CHAPTER III

ANGANAWADI WORKERS:
A PROFILE

3.1 INTRODUCTION
3.2 CONCEPT OF ANGANWADI SYSTEM
3.3 FUNCTIONING OF ANGANWADI SYSTEM WORK
3.4 ANGANWADI WORKER RESPONSIBILITIES
3.5 ROLE OF ANGANWADI’s TO THE SOCIETY
3.6 OVERLAPPING RESPONSIBILITIES OF AWWS, ANMS AND ASHAS
3.7 INTEGRATED CHILD DEVELOPMENT SERVICES
3.8 CHALLENGES AND SOLUTIONS
3.9 CONCLUSION
3.1 INTRODUCTION

A planned approach to child welfare began in the First Five Year Plan when the Planning Commission decided to give priority to the needs of children. Many child welfare programmes were launched under the five year plans. These related to the needs of children in the areas of education, health, nutrition, welfare and recreation. Special programmes to meet the needs of delinquent, handicapped, destitute and other groups of children were also undertaken. Some of these programmes were related to the growth and development of children, especially children belonging to the preschool age group of 0-6 years. However, such child care programmes with their inadequate coverage and very limited inputs could not make much dent on the problems of children. As comprehensive and integrated early childhood services were regarded as investment in the future economic and social progress of the country, it was felt that a model plan which would ensure the delivery of maximum benefit to the children in a lasting manner should be evolved. Accordingly, a scheme for integrated child care services was worked out for implementation in all States.

3.2 CONCEPT OF ANGANWADI SYSTEM

The name anganwadi worker is derived from the Indian word – angan, which means the court yard (an central area in and around the house where most of the social activities of the household takes place). In rural settings, the angan is the open place where people gather to talk, greet the guests, and socialize. Traditional rural households have a small hut or house with a boundary around the house which houses their charpoys,
cattle, feed, bicycle, etc. Sometimes food is also prepared in the angan. Some members of the household also sleep outside in open air, under the sky, in their angans. The angan is also considered as the ‘heart of the house’ and a sacred place which buzzes with activity at the break of dawn. Given the nature of this versatile nature of this space, the public health worker who works in an angan, and also visits other people’s angans, helping with their healthcare issues and concerns, is the Anganwadi worker.

The Anganwadi system is mainly managed by the Anganwadi worker (AWW). She is a health worker chosen from the community and given 4 months training in health, nutrition and child-care. She is in charge of an Anganwadi which covers a population of 1000. About 20-25 Anganwadi workers are supervised by a Supervisor called Mukhyasevika. 4 Mukhyasevikas are headed by a Child Development Projects Officer (CDPO). There are an estimated 10.53 lakh Anganwadi centers employing 18 lakh mostly-female workers and helpers across the country. They provide outreach services to poor families in need of immunization, healthy food, clean water, clean toilets and a learning environment for infants, toddlers and pre-schoolers. They also provide similar services for expectant and nursing mothers. According to government figures, Anganwadis reach about 5.81 crore children and 1.02 crore pregnant or lactating women. Anganwadis are India's primary tool against the scourges of child malnourishment, infant mortality and curbing preventable diseases such as polio. While infant mortality has declined in recent years, India has the world's largest population of malnourished or under-nourished children. It is estimated that about 47% of children aged 0–3 are under-nourished as per international standards.
3.3 FUNCTIONING OF ANGANAWADI SYSTEM WORK

The Anganwadi system in one village/ area is managed by a single Anganwadi worker, who is chosen from the community and has been trained for four months in areas such as health, nutrition and childcare. Each Anganwadi worker covers a population of about 1000 people. It is heartening to know that there more than a million Anganwadi centers in India, employing more than 2 million workers, who are mostly female and intuitive to the health needs of the region. For a country where illness, child mortality, illiteracy and poverty co-exist, this comes as a refreshing statistic.

The Committee have been told that the Anganwadi Workers should be a lady (18-44 years) from the local village and acceptable in the local community. Special care should be taken in her selection so that the children of Scheduled Caste and other weaker sections of the society are ensured free access to Anganwadi. The Government of India instructions with regard to their selection as furnished by the Ministry in a reply is as under:- “It is suggested that the AWWs in the selected project areas may be selected by a committee consisting of the District Social Welfare Officer, the BDO, the CDPO, the Medical Officer of the primary health centre, the President of the Taluka Panchayat/Block Advisory Committee, the district representatives of the State Social Welfare Advisory Board and any other non-officials which the State Government may consider appropriate”

On being asked about the deviations in this regard from any State, the Ministry has submitted as below:- “States of Andhra Pradesh and West Bengal have included the Members of the Legislative Assembly as Chairperson/Member of the Committee
constituted for selection of the AWWs/AWHs under the Scheme. It was felt that involving the MLAs in the selection process of AWWs by involving them on the Selection Committee for AWWs/AWHs was not appropriate. Accordingly, the States/UTs were advised to comply with the Government of India directions in the matter. States viz. Andhra Pradesh and West Bengal have not so far reported compliance in this regard. It has also been clarified that reference to non-officials in the above guidelines for the Selection Committee is meant to be a provision for inclusion of members belonging to those who have expertise in the child development area, non-governmental organizations, persons belonging to the locality from the disadvantaged sections, SCs/ST/Minority Community etc.

