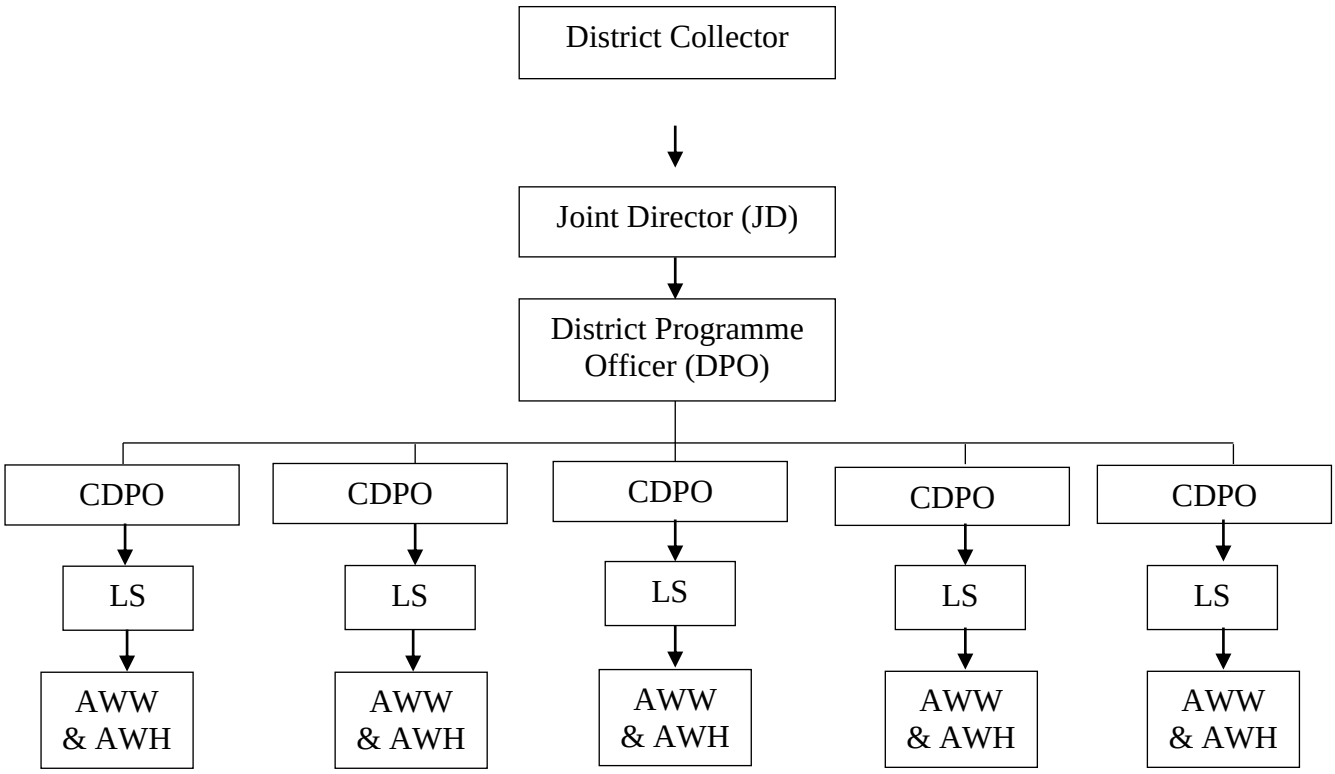
WASH- Water and Sanitation and Hygiene

**DISTRICT- SUPAUL**


| General Information | Statistics |
|---|---|
| (i) Geological Area | 2425 Sq. km |
| (ii) Administrative Division | |
| Number of Blocks | 11 |
| Number of villages | 556 |
| Number of ICDS Project | 11 |
| (iii) Population | 22,29,076 |
| (iv) No. of children 0-59 months | 437,357 |
| (v) No. of Aanganwadi Centers | 2377 |
| (vi) Sex Ratio | 929 |
| (vii) Literacy Rate | 57.67 |

(*Source- Census 2011,WCD MIS)*

**WOMEN AND CHILD DEVELOPMENT: ORGANOGRAM**



# 1. INTRODUCTION

**MALNUTRITION** is a physical condition, which is an immediate result of having an inordinate and deficient measure of supplements in a single's body (either supplement assimilation or utilization related). Unhealthiness alludes to both under sustenance and corpulence.

**UNDERNUTRITION** comes from the deficient amount or potentially nature of sustenance being devoured, or potentially rehashed contamination or ailment bringing about ill-advised assimilation of crucial supplements. It shows itself through squandering, hindering, and micronutrient lacks. Squandering (or intense ailing health) is where a childs weight is unreasonably low for his/her tallness, and his/her body squanders away. It is related with a high danger of mortality in youthful kids.

**STUNTING** (an indication of constant lack of healthy sustenance) is where a kid's tallness is unreasonably low for his/her age in view of long haul dietary hardship. It is related with long haul formative and wellbeing dangers.

**HIDDEN HUNGER** or micronutrient lacks is the immediate result of deficient admission of fundamental nutrients and minerals, which results in imperfect safe capacity while undermining development and improvement.

Undernutrition is a generally disregarded issue. Malnourished youngsters are bound to surrender to, just beyond words, the main sources of kid demise, for example, pneumonia, looseness of the bowels and intestinal sickness. Thus youngsters stall out in a cycle of undernutrition and disease, which unfavorably influences their wellbeing, improvement, and expands the danger of mortality. Sustenance is supported by admission, assimilation and utilization of supplements. There are many, regularly agreeing, socio-political, financial and natural factors that legitimately and in a roundabout way sway on nourishment. These incorporate wellbeing framework and absence of access to safe water, sanitation and

cleanliness. An absence of sustenance can result in a hazardous condition: serious intense ailing health or what is most usually called extreme squandering.

