IAP-IYCF

ESSENTIALS OF MATERNAL, INFANT, YOUNG CHILD AND ADOLESCENT NUTRITION

IYCF Chapter of the Indian Academy of Pediatrics

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Essentials of Maternal, Infant, Young Child and Adolescent Nutrition

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CHAPTER 44

Role of Primary Health Care Workers in Nutrition Services

Mallanagouda M Patil, Shailaja S Patil

Introduction

Primary health care is the foundation of the health care delivery system in India. Especially in rural India, health care services are rendered through a network of community health workers. There are mainly three cadres of Community Health Workers (CHWs) viz. Auxiliary Nurse Midwife (ANM) at Sub center level, Anganwadi Worker (AWW), and an Accredited Social Health Activist (ASHA) at the village level who cater to the vast majority of the rural population of our country. Secondary level is usually at taluk/Block or/community health centers (CHC) at subdistrict level (SDH) hospitals and tetialry care provided by District level hospitals, medical college hospitals

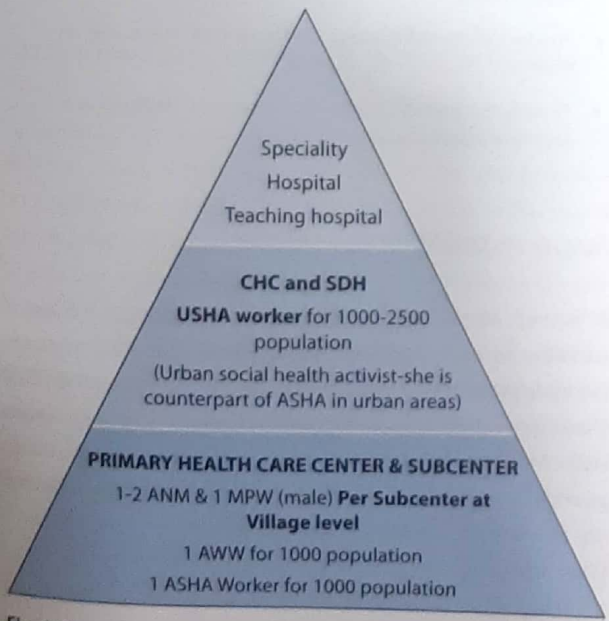

Fig. 1: Pictorial representation of Health Care Delivery system in India

Community health workers are the grass root level workers who directly contact with beneficiaries of the programs as the primary service providers. Their role is most important in the successful implementation of the nutritional interventions; they are the link between health systems and the community.

Community-level health worker's nutrition tasks are common in the majority of developing countries; they can be grouped into 8 main categories:

- Getting to know the community needs.
- Measuring and monitoring the growth and nutrition of children.
- Promoting breastfeeding.
- Giving nutritional advice on feeding infants and young children.
- Giving nutritional advice to mothers.
- Identifying, managing, and preventing nutritional deficiencies.
- Providing nutritional care during common infections.
- Conveying nutritional messages to the community.[1]

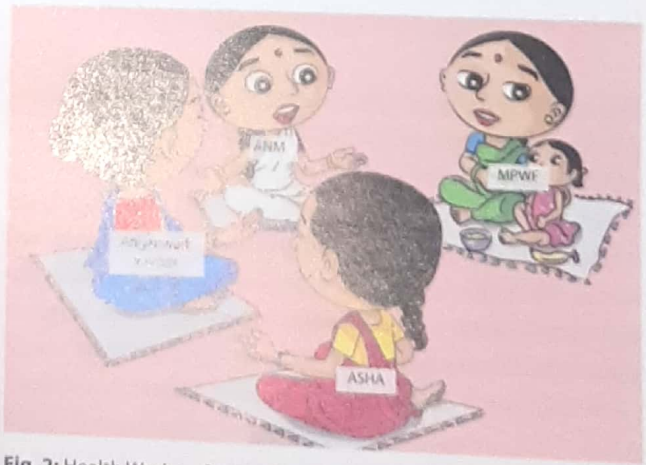

Fig. 2: Health Workers for Nutrition Services[2]

In India, there are two main ministries which are responsible for delivering nutritional interventions to population, especially focused on mother and children.

1. Ministry of Women and Child Welfare [Integrated Child Development Services (ICDS)]
2. Ministry of Health and Family Welfare (MoHFW)

The structure of two major ministries through which nutritional programs are delivered in India are:

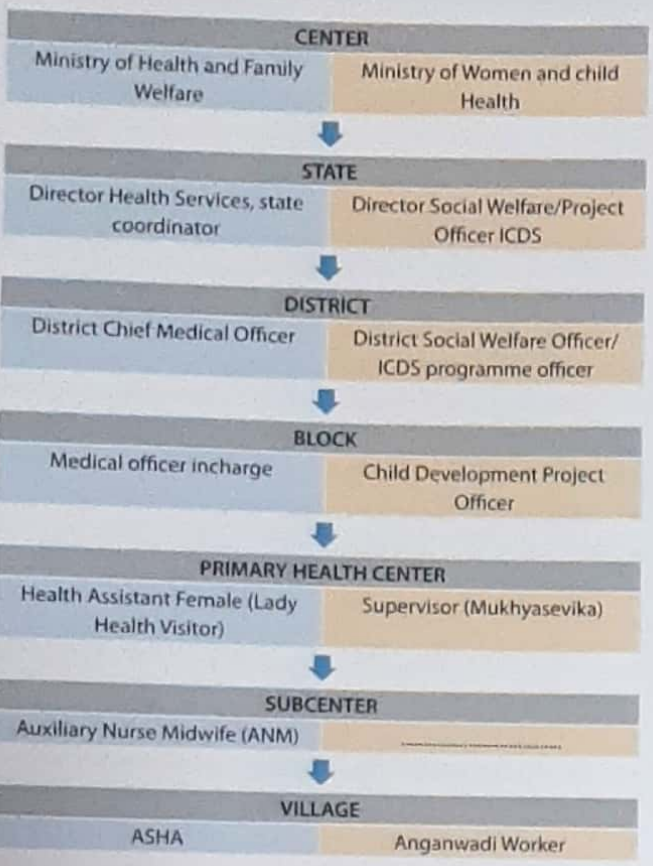

Fig. 3: Organizational Structure of Nutrition Services in India[3]

Auxiliary Nurse Midwife (ANM)/ Multipurpose Health Worker Female (MPWF)

ANM is a female health worker based at the sub-center; she is the first contact person between the community and the formal health service system. When the ANM program started, it mainly focused on midwifery and maternal care.[4,5] Over time, with the recommendation of several committees, ANMs transformed from temporary to permanent staff within the health care system.[6] Their roles now cover a wide range of preventive and basic curative services at the sub-centre level, and they work under the supervision of Lady Health Visitor (LHV) and Medical Officer of the respective primary health center.

Selection of ANM

- Any female in the age group 17 to 35 years, who has passed 10+2 from any recognized board, can get admitted for the ANM training program in a recognized Nursing school across India.[7]
- ANM should receive 18 months of training under the Indian Nursing Council, and in addition to this, she should also receive 3-6 weeks of the skilled birth attendant training program under MoHFW.[8]
- ANMs are employed by the Commissionerate of Health & Family Welfare and are positioned at sub-centers based on vacancies.
- ANMs are paid a monthly salary of Rs. 10000 to Rs. 15000, and it varies from state to state.[9]

Key roles of ANM/MPW Female in Nutrition services[10,11]

- Distribution of IFA tablets to pregnant women, lactating mothers
- Promotes IYCF practice and sanitation
- ANC, PNC and Immunization Services
- Screening anemia in the community, distribution of IFA supplementation and deworming to prevent anemia in under-5 children and adolescents
- Vitamin A Prophylaxis and depot holder of ORS and zinc supplements
- Render Health and nutritional education to community on VHNDs
- Growth monitoring of under 5 children and maintaining a record of under-nourished children

Anganwadi Worker (AWW)

A survey conducted in 1972 indicated poor coverage of nutrition by existing social welfare measures. This prompted the Government of India to start the ICDS (Integrated Child Development Services) program in 1975. Anganwadi centers with Anganwadi workers are the community level service providers under this scheme. ICDS initially concentrated on the health issues of children below 6 years of age.[12] Over time, it has expanded its nutritional interventions to pregnant women, lactating mothers, adolescent girls, and the community in VHNDs.

Selection of AWW

- AWWs should be a female from the local village and acceptable in the local community and willing to work as an Anganwadi worker. She should be in the age group 18-35 years with a minimum qualification up to 10th grade.[13]
- AWWs initially receive three months of training. Later they are supposed to receive a seven-day refresher training at various points throughout their career.[14]
- The AWW selection committee consists of the Chairperson of Panchayat, Medical Officer of PHC, Block Development Officer, and Social Welfare Officer of the block.
- AWWs are paid an "honorarium" of Rs. 4500 month.[13]

Key Roles of AWW in Nutrition services[13,15]

- Promotes IYCF practices and sanitation
- Preparation and Distribution of supplementary nutrition for beneficiaries under ICDS,
- Vitamin A Prophylaxis and depot holder of ORS and zinc supplements
- Distribution of IFA tablets to pregnant women, lactating mothers
- Distribution of IFA supplementation and deworming to prevent anemia in under-5 children and adolescents
- Growth monitoring, follow up and prompt referral
- Organize VHNDs and Immunization services at the Anganwadi center

Accredited Social Health Activist (ASHA)

In the year 2005, the Government of India formed the National Rural Health Mission (NRHM) for strengthening the rural primary health care system, in which public health care expenditure raised from 0.9% of GDP to 2–3% in order to improve community participation in the public health care sector.[16] The government of India implemented the ASHA program under the Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural Health Mission.[17] Ministry of Health and Family Welfare describes ASHAs as "local women trained to act as health educators and promoters in their communities".[18]

Selection of ASHA

- ASHA must be a female from the local village – married/widowed/divorced, preferably in the age group of 25 to 45 years.[19]
- She should be literate with a minimum formal education of up to class 8.
- She is appointed by various community groups such as Anganwadi Institutions, the Block Nodal Officer, District Nodal Officer, the Village Health Committee, and the Gram Sabha.
- She will receive performance-based incentives for each service she renders to the community.[20]