Honorarium: 34. At the beginning of the Scheme in 1975, the Anganwadi Worker was paid honorarium of Rs.100/- per month (Non-Matriculate) and Rs.150/- per month (Matriculate) and Helper was paid Rs.35/- per month. Govt. has increased the honorarium from time to time. Each Anganwadi Centre is managed by one Anganwadi Worker and one Helper, who are the grass roots functionaries to implement the Integrated Child Development Services (ICDS) Scheme. Each Mini-AWC has one AWW only. These workers and helpers are envisaged as honourary workers from the local community who come forward to render their services, on part-time basis on an average 4-5 hours a day in the area of child care and development. As per the ICDS Guidelines, Supervisors have to supervise the work of Anganwadi Workers. She should be a lady officer and a graduate, preferably in Social Work, Home Science or related fields. She should have the aptitude to work in rural, tribal or urban slum areas and should possess capabilities and skills to
supervise the work of the grass-root level field staff. The Supervisors are taken in the pay scale of Mukhyasevikas in the States. Under the ICDS Scheme they are borne on State Cadre and their recruitment, pay scales and other service conditions are governed by the State Government Rules which vary from State to State.

**Mukhya Sevika:** The Supervisor of Anganwadi Workers: For every 10 Anganwadi workers, there is an Anganwadi Supervisor to provide on-the-job guidance, who is also known as Mukhya Sevika. Apart from the healthcare, nutrition and educational work, the following are the responsibilities of the Anganwadi Supervisor:

- Checks the list of beneficiaries from the low economic strata, who are severely malnourished,
- Guides AWWs in the assessment of correct ages of children, correct method of weighing the children, and plotting their weights on growth charts,
- Demonstrates to the AWWs the effective methods of providing health and nutrition education to mothers, and Maintains the statistics of the Anganawadis. The Mukhya Sevikas, in turn, report to the Child Development Projects officer (CDPO).

Every 40 to 65 Anganwadi workers are supervised by one Mukhya Sevika. They provide on the job training to these workers. In addition to performing the responsibilities along with the Anganwadi workers they have other duties such as keeping a check as to who are benefitting from the programme from low economic status specifically those who belong to the malnourished category, guide the Anganwadi workers in assessing the correct age of children, weight of children and how to plot their weights on charts,
demonstrate to these workers as to how everything can be done using effective methods for example in providing education to mothers regarding health and nutrition, and also maintain statistics of Anganwadis and the workers assigned there so as to determine what can be improved. The Mukhya Sevika then reports to the Child development Projects Officer (CDPO).

3.4 ANGANWADI WORKER RESPONSIBILITIES

The Ministry of Women and Child Development has laid down certain guidelines as to what are the responsibilities of Anganwadi Workers (AWW). Some of them are as follows. These include showing community support and active participation in executing this programme, to conduct regular quick surveys of all families, organize pre-school activities, provide health and nutritional education to families especially pregnant women as to how to breastfeeding practices etc., motivating families to adopt family planning, educating parents about child growth and development, assist in the implementation and execution of Kishori Shakti Yojana (KSY) to educate teenage girls and parents by organizing social awareness programmes etc., identify disabilities in children and so on. That can be cancelled

According to the Ministry of Women and Child Development, Government of India, the following are the basic roles and responsibilities listed for the anganwadi worker:

- To elicit community support and participation in running the programme.
• To weigh each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the sub-centres/PHC etc., and maintain child cards for children below 6 years and produce these cards before visiting medical and para-medical personnel.

• To carry out a quick survey of all the families, especially mothers and children in those families in their respective area of work once in a year.

• To organise non-formal pre-school activities in the anganwadi of children in the age group 3-6 years of age and to help in designing and making of toys and play equipment of indigenous origin for use in anganwadi.

• To organise supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.

