AN EVALUATION OF AAGANWADI WORKER IN CONTEXT OF NHED PROGRAM

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ABSTRACT

India is extremely poor on child survival and the quality of survival, as indicated by low birth weight and malnutrition. The first month and within that, the first weeks are especially vulnerable periods. Nutrition and Health Education (NHED) training is an important component of ICDS. Nutrition and health education is an element for overall strategy to address malnutrition, morbidity and mortality. Nutrition and Health Education which involves use of Behavior Change Communication strategy to build capacity of women especially in the age group of 15-45 years so that they can look after their own health, nutrition and developmental needs as well as that of their children and families. This paper is an evaluation of Aaganwadi Worker in context of NHED program. It is a study of Nutritional and Health Education (NHED) activities for few weeks and information regarding nutrition & health in Aaganwadi centre provided by AWW. The aim of this paper is to analyze the response and suggest ways to strengthen the capacity of AWW in doing activities and providing information regarding nutrition & health to make rural women health conscious and bring about the changes in knowledge attitude and practices regarding health. Primary data was collected from AWW at their allotted Aanganwadi centers. The data collection is through sampling. Samples were taken from two blocks of Banka district in Bihar (India), namely Rajoun and Amarpur. Random sampling approach was used. The analysis is made by using coefficient of variation and regression. It is an evaluation of Aaganwadi worker in terms of effectiveness, quality and efficiency.

Field of Research: Integrated Child Development Services, Nutrition and Health Education, Aanganwadi Worker, Child Development Program Officer, Aanganwadi Centers.

1. Introduction

Nutrition is an input to and foundation for health and development. Health and nutrition are the two things that go hand in hand. Proper nutrition leads to a healthier body. Scientifically, it can be said that nutrition guides on the aspect and co-relation of diet and health. With proper intake of food in right proportion provides the right kind of nutrition for health. Better nutrition means stronger immune systems, less illness and better health. Healthy people are stronger, are more productive and more able to create opportunities to gradually break the cycles of both poverty and hunger in a sustainable way. Better nutrition is a prime entry point to ending poverty and a milestone to achieving better quality of life. Poor nutrition leads to malnutrition problem especially in among vulnerable young children. Many nutritional problems affect vast sections of our population. Of these nutritional deficiencies are widely prevalent in India in rural areas particularly among the poor families. Nutritional disorders can occur either due to the deficiency of macronutrients i.e. energy and proteins or micronutrients like vitamin A, iron, iodine, zinc etc. Malnutrition is the most widespread condition affecting the health of children. The proportion of under-nutrition ranges from 1.0 per cent of children in developed countries to 27 per cent in developing countries. In India, one child out of every two and every third woman is undernourished. Childhood malnutrition is responsible for 22 per cent of India's disease burden - and for 50 per cent of the 2.3 million child deaths in India. Malnutrition is the underlying cause in up to 50 per cent under-five deaths. About 25
per cent of children under age five in the world are underweight. In India the underweight prevalence rate is 43 per cent. Average annual rate of decline in malnutrition since 1990 has been 0.9 per cent.

1.1. Health

Health is defined by World Health Organization of the United Nations as the “state of complete physical, mental and social well being and not merely the absence of disease and infirmity.” The essential requisites of health would include achievement of optimal growth and development, maintenance of the structural integrity and functional efficiency of body tissues, mental well being, ability to withstand the inevitable process of ageing with minimal disability and functional impairment and ability to combat diseases.

1.2. Nutrition

Nutrition may be defined as the science of foods, the nutrients and the substances therein, their action, interaction and balance in relation to health and diseases. It is the area of knowledge regarding the role of food in the maintenance of good health. Thus nutrition is the study of food at work in our body.

1.3. Malnutrition

Malnutrition can be defined as a pathological condition resulting from a relative or absolute deficiency or excess of one or more of the essential nutrients. From nutritional standpoint, the malnutrition can be classified into three categories. These categories are under-nutrition, over-nutrition and micronutrient malnutrition.