Key roles of ASHA in Nutrition services[10,19–21]

- Create awareness about health care, nutrition, and basic sanitation in the community
- Assist AWW in organizing VHNDs and mobilize beneficiaries
- Mobilize beneficiaries for a supplementary nutrition program to Anganwadi center and provide home-based neonatal care services
- Assist AWW in growth monitoring of under 5 children and line listing of malnourished children and follow up if needed, prompt referral services
- Assist ANM in screening camp for anemia and deworming
- Depot holder of IFA tablets, ORS, and zinc tablets
- Distribution of IFA tablets to pregnant women, lactating mothers
- Promote IYCF practices and sanitation

New Nutritional Interventions and the Role of Community Health Workers?

The problem of malnutrition is inter-sectoral and is dependent on various dynamics such as institutional delivery, optimal Infant & Young Child Feeding (IYCF) practices, immunization, early childhood development, deworming, food fortification, access to safe drinking water and proper sanitation, provision of timely ORS, zinc and other related factors. Hence, in order to address the problem of imbalance in nutrition, mainly in the form of under-weight, stunting, and wasting, especially

Fig. 4: Convergence of services by CHWs under "Poshan Abhiyaan"[12]

Table 1: Convergence of Services among ANM, AWW, and ASHA at Village Level[13]

S. No.	ANM	AWW	ASHA
1.	Provide basic curative services for minor illness and early referral services on priority	Refer sick children, pregnant/lactating mothers to sub-center, PHC/CHCs	Refer cases to sub-center, PHC/CHC
2.	Impart Health & Hygiene Education to the beneficiaries, Assist by Supervising and the implement programs like Kishori Shakti Yojana (KSY)/Nutrition Program of Adolescent Girls (NPAG), IMNCI, RMNCH+A, Anemia mukth bharath	Assist child development project officer in implementation of ICDS, Kishori Shakti Yojana (KSY)/Nutrition Program of Adolescent Girls (NPAG), Mathru Poshana Yojana, Pradanmanthri Mathruvandana Yojana	Assist and mobilize beneficiaries related to the activities pertaining to programs like Janani Suraksha Yojana, IDSP, IMCI, RMNCH+A, RNTCP Kishori Shakti Yojana (KSY)/Nutrition Program of Adolescent Girls (NPAG)/etc.
3.	Administer drugs as specified by the MOHFW	Administer Over The Counter (OTC) drugs. Distribution of ORS/IFA Tablets. Disposable Delivery Kit (DDK), OCP & Condoms.	Administer OTC drugs, Distribution of ORS/ IFA tablets DDK, OCP & Condoms
4.	Promote breastfeeding of Infant & Young Child Feeding Practices in village and health day and home visits once in two months during pregnancy and 4 visits postpartum under IMCI	Promote breastfeeding of Infant & Young Child Feeding Practices.	Promote breastfeeding of infant & complementary feeding practices and home visits every month during pregnancy and after delivery till the child reaches 6 months of age under IMCI and Poshan Abhiyaan

in children, there is a need to take-up unrelenting and lasting steps with a multi-pronged approach and bring grass-root level collaboration and convergence to negate duplication of work and develop a more efficient workforce.

Although India's major nutrition program started as early as 1975 (ICDS), the coverage was patchy till the early 2000s. However, to address the malnutrition problem, there is a need for comprehensive life cycle approaches to continuum of care care at different nutritionally vulnerable stages of growth. Keeping this in view, a flagship program by the Government of India, National Nutrition Mission (NNM), or "POSHAN ABHIYAN," was launched to cover all nutrition related schemes. The program mainly focuses on improving nutritional outcomes in children, pregnant women, and lactating mothers by using technology, targeted approach, and convergence. The convergent services focus on adolescent girls, pregnant women, lactating mothers, and children from 0-6 years of age. The first 1000 days of a child are most critical - 9 months of pregnancy, the first 6 months of exclusive breastfeeding, and the period from 6 months to 2 years to ensure proper complementary feeding. The NNM not only tries to bring exclusive nutrition services under one umbrella so that the under-nutrition problem is addressed comprehensively, but it also removes the duplicating roles and decreases the burden of documents to be maintained by the community health worker.[22]

The following table explains the convergent roles of health workers involved in nutritional services at the village level.

Challenges/Barriers faced by Health Workers

- Insufficient training in terms of quality and duration contributes to poor skills of CHWs.[23]
- Poor supportive supervision and mentoring by supervisors make the CHWs vulnerable to face any challenges all alone.[24]
- Vacant and unfilled positions of ANM/ASHAs in the interior or remote, underdeveloped regions.
- Poor basic facilities at many of the sub-centers built far away from villages; security is a major threat for most of the ANMs who live alone in sub-centers.
- Too many programs merging at end level service provider puts health workers under constant pressure.
- Lack of felt need for preventive and promotive health services by the community is a major challenge for the health workers to motivate beneficiaries to utilize these services.
- Poor supply of drugs like ORS, Iron, hampers the care to be delivered to the community at the village level by ASHA workers.[25]

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