• To provide health and nutrition education and counseling on breastfeeding/Infant & young feeding practices to mothers. Anganwadi Workers, being close to the local community, can motivate married women to adopt family planning/birth control measures

• AWWs shall share the information relating to births that took place during the month with the Panchayat Secretary/Gram Sabha Sewak/ANM whoever has been notified as Registrar/Sub Registrar of Births & Deaths in her village.

• To make home visits for educating parents to enable mothers to plan an effective role in the child’s growth and development with special emphasis on new born child.

• To maintain files and records as prescribed.
• To assist the PHC staff in the implementation of health component of the programme viz. immunisation, health check-up, ante natal and post natal check etc.

• To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without maintaining stock register as it would add to her administrative work which would effect her main functions under the Scheme.

• To share information collected under ICDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW.

• To bring to the notice of the Supervisors/ CDPO any development in the village this requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments.

• To maintain liaison with other institutions (Mahila Mandals) and involve lady school teachers and girls of the primary/middle schools in the village which have relevance to her functions.

• To guide Accredited Social Health Activists (ASHA) engaged under National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme.

• To assist in implementation of Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general by organzng social awareness programmes/ campaigns etc.

• AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such
record as prescribed under the NPAG.

- Anganwadi Worker can function as depot holder for RCH Kit/ contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.

- To identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.

- To support in organizing Pulse Polio Immunization (PPI) drives.

- To inform the ANM in case of emergency cases like diahorrea, cholera etc.?

The Anganwadi Workers and helpers are the basic functionaries of the ICDS who run the Anganwadi Centre and implement the ICDS scheme. The following are the key duties and responsibility of AWWs.

- To maintain files and records as prescribed.

- Assisting ASHA on spreading awareness for healthcare issues such as importance of nutritious food, personal hygiene, pregnancy care and importance of immunization

- Co-ordination with block and district healthcare establishments to benefit medical schemes.

- Helping to mobilise pregnant or lactating women and infants for nutrition supplements.
- Discover immunization and health check-ups for all.

- To keep a record of pregnant mothers, childbirths and diseases or infections of any kind.

- Maintaining referral card for referring cases of mothers and children to the sub-centres, PHC.

- Conducting health related survey of all the families and visiting them on monthly basis.

- Conducting pre-school activities for children of up to 5 years.

- Organising supplementary nutrition for feeding infants, nursing mothers

- Organising counselling or workshops along with Auxiliary Nurse Midwife (ANM) and block health officers to spread education on topics like correct breastfeeding, family planning, immunization, health check-up, ante natal and post natal check.

- To visit nursing mothers in order to be on course with child's education and development.

- To ensure that health components of various schemes is availed by villagers.

- Informing supervisors for villages’ health progression, or issues needing attention and intervention.

- To ensure that Kishori Shakti Yojana (KSY), Nutrition Programme for Adolescent Girls (NPAG) and other such programmes are executed as per guidelines.
To determine any disability, infections among children and referring cases to PHC or District Disability Rehabilitation Centre if needed.

Immediately reporting diarrhea and cholera cases to health care division of blocks and districts

3.5 ROLE OF ANGANAWADI’s TO THE SOCIETY

India is a country suffering from overpopulation, malnourishment, poverty and high infant mortality rates. In order to counter the health and mortality issues gripping the country there is a need for a high number of medical and healthcare experts. Unfortunately India is suffering from a shortage of skilled professionals. Therefore through the anganwadi system the country is trying to meet its goal of enhanced health facilities that are affordable and accessible by using local population. In many ways an Anganwadi worker is better equipped than professional doctors in reaching out to the rural population. Firstly since the worker lives with the people she is in a better position to identify the cause of the various health problems and hence counter them. Hence she has a very good insight of the health status in her region. Secondly though Anganwadi workers are not as skilled or qualified as professionals they have better social skills thus making it easier to interact with the people. Moreover since these workers are from the village itself they are trusted easily which makes it easier for them to help the people. Last but not the least, Anganwadi workers are well aware of the ways of the people, are comfortable with the language, know the rural folk personally etc. which makes it very
easy for them to figure out the problems being faced by the people and ensure that those problems are solved.

India is home to over-population, mal nutrition, poverty, unemployment, low literacy levels and more, with a target to make healthcare accessible and affordable for everyone. Given the urgency of healthcare issues, child mortality, mal nutrition, etc., our country needs high number of medical and healthcare professionals to cater to the population that is now running into billions. Faced with acute shortage of skilled professionals, the Government’s ICDS scheme is using the local population to help meet its grand goals.

