ASSESSING THE KNOWLEDGE OF ANGANWADI WORKERS REGARDING INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) IN TRIBAL AND NON-TRIBAL BLOCK OF VALSAD DISTRICT, GUJARAT

Dissertation
At
ICDS, Valsad, Gujrat (Department of Women and Child Development (WCD), Gujarat)

By
Nareshkumar Charansingh Prajapti

Under the guidance of
Dr. P.R. Sodani

MBA Hospital & Health Management
2013–15

Institute of Health Management Research
Jaipur
2015

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Nareshkumar Charansingh Prajapati, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Department of Women and Child Development – Integrated Child Development Services (ICDS), Gujarat from 24th February, 2015 to 12th May, 2015.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Professor P.R. Sodani
Dean, Training
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141- 3924738, E-mail: iihmr@iihmr.org, Web.: www.iihmr.org

સંકલિત બાળ વિકાસ સેવા યોજના
મહિલા અને બાળ વિકાસ વિભાગ
ગુજરાત સરકાર

D.I.S.M.U

(District ICDS Strengthening Management Unit)
District, Valsad
email:dpcnutri.valsad@gmail.com

મિશન બલમ સુખમ

CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

The certificate is awarded to

Dr. Nareshkumar Charansingh Prajapati

In recognition of having successfully completed his
Dissertation in the department of

Women and Child Development Department

And has successfully completed his Project on

"Assessment of Knowledge of AWW in Non – Tribal and Tribal Blocks of Valsad regarding ICDS services"

24th Feb 2015 to 12th May 2015

From

District ICDS strengthening Management Unit (DISMU), Valsad

He comes across as a committed, sincere & diligent person who has a
Strong drive & zeal for learning.
We wish him all the best for future endeavors.

Member Secretary and
Programme Officer ICDS
Dist. Valsad
Gujarat

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Assessing the Knowledge of Anganwadi Workers regarding Integrated Child Development Services (ICDS) in Non – Tribal and Tribal blocks of Valsad District, Gujarat** and submitted by Dr.Nareshkumar Charansingh Prajapati Enrollment No. 1467 under the supervision of Professor P.R.Sodani (Dean Training) for award of MBA Hospital and Health Management of the university carried out during the period from 2013 to 2015 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Naresh

Signature

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141- 3924738, E-mail: iihmr@iihmr.org, Web.: www.iihmr.org

Acknowledgement

At the completion of my dissertation I would like to show my sincere gratitude to the ICDS Gujarat authority, especially to the Commissioner Women and Child Development Department, Ms. Anuradha Mall, IAS, and Deputy Director – Nutrition Ms. Sweta Dabhi, mam for providing me such an opportunity. Without her constant support and guidance it would never be a success.

I wish to express my deep sense of gratitude to my District Development Officer, Mr.G.C. Brahmbhatt IAS, Programme Officer Mr. Dipesh M. Patel, ICDS Valsad and my Mentor Dr. Abid Qureshi, State Nutrition Consultant for their constant help and cooperation, able guidance and Valuable suggestion and inspiration. He was kind enough to give his valuable time from his extremely busy schedule.

Words are inadequate to offer my thanks to all the respected staff at ICDS Gujarat for their able guidance and support throughout the dissertation period.

I am glad to acknowledge my guide Professor P R Sodani, Dean Training, The IIHMR University, Jaipur for incorporating right attitude in me towards learning and for helping and supporting whenever required. I am grateful to them for giving me an opportunity to learn administrative tricks and styles.

I genuinely thank my parents, family and friends for their blessings and support.

Dr.Nareshkumar Prajapati
(IIHMR/2013 – 2015/1467)

Contents

List of Figures:

List of Tables

Abbreviations

AG's	Adolescent Girls
AWC	Anganwadi Centres
ANM	Auxiliary Nurse & Midwifery
ANC	Ante-Natal Check-up
AWW	Anganwadi Worker
CDPO	Children Development Project Officer
DWCD	Department of Women and Child Development
ECE	Early Childhood Education
EBF	Exclusive Breast Feeding
ICDS	Integrated Child Development Services
IEC	Information, Education & Communication
INCC	Intensive Nutrition Care Campaign
IFA	Iron & folic acid
GM	Growth Monitoring
MCH	Maternal and Child Health
NFHS	National Family Health Survey
NM	Nursing Mothers
PHC	Primary Health Centre
PNC	Post- Natal Care
PSE	Pre-School Education
SES	Socio-economic Status

SF	Supplementary Food
UIP	Universal Immunization Programme
WHO	World Health Organization

Assessing the Knowledge of Anganwadi Workers regarding Integrated Child Development Services (ICDS) in Tribal and Non-Tribal Blocks of Valsad District, Gujarat

Dr. Nareshkumar C. Prajapati

Institute of Health Management Research, Jaipur

Abstract

Introduction

ICDS was launched on 2nd October 1975, on the 106th birth anniversary of Mahatma Gandhi 'The Father of our Nation'. ICDS is the symbol of India's commitment to her children. It provides an opportunity for the holistic development of children from vulnerable backgrounds.

Objectives

Objectives of the study were to assess the coverage status of registered children of 0 to 6 years in the selected blocks of Valsad district. To assess the level of knowledge of Anganwadi worker regarding ICDS services in selected blocks of Valsad district. To study the association between educations level of AWW and areas (Non – Tribal and Tribal Blocks) and to study the association between knowledge of Anganwadi worker and coverage status of registered children of 0 to 6 years children. To identify the problems faced by AWWs while providing the ICDS services.

Methodology

This particular study was conducted in Non – Tribal and Tribal blocks of Valsad district. Analytical cross sectional study was carried out as the primary goal of the study was to assess the knowledge level among the Anganwadi worker about the ICDS programme and the various services provided by the ICDS programme. This study was carried out from 24th February 2015 to 11th May 2015. Random

samplings of Anganwadi worker in the 6 blocks of the Valsad district were conducted for the study. The sample for the present study comprises of 150 Anganwadi workers working in ICDS were selected for the study. For the study Purposive sampling technique was used. The respondents for the study were Anganwadi Worker of selected AWC of Non – Tribal and Tribal blocks of Valsad. Interpersonal interviews were done to collect the primary data. The secondary data were collected from the official reports (MPR). Semi Structured questionnaire were used with various questions frame on the knowledge among Anganwadi workers regarding the services of ICDS.

Results

Finding of the study reflects that there coverage of registered children of 0 to 6 years were above 90 per cent that suggests that there were no significance association between knowledge level and coverage of beneficiaries. There was difference in the knowledge level of AWW in non – tribal and tribal blocks.

Conclusions

During the study it was observed that in spite of high coverage in Tribal areas, most of the children are still malnourished. Though the knowledge level of AWW of tribal areas was lower than those were in Non – Tribal areas, still coverage of registered children of 0 to 6 years was high in selected blocks. Further there were significance association between education level of AWW and selected blocks.

Key Words: Anganwadi Workers, Tribal and Non – Tribal blocks, Education, Association, Valsad district.

Chapter 1

Introduction

Children are our most precious resources and are the citizens of tomorrow, so nurturing our children is an investment. Hence, we should ensure a brilliant future for our children. ICDS in India is worlds unique and largest integrated early childhood program with over 12.4 lakhs centres nationwide. It was launched on 2nd October 1975, on the 106th birth anniversary of Mahatma Gandhi 'The Father of our Nation'. ICDS is the symbol of India's commitment to her children. It provides an opportunity for the holistic development of children from vulnerable backgrounds. (ICDS-5th Report of the Commissioner to the Supreme Court. Available at (www.righttofoodindiaorg/icds-comrs5th-report-html)

The average Indian child has a poor start to life i.e. infant & under 5 morality rates of Indian children are 49% and 65% respectively and are higher than the developing country average. One in four new born is under weight. Only one in three is exclusively breast fed. One in two children less than five years of age suffers from moderate or severe malnutrition. One in three children does not get a full course of immunization. 44% of India's people live on less than Rs50 per day. Less than 30% have access to adequate sanitation facilities. The major factor is the countries high Maternal Morality Ratio of 540 deaths per one lakhs lives birth. The ICDS programme covers over 4.8 million expectant and nursing mothers and over 23 million children under six age.

Globally, more than 10 million children, of under five years of age, are living in poor countries and every minute 20 children die mostly from preventable causes.

India alone accounts for almost 5,000 deaths of under-five years children (U5) every day. In 1975, the Integrated Child Development Scheme (ICDS) was launched in the country to provide integrated health and nutrition services focusing upon the holistic development of children at the village level.

Immunization is one of the most cost-effective interventions for preventing a series of major childhood illness, particularly in environments where children are undernourished and may die from vaccine-preventable diseases. Immunization has been one of the priority programmes since independence in 1947. To achieve the goal of protecting the target population and reduce the incidence of diseases, it is necessary to generate demand and also to make potent and effective vaccine and immunization services available and accessible.
(www.iimahd.ernet.in/publications/data/2010-02-01Ramani.pdf),

As there is an important role of the mothers in child development, Pregnant and nursing/lactating mothers were also included in the ICDS coverage. ICDS offers a package of services which includes health check-ups, supplementary nutrition, pre-school education, etc.

The decline in child malnutrition has been very slow over the last 15 years from 51.1 per cent in 1992-93 (NFHSI) to 45.9 per cent in 2005-06 (NFHS-III).

This slow decline is in spite of ICDS Scheme which has been functional since 1975 and rapid economic growth post-1990.The ICDS services have been expanded tremendously over its 30 years of operation to cover almost all development blocks in India and offers a wide range of health, nutrition and education services to children, women and adolescent girls. However, while the program is intended to

target the needs of the poorest and the most undernourished, as well as the age groups that represent a significant "window of opportunity" for nutrition investments (i.e. Children under three, pregnant and lactating women), there is a mismatch between the program's intentions and its actual implementation. (www.iimahd.ernet.in/publications/data/2010-02-01Ramani.pdf).

The Department of Women and Child Development's (DWCD) emphasis on a "life-cycle approach" means that malnutrition is fought through interventions targeted at unmarried adolescent girls, pregnant women, mothers and children aged 0 to 6 years. (www.siteresources.worldbank.org/.../undernourished_chapter_2.pdf)

Although ICDS coverage is fairly high; Women with one or more children born in the 6 years before the survey when asked about benefits received from an AWC for their young children and benefits they themselves received during pregnancy and while breastfeeding, it was observed that only 28% of children under age 6 years received any service from an AWC in the last year. The services received by these children are also not satisfactory. Children receiving any service consisted of 33% only 26% and 23% beneficiaries received the services of supplementary feeding and preschool education respectively. (Available at (www.iphaonline.org/academy/concept-papers/pdf/icds_review.pdf)).