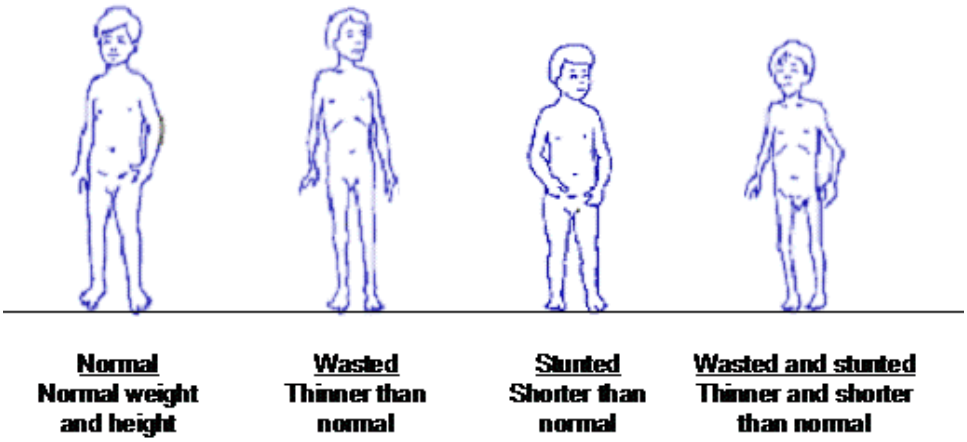



**Figure 1:** types of undernutrition

The **Integrated Child Development Service** (ICDS) Scheme providing for supplementary nutrition, immunization and pre-school education to the children is a popular flagship programme of the government. It is one of the world's largest programs providing for an integrated package of services for the holistic development of the child. ICDS is a centrally sponsored scheme implemented by state governments and union territories.

## 1.1 OBJECTIVES OF ICDS

1. To improve the dietary and wellbeing status of youngsters in the age-bunch 0-6 years
2. To establish the framework for appropriate mental, physical and social improvement of the kid
3. To decrease the rate of mortality, horribleness, ailing health and school dropout
4. To accomplish successful coordination of arrangement and execution among the different offices to advance kid improvement
5. To improve the capacity of the mother to take care of the typical wellbeing and dietary needs of the tyke through appropriate sustenance and wellbeing training.

## 1.2 BENEFICIARIES OF ICDS

1. Children in the age gathering of 0-6 years
2. Pregnant ladies
3. Lactating Moms
4. Adolescent young ladies from age 11 to 18 were included later

## 1.3 SERVICES UNDER ICDS

The ICDS Scheme offers a package of six services,

1. Supplementary Nutrition
2. Pre-school non-formal education
3. Nutrition & health education
4. Immunization
5. Health check-up and
6. Referral services

| Services | Target Group | Service provided by |
|---|---|---|
| (i) Supplementary Nutrition | Children below 6 years, Pregnant & Lactating Mothers (P&LM) | Anganwadi Worker and Anganwadi Helper (Ministry of Women and Child Development (MWCD)) |
| (ii) Immunization* | Children below 6 years, Pregnant & Lactating Mothers (P&LM) | ANM /MO Health system, Ministry of Health and Family Welfare (MoHFW) |
| iii) Health Check-up* | Children below 6 years, Pregnant & Lactating Mothers (P&LM) | ANM/MO/AWW (Health system, MHFW) |
| (iv) Referral Services | Children below 6 years, Pregnant & Lactating Mothers (P&LM) | AWW/ANM/MO (Health system, MoHFW) |
| v) Pre-School Education | Children 3-6 years | AWW (MWCD) |
| (vi) Nutrition & Health Education | Women (15-45 years) | AWW/ANM/MO (Health system, MoHFW & MWCD) |
| AWW assists ANM in identifying the target group. | | |

**Table 1:** services offered, their target group and provider of those services

(Source: ICDS-WCD website)

## 1.4 AWC REGISTERS & TOOLS

Reg-1 Family Details

Reg-2 Supplementary Food Stock

Reg-3 Supplementary Food Distribution

Reg-4 Preschool Education

Reg-5 Pregnancy & Delivery

Reg-6 Immunization & VHND

Reg-7 Vitamin-A Bi-annual Rounds

Reg-8 Home Visits Planner

Reg-9 Referrals

Reg-10 Summaries (Monthly and Annual)

Reg-11 Weight Records for Children

## 1.5 GROWTH MONITORING:

Growth monitoring is crucial for identification of malnourished children at the Aanganwadi centers . POSHAN Aabhiyan also gives emphasis on this. 14th of every month is celebrated ECCE day on which growth monitoring of every child is done and recorded in the register. Every Aanganwadi must contain four growth monitoring devices such as infantometer, stadiometer, infant weighing scale and adult weighing scale. Standard WHO growth charts are used to determine the proper growth of child and based on it decisions are made regarding the status of child growth. MIS register is allotted for recording weight and height of children registered in the center every month. According to WHO a child must grow in following manner

| आयु | बढ़ोत्तरी |
|---|---|
| | प्रति सप्ताह वजन में वृद्धि |
| 0–3 माह | 200 ग्राम |
| 4–6 माह | 150 ग्राम |
| 7–9 माह | 100 ग्राम |
| 10–12 माह | 50–75 ग्राम |
| | प्रति वर्ष वजन में वृद्धि |
| 1–2 वर्ष | 2.5 किलो |
| 3–5 वर्ष | 2.0 किलो |
| | प्रति वर्ष लम्बाई में वृद्धि |
| पहला वर्ष | 25 से०मी० |
| दूसरा वर्ष | 12 से०मी० |
| तीसरा वर्ष | 9 से०मी० |
| चौथा वर्ष | 7 से०मी० |
| पाँचवां वर्ष | 6 से०मी० |

**Table 2.** Estimated growth in child up to five years (ICDS ILA Module 19)

**POSHAN Abhiyaan** was launched by Prime Minister Sri. Narender Modi in Jhunjhunu district of Rajasthan in March 2018. It is a targeted approach and convergence, which strives to lower down the level of stunting, under-nutrition, anemia and low birth weight in children. It is a holistic programme for addressing malnutrition whereby it focuses on adolescent girls, pregnant women and lactating mothers. Bihar had undertaken several initiatives to address the issue of malnutrition.