The Anganwadi worker hails from the village where she works and has her finger on the pulse of the health of the village, its people and children. Apart from the healthcare knowledge that she possesses and gained over a period of time, the Anganwadi worker is so entrenched in the general affairs of the household that she is in a better position to understand the real malady behind the healthcare issues. These latent problems of the household or community could range from relationship issues, daily hassles, sanitation, nutrition, social, peer pressure, and much more. Given the definition of health – the physical, mental, social, spiritual wellbeing of an individual, the Anganwadi worker perhaps has the best insight into the people’s health of her region. While educated doctors, learned nurses and seasoned professionals are excellent in their work and skills, they mostly lack the social skills and expertise which is more than necessary in interacting with the rural folk. An anganwadi worker is well versed in the ways of the
village, knows the people by their names, interacts with them on regular basis and may also has an personal relationship with the people.

Anganwadi workers need to have good communication skills. They are usually adept in using the right language, metaphors and allusions for convincing people to act in a certain way. Religious customs and sentiments work best for them. Here is an interesting account of how the Anganwadi worker convinced the villagers from defecating on open land. From shaming the defecators, convincing the women of the house, to citing the sacred texts that emphasized cleanliness and took the sanitary hygiene of the village to much higher level than one can imagine. Such is the power of the Anganwadi worker. Some Anganwadi workers are very enterprising. Like the ones in Tamil Nadu, they have taken the initiative of growing kitchen gardens to help meet the nutritional needs and achieve the objectives of reducing mal nutrition of 0-6 year olds. So far 200 kitchen garden initiatives have been undertaken where Anganwadi workers will be trained in laying the gardens and growing crops, on one cent of land allotted to them. With minimum qualification to boot, an Anganwadi worker is deemed wise in the ways of the village and in the duties that she performs. Their understanding, communication skills and approach is needed to implement the grand projects of the state and central Governments, making them the most vital link in delivering the ‘health for all’ mission.

The Anganwadis are engaged to provide the following formal services to the areas under their cover:
Immunisation of all children less than 6 years of age

- Immunisation against tetanus for all the expectant mothers
- Supplementary nutrition to children below 6 years of age
- Supplementary nutrition to women who are pregnant and nursing, esp. from the low income group
- Nutrition, health education and health check-ups to all women in the age group of 15-45 years
- Antenatal care of expectant mothers
- Postnatal care of nursing mothers
- Caring for newborn babies
- Caring for all children under 6 years of age
- Referral of serious cases of malnutrition or illness to hospitals, upgraded PHCs/Community Health Services or district hospitals

To organise non-formal pre-school activities in the anganwadi of children in the age group 3-6 years of age and to help in designing and making of toys and play equipment of indigenous origin for use in anganwadi. To organise supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes. To provide health and nutrition education and counseling on breastfeeding/Infant & young feeding practices to mothers. Anganwadi Workers, being close to the local community, can motivate married women to adopt family planning/birth control measures. AWWs shall share the information relating to births that took place during the month with the Panchayat...
Secretary/Gram Sabha Sewak/ANM whoever has been notified as Registrar/Sub Registrar of Births & Deaths in her village. To make home visits for educating parents to enable mothers to plan an effective role in the child’s growth and development with special emphasis on new born child. To maintain files and records as prescribed. To assist the PHC staff in the implementation of health component of the programme viz. immunisation, health check-up, ante natal and post natal check etc. To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without maintaining stock register as it would add to her administrative work which would effect her main functions under the Scheme. To share information collected under ICDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW. To bring to the notice of the Supervisors/ CDPO any development in the village which requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments. To maintain liaison with other institutions (Mahila Mandals) and involve lady school teachers and girls of the primary/middle schools in the village which have relevance to her functions. To guide Accredited Social Health Activists (ASHA) engaged under National Rural Health.

The mission in the delivery of health care services and maintenance of records under the ICDS Scheme.

❖ To assist in implementation of Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general by organizing social awareness programmes/ campaigns etc.
AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such record as prescribed under the NPAG.

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To identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.

To support in organizing Pulse Polio Immunization (PPI) drives.

To inform the ANM in case of emergency cases like diahorrea, cholera etc.?

3.6 OVERLAPPING RESPONSIBILITIES OF AWWS, ANMS AND ASHAS

The Committee observed that the role and responsibilities of Anganwadi Workers, ANMs and ASHA workers overlap and this leads to a lot of problems among these three groups. When asked about the steps being taken by the Ministry to avoid this overlapping and streamline the work of Anganwadi Workers, ANMs and ASHAs, the Ministry in a post evidence written reply stated as under: “The ICDS offers a package of six services viz. supplementary nutrition, pre-school non-formal education, nutrition & health education, immunization, health check-up, referral services of these, the latter three services are delivered by through the Public Health System of the Ministry of Health & Family Welfare. It may therefore be seen that convergence with Health is
inbuilt and integral to the ICDS Scheme. The role of these grass-roots functionaries i.e. AWW, ASHA and ANM has been delineated jointly by this Ministry and the Ministry of Health & Family Welfare. At the village level, some degree of overlap does occur, eg. In organizing immunization sessions, both ASHA and AWW have the role of mobilization and organizing the session. In case of conflict, existing village level coordination committees will play a crucial role in settlement of such issues. In fact, both the Ministries work towards enhanced convergence to fulfill the objectives of the Scheme.”