The coverage of health component of the services like immunization, health check-up and referral is dismal only 20%, 18% and 16% respectively.

The coverage of the other beneficiaries' viz. Pregnant and lactating women is further lower. As much as 78% of pregnant mother and 83% of the lactating mother did not receive any services from the AWC. Of those who received some services only 21%

of the pregnant women and 17% of the lactating women received supplementary food and Health check-up was received by 12% & 9% respectively. Nutrition education was received by 11% of Pregnant and lactating mothers who received any services (NFHS3).

(www.iphaonline.org/academy/concept-papers/pdf/icds_review.pdf)

The 2011 Global Hunger Index (GHI) Report ranked India 15th, amongst leading countries with hunger situation. It also places India amongst the three countries where the GHI between 1996 and 2011 went up from 22.9 to 23.7, while 78 out of the 81 developing countries studied, including Pakistan, Nepal, Bangladesh, Veitnam, Kenya, Nigeria, Myanmar, Uganda, Zimbabwe and Malawi, succeeded in improving hunger condition. (2011 global Hunger Index Report". International Food Research Institute (IFPRI). (Available at

http://www.ifpri.org/sites/default/files/publications/ghi11.pdf)).

"Malnutrition kills 5 million children every year..... One child every 6 seconds.

While breastfeeding is nearly universal in India, less than half of children (46%) are fed only breast milk for the first 6 months. Exclusive breastfeeding is slightly higher among the non-educated mothers and in rural areas. Work conditions and access to breast milk substitutes may impact the feeding pattern among urban and better educated mothers. (National Family Health Survey (NFHS-3) 2005-2006 India National Reports, Nutrition & Malnutrition Resources for India: Strategies for Children under Six. (Available at:

www.unicef.org/socialpolicy/files/ChildrenUnderSix.pdf)).

Only 23.4% of children are breastfed within one hour of birth and the prevalence is significantly lower among the non-educated mothers and in rural areas. However, there has been an overall improvement from 9.5% in 1992-93 to 16% in 1998-99.

"34 million children in the 3-6 year age group are covered by pre-schooling initiatives either under ICDS or private initiatives, excluding about 26 million children from any intervention. Uncovered and unreached children are found in both rural and urban areas." The high incidence of premature births, low birth weight and neonatal and infant mortality can be attributed to poor nutritional conditions of the mothers. (32 million children in India don't get early childhood care – Report January 22, 2009: Copyright 2011 National Network of education (NNE). (Available at: www.igovernment.in Health).

In India, ICDS Universalized with 12.95 Lakhs Anganwadi, benefitting 959.22 Lakhs Children Benefits around 47 Lakhs Adolescent Girls, around 53,000 Pregnant and Lactating Women Benefitted by IGMSY ICPS Covers 1 Lakhs Children in 23 States and 438 Districts. (Financial Daily from THE HINDU group of publications: Press Information Bureau, Mumbai: National Informatics Centre (NIC) Information is provided and updated by: Press Information Bureau, Tuesday, Mar 22, 2005

Available at: www.hindu.com/businessline/2000/01/coinfo/pubs.html)

India is one of the fastest growing countries in terms of population and economics, and having a population of 1,139.96 million (2009) and growing at 10-14% annually (from 2001-2007). India's Gross Domestic Product growth was 9.0% from 2007 to 2008; since Independence in 1947, its economic status has been classified

as a low-income country with majority of the population at or below the poverty line. (“Journal of the American Medical Association”. Source: JAMA 2004. http://jama.ama-assn.org/cgi/content/abstract/291/21/2616 Retrieved 2009-11-26. “The global burden of Chronic Disease”)

National Sample Survey Organization (NSSO) 66th Round and the Annual Reports of National Nutrition Monitoring Bureau (NNMB) both show a decline in the consumption of calories over the past 2 decades. NSSO data shows that the average daily intake of calories dropped by 133 kcal (6.2%) from 2153 kcal to 2020 kcal in rural areas and by 125 kcal (6%) from 2071 to 1946 kcal in urban areas between 1993-94 to 2009-10 and NNMB data shows that between 1991-1992 and 2005-2006 the average daily intake of calories declined from 139kcal/day to 1834kcal/day (a fall of 305kcal/day or 14% of the 1991-1992 total). (“Journal of the American Medical Association”. Source: JAMA 2004. http://jama.ama-assn.org/cgi/content/abstract/291/21/2616 Retrieved 2009-11-26. “The global burden of Chronic Disease”)

Today child malnutrition is prevalent in 7 per cent of children under the age of 5 in China and 28 per cent in sub-Saharan African compared to a prevalence of 43 per cent in India. Experts also claimed that children are not at all being benefited by the Integrated Child Development Services (ICDS) scheme when it is supposed to provide one-third of their total nutritional requirement. "ICDS gives a dry soya and wheat mixture which the children cannot eat. The children need to be given tender, tasty and fresh food. It is alarming that every second child in India is starving," said Dr Veena Shatrugna, former deputy director, NIN.

Three in four children in India are anaemic and one in three are stunted, found the National Family Health Survey-III, the largest ever health survey done simultaneously in 29 states. During 2005 and 2006, With 21 Per cent stunted children; Kerala has the best child nutrition Indices. The worst is Uttar Pradesh, where 46 per cent children are underdeveloped, both physically and mentally, because they do not get quality food to eat. These statistics are shocking but not new. All three National Family Health Surveys between 1992 and 2006 have consistently shown that the nutritional status of children in India is abysmal. (sccommissioners.org/…/ICDS_Indias-future-goes-to-bed-hungry.pdf)

The program has, over the years, undergone transformation in content, scope and coverage of target groups, and now aims at universalization. By 2009-10, more than 7000 projects and 1.4 million Anganwadi centers have been approved by the government, of which 6719 projects and 1.37 million AWCs were operational by December 2010. The number of beneficiaries- both children and women- nearly doubled between 2003-04 and 2008-09 (Child beneficiaries increased from 377 million to 725 million). (Has ICDS Reduced Child Under – nutrition in India? An analysis of program effectiveness and impact. Available at: desiindia.org/child-development.html)

Food Security Bill and the ICDS scheme would reap the benefits to its intended users provided there is proper implementation of those schemes from top to bottom. It has been more than 35 years since this unique programme of early childhood development, ICDS, was launched by the government, still, India would probably top the list of all the web searches for ‘malnutrition in developing countries’. It is

about time to tackle this problem before joining the league of developed nations. (Food Security Bill, ICDS can reap the benefits only with proper implementation. (www.Articles.economictimes.indiatimes.com.Growth-Rate)).

The decline in India's poverty rates compares well against the more lauded performance of china. Over the period 1981-2005, China's poverty rates declined from 40 per cent to 29 per cent, while India's rates declined from 60 per cent to 42 per cent (both represent about a 30 per cent proportionate decline). India needs a national nutrition strategy. Successful implementation needs civil society to play its part, helping shape and deliver the strategy and promoting greater transparency and accountability in the fight against under nutrition. (Recommendations for a reformed and strengthened Integrated child Development Services (ICDS) by National Advisory Council June, 2011.Available at: nac.nic.in/pdf/ICDS.pdf).

There is urgent need to reform and strengthen the delivery of ICDS. Despite the considerable expansion and additional investments made after 2005 (and following the supreme court orders for ensuring ICDS universalization with quality), progress has been slow and uneven. At the first meeting of the Prime Minister's National Council on India's Nutrition Challenges held in November 2010, the Prime Minister noted that "the levels of under-nutrition continue to remain unacceptably high and the rates of reduction in under nutrition over time disappointingly low; this is simply unacceptable. The focus of ICDS on children under 3, pregnant and breastfeeding mothers is relatively weak and there is therefore a need to take a hard look at the ICDS to improve the programme.

Chapter 2

Review of Literature

According to The National Family Health Survey (NFHS-3) 2005-06; Only 28% of children under age 6 years received any service from an Anganwadi Centre; 33% children got services from an Anganwadi Centre; 26% Supplementary food: pre-school education 23%: 20% - immunization coverage: 18% - Growth Monitoring: 16% - Health Check – ups.

A study on the Integrated Child Development Services (ICDS) project chiri, Haryana in 1995: revealed 62% of the women were currently utilizing in the ICDS programme. 23.7% had never used ICDS services. The most frequented services were supplementary nutrition (97.3%), tetanus toxoid prophylaxis (89.3%), and iron and folic acid prophylaxis (87.1%). 62.8% of the women participating in the supplementary nutrition program took the food home to share with family members. The major reasons for never using ICDS services were: could not spare time (53.5%) and working outside the household for long hours (50%). 15% were never approached by an Anganwadi worker and were therefore not aware of ICDS services or the workers did not have an encouraging attitude. Other possible contributing factors to under- or non-utilization were high illiteracy (61%) and unawareness of ICDS services among heads of households (94.9%). (www.esocialsciences.com/essjournalarticles/Article14116.pdf)

A study revealed Mother's reaction in terms of their awareness, perception, attitude and acceptance of the ICDS services Rohtak, Haryana in 1985. Children Aged 3-6 Years: 63.5% was from age group of 25-35 years and 79% were illiterate,

distribution of supplementary food was considered useful by all the respondents. Majority of mothers immunized their children 94%, Health check-up of children was 87.5%, and only 12.5% opinioned that check-up should be done to supervise growth. 91% of the mothers knew that weight was recorded regularly. (Available: nihfw.org/Publications/material/J162.pdf)

A study on "Nutritional status of ICDS and Non-ICDS children" Jammu City, Jammu & Kashmir in 2005 revealed that: Median age of mothers was 27 years in both the groups, educational status in Group I was primary schooling were as Group II was illiterate: type of family in Group I was nuclear and in Group 2 was joint family. Group I: 93% had enrolled their children in age group of 1-3 years to AWC, all the mothers knew about the supplementary food provided in the AWC, 73% mothers knew the nutritional status of their children by the AWW, all AWW did regular growth monitoring for the children, 87% mothers told that their children received supplementary food from the AWC. 67% of mothers had positive attitude regarding AWC and observed some changes in their children after enrolling in AWC. (Sumati.Vaid, Nidhi Vaid.Nutritional status of ICDS & Non-ICDS Children. Journal of Human Ecology 18(3):207-212(2005)).

