

**Current Levels of Knowledge among Anganwadi Workers about
Integrated Child Development Services (ICDS) and their need of
Training Programmes for Capacity Building**

**Internship Training
at
Integrated Child Development Scheme, Patan**

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**Under the guidance of
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**Post Graduate Diploma in Hospital & Health Management
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 **IIHMR UNIVERSITY**
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TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Anita Suresh Mahajan, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at Integrated Child Development Scheme, Patan from February 2014 to April 2014.

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

The internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.



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સંકલિત બાળ વિકાસ સેવા યોજના
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The certificate is awarded to

Dr. Anita Suresh Mahajan

In recognition of having successfully completed her Internship

In

Integrated Child Development Scheme, Patan

and has successfully completed her Project on

Current Levels of Knowledge among Anganwadi Workers about Integrated Child
Development Services (ICDS) and their need of Training Programmes for Capacity Building

From

Date February 2014 - April 2014

Organization ICDS, PATAN

She comes across as a committed, sincere and diligent person who has a strong
drive and zeal for learning.

We wish her all the best for future endeavors.

Name: - Srimati Gauriben Solanki

Designation:- Programme Officer, ICDS Patan.

Signature:-

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I.C.D.S. Cell, D. P. Patan

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Preface

Dissertation is an integral part of the PGDHM curriculum. As a part of the course; the students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

The major objectives of the dissertation programme are as follows:

- 1) To better understand the existing healthcare delivery system including public and private sectors.
- 2) To observe the implementation of various National Health Programmes at State/District/Block levels.
- 3) To acquire more knowledge on roles and responsibilities of key players and stakeholders in health sector.
- 4) To understand various functions of health system by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.
- 5) To work on the project/task assigned by summer training organization.

Acknowledgement

I would like to express my heartfelt gratitude to The Government of Gujarat and Integrated Child Development Scheme, Gujarat for providing me an opportunity to work in such a wonderful organization and for making all the facilities available and giving the support in every way for completion of internship & Dissertation.

I would like thank to Integrated Child Development Scheme, Gujarat and Integrated Child Development Scheme Office, Patan for facilitating my internship work.

I would like to take this opportunity to express great indebtedness to Shrimati Gauriben Solanki, Programme Officer of Integrated Child Development Scheme, without whom this training could not have been accomplished. I would like to extend my sincere regards to Program Officer who despite other preoccupations and busy schedule shared their views.

I would like to thank the staff of Integrated Child Development Scheme, Patan for their support.

I would like to thank Dr. Anoop Khanna, Institute of Health Management and Research, Jaipur for his constant motivation, patience and valuable guidance.

I thank to my family and friends for their moral support.

Dr. Anita Suresh Mahajan

Abstract

Today Integrated Child Development Services (ICDS) represents one of the world's largest programmes for early childhood development. The main objective of this programme is to cater to the needs of the development of children in the age group of 0-6 years. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. Though government is spending lot of money on ICDS programme, impact is very ineffective. Most of the evaluation 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. The key objective of the present study is to assess the correct knowledge among Anganwadi Worker about Integrated Child Development Services (ICDS). The sample for the present study comprises of 150 Anganwadi workers belonging to three Urban Blocks of Patan District. Twenty six knowledge indicators are considered to estimate the mean knowledge score related to six domains of ICDS services. If the response is correct then it is coded as 1 or else equal to 0. Total knowledge score is estimated by adding the individual scores of each response. Results from the analysis suggest that most of the Anganwadi workers are trained; but it was found that performance as well as awareness among Anganwadi workers regarding the importance of growth charts and growth monitoring was not satisfactory. The quality of knowledge was one of the neglected features among job profile of Anganwadi workers. Therefore, the study strongly felt the need of improving the quality of knowledge and awareness among Anganwadi workers about various ICDS Services. Hence, there is a strong and intense need for improving the training quality provided to Anganwadi workers before letting them go into the field jobs. Frequent interactions among Anganwadi workers and supervisors should be introduced for imparting information and awareness. Though Government of India putting lot of money to enhance the health status of both mother and children through AWCs, the results suggest to relook the operational aspects of AWCs at the grass root level.