3.7 INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME

The Integrated Child Development Services (ICDS) Scheme, a centrally sponsored Scheme, was launched in 1975 in 33 Projects in the Community Development Blocks and 4891 Anganwadi Centres (AWCs) on a pilot basis keeping in view the need to holistically address health, nutrition and education needs of children. The ICDS Scheme was introduced as a collaborative initiative of the Government of India, State Governments and the community. The ICDS has expanded tremendously over its 35 years of operation to cover all Development Blocks and major slums in the country. ICDS is the world’s largest community based outreach programme which offers a package of health, nutrition and education services to children below 6 years and pregnant and nursing mothers.

Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs) are employed under the Integrated Child Development Scheme (ICDS) of the Central Government to
provide health, nutrition and education services to children less than 6 years, to pregnant and nursing mothers, and additionally to adolescent girls. They play a critical role in addressing the issues of child nutrition, pre-school education and maternal health that are central to alleviating poverty and improving the quality of life. The Government on many occasions has commended the services of Anganwadi workers but it refuses to recognise them as ‘workers’. Their service is considered voluntary for which the government pays them an honorarium, far below even the agricultural minimum wage. In effect government is paying a poverty wage to the very workers who are engaged in fighting poverty. The Anganwadi worker (AWW) is the community Based voluntary frontline worker of the ICDS programme. The output of the ICDS scheme is to a great extent dependant on the profile of the key functionary i.e. the AWW, her qualification, experience, skills, attitude, training etc. India is home to the largest population of malnourished and hunger-stricken people and children leading to high infant and maternal mortality. Along with these issues are a deluge of problems ranging from diseases, lack of education, lack of hygiene, illness, etc. To combat this situation, the Government of India in 1975 initiated the Integrated Child Development Service (ICDS) scheme which operates at the state level to address the health issues of small children, all over the country. It is one of the largest child care programmes in the world aiming at child health, hunger, mal nutrition and its related issues. Under the ICDS scheme, one trained person is allotted to a population of 1000, to bridge the gap between the person and organized healthcare, and to focus on the health and educational needs of children aged 0-6 years. This person is the Anganwadi worker. The word Anganwadi means “courtyard shelter” in Hindi. They were started by the Indian government in 1975 as part
of the Integrated Child Development Services program to combat child hunger and malnutrition. A typical Anganwadi centre also provides basic health care in Indian villages. It is a part of the Indian public health-care system. Basic health-care activities include contraceptive counselling and supply, nutrition education and supplementation, as well as pre-school activities. The centres may also be used as depots for oral rehydration salts, basic medicines and contraceptives. As many as 13.3 lakh Anganwadi and mini-Anganwadi Centres (AWCs/ mini-AWCs) are operational out of 13.7 lakh sanctioned AWCs/ mini-AWCs, as on 31.01.2013. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services of which later three services are provided in convergence with public health systems.