A "Community based Monitoring system" in 2007, Dehradun, Uttarakhand. The results showed that: Respondents were satisfied with the distribution of the supplementary nutrition. The community was hardly aware of the fact that enrolment of the name of the pregnant women was done to the AWW, to get supplementary food. Almost 33% of villages, pregnant women did not register their name to the AWW. Beneficiaries were reportedly getting IFA tablets but

consumption pattern of IFA was seen to be a major bottleneck. There was no awareness regarding T.T vaccination in adolescent girls in one village of Chamba block. In 40% of villages, Colostrums were not being fed. Only 50% of the children were exclusively breastfed for 6 months.
(wcd.nic.in/icdsworldbank/lCDS%20Consultation%20Report.Pdf).

A study revealed the factors influencing the Non-Enrollment of children in the ICDS Anganwadi centres at Chennai in 2007. The study interpreted the results: the purpose of the AWC was known by the 47.3% mothers, 32.7% knew regarding the supplementary nutrition given at AWC, but were unaware regarding special care given to malnourished children. 40% were not aware regarding the Early Childhood Education (E.C.E), 17.3% enrolled their children to the AWC after the approach of the AWW or the helper. Only 11.3% felt that ICDS offered good quality services to the beneficiaries. 50.7% of the mothers mentioned that the AWW in their habitation was not friendly. 100% mothers told that PSE should be given in their mother tongue which is good for the child but overwhelming majority 91.3% told that teaching in English would be better for the child future. 25.3% mothers did not send their children to the AWC were the reason of the AWW's attitude. (planningcommission.nic.infreports/peoreport/peo/peo_lcds_voll.pdf).

The study "Impact, Assessment and Evaluation of ICDS programme in Bhubaneswar, Orissa" in 2006. Revealed that supplementary nutrition was considered adequate by 96% mothers of the beneficiaries. 92% of the mothers mentioned that the quality of the food was good. Over 26.32% received complete immunization of children (9-12 Months), about 73% of the children had received

health services from AWW. 99% mothers of beneficiaries were sending their children for preschool education. Among them females were 53% and males were 47%, it was found that out of 10 lactating mothers 8 did not receive any IFA tablets from AWW. 93% of the pregnant women had received at least 1 ANC, but 22% pregnant women received supplementary food. And 90% pregnant women received IFA tablet from the AWW. Place of delivery was home that is in 58% and 39% in the hospital. Type of birth Attendant: Traditional Birth Attendant: Traditional Birth Attendant (T.B.A)-22%, ANM-7%, PHC-34%. 88% said that there was no Balika Mandal Yojana in their village. About 92% of the AWW did growth monitoring correctly. 12% of the mothers told that there was irregular supply of the food and 12% told that even medicines given at AWC were irregular. (Available at: www.ksrmccs.ac.in/ACCESS-TO-Child-Development-SERVICE)

A study on awareness and perception of mothers about functioning and different services of ICDS, 2007 in Howrah and Purulia districts of West Bengal. The study concluded that as per the opinion of the mothers 73% Anganwadi Centres opened regularly: behaviours of the Anganwadi worker were friendly i.e. 71% and 63% mothers opinioned that ICDS is beneficial to their children. 84% mothers were aware of any ICDS services, quality and quantity of supplementary food was acceptable to 88% and 72% mother's respectively. 79% and 87% mothers did not receive any advice on child feeding and growth chart. Making beneficiaries aware about ICDS services by targeted interventions will ensure better utilization of ICDS. (Available at: www.ncbi.nlm.nih.gov/pubmed/20859049).

The Evaluation study of ICDS in Haryana, 2002-2003, showed that achievements under immunization for children was 100%, the non-formal pre-school education

was 98%, SNP for children 3-6 years was 76% and 74% for nursing & pregnant women enrolled. The growth monitoring was 99%, health check-up for the beneficiaries was 32%, 83% of children received pre-school education in AWC, among them 53% were males and 47% were females. 88% pregnant females received IFA tablets from AWC. 89% received advice on ante-natal care. 97% did breastfeeding for their babies. 88% beneficiaries got advice on the family planning norms by the AWW. 96% mothers of children 3-6 years mentioned that SN was of good quality. 98% 3-6 years children were growth monitored in the AWC. (Available at: esaharyana.gov.in/.%5Cdata%5CMahilaMandalReport.pdf).

Chapter 3

Rationale for the Study

Though Anganwadi Workers are key player to enhance health and nutritional status of women and children at the grass root level, but recent studies show that they are less capable of providing recommended Material and Child Health (MCH) services to the deprived group of population (Davey and Datta, 2004; Thakare et al 2001). When eligible beneficiaries are not enrolled under ICDS, they are deprived of services which are their due right. Though government is spending lot of money on ICDS programme, impact is very ineffective. Most of the study concentrated on the nutritional and health status of the beneficiaries of ICDS. Less focus has been shifted over to assess the knowledge and awareness among AWW regarding recommended ICDS programmes, who are actually the main resource person.

Chapter 4

Research Methodology

4.1. Research Questions

1. What is the coverage status of registered children of 0 to 6 years in the selected blocks of Valsad district?
2. What is the knowledge Level of Anganwadi worker regarding ICDS services in selected blocks of valsad district?
3. Weather there is any association between area (Non – Tribal and Tribal Blocks) and education level of AWW?
4. Whether there is any association between knowledge of Anganwadi worker and coverage status of registered children of 0 to 6years in Non - Tribal and Tribal block of Valsad district?

4.2. Objectives

The study aimed to:

1. To assess the coverage status of registered children of 0 to 6 years in the selected blocks of Valsad district.
2. To assess the level of knowledge of Anganwadi worker regarding ICDS services in selected blocks of Valsad district.
3. To study the association between areas (Non – Tribal and Tribal Blocks) and education level of AWW.
4. To study the association between knowledge of Anganwadi worker and the coverage status of registered children of 0 to 6 years.
5. To identify the problems faced by AWWs while providing the ICDS services.

4.3. Null Hypotheses:

1. There is no association between area (Non – Tribal and Tribal Blocks) and education level of AWW.
2. There is no association between knowledge of Anganwadi worker and coverage status of registered children of 0 to 6years in Non – Tribal and Tribal block of Valsad district.

4.4. Methodology

4.4.1 Area of Study: Valsad district is having five Talukas named Valsad, Pardi, Umargam, Dharampur and Kaprada. There are total 12 blocks in these five talukas. These blocks are divided in to two groups

1) Non-Tribal block

2) Tribal block

Out of them, blocks come under Non - Tribal Blocks are namely Valsad -1, Valsad -2,Valsad – 3, Pardi – 1, Pardi -2, Pardi -3, Umargam -1, Umargam -2, and remaining blocks come under Tribal blocks they are namely Dharampur -1, Dharampur -2, Kaprada -1, Kaprada -2.

For this study total 6 block were selected and these were as under

Out of 8 Non-tribal blocks, Valsad- 1, Pardi- 1 and Umargam-1were selected.

Out of 4 Tribal blocks, Dharampur-2, Kaparada-1, and Kaparada-2 were selected.

Primary data was collected from the field through semi structured questionnaires and interpersonal interview. The questionnaire included questions regarding the ICDS services.

4.4.2. Type of Study: Analytical cross sectional study was carried out as the primary goal of the study was to assess the knowledge level among the Anganwadi worker about the ICDS programme and the various services provided by the ICDS programme.

4.4.3. Study Duration: From 24th February 2015 to 11th May 2015.

4.4.4. Sampling: Random samplings of Anganwadi workers in the 6 blocks of the Valsad district were conducted for the study. The sample for the present study comprises of 150 Anganwadi workers working in ICDS were selected for the study and information was gathered from those Anganwadi workers who were from 6 blocks of the Valsad district in Gujarat.

4.4.5. Sample Size:

For the study total 10% of total Anganwadi worker of each selected blocks were selected. Therefore sample size were

Table 4.4.5.1 Number of respondents of selected blocks

Sr.No	Name of Block	Total No. of Anganwadi Worker	Total No. of Selected Anganwadi worker
1.	Valsad 1	208	20
2.	Pardi 1	191	20
3.	Umargam 1	180	18
4.	Dharampur 2	168	17
5.	Kaparada 1	184	18
6.	Kaparada 2	168	17
	Total	1099	110

Along with this, after adding 3 per cent of non-response error sample size were 135 respondent. Therefor total selected sample size was 150 respondents.

4.4.6. Sampling Technique: For the study Purposive sampling technique was used.

4.4.7 Target Population: The respondents for the study were Anganwadi Worker of selected AWC of Non – Tribal and Tribal blocks of Valsad.

4.4.8. Data collection Method: Interpersonal interviews were done to collect the primary data. The secondary data were collected from the official reports (MPR).

4.4.9. Tool for data collection: Semi Structured questionnaire were used in duel language i.e. in English and in Gujarati with various questions frame on the knowledge among Anganwadi workers regarding the services of ICDS. Major content of the interview schedule were : socio-economic and demographic profiles of AWWs, Knowledge about various ICDS services (like immunization, nutritional and health education, supplementary nutrition, growth monitoring) and problem faced by AWW while implementing ICDS programmes.

As Anganwadi Worker she has the following role and responsibilities and she must have the knowledge of various services provided by the ICDS programme. Therefor this tool contains the questions regarding various services provided by the ICDS.

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.

- Accompany 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), SABLA, 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 diarrhoea and cholera cases to health care division of blocks and districts.

4.4.10 Ethical Consideration

Informed consent was taken for conducting the interpersonal interviews.

Chapter 5

Result

5.1. Results for the Coverage status of 0 to 6 years Children

According to the verdict of Government of India, registration of 0 to 6 years beneficiaries should be 100 per cent. After registration each and every beneficiaries should be covered for providing services of ICDS. In spite this there is no full coverage of beneficiaries. Behind this problem number of factors is responsible. So it should be minimum 80 per cent.

The study from the MPR of the block shows that only Umargram- 1block has covered 100 per cent.