Over a time of one decade there is a considerable decline in stunting wasting and underweight of children, of age under 5 years, in rural Bihar.

However, the status of malnutrition continues to remain a challenge with nearly half of the children still malnourished and one-fifth are wasting among children under 5 years over a decade. Bihar is one of the few states where wasting has shown a decline. According to NFHS 4 more than three-fifth of women and children are still anemic in rural Bihar. This could be due to lack of iron rich diet and other comorbid factors due to malnutrition in turn affecting the iron absorption. NNM will coordinate and monitor all the nutrition related schemes working in Bihar and improve the nutritional status of Bihar.

**The India Nutrition Initiative (TINI)** is an implementation arm of the Tata Trusts and is envisioned to carry forward the work of the Trusts to address the problem of malnutrition in India by identifying, undertaking and supporting relevant initiatives in the said thematic area. TINI's programs have strong linkages with the Government of India's and respective State Government's ongoing nutrition/health programs. TINI is functional in all the district of the country from 2019-20.

**The National Nutrition Mission** targets reduction in the level of under-nutrition and other related problems by ensuring convergence of various nutrition related schemes i.e. Anganwadi Services which include all the services offered at the AWC, Pradhan Mantri Matru Vandana Yojana is a maternity benefit program which provides conditional cash transfer to the pregnant and lactating women of age 19 years and above for their first live birth.

Scheme for adolescent girls of MWCD is a halfway supported plan which centers around enabling immature young ladies of 11 to 18 years old by improving their wellbeing and healthful status, upgradation of home aptitudes, fundamental abilities and professional abilities. The young ladies will be prepared on data about nourishment, wellbeing, cleanliness

and family welfare ; Janani Suraksha Yojana (JSY) is a sheltered parenthood intercession under the National Rustic Wellbeing Mission (NRHM) being actualized with the target of diminishing maternal and neo-natal mortality by advancing institutional conveyance among the poor pregnant ladies, National Wellbeing Mission (NHM) of MoH&FW; Swachh Bharat Mission of Service of Drinking Water and Sanitation (DW&S); Open Dispersion Framework (PDS) of Service of Buyer Undertakings, Sustenance and Open Circulation (CAF&PD); Mahatma Gandhi National Country Work Certification Plan (MGNREGS) of Service of Provincial Advancement (MoRD); Drinking Water and Toilets with Service of Panchayati Raj and Urban Nearby Bodies through Service of Urban Improvement. These plans have been very compelling in taking care of individual issues somewhat. Be that as it may, whenever facilitated with combination of all the dependable offices then they can largely affect the improvement of nourishment in the nation.

### 1.6 BENEFICIARIES OF NNM

1. 0-6 years of age children
2. Girls of age 15 to 49 years
3. Lactating and pregnant mothers

### 1.7 OBJECTIVES AND TARGETS OF NNM

| S.NO. | OBJECTIVES | TARGETS |
|---|---|---|
| **1** | Prevention and reduction of stunting in children 0-6 years | By 2% per annum |
| **2** | Prevention and reduction of undernutrition (Underweight prevalence) in children 0-6 years | By 2% per annum |
| **3** | Reduction of the prevalence of anemia among children of age 6-59 months, women, adolescent girls of age 15 to 49 | By 3% per annum |
| **4** | Reduce low birth weight | By 2% per annum |

### 1.8 COMPONENTS OF NNM

1. Convergence of the departments working towards improving nutrition status
2. Behavior Change through Jan Andolan among the people
3. Promotion of use Technology (ICDS-CAS) for increasing the efficiency of the schemes
4. Capacity building of the front-line workers utilizing Incremental Learning Approach.
5. Incentives for promoting good work and motivating others to do the same
6. Innovations will be promoted. Effective Success stories from all the districts will be collected and then replicated in all other districts.

## 2. LITERATURE REVIEW

There has been many studies done on ICDS over time assessing different aspects of Anganwadi centers such as the facilities and services being provided in the AWCs by the AWWs under ICDS. One of the study carried out was study was in the northeast district of Delhi whereby 41 AWCs were selected and their AWW were interviewed. It was found that the room size was approximately 109 square feet. Weighing machine was available in 70% of AWCs, growth charts for growth monitoring of children were present in 68.3% of AWCs. Only 34.1% AWCs had the essential drug kits. It showed that the AWWs lacked in knowledge regarding norms for calorie and protein for beneficiaries.

Another study evaluated the ICDS program in terms of inputs, processes, outcomes, utilization and issues related to the ICDS program in the state of Gujarat where 130 AWCs were identified from rural and urban areas. The information was collected in terms of infrastructure, characteristics of AWWs, provision, coverage and utilization of ICDS services. There were 14.9 % children underweight, 13.5% children moderately underweight and 1.4 % children were severely malnourished. Only 14.5 % of AWCs were providing preschool education to the children. The study has shown various gaps in infrastructure, trainings, supplementary nutrition for beneficiaries, immunization, health check-ups, referrals, etc.

Study carried out in rural area of Odisha with the objective of assessment of operational aspects of ICDS scheme. 36 AWCs were included in the study whereby assessment was done through checklist mainly focusing on 3 domains such as, material, resource and functional aspects of AWCs. It was observed that the most common problems were in the infrastructure

and logistic supply which were the main causes of poor implementation of ICDS program(10).

A cross sectional study was done to assess the availability of basic infrastructure of AWCs in rural area named Sondekoppa area, Bangalore where 21 AWCs were selected. 81% of AWCs were running in government owned buildings. Only 10% of AWCs had a compound wall and toilets were available only in 57% of AWCs. 61.5% of AWCs had clean room and kitchen in the facility.