1.4. Magnitude of Malnutrition

Malnutrition continues to be significant health problem for children and adults in India. Pregnant women, nursing mothers and children are particularly vulnerable to the effects of malnutrition. Malnutrition is the most widespread condition affecting the health that 42.5 per cent, 48.0 per cent and 19.8 per cent children under age 5 years are underweight, stunted and wasted respectively. While there have been some improvements in the nutritional status of young children in several states, nutritional deficiencies are still widespread. There has been the increase in wasting (excessively thin), or weight per height, among children under age 3 years. Around 23 per cent of children were wasted. At the same time, there has been very marginal change in the percentage of children who are underweight (43 per cent in NFHS-2 and 40 per cent in NFHS-3). 40.4 per cent children under three years of age are moderately underweight and 21.5 per cent children are born...
with low birth weight (< 2500 grams). More than one-third of women (35.6 per cent) and men (33.7 per cent) have a low BMI. Low BMI indicates chronic energy deficiency. Thirteen per cent of women are overweight or obese (10 per cent are overweight and 3 per cent are obese). Overweight and obesity have become substantial problems particularly among older women, women living in urban areas and who are educated. Nutritional anemia which affects all age groups reduces resistance to fatigue and has profound effect on psychological and physical behavior. Iron Deficiency Anemia (IDA) is a common public health problem.

**Life Cycle Approach**

Adolescent → Pregnancy → Lactating → Infancy

School age ← Pre-School Children

The entry point into the life cycle is the adolescent girl who will be the future mother and should be given adequate attention. Their nutrition should be ensured and family should be educated against the practices like adolescent marriages and pregnancies so that they would be prepared to handle pregnancy, lactation and child care effectively. Advice should include both health care and nutrition measures which would help in prevention of PEM.

The relationship between malnutrition and infection can be described as a vicious cycle.

Malnutrition can increase the risk of infections and infections can, in turn, lead to malnutrition. This interrelationship and the synergistic effect of malnutrition and infections often lead to a high rate of child deaths in poorer communities in India.

The cumulative effect of malnutrition and infection produces retardation of physical growth leading to stunting or short stature in children. The effects of stunting are long lasting. As a result, the capacity to do physical work of adults may also reduced. We can, for example, see as to what generally happens to a par rural child starting from birth to adulthood in India. The child at birth weighs much lower than a normal child. Subsequently he/she is solely breast fed for longer periods. The delayed supplementary feeding i.e. delayed introduction of additional food usually triggers slowing in growth. In other words, malnutrition sets in. In view of the poor environment and lack of hygiene, the children are constantly exposed to infections like diarrhea and respiratory infections. There, is reduction in food intake by the child due to loss of appetite due to these infections. As a result, there is further slowing down of growth. The cycles of dietary deficit aid infections ultimately may lead to kwashiorkor in a child.

From the above discussion importance of Nutrition and Health Education can be scrutinized. Nutrition is closely interlinked with health. If a person eats the right kind of foods in the required amounts, he or she will keep good health provided no other factors intervene. On the other hand, a poor eating pattern or eating too little or too much will result in poor health.

It must be emphasized that though good food is one of the crucial factors in ensuring health, it is not the only one. The food eaten must not only be nutritious but it must be wholesome and clean and free from harmful germs. If this is not so, the person eating the food would get ill even if the food is nutritious.

The importance of nutrition and health education for improving the nutritional and health status of children and mothers, for adopting optimal infant and young child feeding practices, promoting
consumption of micronutrient rich foods and also to increase compliance under vitamin A and IFA supplementation programmers and use of iodized salt cannot be overstated. Nutrition & Health Education (NHE) is not merely a process of transferring facts or information about nutritive value of foods, the role of food in preventing nutritional deficiency diseases or methods preparation. The fundamental objective of Education in Nutrition is to help individual to establish food habits & practices that are consistent with nutritional needs of the body and adapted to the cultural pattern and food resources of the area in which they live. The NHE component under the project is redesigned with a particular emphasis on Mahila Mandal to a more comprehensive parenting support initiative.