Figure 5.1.1 Percentage Distribution of Coverage status of Non-Tribal block of Valsad from Oct – 14 to Mar – 15

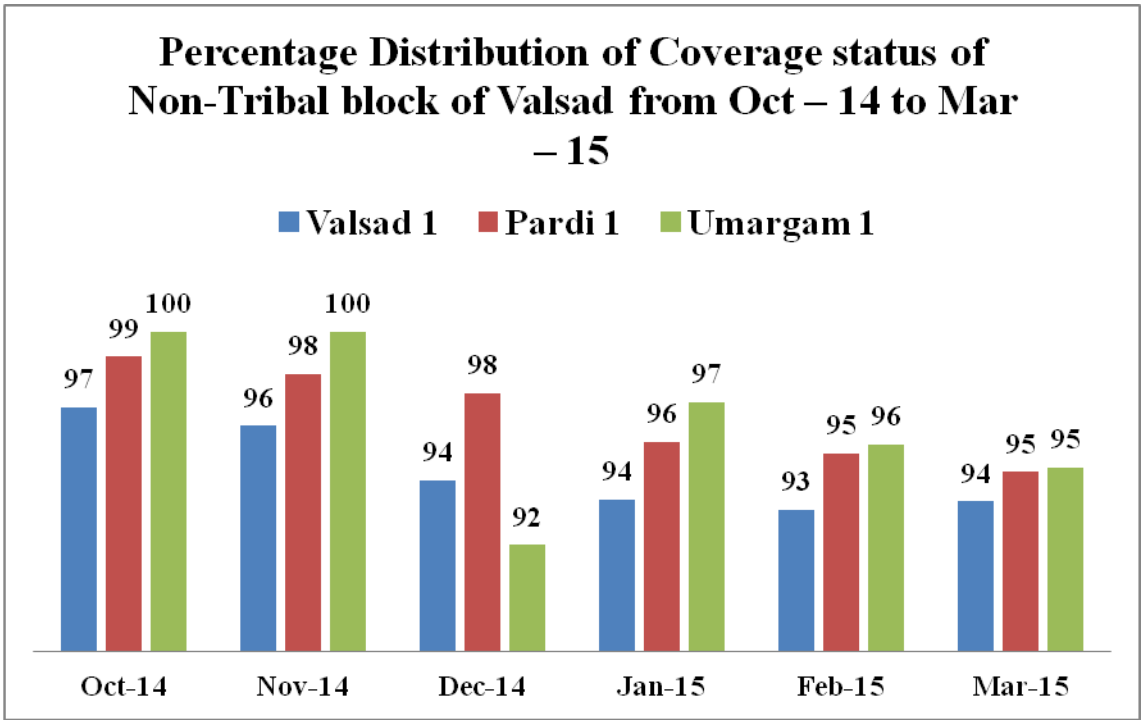


Fig 5.1.1 shows that in October – 14,coverage of 0 to 6 years children were 97 per cent in Valsad 1, 99 per cent in Pardi 1 and 100 per cent in Umargam 1. Further this

data suggest that in November – 14, coverage of 0 to 6 years children were 96 per cent in Valsad 1, 98 per cent in Pardi 1 and 100 per cent in Umargam 1. Along with this data suggest that in the month of December coverage of children were lower than previous months and it was 94 per cent in Valsad 1, 98 per cent in Pardi 1 and 92 per cent in Umargam 1. Further this data shows some improvement in coverage of 0 to 6 years children in Umargam 1 which was 97 per cent where as in Valsad 1 and Pardi 1 it was same as last two months which was 94 per cent and 96 per cent respectively.

Also this data depicts that in the month of February – 15 and March – 15 coverage of children were almost same in all non – tribal blocks which was 93 per cent and 94 per cent respectively in Valsad 1 in Feb – 15 and Mar – 15, 95 per cent in both Feb and March – 15 in Pardi 1 and 96 per cent and 95 per cent in Feb and March – 15 respectively in Umargam 1.

Figure 5.1.2 Percentage Distribution of Problems faced by AWWs in Non – Tribal and tribal blocks of Valsad (N = 150)

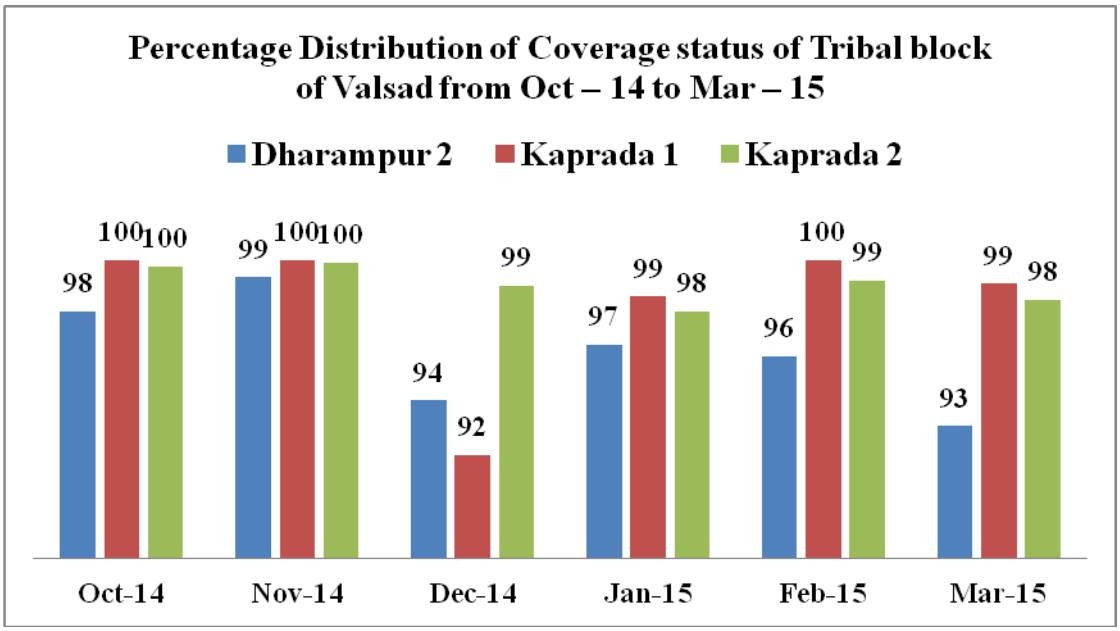


Fig 5.1.2 shows that in October – 14,coverage of 0 to 6 years children were 98 per cent in Dharampur 2, 100 per cent in Kaparada 1and Kaprada 2. Further this data suggest that in November – 14, coverage of 0 to 6 years children were 99 per cent in Dharampur 2, 100 per cent in Kaparada 1and Kaprada 2. Along with this data suggest that in the month of December coverage of children were lower than previous months and it was 94 per cent in Dharampur 2, 92 per cent in Kaprada 1 and 99 per cent in Kaprada 2. Further this data shows some improvement in coverage of 0 to 6 years children in Dharampur 2 which was 97 per cent where as in Kaprada 1 and in Kaprada 2 it was 98 respectively.

Also this data depicts that in the month of February – 15 and March – 15, coverage of children were almost same in Kaprada 1 and 2 which was 100 per cent and 99 per cent respectively in Kaprada 1 and 99 per cent and 98 per cent in Kaprada 2 respectively. But in Dharampur coverage was 96 per cent in the month of Feb – 15 and in March – 15 it was only 93 per cent.

The Above data shows that in the month of Feb – 15, coverage of children was low as compared to previous months. This was because of improvement in reporting from block level and verification of data at district level.

5.2. Socio – demographic characteristics of AWWs in Non – Tribal and Tribal block of Valsad

Table 5.2.1 Percentage distribution of Socio – demographic characteristics of AWWs

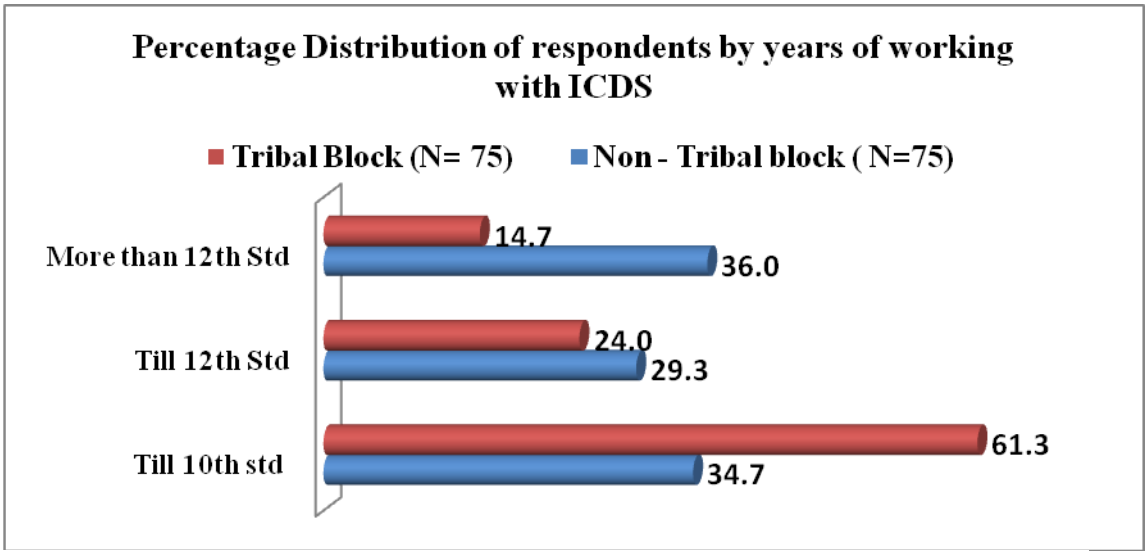
Table 1 Socio - Demographic Characteristics of AWW (N = 150)			
No.	Characteristics		Percentage (%)
1	Age of respondents	15 to 20 years	0
		21 to 25 years	14
		26 to 30 years	17
		More than 30 years	69
2	Marital status	Married	96
		Unmarried	0
		Widow	4
		Divorce	0
		Others	0
3	Cast	General	1.3
		SC	2
		ST	64.7
		OBC	30
		Others	2
4	Religion	Hindu	96
		Muslim	0.7
		Christian	0
		Sikh	3.3
		Other	
5	Education Qualification	Till 10 std	48
		Till 12 std	26.7
		Higher than 12 std	25.3
6	Residence of AWW in same village	YES	95.3
		NO	4.7

Table No. 5.2.1 shows that 14 per cent respondents were belong to the age group 21 to 25 years and 17 per cent AWWs belongs to the age group 26 to 30 years and

reamining 69 per cent were belongs to age group more than 30 years. Furthe this data depicts that 96 per cent AWW were married and 4 per cent AWW were widow. Also this data suggest that one per cent AWW belongs to General cast, Two per cent were belongs to sheduled cast 65 percent belongs to ST , 30 per cent belongs to OBC and remaining Two per cent were belongs to Other cast.In addition to this, data shows that 96 per cent AWW followed Hindu religion, One per cent followed Muslim and remaining Three per cent followed Sikh religion in Valsad. Further this data depicts that, 48 per cent AWW had till 10th class education, 27 per cent had till 12th class education and remaining 25 per cent AWW had more than 12th class education. Further this data shows that 95 per cent AWW working with ICDS were the residence of same villege and Five per cent belongs to other villege.