Another study was carried out to assess the functioning of AWCs of urban ICDS block on Auranagabad city where 28 AWCs were identified. A cross sectional study was done and the assessment was done through observing the infrastructure, interviewing the AWWs and checking the records. The study revealed that all AWCs were being run in a pucca rented buildings and electricity supply, piped water supply and sanitary toilets are available with 60.71%, 64.28% and 53.57 % of AWCs.

## 3. RATIONALE OF THE STUDY


**Figure 2.** Comparison of undernutrition indicators of India, Bihar and Supaul (Source:NFHS 4)

According to NFHS 4, there is high prevalence of stunting in the Supaul district of Bihar i.e. 48.1%. Nearly 30 out of 100 children in Supaul district are wasted. Around 7.2 percent

children in Supaul are severely wasted. Anemia is very prevalent in Supaul with nearly 72 percent children under five suffering from it.In India there is an inter-generational cycle of under-nutrition, the life cycle approach needs to be adopted and strengthened with continuum of care with a focus on critical periods of nutritional vulnerability. The first 1000 days of a child are the most critical, which includes the nine months of pregnancy, six months of exclusive breastfeeding and the period from 6 months to 2 years to ensure focused interventions on addressing under-nutrition. Attention is also needed on children in the age group of 3-6 years for their overall development through the platform of the Aanganwadi Centers (AWCs).

Sustained support to AWCs of the district could create a promising improvement in the quality of services offered in the AWCs and improve the reach of the Anganwadi services. Many programmes / schemes had been started by government such as Pradhan Mantri Matru Vandana Yojana, Integrated Child Development Scheme, Poshan Ahaar, Mid-day Meal, Atal Bihari Vajpayee Bal Aarogya Yojana, etc. to improve the nutritional status of the children. But there has been minimal improvement in the level of nutrition in the children.To reduce the level of malnutrition in Supaul district, it is important to map the existing service coverage at the AWCs and develop a plan of action to improve the services.This study aims to ensure that the Aanganwadi Centres in Suapul district of Bihar follow the guidelines and strengthen the service delivery of AWCs to reduce the malnutrition.It would further create a ripple effect in improving health and nutrition service coverage in the short term and impact health outcomes if sustained in the long run.

## 4. RESEARCH QUESTIONS

1. What is the current status of Anganwadi Centres of Supaul District in Bihar?
2. What gaps are to be fulfilled to strengthen the existing AWCs in the Supaul district of Bihar?

## 5. OBJECTIVES OF RESEARCH

### 5.1 General Objective

1. To assess the Anganwadi Centers of Supaul District in Bihar.

### 5.2 Specific Objectives

1. To assess the status of MIS registers in AWCs of the Supaul District in Bihar.
2. To assess status growth monitoring at AWCs in the Supaul District in Bihar.
3. To assess home visit status of AWW at AWCs in the Supaul District in Bihar.
4. To assess status of monitoring by lady supervisors at AWCs in Supaul District in Bihar.
5. To assess practices of handwashing and use of water filter at AWC.

## 6. METHODOLOGY

**Study design**: Descriptive, cross-sectional, study

**Study area**: Supaul District in Bihar

**Duration of study**: 3 months (11$^{th}$ February to 10$^{th}$ May)

**Type of Data Collection**: Primary data was collected through structure questionnaire/ checklist from 50 AWCs

**Sampling technique:** convenience sampling (AWC under the 2 Km of each block office)

**Sample size**: 50 AWCs

**Target Population**: Lady Supervisor, Aanganwadi worker, Aanganwadi helper.

**Method of data collection**: Data collection was done by observing and interviewing the available staff (LS, AWW, AWH) of Anganwadi Centers through structure questionnaire/checklist.

**Data analysis plan:** After the collection of data, it was compiled in Microsoft excel. Most of the data analysis was done in Microsoft excel by using frequency table, cross tabulation, and figures.

## 7. ANALYSIS OF THE STUDY

Based on the data collected from the AWC in various blocks of Supaul district following analysis was done.

### 7.1.INCOMPLETE MIS REGISTERS

There must be 11 registers present at the AWC. Training on these registers were given to all the Sevikas when these registers were introduced. If any one of the registers were not available at the AWC or not filled in last three months, then it was considered incomplete.

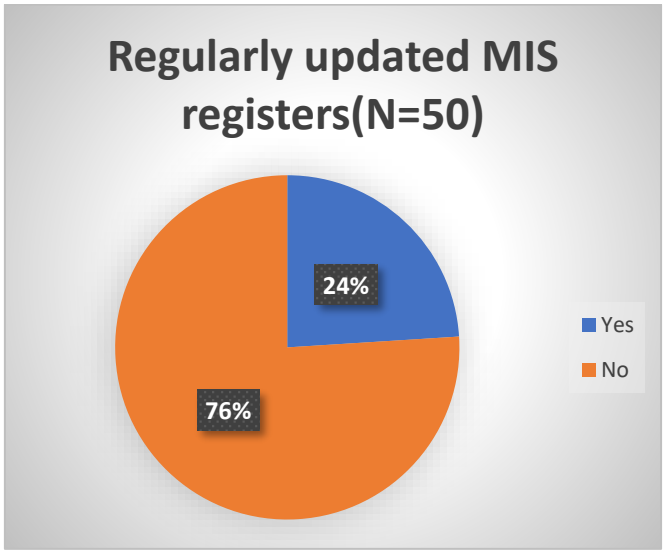



**Figure 3.** Are MIS registers updated regularly

As seen above that more than 75 percent of sevikas does not update their MIS registers which results in poor monitoring and data quality.

### 7.2.GROWTH MONITORING

Growth monitoring is one of the important aspects of nutrition. The data was collected by observing the MIS register no 11 which is used for recording height and weight of all the registered children every month.14$^{th}$ of every month is allotted for this. If the data is not filled in last two months then growth monitoring has not been done.