ABBREVIATIONS

ABBREVIATIONS	FULL FORMS
ANC	Ante Natal Care
ATVT	Apna Taluka Vibrant Taluka
AWCs	Anganwadi Centers
AWH	Anganwadi Helpers
AWW	Anganwadi Workers
AWTC	Anganwadi Training Center
BCC	Behavior Change Communication
CDPO	Child Development Project Officer
CMTC	Child Malnutrition Treatment Center
DmAP	District Action Plan
DDO	District Development Officer
DFHS	District Family Health Survey
ECCE	Early Childhood Care and Education
GIS	Geographical Information System
GOG	Government Of Gujarat
GOI	Government Of India
GLPC	Gujarat Livelihood Promotion Company
H&FW	Health & Family Welfare
ICDS	Integrated Child Development Service
IEC	Information Education and Communication
IFA	Iron Folic Acid
IGMSY	Indira Gandhi Matritva Sahyog Yojna
IYCF	Infant and Young Child Feeding
KSY	Kishori Shakti Yojna
LM	Lactating Mother
MAM	Moderate Acute Malnutrition
MLTC	Middle Level Training Center
MPR	Monthly Progress Report
MUW	Moderately Under Weight
NA	Not Applicable
NCV	Nutrition Counseling Volunteer
NGO	Non-Government Organization
NRC	Nutrition Rehabilitation Center

PNC	Pre-Natal Care
PO	Program Officer
PPP	Public Private Partnership
PW	Pregnant Women
SAM	Savior Acute Malnutrition
SUW	Severely Under Weight
VCNC	Village Child Nutrition Center
WASMO	Water and Sanitation Management Organization
WHO	World Health Organization

Part A: Internship

Introduction

Internship is a part of the second year program, where we have to observe and learn the work culture of organization. Also it will be necessary to participate in various department/activities so we could orient our self with different departments that gives us first hand exposure.

Internship is the process, through which we can understand process of work and thereafter be able to involve in decision making.

I am appointed as District Program Coordinator and Child Development Officer under Integrated Child Development Scheme Patan, Gujarat. ICDS is now currently known as Mission Balam Sukham.