5.3. General Information of AWWs

Figure 5.3.1 Percentage distribution of respondent by Years of working with ICDS



The above graph shows that 81 per cent of AWW of Non-tribal blocks and 73 per cent AWW of tribal blocks were working with ICDS since more than 4 years. In addition to this, data shows that 15 per cent of AWW from non – tribal blocks and

21 per cent AWW of tribal blocks were working with ICDS from 2 to 4 years, whereas Thirteen per cent AWW from non – tribal blocks and 5 per cent AWW of tribal blocks were working with ICDS since last one to two years.

5.4. Null Hypothesis

1. There is no association between area (Non – Tribal and Tribal Blocks) and education level of AWW

Table 5.4.1 Percentage Distribution of association between Areas and Education level AWWs

			What is your educational qualification?			Total
			Till 10th std	Till 12 std	More than 12th Std	
Area status tribal Non – tribal	Tribal	Count	46	18	11	75
		% within area status tribal nion tribal	61.3%	24.0%	14.7%	100.0%
	Non-tribal	Count	26	22	27	75
		% within area status tribal Non - tribal	34.7%	29.3%	36.0%	100.0%
Total		Count	72	40	38	150
		% within area status tribal Non – tribal	48.0%	26.7%	25.3%	100.0%

*Chi squared Value 0.002, p value > 0.5

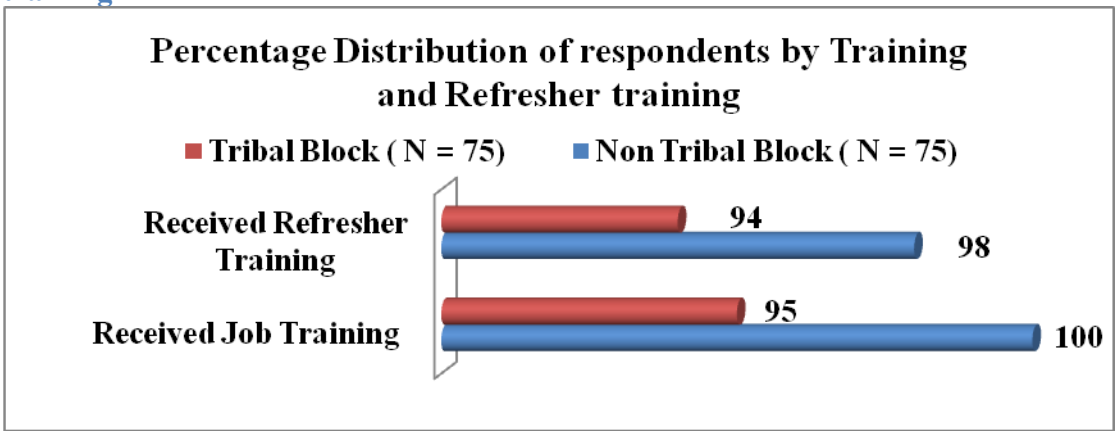
In tribal area 61 percent of beneficiary had education up to 10th standard, 24 percent had education up to secondary level and rest 14 percent had education more than 12th class whereas in non-tribal area 35 percent had education up to 10th standard whereas 36 percent had education more than 12th standard.

The chi squared value was 0.002 which is less than 0,5 which suggest that Null hypothesis was rejected. So, there were significance association is found between education and area.

Figure 5.1. and 5.2 depicts that coverage of registered children in Non – Tribal and Tribal blocks was above 90 per cent, which itself shows that coverage of registered children of 0 to 6 years were not depend on the knowledge level of AWW in Non – Tribal and Tribal blocks as the knowledge level of AWW were low in Tribal blocks as compared to Non – Tribal blocks. So, Null hypothesis was accepted that means there is no association between knowledge of Anganwadi worker and coverage of registered children of 0 to 6years children in Non – Tribal and Tribal block of Valsad district.

5.5 Training and Refresher Training of AWW in Non – Tribal and Tribal blocks of Valsad

Figure 1.5.1 Percentage distribution of respondent by Training and Refresher training

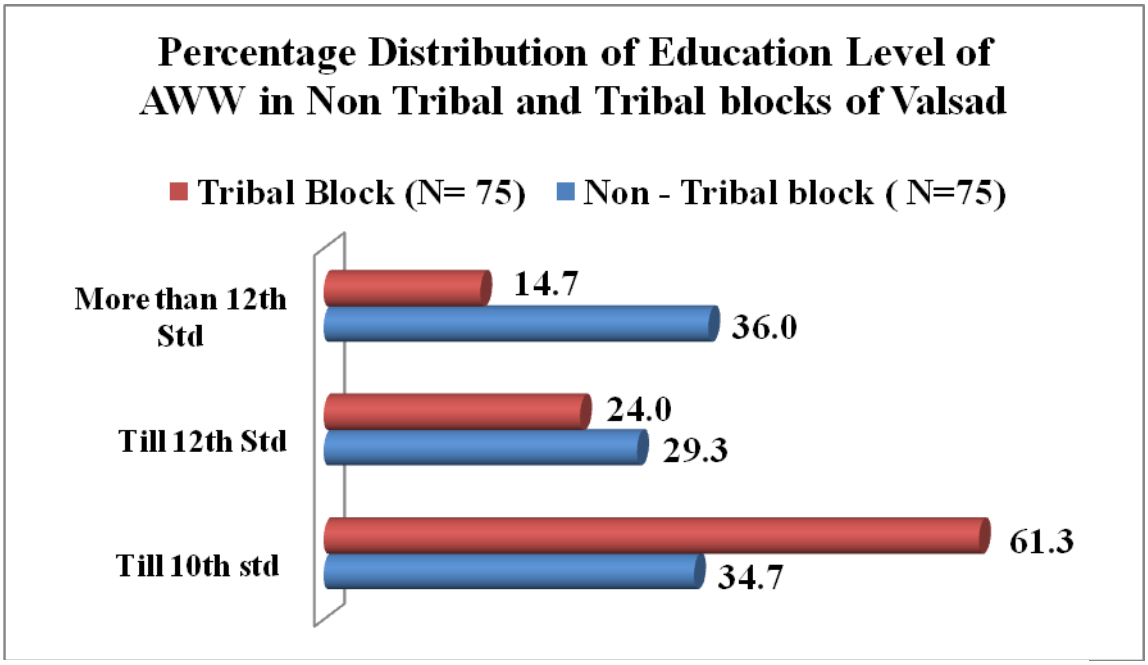


As for as training status of Anganwadi worker was concerned, it was found that majority of Anganwadi workers of Non – tribal blocks were 100% trained and in Tribal blocks only 95 per cent Anganwadi workers were trained and attended the ICDS training programme but among all 75 workers, only 98 per cent of them from

non – tribal blocks and 95 per cent of tribal blocks were attended the refresher training.

5.6 Education Level of AWW

Figure 5.6.1 Percentage distribution of Education level of AWW in Non – Tribal and Tribal block of Valsad



From the above graph it is very clear that education level of Anganwadi worker of Non-tribal blocks was higher than Anganwadi worker of tribal blocks. Graph shows that education level of AWW in Non – tribal blocks were 35 per cent whereas in tribal area it was 61 per cent. In addition to this, twenty four per cent AWW who were residing in tribal areas (blocks) had education till 12^{th} class and in non – tribal areas twenty nine per cent AWW had the education level till 12^{th} class. Further this graph represent that AWW who had more than 12^{th} class education were high in non – tribal blocks which was 36 per cent whereas in tribal areas (blocks) it was only fifteen per cent which was very low as compared to non – tribal blocks.

5.7 Knowledge Level of AWWs

Figure 5.7.1 Percentage Distribution of Knowledge Level of AWWs regarding the services provided by ICDS in Non – Tribal and Tribal Blocks of Valsad

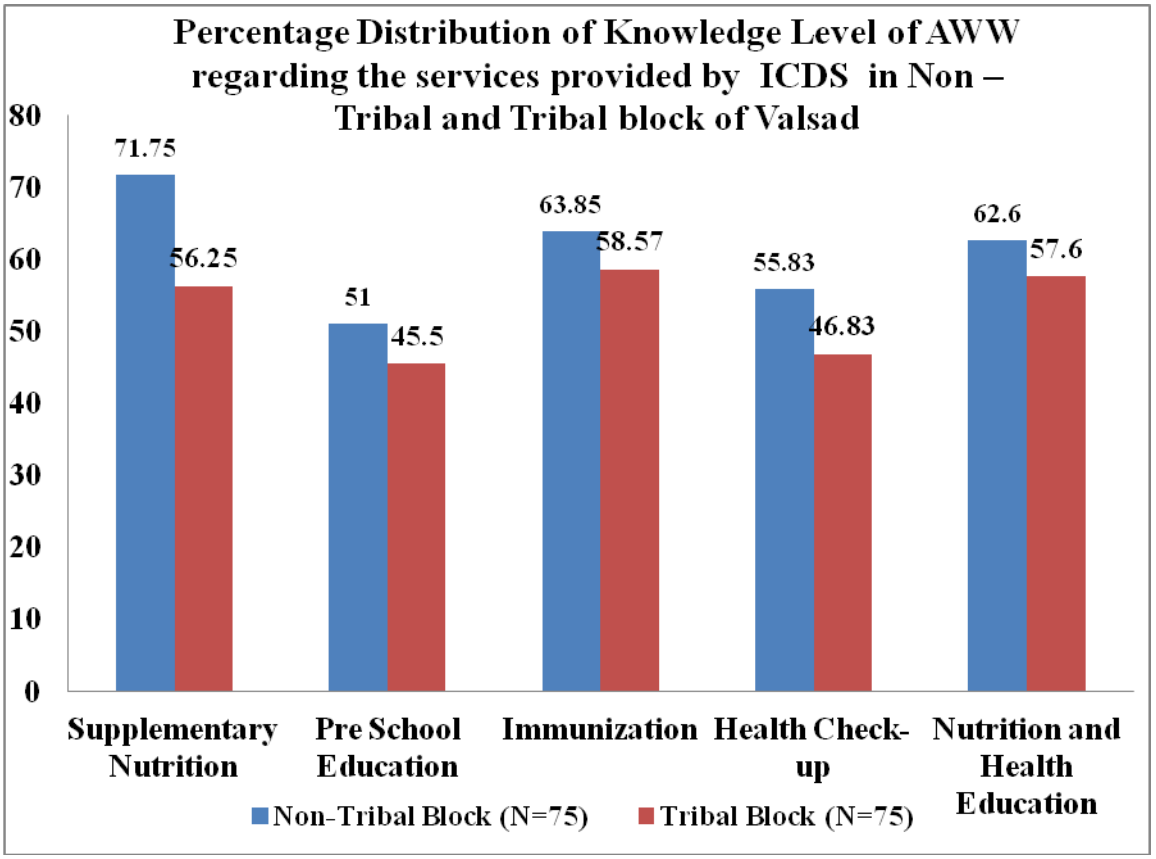


Figure 5.7.1 depicts that knowledge regarding various services provided by ICDS scheme were higher in Non – Tribal blocks of Valsad as compared to Tribal blocks. In case of supplementary Nutrition, 71 per cent AWW were aware whereas only 56 per cent AWW were about the supplementary nutrition. Similarly regarding other services, knowledge level of AWW in Non – Tribal blocks were higher as compared to AWW of Tribal blocks.