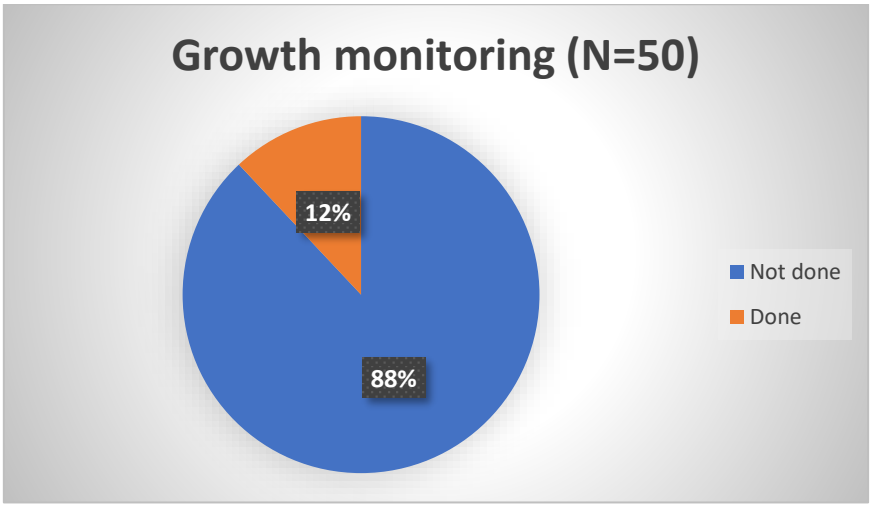



**Figure 4.** Growth monitoring at AWC

Based on the observed data it is clearly seen that Growth monitoring is done in less than 15 percent of the centers which is a major issue in Supaul. When inquired about the reasons for not doing growth monitoring it was found that most of the AWW said that their machine is not functioning properly, or they do not know how to operate the devices. All the sevikas have already been trained in growth monitoring.

### 7.3.HOME VISIT BY SEVIKAS

This data was observed through MIS register 8 which is used by sevikas to plan home visit and convey the important message to the women throughout her pregnancy and first two years of child. The sevika must plan her visit in advance as soon as a pregnant lady is registered in her center and then visit her using her plan.

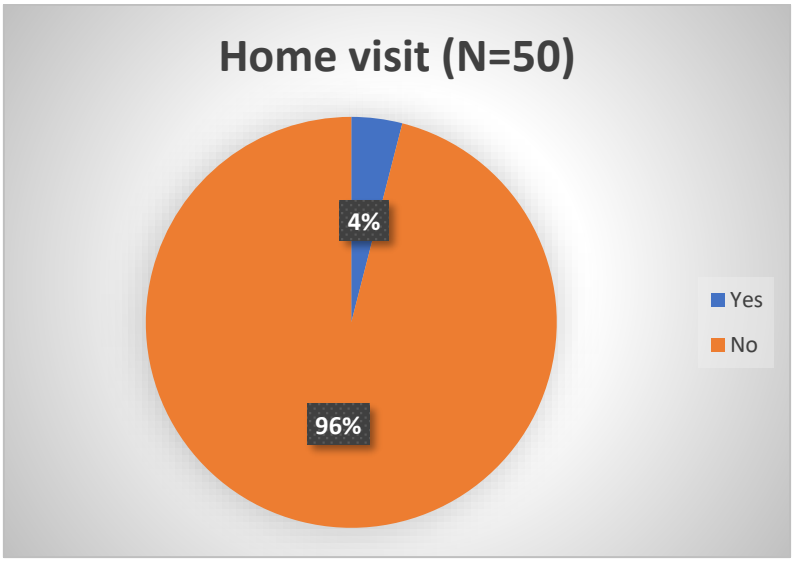



**Figure 6.** Home visit by Sevikas

In Supaul district home visits by sevikas is next to nil and serious attention is needed to this issue. It was measured by looking at the home visit register and last date of visit done.

### 7.4.LADY SUPERVISOR VISIT

Lady supervisor visit is very crucial to the function of the AWC. This data is collected by observing inspection register present at the AWC in which all the data regarding the inspection visits made by all the official are recorded. There must be at least one visit of LS in last month present on the register.

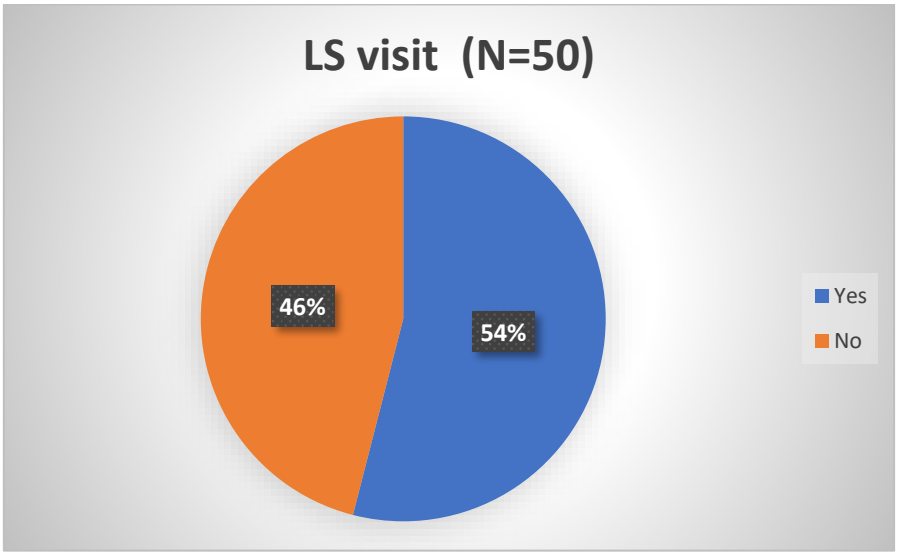



**Figure 7.** Lady supervisor visit to AWC

It is observed that only half of the LS make regular visits to the AWC in their sectors regularly, so it shows that proper monitoring of AWC are not carried out. Angan app is a monitoring app given to all the lady supervisors in which they must geographically tag their position and take pictures of the children while visiting the centers. As it is seen in figure 8 that less than half of the AWC were inspected in last month by the lady supervisors. This lack of inspection has resulted in many malpractices at the centers. The resources are not being properly utilized.

