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RESEARCH ARTICLE

Perception towards functioning of anganwadis and utilization of ICDS services by the adolescent girls of Urban Belagavi – A cross sectional study

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Abstract

Background: The Integrated Child Development Services (ICDS) scheme is one of the largest programmes for improving child health, nutrition and development in India. It mainly consists of health education, supplementary nutrition, health care & referral.

Objectives: To know perception towards functioning of anganwadis and utilization of ICDS services by the adolescent girls under Ramnagar urban health center.

Material and Methods: Total 188 ICDS beneficiaries were selected for the study and the data collection was carried out in all the 18 anganwadis under Ramnagar urban health center, Belagavi for a period of 9 months. A pre-designed and pre-tested questionnaire was used to collect information on demographic, socio-economic, nutritional, health variables and also to know the functioning of anganwadis and the utilization of ICDS services by the adolescent girls residing in the Ramnagar urban area.

Results: Eighty per cent adolescents were enrolled at the Anganwadi center. 73.4% adolescents received health education and 70.7% adolescent girls received health check-up at Anganwadi center. Only 45.7% adolescents received de-worming tablets whereas merely 17% adolescents were distributed sanitary pads.

Conclusion: The ICDS services are not provided adequately to the adolescent girls as per the protocol of the ICDS scheme. There is a need to comprehensively address socio-cultural barriers to improve the service utilization and coverage of ICDS in the areas of deworming, menstrual hygiene management and consumption of IFA tablets.

INTRODUCTION

The Integrated Child Development Services (ICDS) scheme, launched on 2nd October 1975, is one of the largest programmes for improving child health, nutrition and development in India. A centrally-sponsored scheme, ICDS benefits pre-school children in the age group of zero to six years, adolescents, pregnant women, lactating and nursing mothers through the Anganwadi. The Planning Commission in 2011 reported that nearly 70% of the

anganwadis provided health check-ups and 50% provided referral services.[1] ICDS comprises of more than 6000 operational projects and 10 lakh AWCs.[2] ICDS mainly consists of health education, supplementary nutrition, health care & referral. This package of services includes all levels of prevention like promotive, preventive, curative & rehabilitative services.[3] NFHS-III shows that the improvement has not been as high as compared to the amount of money spent on nutritional supplementation schemes both by the centre and states.[4] In spite of its expansion, ICDS reaches out to only 30% of the beneficiaries. The remote scattered areas and new slum clusters often remain deprived of ICDS services.[5]

ICDS aims to reduce socioeconomic and gender inequalities for early childhood development for which a special intervention has been devised for adolescent girls using the ICDS infrastructure – Kishori Shakti Yojana (KSY). The KSY focuses on school dropouts, girls in the age group of 11-18 years, with a view to meet their needs of self-development, nutrition, health, education and literacy. This yojana is undertaken in 6,118 ICDS projects. Under KSY, various programmes are intervened for the development of the adolescent girls on the basis of their needs. Schemes of the Health Department are converged with KSY in order to improve the nutritional and health status of the adolescent girls. Nutritional anemia is specially emphasized to be reduced among this group.

Through centre based instructions, training camps and hands on learning as well as sharing of experiences, the KSY scheme also attempts to improve their capabilities in addressing nutrition and health issues. Overall in India, only 41.7% of the adolescent girls received nutrition support in the delivery registers. The adolescent girls received such support for only 6 days in a month, as compared to a stipulated norm of 25 days. The effective coverage is merely 10 per cent at the national level. Just 26.8 per cent of them were aware about their entitlement of food support. ICDS also makes an effort for adolescent girls in respect to nutrition and other health and hygiene requirements. According to ICDS scheme, AWC is expected to provide services to adolescent girls like regular weighing, provision of deworming tablets, health and nutrition education, sensitizing about HIV/AIDS, information about ideal birth interval, creation of awareness about preventing anemia and encouraging participation in income generating activities. The interventions around the adolescent girls are to be considered to provide results in a long term perspective as they would ensure a higher status of health and hygiene for the prospective mothers who would, in turn, deliver healthy babies in the future.[6]

The delivery of ICDS urgently needs to be reformed and strengthened. Despite the considerable expansion and additional investments made after 2005, progress has been slow and uneven.[7]

Evaluating the proper implementation of ICDS is essential for proper planning and allocation of resources. The coverage and service utilization among the beneficiaries of ICDS in Northern Karnataka is understudied.

Materials and Methods

The present study was carried in all the 18 anganwadis under Ramnagar urban health center, Belagavi from February 2014 to October 2014. A pre-designed and pre-tested questionnaire was used to collect information on demographic, socio-economic, nutritional, health variables and also to know the functioning of anganwadis and the utilization of ICDS services by the adolescent girls residing in Ramnagar urban area.

The data collection was carried out for a period of nine months from February 2014 to October 2014. Assuming the prevalence to be 50% among the beneficiaries, sample size was calculated using the formula: $n=4pq/d^2$ and the total sample were 188. A house to house visit was undertaken and interviews were conducted with the study participants after obtaining assent and/or consent. List of the beneficiaries were collected from the Child Development Project Officer (CDPO) office. All the 18 anganwadis under Ramnagar urban health center were perused and the participants from each anganwadi were chosen by using a random number table. All the participants who were contacted participated in the study. The data was collected and analyzed using SPSS version 16 and Microsoft Excel 2010. The data were expressed in terms of percentage.