Figure 5.7.2 Percentage Distribution of Knowledge Level of AWW in Non – Tribal Block N = 75

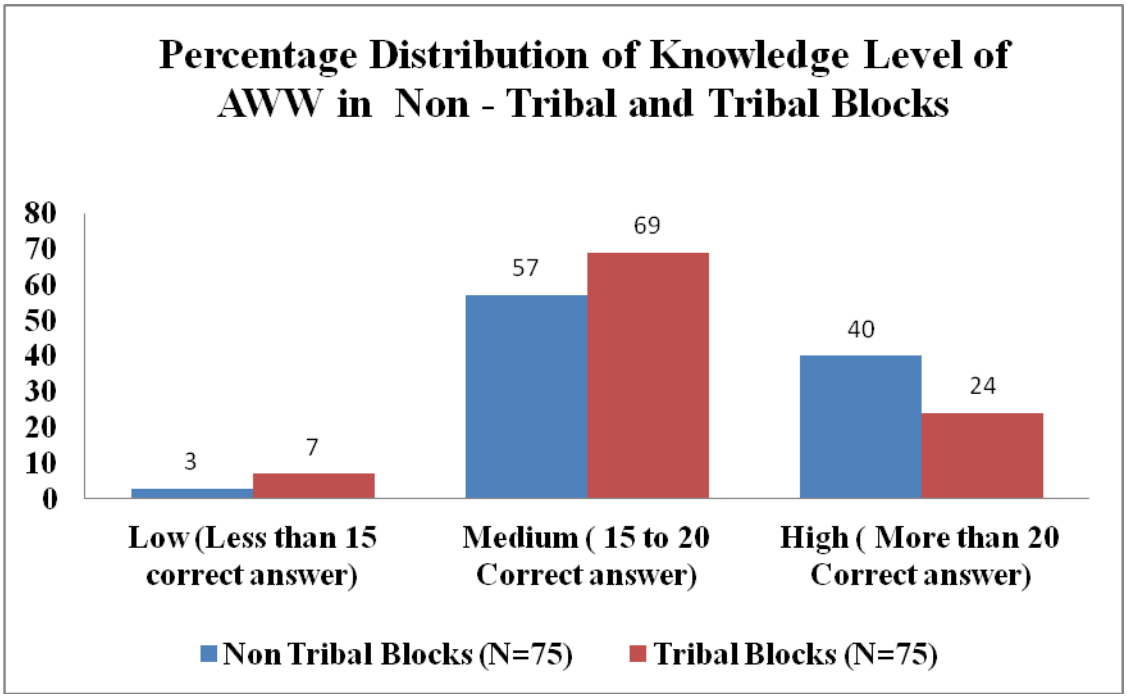
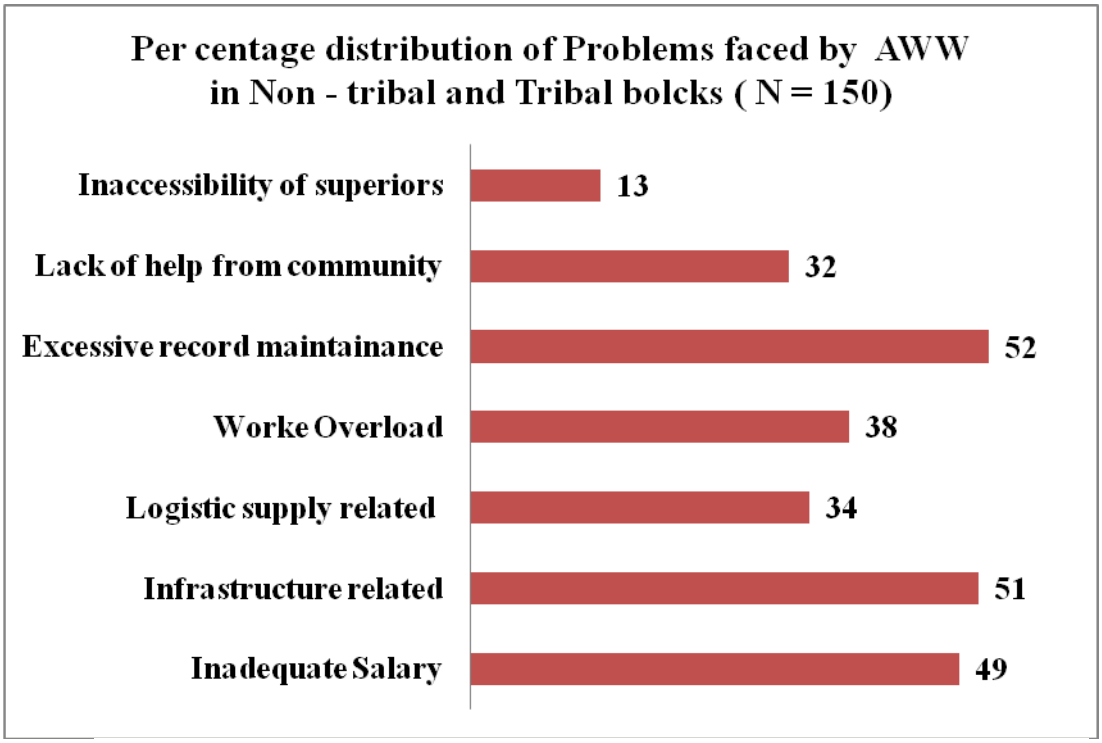


Figure 5.7.2 represents that only Three per cent respondents of Non – tribal blocks were there who gave less than 15 correct answer whereas it was Seven per cent from Tribal blocks. In addition to these 57 per cent respondents of Non-Tribal blocks and 69 per cent from tribal blocks were gave up to 15 to 20 correct answers. But in Non – Tribal blocks 40 per cent and only 24 per cent respondents from tribal blocks were there who has High knowledge and gave more than 20correct answers.

5.8 Problem faced by AWW

Figure 5.8.1 Percentage Distribution of Problems faced by AWW in Non – Tribal and tribal blocks of Valsad (N = 150)



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 49 per cent were complained of inadequate salary while only 34 per cent complained of lack of logistic supply related problems. 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. 38 per cent of workers not happy because of overload of work. And 52 per

cent 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, Pradhanmantri bima surksha Yojana, Swachhata Abhiyanetc. Thirteen per cent complained about inaccessibility of superiors.

During interaction with Anganwadi workers of the centre, they told that though the Anganwadi building is given by Government but it is worthless because it has lack of space, and there is no safe water facility, no toilet facility and no electricity also. Those children are come to this Anganwadi centre, for them there is no sufficient place for playing games and no playing toys also. It is also observed that because of no safe drinking water in this Anganwadi centre, the helper has to go to another place to take drinking water for cooking and also for children.

Chapter 6
Conclusion

Although ICDS services in India have been created, strengthened and expanded over the years, their output in terms of function and utilization particularly in rural areas is still limited.

During the study it was observed that in spite of high coverage in Tribal areas, most of the children are still malnourished. Though the knowledge level of AWW of tribal areas was lower than those were in Non – Tribal areas, still coverage of registered children of 0 to 6 years was high in both Non – Tribal and Tribal blocks of Valsad District.

Further it was observed that there were significance association between education level of AWW and areas (Non – Tribal and Tribal blocks). During this study it was observed that majority of AWW residing in Non-tribal blocks belongs to more than 30 years. As the AWW were more experienced in Non-tribal blocks and received their job training as well as refresher training, they were more experienced as compared to those in tribal blocks.

Last but not the least, more than 50 per cent of AWW of both Non – tribal and tribal blocks faced infrastructure related problems and felt excessive record maintenance.

So, in conclusion a comprehensive approach to improve the knowledge of ICDS services in the study area is needed.

Chapter 7

Limitations of the study

This study was done in selected blocks of Valsad district only.

Perception of all the beneficiaries could have been included.

Study duration was limited.

Chapter 8

Recommendations

Based on the findings of the present study, the following recommendations are being suggested for the improvement in the knowledge of AWW in ICDS services in that area.

- AWW who has more than higher secondary education should be recruited and minimum eligibility criteria in context of education up to 12^{th} class should be focused though it is up to 10^{th} class.
- Along with the coverage of registered children of 0 to 6 years in AWC, delivery of ICDS services to beneficiaries and their nutrition status should also be focused.
- Training of newly recruited AWW and refresher training of previously recruited AWW should be done at regular interval.
- Try to reduce problems faced by AWW.
- Focus of AWW should be only on providing ICDS services. AWW should not be given multiple responsibilities other than ICDS services.

Reference

1. ICDS-5th Report of the Commissioner to the Supreme Court.
   Available at: www.righttofoodindiaorg/icds-comrs5th-report-html
2. INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) IN INDIA.
   Available at:
   www.unicef.org/chinese/earlychildhood /files/india_icds.pdfwcd.nic.in/icd.htm
3. Available at: www.childmortalityorg.india.com
4. Ramani.k, Dileep.M, Sanjay.j, Imran Malik, and Tapasvi P, Harish K: why should 5,000 children die in India every day? Major causes of death & managerial challenges, VIKALPA, Volume-35, NO.2, April-June 2010.
   Available at: www.iimahd.ernet.in/publications/data/2010-02-01Ramani.pdf
5. Integrated Childhood Development services Program (ICDS) – Are results meeting expectations? Chapter 2.
   Available at: www.siteresources.worldbank.org/.../undernourished_chapter_2.pdf
6. Professor Ahmed F.U, Integrated Childhood Development Services Program (ICDS) – a turning point in Indian Public Health.
   Available at: www.iphaonline.org/academy/concept-papers/pdf/icds_review.pdf
7. "2011 global Hunger Index Report". International Food Research Institute (IFPRI).
   Available at: http://www.ifpri.org/sites/default/files/publications/ghi11.pdf
8. Nutrition Data 2005-2006 National Family Health Survey (NFHS-3) India Fact Sheet.
   Available at: www.nfhsindia.org/factsheet.html
9. National Family Health Survey (NFHS-3) 2005-2006 India National Reports, Nutrition & Malnutrition Resources for India: Strategies for Children under Six.