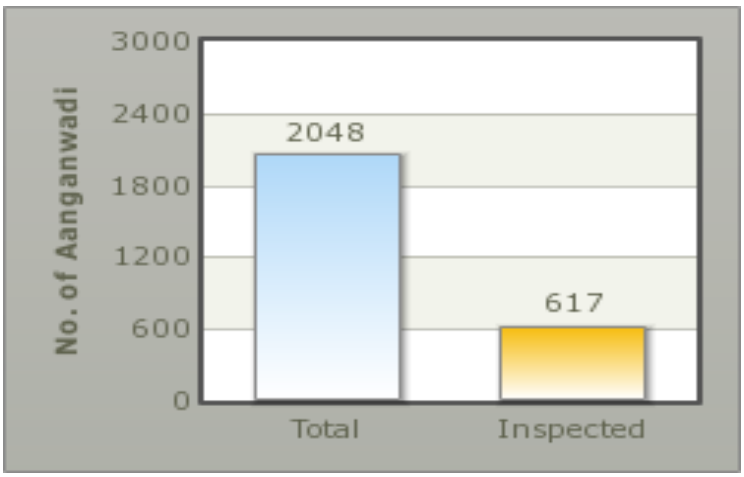



**Figure 8.** Angan app Ls inspection data of March month of Supaul district

(Source: Angan app Dashboard)

### 7.5.PRACTICES OF HANDWASHING AND USE OF WATER FILTERS IN AWC

Sanitation and safe drinking water are very important to avoid malnourishment in children because it is very hard to retain nutrition of the body after sickness. In Supaul district only in 46 percent of centers practices handwashing and worse then that only 28 percent of centers have safe drinking water to drink. This can cause diarrhea among children which is a major cause of malnourishment among children.

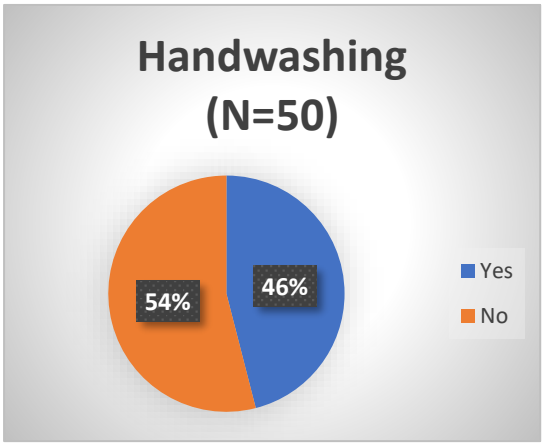



**Figure 9.** Handwashing

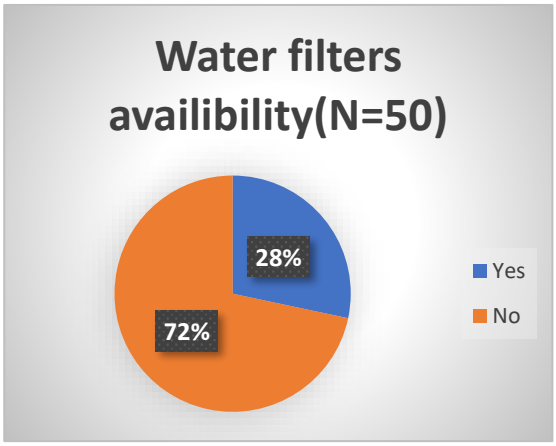



**Figure 10.** Availability of water filters

### 7.6.Association between the service components and the LS visit

Based on the results obtained let us try to find the association between the various services and the LS visit to understand the significance of the Lady Supervisor

#### 7.6.1. LS visit and MIS register

| | | LS VISIT | | |
|---|---|---|---|---|
| | | YES | NO | Total |
| **MIS registers** | YES | 47.8% (11) | 14.8% (4) | 15 |
| | NO | 52.2% (12) | 85.2% (23) | 35 |
| Total | | 100% (23) | 100% (27) | N=50 |

**Table 3.** Cross tabulation of LS visit and MIS register

As it is shown in Table 3 nearly 48% of Anganwadi centers where lady supervisors are inspecting MIS registers are updated regularly Where as Little more than 52% of Centers are those where MIS registers are not updated irrespective of LS visits. 85% of centers where LS are not visiting Mis registers are not being filled.so it depicts that where Ls are not visting the condition of MIS registers are poor but those Centers where LS are visiting are just little better and needs much improvement.

#### 7.6.2. LS visit and Growth Monitoring

| | | LS VISIT | | |
|---|---|---|---|---|
| | | YES | NO | Total |
| **Growth monitoring** | YES | 26% (6) | 7% (2) | 8 |
| | NO | 74% (17) | 93% (25) | 42 |
| total | | 100% | 100% | N=50 |

**Table 4.** Cross tabulation between LS visit and Growth Monitoring

As it is shown in table 4 26% centers where LS are inspecting growth monitoring is regular and 74% centres where LS are inspecting still growth monitoring is not happening. 93% canters where Ls are not visiting growth monitoring is not happening. So, it is clear from table that LS visit is not having any significance effect on Growth monitoring

### 7.6.3. Home visit and LS visit

| | | LS VISIT | | |
|---|---|---|---|---|
| | | YES | NO | Total |
| **Home visit** | YES | 13% (3) | 0% (0) | 3 |
| | NO | 87% (20) | 100% (27) | 47 |
| Total | | 100% | 100% | N=50 |

**Table 5**. Cross tabulation of home visit and LS visit

As it is shown in table 5 Nearly 13% of centres are were LS visits are happening, home visit are regular 87% AWC are where LS visit is happening still no home visit. 100% AWC are those where neither LS are visiting, nor home visits are happening, so it is observed that LS visit is not having significant effect on home visits done by AWW.