Various studies in recent past clearly highlighted the importance of socio-economic and demographic characteristics of AWWs in implementing the ICDS programmes (Basin et al, 2001; Davey and Dutta, 2004). In the present study 30 Anganwadi Workers were interviewed. The Anganwadi Worker and helper are the basic functionaries of the ICDS. They are not government employees, but are called "social workers" or "voluntary workers". All the Anganwadi workers get about Rs.3500 as payment per month. The working hours are from 9 A.M to 1 P.M and then they go for home visit another 1 hour till 2 P.M. They visit 5 houses every day. All Anganwadi workers get guidance from Auxiliary Nurse Midwife (ANM). As mentioned by the AWW, it was found that the workers have only 6 days holiday during Christmas. The background characteristics of all selected AWWs are given in the following sections. Although much of the researches have been done on the nutritional status of the beneficiaries of
ICDS, evaluation of nutrition and health services rendered by Anganwadi centers but very less focus has been shifted over to knowledge and awareness among the Anganwadi workers, who are actually the main resource person of the programme and whose knowledge and skills do have a direct impact on the implementation of the programme. As the Anganwadi workers play an important role due to their close and continuous contact with the people of community, especially the children and women, so there is an utmost need to assess the level of awareness in Anganwadi workers regarding services provided by them in Anganwadi centers. As the Anganwadi worker is the key person in the programme, her education level and knowledge of nutrition plays an important role related to her performance in the Anganwadi centre (AWC). It has also been reported that, in addition to education level, training of Anganwadi workers about growth monitoring plays a beneficial role in improving their performance (Gopaldas et al., 1990). Nutrition knowledge was the most powerful determinant of performance, followed by guidance from the supervisors or health functionaries and education level (Gujral et al., 1992). Most of the Anganwadi workers were performing mechanically and were not clear with the basic concepts of their working. The national evaluation of ICDS by NIPCCD (1992) also shows that about 36.3 percent Anganwadi workers were not able to monitor the growth of children. The main reason that was pointed out was the lack of skills among Anganwadi workers in filling up growth charts. Since the success rate of this nationwide integrated programme solely depends upon the fact as to how we are preparing our ground workers to combat with the problem of malnutrition, it becomes really important to upgrade our ground worker i.e. Anganwadi worker with quality training and enhanced and advanced nutrition knowledge as nutrition knowledge was the
most powerful determinant of performance (Gujral et al., 1992). The Integrated Child Development Services (ICDS), the nationwide programme of the Government of India offers the most important interventions for addressing the nutrition and health problems and promoting early childhood education among the disadvantaged population of the country.

Anganwadi Workers (AWWs) are the implementers of Integrated Child Development Scheme (ICDS). It is important to obtain the worker’s viewpoints on their job-description, the problems they face and the levels of stress that they encounter, to address the quality of their services. The stressed AWWs are likely to be unhealthy, poorly motivated, less productive and less efficient in implementing the ICDS scheme. Thus, there is a need to evaluate the stress levels among the anganwadi workers and to understand the factors that influence the stress in this class of the population. This study was planned to study the stress among the anganwadi workers and the factors that are related to the stress. This study was conducted among randomly selected anganwadi workers from amongst all the AWWs who attended the monthly meeting at the Child Development Project Officers (CDPO) office Mangalore. This study was approved by the institutional ethics committee of Kasturba Medical College, Mangalore, India. After obtaining the necessary permissions and after taking the informed consent, the data was collected by one of the authors (VNK) by personally interviewing the AWWs, to ensure its reliability.
The main Objectives of ICDS

- The following are the objectives of the scheme:-i) to improve the nutritional and health status of children in the age-group 0-6 years;
- To lay the foundation for proper psychological, physical and social development of the child
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and
- v) to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The ICDS Scheme provides a package of the following six integrated services:-(i) Supplementary Nutrition,(ii) Immunization,(iii) Health Check-up,(iv) Referral Services,(v) Pre-school non-formal education and (vi) Nutrition & Health Education. Services of immunization, health check-up, referral services and health education are delivered through public health system.

Every SC/ST habitation has it; and every minority habitation has it. We want them to certify after having done them mapping that this is achieved. They also are required to certify that the revised feeding norms which have been put into effect from 1.4.2008 have been implemented. The new financial norms have also been given effect. So
universalisation of the ICDS programme which is a major challenge with us today, as per the decision of the Government following, of course the Supreme Court direction, this is ongoing. We are hopeful that we will be able to complete it but it may slip beyond March 2011 which was the target date we have set for ourselves.” The Committee have observed that the 3rd Phase of expansion of ICDS Scheme has a special focus on SC/ST and minority habitations. When desired to know about the rate of success in reaching out to SC/ST and minority habitations, the

**Retirement and pension benefits**

When asked about the retirement age and benefits as prescribed by States for AWWs, the Ministry in a written reply stated as under: “As AWWs/AWHs are honorary workers under the ICDS Scheme, the Government of India has not prescribed any retirement age. However, it has been left to the discretion of the States to decide the upper age limit for these functionaries. Recently, the States of Kerala, U.P. and M.P. have declared 60 years as the upper age limit of AWWs/AWHs. Apart from this, as per the information received from 31 States/UTs the upper age limit for AWWs and AWHs varies from 58 to 65 years. As regards benefits extended to them upon completion of their honorary service, Goa has a provision of giving lump sum financial assistance of Rs.1.00 lakhs and Rs.50,000/- to AWWs and AWHs respectively. Similarly, the State of Tamil Nadu has kept a provision of lump sum grant of Rs.50,000/- for AWWs/AWWs of Mini/AWCs and Rs.20,000/- for AWHs. Regarding the pension benefits made available to Anganwadi Workers and Anganwadi Helpers by the States, the Ministry stated as under:
As per information received from 20 States/UTs, Govt. of Kerala has informed that benefits of pension scheme are made available to those Anganwadi Workers and Helpers who have completed 60 years of age, having 10 years service and who are members of the AWW’s and Helper’s Fund. AWWs will be paid Rs.500/- and AWHs will be paid Rs.300/- per month. Those AWWs and AWHs who have less than 10 years of service are eligible only for the amount they have remitted in the AWW’s and Helper’s Welfare Fund along with 11% interest and the State share. In case of pensioner’s death, the heir of the AWWs will get Rs.15,000 and that of AWHs will get Rs.10,000/- as one time ex-gratia. Govt. of Tamil Nadu has informed that Pension Scheme has been introduced w.e.f.15.9.2008 and AWWs/Mini-AWWs will get Rs.700/-per month and Anganwadi Helpers will get Rs.600-700/- per month. Govt. of Andhra Pradesh has informed that many AWWs are enrolled in YSR Abaya Hastam to get pension after they attain 60 years of age. Further details in this regard are still awaited.”