RESULTS

A total of 188 adolescent girls were interviewed and the response rate was 100%. Assent was taken from each adolescent before including in the study.

Table 1: Distribution of Adolescent Girls by Socio-demographic Characteristics

Variable	Frequency (N=188)	Percentage
Occupation		
Housewife	20	10.6
Student	107	57

Drop-out	61	32.4
TOTAL	**188**	**100**
Religion		
Hindu	77	41
Muslim	109	58
Christian	2	1
TOTAL	**188**	**100**
Literacy status		
Illiterate	13	6.9
Primary	75	39.9
Secondary	89	47.3
College	11	5.9
TOTAL	**188**	**100**
Family type		
Nuclear	52	27.7
Joint	106	56.4
Extended	30	16
TOTAL	**188**	**100**
Social class		
I	1	0.5
II	9	4.8
III	26	13.8
IV	94	50
V	58	30.9
TOTAL	**188**	**100**

Table 1 shows that majority of the adolescents were students with 57% whereas 32.4% were drop outs. About 11% of the adolescents were housewives in the study area. Majority of the adolescents were Muslims (58%) and the remaining 41% & 1% were Hindus and Christians respectively in the study population. Forty seven per cent of the adolescents were secondary school educated, 40% attended primary school, 7% were illiterate and about 6% attended college. 56% adolescents belonged to the joint family whereas 28% belonged to nuclear family. Adolescents belonging to the extended family were 16%. The study revealed that about 50% were from social class IV, 31% from social class V, 13% from social class III, 5% from social class II and 1% was from social class I according to modified B.G. Prasad classification-2014.

Table No 2: Enrolment and attendance at AWC by adolescent girls

Variable	Frequency (N=188)	Percentage
Enrolment of name		
Yes	150	79.8
No	38	20.2
TOTAL	**188**	**100**
Regularly attended AWC		
Yes	146	77.7
No	42	22.3
TOTAL	**188**	**100**

Table 2 reveals that 79.8% of the adolescents enrolled their name at AWC whereas 20.2% did not enroll their name at AWC. 77.7% of the adolescents attended AWC regularly and about 22.3% did not attend AWC for any of the services available at AWC.

Table 3: Health education and check-up received at AWC by adolescent girls

Variable	Frequency (N=188)	Percentage
Health education		
Yes	138	73.4

No	50	26.6
TOTAL	**188**	**100**
Health check-up		
Yes	133	70.7
No	55	29.3
TOTAL	**188**	**100**

Table 3 shows that 73.4% of the adolescents knew about the advice on health education provided at the AWC. 26.6% were not provided with the health education at AWC. Majority of the adolescents (70.7%) knew about the health check-up at AWC whereas 29.3% did not know that health check-up was done at AWC.

Table 4: Distribution of Adolescent Girls by health-related services received at AWC

Variable	Frequency (N=188)	Percentage
Distribution of IFA tablets		
Yes	144	76.6
No	44	23.4
TOTAL	**188**	**100**
Distribution of D-worm tablets		
Yes	86	45.7
No	102	54.3
TOTAL	**188**	**100**
Distribution of sanitary pads		
Yes	32	17
No	156	83
TOTAL	**188**	**100**

Table 4 shows that 76.6% of the adolescents knew that distribution of IFA tablet were available at AWC. Only 23.4% told that there was no distribution of IFA tablet in AWC. Almost half of the adolescent girls (54.3%) did not know that distribution of D-worm tablet was available at AWC whereas 45.7% knew about its distribution. Majority of the adolescents (83%) did not know about the distribution of sanitary pads in the AWC during periodic menses. Only 17% knew that sanitary pads were available at AWC.

DISCUSSION

The present study was undertaken at the anganwadis under Ramnagar urban health center area of Belagavi city which belonged to field practice area of J.N.Medical College, Belagavi. The study population consisted of adolescent girls.

Forty seven per cent adolescent girls were educated up to secondary level and 40% were educated up to primary level. 58% of them were Muslims and 56% belonged to joint family. Out of 188 adolescent girls, 50% of them belonged to social class IV.

In the present study, enrolment at AWC was 80%. 78% of AG's among them attended AWC compared with other studies done at Gurgaon where no adolescent in the study area had participated for the utilization of ICDS services, at Uttaranchal where there was no awareness regarding ICDS services, at Uttar-Pradesh where 93% of AG's with PPP (UMANG) received IFA tablets compared to present study where 77% of AG's received IFA tablets and 73% of the AG's received health education (F.L.E).[8,9,10] In a study done at Gujarat, 87% of the adolescent girls received ICDS services and 86.7% received health education as compared to 73.4% in the present study.[11]

CONCLUSION

In this study, it has been observed that socio-cultural characteristics (low female literacy, low literacy of the decision maker of the family, type of the family, gender of the child), socio-economic status significantly affect the utilization of ICDS services. Hence, a comprehensive approach is needed to improve the utilization of ICDS services in the study area.

RECOMMENDATION

Keeping in mind the socio-cultural contexts, results show that a behavioural change extending beyond the beneficiaries may be needed urgently and the barriers for utilization of services should be taken into considered accordingly. Information, Education & Communication (I.E.C) strategies need to be strengthened. IEC should be supported with the availability of the services like: sanitary napkin availability and health education materials for the beneficiaries.

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