### 7.6.4. LS visit and hand washing

| | | LS VISIT | | |
|---|---|---|---|---|
| | | YES | NO | Total |
| **Hand washing** | YES | 52% (12) | 44% (12) | 24 |
| | NO | 48% (11) | 56% (15) | 26 |
| Total | | 100% | 100% | N=50 |

**Table 6.** Cross tabulation between LS visit and hand washing

As it is shown in table 6 52% of AWC where LS are visiting hand washing is practiced and 48% of AWC where LS is visiting but still hand washing is not practiced so it is observed that LS visit have some significance in the handwashing practices at centre.

## 8. DISCUSSION

Based on the data analysis of the data acquired there are big gaps in the proper functioning of the AWC in the district. MIS registers which are very important tool for proper management of the centers are not properly utilized. Only handful of sevikas are regularly updating the registers.it also shows routine functions which must be carried out by the sevikas are not happening. This is a major problem which must be tackled if we need to improve the efficiency of the centers. Without the reliable data no analytical decisions can be taken. Accountability of the sevikas can easily be questioned. Also, there has been an emerging need for greater outcomes focus in ICDS; the need for more relevant and precise summary data for monitoring the programme implementation at the block, district and State levels; the need for the MIS to reflect the current technical understanding of interventions implemented through the programme and the need to prepare for future requirements, including digitization of data.

The complexity of the programme interventions in a diverse setting, necessitate a certain minimum record keeping and reporting at the AWC level, and the current effort has been to simplify and streamline these tasks for the AWWs to the extent possible without compromising on the principles of sustaining universal coverage and quality. An important and substantial part of this challenging task has since been completed with the standardization and testing of the base records and reports of the programme through a systematic and consultative process.

Another major observation was regarding Growth monitoring. Only 12 percent of AWW were regularly monitoring growth of the children. Growth monitoring helps in following ways

- A helpful instrument for development checking.
- Diagnostic apparatus to recognize a high-chance youngster.
- An instructive apparatus for moms to take an interest more effectively in development checking and to show them the significance of sufficient feeds amid sicknesses like the runs.
- Tool for activity on the kind of intercession that is required and helps make referrals simpler.
- Helps in assessing the viability of remedial measures and along these lines to take note of the effect the projects.

- Helps in strategy making at nearby and focal dimensions.

Without growth monitoring malnourishment cannot be reduced and resources allotted will go unutilized. This is a major problem in context of nutrition.

The condition of home visit by sevikas are also very poor in district. It is next to nil. There is a grave need to change behavior among the people and home visits are the most effective way. But lack of home visits shows that there is no interaction of the people with the Anganwadi worker. The important message about nutrition, health, water and sanitation are not being conveyed to the people. Home visit is a major component of IEC. It has a direct impact on the nutrition of the child because the first 1,000 days of life - the time spanning roughly between conception and one's second birthday - is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established. If continuous monitoring of child is done throughout this period with regular home visits, then the child can be prepared to face most of the challenge his body is exposed to in the future. If the family is uniformed, then their ignorance can ruin the child's life forever.

Supervision of AWC are very important because of the resource invested and to monitor the efficiency of the interventions carried out at them. Nearly half of the AWC are not being monitored by the lady supervisor regularly. The Supervisor is the immediate senior official of the Anganwadi workers and subordinate to the Child Development Project Officer. Lady supervisors are the key person for implementation of this programme at ground level. Supervisors are directly monitoring the work of the Anganwadi worker on the spot when she is conducting the activities. Then assess the strengths and weaknesses of the worker. Supervisors can then build on the strengths of the worker and suggest concrete ways in which she can improve her performance in the areas where she needs guidance. Lack of adequate supervision in terms of monitoring and evaluation is having an adverse effect on the quality of services provided at the AWC.

As indicated by the World Health Organization (WHO), generally half of all hunger is related with rehashed the runs or intestinal worm contaminations as an immediate aftereffect of deficient water, sanitation and cleanliness. This does not catch the subclinical contaminations from ecological enteropathy, which ebb and flow explore is uncovering as a noteworthy factor for poor development and undernutrition. At the point when youngsters are

undernourished, their protection from contamination is brought down and they are progressively helpless and bound to bite the dust from diarrheal ailment and different diseases. Indeed, looseness of the bowels is the second-driving reason for death universally in youngsters under five years. Where youngsters normally experience the ill effects of looseness of the bowels, they are additionally in all respects liable to be malnourished thus. For newborn children, especially those under a half year of age, looseness of the bowels can make lasting harm intestinal advancement, lessening a kid's capacity to ingest supplements.

Studies show handwashing with cleanser can lessen occurrences of looseness of the bowels by 42 to 47%, and it is straightforward, successful and cost-effective. Decreases in diarrheal illness through water, sanitation and cleanliness mediations can forestall at any rate 860,000 child passing a year brought about by undernutrition (WHO, 2008). Upgrades in sanitation, particularly in disposing of open crap, are related with a 4 to 37 percent decrease in hindering in rustic settings and with a 20 to 46 percent decrease in urban settings. (Cochrane Survey 2013). Parasitic contaminations brought about by poor sanitation and cleanliness can prompt sickliness and effect the typical development and intellectual improvement.

## 9. CONCLUSION

AWC are crucial to improving the conditions of nutrition, health and sanitation. They are platform for reaching each and every one in the community and inform them about the healthy practices. Hence it is necessary to ensure that they are functioning properly and all the services under ICDS scheme are provided to the community equally and fairly.