So ICDS is giving lot of emphasis on Nutrition and Health Education (NHED) to enhance community awareness on the issues pertaining to Health and nutrition. Different strategies are adopted to get to the community with the messages of nutrition and health. On various aspects of community based new born care, nutrition strategies, complementary feeding practices, immunization etc. The education session on health and nutrition gives a platform to the community to own the nutrition and health intervention and ensures the participation of in nutrition and health aspects of the village in general and the activities of the AWC in particular. Nutrition and Health education being the key element of the ICDS program, all women in age group of 15 to 45 years are covered by this component to look after their own health, nutrition and development needs as well as of their children. The ICDS and Health functionaries are imparting Nutrition and Health Education to the Pregnant Women, Nursing Mother and mother of risk children on different health issues. Nutrition and health education is organized at the Anganwadi for mothers and pregnant women. All women between 15 and 45 are invited and special care is taken to ensure attendance of pregnant and nursing mothers and mothers of children who suffer from repeated illness of malnutrition. Information about balanced diet is provided to increase awareness among the people and prevent unhealthy food habits.

1.5. Behavioral Change Communication

Behavioral aspects of child health and nutrition outcomes are complex and are determined by interrelated, multilevel factors present in the environment of the mother. Due to the significance of maternal health behaviors in affecting her child’s health and nutritional status, programmatic interventions have attempted to modify these behaviors in varied contexts and through various platforms.

Communication is a central aspect of behavior change, and communication has been a major strategy to impact such change. Behavior change communication can be broadly defined as a process of understanding people's situations and influences, developing messages that respond to the concerns within those situations, and using communication processes and media to persuade people to increase their knowledge and change the behaviors and practices that place them at risk. Communications strategies have evolved to focus more on the receiver rather than the sender as the center of communications, and the new terminology, behavior change communication (BCC) reflects this shift. Unlike the instructive programs, which are set to “sell” a particular message or idea, BCC recognizes individuals within the intended audience as active, rather than passive, receivers of information and messages, who act on messages only if they are seen as advantageous or useful. BCC encourages that the audience need new skills and social support to make and maintain behavior change. BCC is one component of Behavior Change Interventions (BCI). The communication in BCC involves information dissemination and awareness to address motivation to change and ability to assess benefits of practicing and sustaining new behaviors. Human behaviors, those related to health are complex, multifactorial and interrelated determinants that cannot be addressed by BCC alone, and need social, economic and systemic changes.
Research evidences indicate that child nutritional status, childhood morbidities and health outcomes are determined most importantly by maternal roles of mothers and feeding. Mothers spend a greater amount of time per day in child care and household activities than that of other members of the household and their role as the primary caregiver is of utmost significance in determining child health and nutrition outcomes. The decisions made by mothers depending on her individual knowledge, prior experiences, and external environmental conditions is observable in her behavior to ensure that her child's health and nutrition are important factors for the prevention of child morbidities and mortality.

Maternal education regularly emerges as a key element of an overall strategy to address malnutrition, maternal knowledge about child health and nutrition, acquired outside the classroom is also crucial in improving mother’s nutritional education. Various research studies shows that maternal knowledge imparted through health and nutrition education programs can reduce the incidence of childhood malnutrition by 13 to 43 percent. The impact of maternal education and maternal knowledge on health and nutrition behaviors for child health has also been studied. Even in communities where formal education is limited, it is possible to increase child health and nutrition through specific health education programs. While certain studies have found maternal knowledge to be more effective in changing health related behaviors than maternal education. The study also found that although most health and nutrition education programs focus on very specific information related to child micronutrient deficiencies yet they improved the general quality of diet in the population.

Out of the various causes of morbidities and mortalities prevalent among children and reflected in the poor child health indicators, more than half are preventable. Besides clinical preventive measures such as immunization and treatment of childhood illnesses, health behaviors of the primary caregiver (mother) plays a significant role in alleviating these conditions leading to disease and death in children. Child health denotes the health and nutrition indicators of the child between 0-3 years of age the most formative years of life, and the age during which the child is most vulnerable, and the period in which the mother’s role in determining the child’s health and nutrition is the most significant. In conceptualizing child nutrition the behaviors of mother are important factors to the direct determinants of child nutrition that impact on child growth. Programs have introduced communication based interventions at the community level through pre existing community based structures, such as Gram Panchayats, Mahila Mandals, Yuva Mandals, Village Health Committees and self help groups.

