International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

An Analytical Study on Challenges of Anganwadi Workers During Post Covid: A Review

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Abstract:
Anganwadi workers provide primary health care as part of India's national health system that is affordable and accessible to the local population. Also, since most of the workers are from the same village, it is easy to trust them, which makes it easier to help people. Anganwadi workers have played a vital role in helping people across the states deal with the pandemic on a grassroots basis. Their contribution to providing basic health care, including immunization and nutrition, to large rural population and combating the pandemic was recognized as 'unparalleled' and 'Commendable'. Meanwhile, the Anganwadi workers also faced many challenges. Present paper showing the challenges and problems faced by Anganwadi Workers during the Post Covid.

Keywords: Pandemic Challenges, Anganwadi Workers, Integrated Child Development Scheme.

Introduction:
The Anganwadi institution is very little studied and their plight awaits a proper discourse from the politicians. The plight of Anganwadi workers in rural India has increased during the COVID-19 pandemic due to inadequate decentralization of health care at the grassroots level. The analysis of this paper analysis the challenges and problems faced by Anganwadi Workers during Post Covid.

Anganwadi Workers:
In India, Integrated Child Development Services (ICDS) Scheme was established in 1975 after an inter-ministerial study in 1972 found that child care programs in India were not having the desired impact. Anganwadi worker - a community health worker working with ICDS - was created to provide nutritional care to communities, especially pregnant women and children aged 0-5 years. Currently, ICDS is estimated to be the largest integrated early childhood program in the world. The ICDS Currently offers six majors services across the country which includes:

a) Supplementary Nutrition
b) Pre- School Education
c) Nutrition and Health Education
d) Immunization
e) Health Check ups

f) Referral Services

Covid-19 Pandemic:

Corona virus (COVID-19) is a disease caused by severe acute respiratory syndrome corona virus 2 (SaRS-COV2) (Hainaut, 2021). The first case of COVID-19 was identified in Wuhan, China and spread to other parts of the world, causing an ongoing global pandemic (World Health Organization, 2020). Due to the sudden and intense global spread of COVID-19, the Government of India announced restrictions on 24/03/2020 as a precaution to contain the increasing cases (Nijhawan, 2020). Since then, however, India has seen two notable waves. As a result, many institutions in urban and rural areas were temporarily closed with a significant impact on several critical services, one of which was Anganwadi Centers in rural areas.

Objectives:

1. To understand the challenges faced by the Anganwadi Workers during post COVID- 19.
2. To know the work burden of the respondents during post COVID-19

Research Methodology:

According to the objectives the present study is adopted descriptive research design. The present study is primarily based upon the secondary data. For this paper conduct through literature review, without any empirical study was not conducted. A large resource of written material used for the study, which included books, magazine articles, academic journals as well as the websites.

Review of Literature:

Devi and Padmavati (2006), The aim of this study was to examine the impact of the nutrition and health education program of the Integrated Child Development Service on women's level of nutrition/health knowledge and hygiene practices and the nutritional status of children. Anganwadi workers conducted a training program consisting of 12 sessions (one per month). A total of 300 children and their mothers belonged to the intervention group and 100 children and their mothers to the comparison group. All participants were recruited from rural communities in the Mahaboobnagar district of Andhra Pradesh, India. Mothers in the intervention group had significantly higher scores on nutrition and health information and hygiene practices than control mothers. The educational intervention had no significant effect on the nutritional status of the children. This study confirms the value of the training program to increase the nutrition and health knowledge of rural mothers.

Thakre et al, (2011), considered that, Anganwadi Workers is the Community based intentional cutting edge workers of the ICDS programs. Chosen from the community, she expect a significant part due to her near and persistent contact with the recipients. The yield of the ICDS plot is to a extraordinary degree subordinate on the profile of the key functionary i.e. the Anganwadi Workers, her capability, encounter, ability, information, mindfulness etc. being the useful unit of ICDS program which includes diverse bunches of recipients, the AWW needs to conduct different work obligations. She had to reach to assortment of recipient bunches. She should give them with distinctive administrations which incorporate nourishment and well being instruction, Pre-school instruction, supplementary nourishment too arranges in

organizing immunization camps and wellbeing check up camps.

WHO (2020), reported that, the recent COVID-19 pandemic has resulted in a rapid spread of the corona virus, causing global concern. WHO declared it as a global public health emergency threatening the lives of millions and potentially requiring "a coordinated international response", due to an exponential increase in infections. While many countries opted for strict measures to limit the spread of the disease and others imposed partial restrictions on non essential internal movement calling for a lockdown.

The Central government of India imposed a nationwide lockdown on 24 March 2020 to limit the spread of the highly-contagious COVID-19 and asked people to stay at home and maintain social distancing. With cities and work shut down, there has been a substantial increase in the number of migrants returning to their villages with almost little or no money. On arrival in their native villages, Anganwadi Workers have been assigned the responsibility of community surveillance by recording incoming migrants' travel history, asking them to stay in quarantine for 14 days, nothing symptoms, and assisting district and local administration in tracking contacts. "Anganwadi worker' refers to a trained woman selected as a voluntary worker from the local community to deliver integrated services, improve linkages with the health system, and attain they key objective of enhancing the capacity of community and mothers for childcare, survival and development.