**Mini-Anganwadi Workers**

Regarding the concept of Mini Anganwadis, the Ministry of Women and Child Development in a written reply, stated as below:- “As per the population norms, a Mini-Anganwadi Centre for Rural/Urban Project can be sanctioned for a habitation having a population of 150-400. For Tribal/Desert/Hilly and difficult areas, with a population of 150-300, one Mini-AWC can be sanctioned. The concept of Mini-AWC is therefore meant for areas where there is lesser population and fewer beneficiary children. The Mini-AWC is meant to ensure better outreach and coverage in difficult to reach areas.”
There is, therefore, no proposal for merging Mini-AWCs with AWCs.” The Committee have observed that there is no helper in a Mini Anganwadi and the worker has to take care of the children all alone. At the same time these worker in Mini Anganwadis are paid only the wages of a helper which was Rs. 750/- till April 1, 2011. The Committee during the course of examination of the subject have observed that most of the Mini Anganwadis are located in the tribal areas and tribal women are working as Anganwadi workers. Tribal hamlets are usually situated very far off and they are working in very difficult circumstances.

The Committee observed during evidence that the discrimination in the remuneration of Mini-Anganwadi Workers is without any justification as their work is not „mini”. In response, the Secretary, Ministry of Women and Child Development submitted before the Committee as under:-“the issue is about the mini anganwadis and there is difference in wages. That is the scheme today. I cannot say. A sum of Rs. 750 was sought to be given to the anganwadi helpers on the assumption that the work load would be less because the number of children would be less. But since you have made a point, we can look at it. We have not yet talked to the States and no State has\told me that they need to pay higher. But since you have raised this issue, we can look into it. I can discuss and work it out. But as of now, the position is Rs. 750 is the wage equivalent to the anganwadi helper being given to them.”

i) Training Programmes for Anganwadi Workers.
The types of training are imparted to AWWs through the State based Anganwadi Workers Training Centres (AWTCs): Job Training Once in entire service 32 days (26 working days) Refresher Training Once in every two years 7 days (5 working days) Apart from the above, those AWWs who on their engagement cannot be deputed for job training course are given a 6 days-Induction Training in order to operationalise the AWCs.

3.8 CHALLENGES AND SOLUTIONS

There have been public policy discussions over whether to make anganwadis universally available across the country to all eligible children and mothers. This would require significant increases in budgetary allocation and a rise in Anganwadis centers to over 16 lakh. Anganwadis are staffed by officers and their helpers, who are typically women from poor families. The workers do not have permanent jobs with comprehensive retirement benefits like other government staff. Worker protests (by the All India Anganwadi Workers Federation) and public debates on this topic are ongoing. There are periodic reports of corruption and crimes against women in some Anganwadi centers. There are legal and societal issues when Anganwadi-serviced children fall sick or die. In announcing the 2008-2009 Budget, Indian Finance Minister P Chidambaram stated that salaries would be increased for anganwadi workers to Rs 1500 per month and helpers to Rs 750 per month. In March 2008 there is debate about whether packaged foods, such as biscuits, should become part of the food served. Detractors, including Nobel Prize winner Amartya Sen, disagreed saying it will become the only food consumed by the children.
Options for increasing partnership with the private sector are continuing.