1.6. Capacity building

Capacity building occurs within programs or more broadly within systems and leads to greater capacity of people, and communities to promote health.

Capacity building is developing skills learning and training opportunities for individuals and groups, and sharing through networks and mutual support, to develop skills, knowledge and confidence. It is developing support, developing the availability of practical support to enable the development of skills and structures.

Capacity building is defined as activities, resources and support that strengthen the skills and abilities of people and community groups to take effective action and leading roles in the development of their communities.

- Understanding the present capacities of the target group i.e. women.
- Understanding the problems faced by these groups.
- To understand the specific intervention points to enhance the capacities of the target groups.
• Know the possible capacity building methods to enhance the capacities.

Training is an important component of ICDS owing to a large workforce involved in its implementation. Training and capacity building is most crucial component of the ICDS that includes both pre-service and in-service training of AWWs (Anganwadi Workers). Trainings for ICDS functionaries needs focus on development of technical understanding and necessary capacity of the front line workers. There is immense need for the ICDS personnel to understand their role in implementation of the program. Training curriculum needs to incorporate the coordination and synergy the front line staff need to have with other line departments (health, education, water/sanitation, rural development). The weakest link in ICDS is Nutrition and Health Education (NHED). It is thus important to build capacity on Behavior Change Communication (BCC). This will help AWWs to prioritize home visits and provide nutrition education to families on child care. Building AWWs capacity to facilitate and support kitchen gardens and in preparing nutritious food from locally available food will help ensuring nutrition and health of the communities in a long term and sustainable way. In all capacity building programs be related to enhance self-esteem of girls, women and concerns of addressing and involving men and communities in the women’s health concerns are consciously integrated.

2. Area of Study

The study was conducted in Banka district in ICDS project of two Blocks namely Rajoun and Amarpur. The activity was observed in two panchayat one in Rajoun (Village Gidda) and other in Amarpur village (Balua).

<table>
<thead>
<tr>
<th>Block</th>
<th>C.D.P.O</th>
<th>Panchayat</th>
<th>AWW</th>
<th>AWC in Villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amarpur</td>
<td>1</td>
<td>19</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Rajoun</td>
<td>1</td>
<td>14</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>33</td>
<td>67</td>
<td>67</td>
</tr>
</tbody>
</table>

2.1 Research Methodology

Different methods have been used for the collection of data regarding the NHED activity/ information regarding nutrition & health in Aaganwadi centre provided by AWW. The collection of data uses the various techniques. The data collected are from two sources (1) Primary sources (2) Secondary sources.

Primary Sources

Primary data was collected from surveys and field visits.

Secondary Sources

The secondary data collected from the CDPO’s office and Supervisors. It is the information which is obtained at second hand regarding the NHED activity information regarding nutrition & health in Aaganwadi centre provided by AWW.

The various method of data collection which I used in my study is given below:

- Observation
- Participant interview
- In-Depth Interviews
- Focus Groups

- Survey
- Questionnaire
- Sample size

Among various methods of sampling, simple random sampling method was adopted. Selection of AWW and AWC in various villages was randomly selected. The larger the sample size, the more sure that their answers truly reflect the population. This indicates that for a given confidence level, the larger your sample size, the smaller your confidence interval. However, the relationship is not linear (i.e., doubling the sample size does not halve the confidence interval). Determining sample size is very crucial, as in this research Anganwadi worker and centre both are homogenous in nature so in
this type of universe small sample size can serve the purpose. The interview schedule was prepared. It has been prepared in a simple way so that the respondent can understand easily and give their answers frankly.