World Bank (2020) reported that, the Anganwadi worker in charge of enhancing the nutrition of women and children across India in days of normal function, now they have been assigned the responsibility of local level surveillance in different parts of the country while their usual duty involves supporting breastfeeding mothers and feeding young children. ILO (2020) also reported that, the Maharastra, Anganwadi Workers have been involved in home delivery of cooked food to vulnerable groups, such as pregnant lactating women and children (7 months to six years), under the Bharat Ratna APJ Abdul Kalam Amrut Yojana.

Functioning and Roles of Anganwadi Workers (Before and After the Pandemic):

"According to the Integrated Child Development Scheme (Department of Administrative Reforms and Public Grievances, 2017), some of the roles and responsibilities of the Anganwadi workers before the COVID-19 pandemic included community support and participation in running the programme. They were expected to make home visits and carry out surveys of families in their areas once a year to educate parents, specifically mothers, to ensure an effective role in the child's growth and development. Anganwadi workers' essential duties were organising informal preschool activities for children between the ages 3 and 6 and organising nutritional feeding for children between the ages 0 and 6 and nursing mothers. The Anganwadi workers also provided counseling to young mothers and informed married women about the importance of family planning. They had to maintain files and records as per their duties and were also required to guide ASHA workers employed under the National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme (Integrated Child Development Services Chennai Head Office, 2019). (Problems Plaguing Anganwadis: A Study of Decentralized Healthcare in Rural India During the COVID-19 Pandemic, IJPSL, Vol-2, page-no-5).

Anganwadi centers have been given additional responsibilities due to the pandemic. They conducted contact surveys and door-to-door visits in the community as part of monitoring the spread of the COVID-19 virus.

In addition, AWWs conducted test drives, raised awareness about precautions and are currently monitoring the immunization process for 4,444 viruses. As AWCs were closed during the first and second waves, AWWs deliver everything needed to registered children and homes, deliver food to pregnant and lactating women, PDS (Public Distribution System) rations to villages and essential medicines to COVID-19 patients. Anganwadi workers also set up quarantine rooms for all returning migrants (Mathur, 2021).

Burden of Work on Anganwadi Workers:

As a community health worker, an Anganwadi worker serves 1000 to 1500 people in her area. Apart from routine prenatal check-ups, immunizations, monitoring of communicable and non-communicable diseases, Anganwadi workers in various states have been at the forefront of Covid-19, performing vital functions of Covid. These include,

Door-to-door Surveys: Anganwadi workers conducted syndrome surveys across the state and screened community members for symptoms of Covid-19. In the states of Haryana, Karnataka and Delhi, there are 10-12 rounds of Covid-19 screening during interviews with Anganwadi and ASHA workers. In each round, they had to collect descriptive data about the histories, occupations and demographics of several groups of people. Each survey round covering a specific population had to be completed within a week.

Apart from the Covid-related surveys, they had to conduct other surveys as well. In Haryana, ASHA workers were to distribute Ayurvedic ingredients recommended by the Ministry of AYUSH to every household. In Uttar Pradesh, ASHA workers were told to conduct additional surveys during Diwali and Chatt Puja when large numbers of people returned to their villages to participate in these festivals. ASHA workers in Karnataka have been asked to test all pregnant women for Covid-19, without which they would not be admitted to health facilities.

Contact tracing: Anganwadi and ASHA workers in all states are engaged in contract tracing of suspected Covid-19 patients using a detailed list of travel and contact details. Especially in relation to migrant returnees and travelers, in the early months of the closure, travel information and the contact persons of each person arriving in the village were recorded.

Policing Quarantine Centers: In the early months of the pandemic, Covid-19 positive patients were sent to either hospitals or institutional quarantine centers manned by Anganwadi workers.

Due to the large waves of migrants returning to their homes, Anganwadi workers had to be on alert around the clock, meeting and gathering information about all outsiders entering their area. Due to shortage of police personnel, especially in rural areas, Anganwadi and ASHA workers managed the quarantine centers. In the final months of the pandemic, Anganwadi workers were also responsible for ensuring that families followed home isolation practices.

Working in Containment Zones: As a measure to combat Covid-19, areas with a high number of Covid-19 cases are declared protected zones with limited access. In many states, Anganwadi and ASHA workers risked their lives working in protected zones that lacked adequate facilities. In Delhi, ASHA workers were given the task of identifying every Covid-19 patient in the isolation zone and were asked to survey 50 houses surrounding each Covid-19 case for contact tracing. ASHA was also required to set up test camps in protected zones, collect and maintain records of all tested persons. On average, ASHA workers had to visit 25-50 households every day. ASHA helpers visited 50-100 households daily. Due to the increased workload

associated with the pandemic, Anganwadi and ASHA workers had to work in the field for an average of 8-14 hours per day including weekends.

They have already organized vaccination camps in Anganwadi centers and check-ups of pregnant women, following all social distancing protocols during the lockdown. As community members are afraid to go for vaccinations and check-ups for pregnant women, door-to-door counseling was also done.

Conclusion:

Issues such as food insecurity and lack of community support during the COVID-19 pandemic have led to social pressures in the communities served by Anganwadi workers. During the lockdown, Anganwadi centers in remote areas struggled with virtual lack of connectivity due to lack of network towers and isolation from urban areas. The growing importance of Anganwadis during the pandemic needs to be considered and factored into government policies. Strengthening public health is critical to ensuring the prosperity of rural India in the coming years.

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