The Anganwadi worker and helper are the basic functionaries of the ICDS who run the anganwadi centre and implement the ICDS scheme in coordination with the functionaries of the health, education, rural development and other departments. Their services also include the health and nutrition of pregnant women, nursing mothers, and adolescent girls. Today in India, about 2 million aanganwadi workers are reaching out to a population of 70 million women, children and sick people, helping them become and stay healthy. Anganwadi workers are the most important and oft-ignored essential link of Indian healthcare. Anganwadi workers are India’s primary tool against the menace of child malnourishment, infant mortality, and lack of child education, community health problems and in curbing preventable diseases. They provide services to villagers, poor families and sick people across the country helping them access healthcare services, immunization, healthy food, hygiene, and provide healthy learning environment for infants, toddlers and children. Anganwadi workers are key informants of healthcare issues but given the nature of their work, they are also being called as social workers and many more activities are being added to their job profile, such as the kind of services they provide in Dindigul.

While performing different types of functions it is obvious that Anganwadi workers supposed to face variety of problems. As per the Govt. Guideline the minimum qualification for AWW is 10th pass but she is expected to perform all these job responsibilities. Also community participation, co-ordination with the superiors,
beneficiaries and helper are important parts of her daily work. Results suggest that 56.7% are complained of inadequate salary while only 16.7% complained of lack of logistic supply related problems (Table 3.1). About half of the AWWs complained that they have Infrastructure structure related problem like inadequate space for displaying non-formal preschool education (NFPSE) posters or other posters related to nutrition and health education, space is not available for conducting fun activities like outdoor activities, irritation by animals entering into AWC. Forty three percent of workers not happy because of overload of work. And 40% of the workers complained for excessive record maintenance as they have to assist for other health programmes apart from their Anganwadi related work like in pulse polio programmes, vitamin A distribution programme conducted by Municipal Corporation.

3.9 CONCLUSION

The Anganwadi worker is the key human factor in the programme - the person who relates to the children and the families. Her confidence, her skills and her motivation are most important. But little attention has been given to this. The Anganwadi worker has been given countless responsibilities. Apart from children's health, nutrition and pre-school education, she is supposed to reach out to pregnant and nursing mothers, make home visits, provide nutrition counselling, help with immunization campaigns, carry out surveys, keep numerous registers, and so on. In addition she is frequently mobilised by other government departments for special duties, such as setting up “Self Help Groups”. This further reduces the time available for the children. To make things
worse, the training of Anganwadi workers is very limited, and their wages (called an “honorarium”) are very low. This affects the status of the Anganwadi worker in the village. She seldom gets the respect due to her, and this undermines her efficiency and her morale. In the worst cases, she is exploited or harassed. In Uttar Pradesh, for instance, the FOCUS survey found that Anganwadi workers had to pay substantial bribes to the supervisor every month to avoid being victimised. Unreliable food supply This is also a big problem in many states. If there is no food at the Anganwadi, or if the food is tasteless and monotonous, few children attend and no activity can take place. Unfortunately, food supply is often erratic. In some states, food supplies are disrupted for months at a time for trivial reasons, such as delays in sanctioning funds or administrative bottlenecks. Irresponsible and corrupt contractors (who have been banned by the Supreme Court, but continue to operate in many states) is also common. Even where food supply is regular, there is much carelessness in food storage, and the quality of food is poor in many cases. There are, of course, major variations in all these respects between different states. Some states have been able to ensure regular food supply and adequate quality standards. These contrasts are illustrated in Poor integration with health services Health services provided at the Anganwadi tend to be quite popular. However, the success of these services depends on effective coordination between the Anganwadi worker and the ANM. For instance, both need to be present for immunization sessions. The rehabilitation of severely malnourished children is another matter on which close cooperation between ICDS and the Health Department is essential. Unfortunately, lack of coordination is a common problem. The National Rural Health Mission is in the process of creating a cadre of women voluntary health workers (ASHA or “accredited
social health activist”) at the village level, who are also expected to work with the ANM and Anganwadi worker to improve the nutrition and health of women and children. This is an important opportunity to achieve a better integration of ICDS with health services. The introduction of a monthly “health and nutrition day” at the local Anganwadi is another useful initiative in this direction. However, the effectiveness of these initiatives remains to be seen. Neglect of the pre-school component of ICDS Children need a good learning environment and plenty of activities to help the development of language; help them learn to think and reason; find out about the world around them, and so on. They need to learn to coordinate eye and hand, which will help in writing, and to recognize shapes and distinguish between them, which will help with reading. Most parents are very keen that their children should learn, and want them to be well prepared for entering primary school. Some states, like Kerala and Tamil Nadu, have made great strides with “pre-school education” (PSE). The PSE programme tends to be well designed to suit the needs of young children, with teaching being done through a variety of creative games aimed at developing key skills such as language, recognition or objects, comparison skills, etc. In most states, however, this component of ICDS has been grossly neglected. More emphasis has been placed on distribution of food, and to some extent on immunization. Greater attention to pre-school education is urgently needed. This would also help to foster more active community support for all ICDS activities.