## 10. REFRENCES

1. Census of India Website: Office of the Registrar General & Census Commissioner, India [Internet]. [cited 2019 May 7]. Available from: http://censusindia.gov.in/

2. Administrative_Guidelines_NNM-26022018.pdf.

3. Malik A, Bhilwar M, Rustagi N, Taneja DK. An assessment of facilities and services at Anganwadi centers under the Integrated Child Development Service scheme in Northeast District of Delhi, India. Int J Qual Health Care J Int Soc Qual Health Care. 2015 Jun;27(3):201–6.

4. Chudasama RK, Patel UV, Kadri AM, Mitra A, Thakkar D, Oza J. Evaluation of integrated Child Development Services program in Gujarat, India for the years 2012 to 2015. Indian J Public Health. 2016 Jun;60(2):124–30.

5. Sahoo J, Mahajan PB, Paul S, Bhatia V, Patra AK, Hembram DK. Operational Assessment of ICDS Scheme at Grass Root Level in a Rural Area of Eastern India: Time to Introspect. J Clin Diagn Res JCDR. 2016 Dec;10(12):LC28-LC32.

10. Debata I, P A, S RT. A study to assess availability of basic infrastructure of anganwadi centers in a rural area. Int J Community Med Public Health. 2017 Jan 5;3(8):1992–7.

11. iblt11i3p253.pdf [Internet]. [cited 2019 Apr 30]. Available from: http://medind.nic.in/ibl/t11/i3/iblt11i3p253.pdf

## ANNEXURES

### ANNEXURE 1: TOOL USED FOR ASSESSMENT

# A STUDY ON ASSESSMENT OF AANGANWADI CENTERS IN SUPAUL DISTRICT OF BIHAR

## Checklist for Anganwadi Centers

**Section A. GENERAL INFORMATION**

a) Name of District:
b) Name of Project:
c) Name of Sector:
d) Code No. of Anganwadi Center:
e) Ward no.:
f) Type of AWC: Regular/Mini
g) Who is presently working in AWC: AWW/AWH/ Both/ None

**POPULATION COVERAGE BY AWC**

a) Total Population:
b) Children population
   i. 0 to 6 months:
   ii. 6 months to 3 years:
   iii. 3 years to 6 years:
c) No. of children present on the time of visit:
d) No. of out of school girls:
e) No. of pregnant women:
f) No. of lactating women:

**Section B. INFRASTRUCTURE**

**101) Building Type**

1. Government owned
2. Rented
3. Community owned
4. Other:

**102) Structure of Anganwadi Centre (AWC)**

1. Kutcha
2. Pucca
3. Ardh pucca

**103) Availability of toilets in the AWCs and their functional status**

1. Yes & functional
2. Yes & non-functional
3. Not available

**104) Availability of electricity connection in the AWCs and their functional status**

1. Yes & functional
2. Yes & non-functional
3. Not available

**105) What type of drinking water source is available**

1. Hand pump
2. Well
3. Piped water
4. jet
5. Other, specify

**106) Hand wash facility availability**

1. Yes
2. No

**107) Availability Of water filter**

1. Yes
2. No

**Section C. <u>GROWTH MONITORING DEVICES AVAILABILITY</u>**

**201) Infant weighing scale availability**

1. Yes & functional
2. Yes & non-functional
3. Not Available

**202) Children's weighing scale availability**

1. Yes & functional
2. Yes & non-functional
3. Not Available

**203) Adult weighing scale availability**

1. Yes & functional
2. Yes & non-functional
3. Not Available

**204) WHO growth charts availability for Weight for Age for underweight (select all that is available)**

1. Separate charts for male and female children
2. Both male and female charts in one book
3. Growth chart not available

**205) Availability of stadiometer**

1. Yes & functional
2. Yes & non-functional
3. Not Available

**206) Availability of infantometer**

1. Yes & functional
2. Yes & non-functional
3. Not Available

**207) How is weight for length/height is captured to plot for wasting?**

1. Growth chart
2. CAS
3. Not captured (If not captured skip 302 question of section D)
4. Other:

**208) How is height for age captured to plot for stunting**

1. Growth chart
2. CAS
3. Not captured (If not captured skip 303 question of section D)
4. Other:

209) Monthly growth monitoring of children in register 11

1. Done
2. Not done

**Section D. <u>NUTRITIONAL STATUS OF CHILDREN AT AWC</u>**

**301) Weight for age (Underweight)**

1. No. of severely underweight children (Red Zone):
2. No. of moderately underweight children (Yellow Zone):
3. No. of healthy children (Green Zone):

**302) Weight for length/height (Wasting)**

1. No. of SAM children
2. No. of MAM children:
3. No. of healthy children:

**303) Length/Height for age (Stunting)**

No. of stunted children:

**Section E. <u>AVAILABILITY OF ESSENTIAL SUPPLEMENTS</u>**

**401) Availability of IFA syrup**

1. Yes
2. No

**402) Availability of IFA tablet**

1. Yes
2. No

**402.1) If yes, which IFA tablets are available?**

1. Red Tablets
2. Blue Tablets
3. Both
4. Not availabile

**403) Availability of zinc and ORS at the Anganwadi center**

1. Yes
2. No

**404) Availability of Albendazole Tablet at the Anganwadi center**

1. Yes
2. No

## Section E. SUPPLEMENTARY NUTRITION

**501) Availability of hot cooked meal**

1. Yes
2. No

**502) Availability of take-home ration (THR)**

1. Yes
2. No

**503) Is THR micronutrient fortified?**

1. Yes
2. No

## Section F. MIS REGISTERS

**601) MIS registers updated regularly**

1. Yes
2. **No**

**602) Visit by LS in last month**

1. Yes
2. No

**603) Home visit done by Sevika in last month**

1. Yes
2. No