Available at: www.unicef.org/socialpolicy/files/ChildrenUnderSix.pdf

10. 32 million children in India don't get early childhood care – Report January 22, 2009: Copyright 2011 National Network of education (NNE).
    Available at: www.igovernment.in ⇨ Health

11. Chandrasekha r.P, Jayati Ghosh.C: Integrated Child Development Services scheme – the unfulfilled potential.
    Available at: www.thehindubusinessline.com/2005/03/2005032202430900.html

12. Financial Daily from THE HINDU group of publications: Press Information Bureau, Mumbai: National Informatics Centre (NIC) Information is provided and updated by: Press Information Bureau, Tuesday, Mar 22, 2005
    Available at: www.hindu.com/businessline/2000/01/coinfo/pubs.html

13. Malnutrition in India
    Available at: "Journal of the American Medical Association". Source: JAMA 2004.
    http://jama.ama-assn.org/cgi/content/abstract/291/21/2616
    Retrieved 2009-11-26. "The global burden of Chronic Disease"
    k
14. India's future goes to bed hungry
    Available at: sccommissioners.org/…/ICDS_Indias-future-goes-to-bed-hungry.pdf

15. 77 babies die of hunger every day in Maharashtra
    Available at: daily.bhaskar.com Maharashtra

16. UNICEF India – Nutrition – Under-nutrition – a challenge for India
    Available at: www.unicef.org/india/nutrition_1556.htm

17. Has ICDS Reduced Child Under – nutrition in India? An analysis of program effectiveness and impact.
    Available at: desiindia.org/child-development.html

18. Food Security Bill, ICDS can reap the benefits only with proper implementation. Available at: www.Articles.economictimes.indiatimes.com.Growth-Rate 2 Feb. 2012

19. Recommendations for a reformed and strengthened Integrated child Development Services (ICDS) by National Advisory Council June, 2011. Available at: nac.nic.in/pdf/ICDS.pdf

20. International Institute for Population Sciences (IIPS) and Macro International 2007. NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-2006: Vol-1.252-263,267 & 287. Available at: http://www.nfhsindia.org

21. Sumati. Vaid, Nidhi Vaid. Nutritional status of ICDS & Non-ICDS Children. Journal of Human Ecology 18(3):207-212(2005). Available at: www.krepublishers.com/valid/JHE-18-3-207-212-2005-1324

22. Dongre.A, Deshmukh P, Garg.B. Eliminating Childhood Malnutrition Discussion with Mothers and Anganwadi workers. JOURNAL OF HEALTH STUDIES. 2008: 1, 2, 3. Available at: www.esocialsciences.com/essjournalarticles/Article14116.pdf

23. Vinnarason. A.A Study on factors influencing non-enrollment of the children in the ICDS Anganwadi centers' at Chennai Corporation, Chennai: Loyala College, Department of Social work,170p. Available at: planningcommission.nic.infreports/peoreport/peo/peo_icds_voll.pdf

24. Nutritional health and Pre-school education status of children covered under the ICDS scheme in Orissa. Bhubaneshwar: Indian Institute for social Development (IISD), 222p. Available at: nipccd.nic.in/dcweresearch%20bulletin/jul-sep-2007.doc

Annexure

INFORMED CONSENT FORM

Investigator:

My name is Dr.Nareshkumar Prajapati and I am a postgraduate student, working as District Programme Coordinator- Nutrition in DISMU Valsad. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. I am now going to explain the study to you. Please feel free to ask any questions that you may have about the research; I will be happy to explain anything in greater detail.

"I am interested in learning more about the knowledge of Anganwadi worker in District Valsad. You will be asked to give answer of these questions related with the ICDS services. This will take approximately 45 min. of your time. All information will be kept confidential. If anonymous, this means that your name will not appear anywhere and no one except me will know about your specific answers. If confidential, I will assign a number to your responses, and only I will have the key to indicate which number belongs to which participant. In any articles I write or any presentations that I make, I will use a made-up name for you, and I will not reveal details or I will change details about where you work, where you live, any personal information about you, and so forth.

The benefit of this research is that you will be helping us to understand about Knowledge of Anganwadi worker in District Valsad. This information should help us to understand about whether there is any association between Knowledge of Anganwadi worker and enrollment of 0 to 6 years of children (beneficiaries). There are no any risks to you for participating in this study. If there is any risk that will be minimized by keeping your identity confidential. If you do not wish to continue, you have the right to withdraw from the study, without penalty, at any time."

Participant - I, the undersigned, confirm that
I have read and understood the information about the project, as provided in the Information. I have been given the opportunity to ask questions about the project and my participation. I voluntarily agree to participate in the project. I understand I can withdraw at any time without giving reasons and that I will not be penalized for withdrawing nor will I be questioned on why I have withdrawn. The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me. I, along with the Researcher, agree to sign and date this informed consent form.

Signature of Respondent **Date:**

Questionnaire Assessing the knowledge of Anganwadi workers regarding ICDS services in Non – Tribal and Tribal blocks of Valsad						
SECTION A	**SOCIO DEMOGRAPHIC INFORMATION**	R 1	R 2	R 3	R 4	R 5
A1	What is your age? (તમારી ઉંમર કેટલી છે?) 1) 15 થી 20 વર્ષ 2) 21 થી 25 વર્ષ 3) 26 થી 30 વર્ષ 4) 30 કરતા વધારે	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
A2	Marital status (વૈવાહિક સ્થિતિ) : 1) લગ્ન કર્યા (Married) 2) અપરિણીત (Unmarried) 3) વિધવા (Widow) 4) છૂટાછેડા (Divorced) 5) અન્ય (સ્પષ્ટ)(Others)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
A3	Caste (જાતિ) 1) જનરલ (General) 2) એસસી (SC) 3) એસટી (ST) 4) ઓબીસી (OBC) 5) અન્ય (સ્પષ્ટ) (Other (Specify))	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
A4	Religion (ધર્મ): 1) હિન્દૂ (Hindu) 2) મુસ્લિમ (Muslim) 3) ખ્રિસ્તી (Christian) 4) શીખ (Sikhh) 5) અન્ય (સ્પષ્ટ) (Other (Specify))	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
A5	What is your educational qualification? (તમારા શૈક્ષણિક લાયકાત શું છે?) 1) ધોરણ 10 સુધી I(Till 10th Std) 2) ધોરણ 12 સુધી (Till 12th Std) 3) ધોરણ 12 કરતા વધારે (More than 12th Std)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
A6	Are you resident of this village? (શું તમે આ ગામનાં રહેવાશી છો?) 1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2

SECTION B	GENERAL INFORMATION	R 1	R 2	R 3	R 4	R 5
B1	From how long you are working with ICDS as AWW? તમે કેટલા સમય થી આઇસીડીએસ માં આંગણવાડી કર્યાકર તરીકે ફરજ બજાઇ રહ્યા છો? 1) Less than 2 years 2) 2 Years to 4 Years 3) More than 4 Years	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
B2	Have you undergone training? (If answer is No than skip Q. B_{1a}) (શું તમે તલીમ લીધી છે? (જો જવાબ ના હોય તો Q. B_{1a} ને સ્કિપ કરવું(1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2
B2a	If yes, when and How many times (જો હા, તો ક્યારે?) 1) 1 વર્ષ પહેલા (Before 1 Year) 2) 2 વર્ષ પહેલા (Before 2 Year) 3) 3 વર્ષ પહેલા (Before 3 Year) 4) > 4 વર્ષ પહેલા (Before >4 Year)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
B3	Have you undergone refresher training?(If answer is No skip Q.B2a) શું તમે રીફ્રેશર તાલીમ લીધી છે?(જવાબ ના હોય તો Q B2a ને છોડવું(1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2
B3a	If yes, when and How many times (જો હા, તો ક્યારે?) 1) 1 વર્ષ પહેલા (Before 1 Year) 2) 2 વર્ષ પહેલા (Before 2 Year) 3) 3 વર્ષ પહેલા (Before 3 Year) 4) > 4 વર્ષ પહેલા (Before >4 Year)	1 2 3 4 -- --	1 2 3 4 -- --	1 2 3 4 -- --	1 2 3 4 -- --	1 2 3 4 -- --
B4	What do you feel that about the training you received was enough practical oriented? (શું આ તાલીમ તમને સંપૂર્ણ રીતે ઉપયોગી છે, તે વિશે તમારો શુ અભિપ્રાય છે?) 1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2

B5	On what all aspect do you counsel to the member of child's family? (તમે કયા કયા વિષયો પર બાળકો ના માતા પિતા ને સમજાવો છો?) 1) પૂરક પોષણ વિશે (Supplementary Nutrition) 2) પૂર્વ પ્રાથમિક શિક્ષણ વિશે (Pre School Education) 3) રશીકરણ વિશે (Immunization) 4) આરોગ્ય ની તપાસ વિશે(Health Check-up) 5) પોષણ & આરોગ્ય શિક્ષણ વિશે (Nutrition & Health Education) 6) રેફરલ સુવિધાઓ વિશે (Referral Services) 7) ઉપર બતાવેલ બધા વિશે (Above All)	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
B6	Do all the families whom you counsel get their child enrolled? શું તમે જે પરિવાર ને સમજવો છો તે બધા પોતાના બાળકો ની નોંધણી કરાવે છે? જવાબ હા હોય તો) Q. B6a પૂછવું, જો જવાબ ના હોય તો Q. B6b પૂછવું 1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2
B6a	If they, do they remain enrolled and utilized ICDS services for 6 years? જો હા, તો શું તે 6 years સુધી આઇસીડીએસ સુવિધઓ નો ઉપયોગ કરે છે? 1) હા (Yes) 2) ના (No)	1 2	1 2	1 2	1 2	1 2
B6b	If No, what are the reasons? Please specify જો ના તો, એના શું કારણ છે ?					