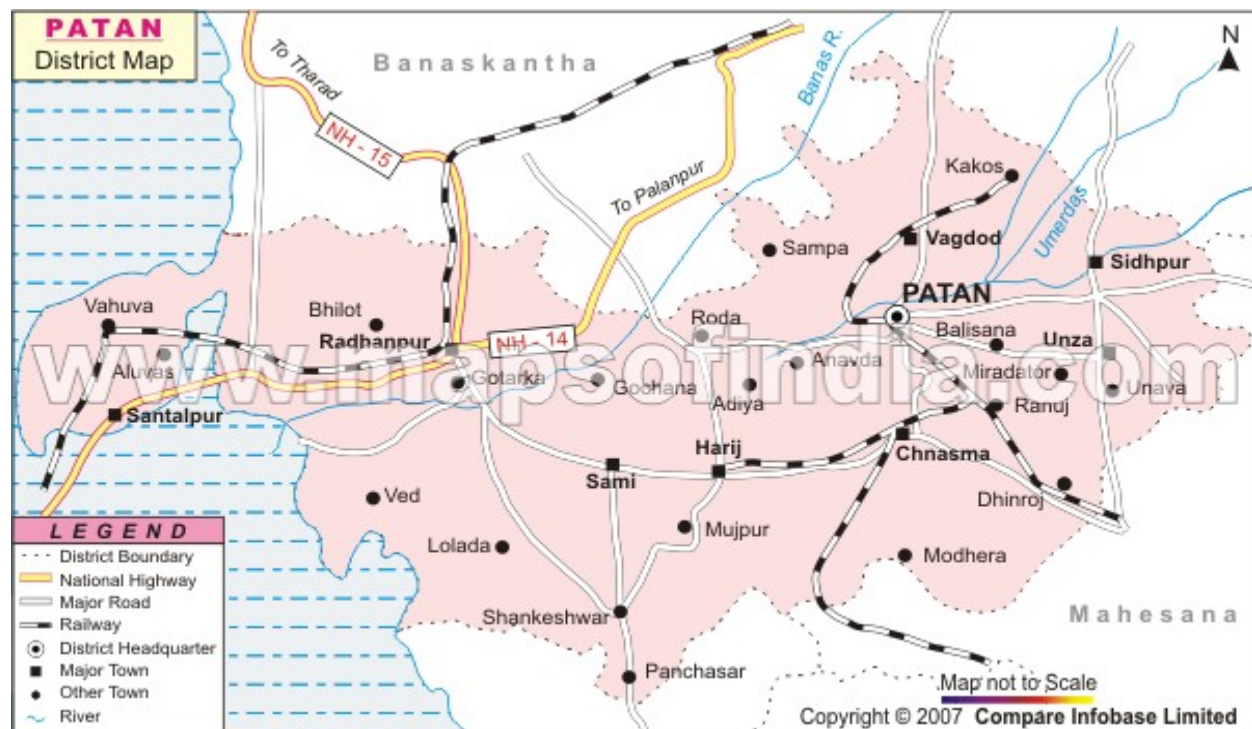
Objective of Internship

- a) To understand the work pattern of ICDS Patan, Gujarat and its organizational structure.
- b) The next objective of internship was to learn various managerial and administrative skills needed to work in a government system and to effectively implement all the ICDS and ICDS related programmes in the government setup to ensure the overall benefit of the community.

DISTRICT PROFILE:

Patan district has nine talukas, out of which three talukas Sami, Shankheshwar Radhanpur and Santalpur talukas has been allotted with high priority status and rest six talukas like Patan, Sarashvati, Siddhpur, Chanasma and Harij have been allotted non high priority status. District health action plan has been prepared considering the health related matter of this talukas.

Patan district is situated at north of Gujarat. It was newly created on 2nd October 1998. This is the district where there is a lack of resources as well as manpower. Geographically it has 7 talukas which distributed in 6 blocks. It has 517 revenue villages. Main business of people from Patan is labour, agriculture and animal husbandry. Patan, Sidhpur and Radhanpur are well known cities of the District. Patan city is a main city having population of approx. 1,35,000/-. All kind of higher education is available and Patan city is the head quarter of local University. This is a center of medical specialist and well sophistications in medical field are available in Patan City. District do not have any Municipal corporation, it have 2 Nagarpalika i.e. Patan & Sidhpur and 3 Muni. Bureau i.e. Radhanpur, Chanasma and Harij.



Patan is a historical place as:

- Anciently Patan was a capital (in era of “Siddhraj”)
- Really there was prosperity and greenery at the time of “Solanki Era”.
- Till today existing monuments like ‘Raniki Vav’, ‘Sahastraling Talav’, and Rudramahal of Sidhpur’ attracts people.
- Known “Patola” is a wonderful art of handloom, made from fine silk fibers.
- Rivers ‘Saraswati’ and ‘Banas’ known as Virgin River pass through Patan district and mergers in small desert of ‘Kutchh.’

General Information:

Patan district came in to existence in 1999 because of the merger of various princely states in the Bombay state. Patan district is located between 23’ to 24.09’ North latitude and 71’.26 and 72’.52 east longitude. Thus, this district is situated on north western part of the state Sabarkantha district in the east on the north and western part, there are Banaskantha and Surendranagar District and Ahmedabad district in South are situated.

As per the 2011 census, district is having a total population of 13.43 lakhs with a total area of 9027. Sq.kms. The district has 106% in habited villages and five towns spread over 9 talukas.