The analysis is made by using coefficient of variation and regression analysis. The coefficient of variation represents the ratio of the standard deviation to the mean, and it is a useful statistic for comparing the degree of variation from one data series to another, even if the means are drastically different from each other. It indicates the relationship between the standard deviation and arithmetic mean expressed in terms of percentage. It is used to compare variability, stability, uniformity and consistency between two sets of data. The higher coefficient of variation has higher degree of variation. Regression analysis is the determination of a statistical relationship between two or more variables. Regression can interpret what exist physically. It shows that there is any cause and effect relationship between two variables or more variables. If yes, of what degree and in which direction.

3. Analysis and Observations

- There are 50% matriculate AWW, 34.6% are intermediate, 13.5% are graduate and 1.9% masters. Low percentage of masters and graduate AWW shows the low rate of literacy among recruited AWW. Minimum qualification is matriculation. It shows minimum criteria is following and it affects the quality of service.

- 65.4% of AWW responded that 6-10 women & adolescent presents in NHED day. 34.6% told that 11-15 women & adolescent present. Attendance at the monthly meeting is unsatisfactory. It is due to ineffectiveness in activity at AWW and also there is lack of community involvement. Information & activity provided is not up to mark, it is unsatisfactory in general.

- 76.9% of AWW have no information about nutrition. They responded wrong answers where as 13.5% replied partially correct and 9.6% responded correct answer. There is lack of Information regarding Nutrient Domain area:
  - Macro Nutrient
  - Micro Nutrient

  For example Why protein is important / or what is the role of protein in human body.

- 9.6% of AWW responded that they organize activity in morning where as 90.4% responded that they organize in noon. There is lack of coordination between Anganwadi worker & community in general. It is also observed that timing is also the obstacle in organizing NHED activity.

- 61.5% of AWW responded that charts and posters are little effective in providing nutritional information where as 38.5% were responded that they are not effective. There was lecture method in giving information by using chart & posters given by CDPO office. There is meeting of women at Bal Diwas and meeting of adolescent girl at Kishori Diwas in which information is provided regarding malnutrition, anemia, advantages of breast feeding and general information.
regarding health but the information is not sufficient, generally this information is provided by lady supervisors. All the information’s are provided through charts and posters and, by lecture method which is insufficient in providing information.

![Pic.1: Very low attendance](image1)
![Pic.2: Above slogans doesn’t contain information about nutrients but acting as a behavioral change communication and attitudinal change, it needs more informative.](image2)
![Pic.3: Mother & child care information, less nutritive information.](image3)

### Table-2: COV

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>.47</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>.50</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>.52</td>
<td>5</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>.53</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>.55</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>.56</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>.58</td>
<td>18</td>
<td>34.6</td>
</tr>
<tr>
<td></td>
<td>.61</td>
<td>6</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>.62</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>.64</td>
<td>5</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>.67</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>.68</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>.69</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

NHED services provided by AWW.

#### 3.1. Regression

**Table-3 : Model Summary**

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A0.459&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.211</td>
<td>0.195</td>
<td>0.441</td>
</tr>
</tbody>
</table>

<sup>a</sup> Predictors: (Constant), Information provided about Nutrition

**Table-4 : ANOVA<sup>b</sup>**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>2.596</td>
<td>1</td>
<td>2.596</td>
<td>13.368</td>
<td>B 0.001&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Residual</td>
<td>9.711</td>
<td>50</td>
<td>0.194</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12.308</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Predictors: (Constant), Knowledge of Nutrition in AWW.
<sup>b</sup> Dependent Variable: Do you think chart/ posters are effective in providing nutritional information.