SECTION C SUPPLEMENTARY NUTRITION		R 1	R 2	R 3	R 4	R 5
C1	What amount of calories should be given to child to each child through supplementary nutrition? (પ્રત્યેક બાળક ને પૂરક પોષણ માર્ફતે કેટલી કેલેરી પુરી પાડવી) આપવી(જોઇએ?) 1) 200 કૅલરી (200 cal) 2) 300 કૅલરી (300 cal) 3) 500 કૅલરી (500 cal) 4) 600 કૅલરી (600 cal)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
C2	What amount of protein should be given to child to each child through supplementary nutrition? (પ્રત્યેક બાળક ને પૂરક પોષણ માર્ફતે કેટલું પ્રોટીન પુરૂ પાડ્વુ આપવ) ુ(જોઇએ?) 1) 5 ગ્રામ પ્રોટીન (5 gm proteins) 2) 10gm પ્રોટીન (10 gm proteins) 3) 15gm પ્રોટીન (15 gm proteins) 4) 20 ગ્રામ પ્રોટીન (20 gm proteins)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
C3	What amount of calories & proteins given to grade 4 malnourished child? (ગ્રેડ 4 નાં કુપોષિત બાળકોને કેટલા પ્રમાણમાં કેલરી અને પ્રોટીનનો જથ્થો આપવામાં આવે છે?) 1) અન્ય જેટ્લુ જ (same as others) 2) ડબલ (Double) 3) ટ્રિપલ (Triple)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C4	How much Calories & proteins a pregnant woman should receive from AWC? (AWC માંથી સગર્ભા માતાએ પૂરક પોષણ માર્ફતે કેટલી કેલેરી અને પ્રોટીન મેળવવુ જોઇએ?) 1) 400 કૅલ; 40gm પ્રોટીન્સ) 400 Cal;40gm Proteins) 2) 300 કૅલ; 10gm પ્રોટીન્સ (300 Cal;10gm Proteins) 3) 500 કૅલ; 20 ગ્રામ પ્રોટીન્સ (500 Cal;20gm Proteins) 4) 600 કૅલ; 15 ગ્રામ પ્રોટીન (600 Cal;15gm Proteins)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

	SECTION D NON-FORMAL PRESCHOOL EDUCATION & GROWTH MUNITERING	R 1	R 2	R 3	R 4	R 5
D1	Growth monitoring should start from?(વૃદ્ધિ મોનીટરીંગ શરૂ કરવું જોઈએ?) 1) જન્મથી (From birth) 2) 3 મહિના (3 months) 3) 6 મહિના (6 months) 4) 9 મહિના થી (9 months)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
D2	The red colour in mid upper arm circumference (MUAC) strip means? (મધ્ય હાથ ઘેરાવો માપવા વાળી સ્ટ્રીપ માં લાલ રંગ)MUAC સ્ટ્રીપનો(શુ અર્થ થાય છે?) 1) સારી રીતે પોષણ મળેલ છે (Well nourished) 2) પોષણ ઓછુ મળેલ (Under nourished) 3) બન્ને ની વચ્ચે (In between) 1) અતી કુપોશીત (Severely malnourished)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
D3	Yellow colour on MUAC strip means a circumference of? મેક (MUAC) સ્ટ્રીપ પર પીળા રંગનો મતલબ કેટલો ઘેરવો ? 1) 11.5-12.5 2) 12.5-13.5 3) 13.5-14.5 4) 14.5 - 15.5	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
D4	Flattened growth line on growth card means? ગ્રોથ ચાર્ટ વૃદ્ધિ) કાર્ડ પર સપાટ વૃદ્ધિ રેખા નો અર્થ શું છે (? 1) વજન ઘટી રહ્યું છે (Weight is declining) 2) વજન ધીમે ધીમે વધી રહ્યો છે (Weight is increasing gradually) 3) ઉંમર કરતા વજન ઓછું છે (Weight is low for Age)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
D5	At what level of weight gain per year between age group 3? 3 વર્ષ સુધી પ્રતી વર્ષ વજનમાં કેટલો વધારો થાય છે? 1) પ્રતિ વર્ષ 1 કિલો (Every year 1kg) 2) પ્રતિ વર્ષ 2 કિલો (Every year 2kg) 3) પ્રતિ વર્ષ 3 કિલો (Every year 3kg)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
D6	What is the average weight of a 1 year old child? (1 વર્ષ ના બાળક નું સરેરાશ વજન કેટલું હોય છે?) 1) 7kg 2) 10kg 3) 12 kg	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

SECTION E	IMMUNIZATION	R 1	R 2	R 3	R 4	R 5
E1	BCG Vaccine should be given at – (BCG રસી ક્યારે આપવી જોઇએ?) 1) જન્મ સમયે (At Birth) 2) 1 વર્ષ પર (1 Year) 3) 2 વર્ષ પર (2 Year)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E2	If BCG not given at birth than when it should be given? (જો BCG રસી જન્મ સમાયે ના અપાઇ હોય તો ક્યાર સુધી આપી દેવી જોઇયે?) 2) 1વર્ષ ની અંદર 3) 2વર્ષ ની અંદર 4) કયારે બી આપી સકાય	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E3	What is the gap between 2 successive doses of DPT vaccine? D P T રસી ના 2 ક્રમિક ડોઝ વચ્ચે કેટ્લું અંતર હોય છે? 1) 1 અઠવાડિયું (1week) 2) 4 અઠવાડિયા (4 weeks) 3) 8 અઠવાડિયા (8 weeks)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E4	Measles vaccine given at what age? (ઓરી રસી કયા ઉંમરે આપવામાં આવે છે?) 1) 6 month 2) 9month 3) 1 year	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E5	Booster dose of DPT given at what age? (DPT રસીનો બૂસ્ટર ડોઝ કઈ ઉંમરે આપવામાં આવે છે?) 1) 1 વર્ષ (1 year) 2) 1 ½ વર્ષ (1 ½ years) 3) 2 વર્ષ (2 years)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E6	What type of Vaccines given at 5yr age? 5 વર્ષની ઉમરે કયા પ્રકારની રસી આપવામાં આવે છે? 1) DPT 2) DT 3) TT	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E7	What No. of tetanus toxoids that a pregnant lady should receive? ગર્ભવતી મહિલાઓ એ ટીટી ના કેટલા ડોઝ લેવા જોઇએ? 1) 1 2) 2 3) 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

SECTION F	HEALTH CHECK-UP	R 1	R 2	R 3	R 4	R 5
F1	What is the earliest symptom of vitamin A deficiency? વિટામિન એ ની ઉણપનું સૌથી પહેલા લક્ષણ શું છે 1) વાંચવા માટે અક્ષમતા (Inability to read) 2) રાત્રે અંધત્વ (Night blindness) 3) આંખ માથી પાણી નિકડવું (Lacrimation)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F2	Dose of vit. A below 1 year age? (1 વર્ષથી નાના બાળકોમા વિટામીન એ ની કેટલી માત્રા આપવામા આવે છે?) 1) એક લાખ IU (One lakh IU) 2) બે લાખ IU (Two lakh IU) 3) 0.5 લાખ IU (0.5 lakh IU)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F3	Dose of vit. A above 1 yr age? (1 વર્ષથી ઉપર ના બાળકોમા વિટામીન એ ની કેટલી માત્રા આપવામા આવે છે?) 1) એક લાખ IU (One lakh IU) 2) બે લાખ IU (Two lakh IU) 3) 0.5 લાખ IU (0.5 lakh IU)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F4	First dose of vit. A given at? વિટમીન એ નો પ્રથમ ડોઝ કઇ ઉમરે આપવામા આવે છે? 1) 6 months 2) 9 months 3) 1 year	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F5	Gap between 2 successive doses of vitamin A? વિટામીન A ના બે લગાતાર ડોઝ વચ્ચે કેટલા સમય નો અંતર હોય છે? 1) 2 months 2) 6 months 3) 1 year	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F6	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume.) આયર્ન અને ફોલિક એસિડની ન્યુનત્તમ કેટલી ટેબલેટો ગર્ભવતી મહિલાઓ એ ગળવી જોઈએ?) 1) 60 2) 90 3) 200	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

	SECTION G NUTRITION & HEALTH EDUCATION	R 1	R 2	R 3	R 4	R 5
G1	Exclusive breast feeding should be continued till? ક્યાંસુધી એક્સક્લુઝિવ સ્તનપાન ચાલુ રાખવી જોઇએ? 1) 3 months 2) 6 months 3) 1 Year	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
G2	Nutrition & health education especially in what age group of? ખાસ કરીને કયા વય જૂથ માં પોષણ & આરોગ્ય શિક્ષણ આપવુ જોઇએ? 1) 15 to 25 2) 15 to 35 3) 15 to 45 4) 15 to 55 5) Other (Specify)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
G3	At what age can a child begin to eat (Complimentary Feeding) from the family pot or meal? (ઘરનો ખોરાક ચાલુ કર્યા (કોમ્પ્લીમેન્ટ્રી ફીડીંગ) પછી સ્તનપાન કેટલા સમયસુધી ચાલુ રાખી શકાય?) 1. months 2. 6 months 3. 9 months 4. 1 Year	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
G4	For how long breastfeeding should be continued with complementary feeding? (ઘરનો ખોરાક ચાલુ (કોમ્પ્લીમેન્ટ્રી ફીડીંગ)કર્યા પછી સ્તનપાન કેટલા સમય સુધી ચાલુ રાખી શકાય?) 1) 1 Year 2) 2 Year 3) 3 Year 4) 4 Year	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
G5	What Kind of diet that should be given during diarrhea? ઝાડા (ડાયેરીયાહોય તો કયા પ્રકારનો ખોરાક આપવુ જોઇએ (ડાયેટ)? 1) ફક્ત પ્રવાહી(only liquids) 2) હળવો અને પોષ્ટિક આહાર(light & nutritious diet) 3) ખોરાક આપવાનું સ્થગીત કરવું (diet should be Withheld)	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
G6	ORS should be discarded if not used completely after? (જો ORS ઉપયોગમાં ન લીધો હોય તો તેનો નિકાલ કેટલા સમયની અંદર કરવો? 1) 4 hrs 2) 24 hrs 3) 36 hrs	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

SECTION H	PROBLEM FACED BY AWW	R 1	R 2	R 3	R 4	R 5
H1	Do you face any problems? (If answer is No than end up the interview) શું તમે મુશ્કેલીઓનો સામનો કરો છો? 1) હા (YES) 2) ના (NO)	1 2	1 2	1 2	1 2	1 2
H2	If yes than what they are? (જો હા તો તે કયા છે?) (Multiple response are allowed) (YES = 1 NO = 2) a) અપૂરતી પગાર (Inadequate salary) **(Y/N)** b) બાંધકામને લગતા (Infrastructure related) **(Y/N)** c) સંબંધિત પરીવહન પુરવઠો (Logistic supply related) **(Y/N)** d) વર્ક ભારને (Work overload) **(Y/N)** e) અતિશય રેકોર્ડ જાળવણી (Excessive record maintenance) **(Y/N)** f) સમુદાયથી મદદનો અભાવ (Lack of help from community) **(Y/N)** g) ઉપરી અધિકારીઓની અસુલભતા(In accessibility of superiors) **(Y/N)** h) અન્ય કોઈ હોય તો (Other if any specify) **(Y/N)**					

Signature of investigators:

Thank You