**Table-5 : Coefficients<sup>a</sup>**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standardized</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
</table>

Proceeding of the Social Sciences Research ICSSR 2014 (e-ISSN 978-967-11768-7-0). 9-10 June 2014, Kota Kinabalu, Sabah, MALAYSIA. Organized by [http://WorldConferences.net](http://WorldConferences.net)
• From A in the table no 3, the correlation coefficient, R, is 0.459, it means intermediate correlation between knowledge of Nutrition in AWW and do you think chart/ posters are effective in providing nutritional information. Table no 6, R, is 0.037, it means weak correlation between Women & Adolescent Present in NHED and What is the time of organizing NHED training at your AWC. From B in table no 4, since the p-value is 0.001 < 0.05, the relationship between Information provided about Nutrition and do you think chart/ posters are effective in providing nutritional information is significant. Table no 7, since the p-value is 0.795 > 0.05 Women & Adolescent Present in NHED and What is the time of organizing NHED training at your AWC is insignificant. From in the table no 5, regression equation is Y=aX+B, a=0.348 b=1.685, Y= Do you think chart/ posters are effective in providing nutritional information (Dependent Variable). X= Knowledge of nutrition in AWW (Independent Variable). From table no. 8, Y=aX+b, a= -0.023 b= 1.958, Y = What is the time of organizing NHED training at your AWC (Dependent Variable). X= Women & Adolescent Present in NHED (Independent Variable)

• The 30 day training to Anganwadi Worker (AWW) were given some years ago which include nutrition, health & education (NHED) training.
• The work of graduate anganwadi worker is better than matriculate & intermediate passed worker in terms of managing the center. It has been observed that AWW with sound economic status do not organize NHED activity at their AWC regularly. Most of the AWC was allotted in
2004. It means AWW has around 8 years of experience but the impact on beneficiaries is unsatisfactory.

4. Conclusions & Suggestion

ICDS has great potential to improve the nutritional status of India’s children is undeniable, but it needs to overcome some challenges if this potential is to be realized. Worst is Bihar where, an underweight prevalence of 55 per cent. ICDS is not making the expected contribution in reducing the malnutrition in India.

It might be more beneficial to focus energies on improving service delivery within existing AWCs projects, rather than just on expanding coverage.

To retain the present structure, a preschool function for older children (4 to 6 years), on the one hand, maternal and child health and nutrition interventions with stress on younger children (0 to 3 years), on the other, are offered within the same program. Then present structure should introduce a system of two workers one charged with health and nutrition functions and one charged with the preschool function.

State governments should be encouraged to modify the basic model to local needs and take up responsibility for the management of the overall program rather than focus almost totally on the procurement and distribution of supplementary food, i.e., the only activity in the program that they finance directly.

Increase target of children under three and pregnant women, Strengthen nutritional and health education activities, Increase home visits with respect to NHED activities.

Improve skills of anganwadi workers and their helpers and develop capacity to deliver all nutrition interventions

The main reasons behind this is lack of awareness among masses about the nutrition and health which requires more attention. To strengthen the nutrition and health education component of the ICDS Scheme every month. The NHED should be theme based for which the following points are proposed.

Various themes / topics proposed to be covered during the year by an anganwadi worker are as follows:

<table>
<thead>
<tr>
<th>January</th>
<th>Importance of food type of nutrient – their functions /importance and sources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>Malnutrition Courses &amp; consequences, identification and growth monitoring.</td>
</tr>
<tr>
<td>March</td>
<td>Nutritional / dietary needs of children, adolescent girls</td>
</tr>
<tr>
<td>April</td>
<td>Anemia – identification causes &amp; consequences, food required during anemia.</td>
</tr>
<tr>
<td>May</td>
<td>Causes and prevention of other deficiency disorder like iodine deficiency, vitamin – a deficiency etc.</td>
</tr>
<tr>
<td>June</td>
<td>Care &amp; dietary needs during pregnancy, lactation and old age.</td>
</tr>
<tr>
<td>July</td>
<td>Immunization – importance, schedule.</td>
</tr>
<tr>
<td>August</td>
<td>Breast feeding – importance of colostrums, mother’s milk, disadvantages of bottle feeding.</td>
</tr>
<tr>
<td>September</td>
<td>Waning food / complementary food – what, when, why &amp; how to introduce.</td>
</tr>
<tr>
<td>October</td>
<td>Preservation &amp; conservation of nutrients.</td>
</tr>
<tr>
<td>November</td>
<td>Hygiene – food hygiene, personal hygiene, safe drinking water &amp; environmental sanitation.</td>
</tr>
</tbody>
</table>
December Miscellaneous topic like – Diarrhea & management, AIDS awareness, family planning etc.

One specific theme should be kept for discussion every month in meeting conducted by Anganwadi Workers.

Messages can be positive or negative. A positive message for a group of poor People would be-eat greens to keep your eyes healthy. An example of the same message in negative form could be-Eat greens or you’ll go blind.

As adolescent girls also needs to be made aware about the family’s nutritional needs and health aspects so these topics should be discussed in Balika Mandals also.

Nutrition & Health Education (NHED) is not merely a process of transferring facts or information about nutritive value of foods, the role of food in preventing nutritional deficiency diseases or methods of food preparation. The fundamental objective of Education in Nutrition is to help individual to establish food habits & practices that are consistent with nutritional needs of the body and should be adopted in the cultural pattern and food resources of the area in which they live.

Nutrition & Health Education will remain to be a continuous activity at the AWC, a fixed day in a month and will be mandatory to observe by each AWC. The Supervisor and CDPO would monitor the session on health and nutrition issues. Camera approach of monitoring can be applied to Anganwadi centers as well. Each supervisor can be given a camera and taught how to use it. A seal should make the date and time functions of the camera to tamper proof. The supervisor could then be instructed to take a picture of themselves along with the women and adolescent girl in every field visit. Once a month, when the supervisors meet at the CDPO office they attach this photograph with monthly progress report. CDPO officer could check the camera for a photograph with a date corresponding to each NHED activity of the Anganwadi. The payment of a component of the workers’ salary could depend on showing the required set of photographs with the corresponding dates.

- Participative learning should be adopted
- Methods of participative learning
- We should consider the psychological environment. In other words, women and adolescent learners need to feel comfortable in their minds when they learn. In order to make the situation relaxed and friendly, we may play some games. We call them ‘ice breakers’ or ‘energizers’. For examples Name Game
  - Ask the participants to form a circle.
  - Ask them to think of an anything that starts with the first letter of their name.
  - They will introduce themselves by saying anything and their name (e.g., Deep Deepa).
  - The AWW may start the game by introducing herself. She may say, Hello, everyone, welcome to the NHED activity, I am Sangeet Sarita.
  - The participant on her right introduces himself next. After the introduction, she adds the name of the facilitator (e.g. Deep Deepa, Sangeet Sarita)
  - The third participant will introduce herself and will add the names of Deep Deepa, Sangeet Sarita), Continue until all participants have introduced themselves and have learned the names of the participants.

4.1. Group Discussions

Group discussion is a useful participatory learning method. Group discussion gets people interacting and sharing ideas in a structured way. When we join a group discussion we learn to agree, disagree
and have mutual respect for each other. Group discussion empowers us to learn different viewpoints on a particular issue or the other side of a story. It provides an opportunity to hear everyone’s ideas and to move on to concrete actions.

- **Steps for a group discussion**
  - State the reasons for and the goals of the discussion beforehand.
  - Talk in an informal way and ask about the concerns learners have so that they can help choose a topic (family planning is one example).
  - Select a moderator to start the discussion.
  - Encourage group members to present the pros and cons of the topic. Everyone should have a chance to speak and share ideas.
  - Gather information and analyze. Have someone take notes on the blackboard.

### 4.2. Role Playing

Role play can add a new dimension to a program. Acting out problems that have come up during discussion makes them more vivid and meaningful for everyone. We can also build up the confidence of the participants. Art is from the people and for the people. The learning process through role play is enjoyable and learner centered. Role plays help us to experience an issue directly. We can then use the experience of the role play to write about how we feel.

- **Steps to follow for a role play**
  - Choose the subject matter and outline a basic plot.
  - Select the actors do a small role play first.
  - Prepare flash cards of proverbs or sayings that the actors can use at any time.
  - Encourage the actors to make up their own spontaneous dialogue to suit the story line and plot.
  - Arrange some time after the role play to discuss the experience.

### References


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