The district is traversed by 5 (five) rivers viz, Banas, Saraswati, Rupen, Sabarmati & Khari. Geographically 90% of the district is plain western part of the district is (Harij, Sami, Radhanpur and Santalpur Taluka) mostly salty area.

There is one medium irrigation project (Dharoi dame in Kheralu Taluka) on Sabarmati River. Drought and scarcity condition occurs mostly every year in Harij and Sami Talukas. There are no major industries in district. The major categories of laborers / workers are the agriculture labor and cultivators.

- | | | | |
|-----|------------------|---|--|
| (1) | Total Areas | : | 566755 Hactor.
(11284 Hactor Urban & 555471 Hactor Rural) |
| (2) | Agriculture Area | : | 459488 Hactor, Non-agri. Area 334688 Hactor |
| (3) | Nature of Soil | | |

	None salty area	:	Patan, Sidhpur & Chanasma Talukas.
	Salty area	:	Sami, Harij, Radhanpur & Santalpur Talukas. Effecting vector borne diseases.
(4)	Weather	:	Dry / Humid
(5)	Rain fall and water	:	Average rain – 518.63 mm.
	Habited:		
(6)	Area sensitivity	:	Border area.
(7)	Rivers	:	4 (Saraswati, Rupen, Banas & Puphpawati)
(8)	Ponds	:	1303
(9)	Check dams	:	01 (Saraswati dame Patan)
(10)	Animal Husbandry	:	358667
(11)	Wild Plant Product	:	Gum
(12)	Co-operative societies:	:	17
(13)	Occupations	:	Agriculture, Animal Husbandry & Labors.

1.1 District Profile

An official Census 2011 detail of Patan, a district of Gujarat has been released by Directorate of Census Operations in Gujarat. Enumeration of key persons was also done by census officials in Patan District of Gujarat.

Patan District Population 2011

In 2011, Patan had population of 1,343,734 of which male and female were 694,397 and 649,337 respectively. In 2001 census, Patan had a population of 1,182,709 of which males were 612,100 and remaining 570,609 were females.

Patan District Population Growth Rate

There was change of 13.61 percent in the population compared to population as per 2001. In the previous census of India 2001, Patan District recorded increase of 14.16 percent to its population compared to 1991.

Patan District Density 2011

The initial provisional data released by census India 2011, shows that density of Patan district for 2011 is 232 people per sq. km. In 2001, Patan district density was at 206 people per sq. km. Patan district administers 5,792 square kilometers of areas.

Patan Literacy Rate 2011

Average literacy rate of Patan in 2011 were 72.30 compared to 60.36 of 2001. If things are looked out at gender wise, male and female literacy were 82.90 and 61.05 respectively. For 2001 census, same figures stood at 73.63 and 46.33 in Patan District. Total literate in Patan District were 837,913 of which male and female were 494,631 and 343,282 respectively. In 2001, Patan District had 599,082 in its district.

Patan Sex Ratio 2011

With regards to Sex Ratio in Patan, it stood at 935 per 1000 male compared to 2001 census figure of 932. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In 2011 census, child sex ratio is 890 girls per 1000 boys compared to figure of 865 girls per 1000 boys of 2001 census data.

Patan Child Population 2011

In census enumeration, data regarding child under 0-6 age were also collected for all districts including Patan. There were total 184,779 children under age of 0-6 against 190,192 of 2001 census. Of total 184,779 male and female were 97,762 and 87,017 respectively. Child Sex Ratio as per census 2011 was 890 compared to 865 of census 2001. In 2011, Children under 0-6 formed 13.75 percent of Patan District compared to 16.08 percent of 2001. There was net change of -2.33 percent in this compared to previous census of India.

Description	2011	2001
Actual Population	1,343,734	1,182,709
Male	694,397	612,100
Female	649,337	570,609

Population Growth	13.61%	14.16%
Area Sq. Km	5,792	5,792
Density/km2	232	206
Proportion to Gujarat Population	2.22%	2.33%
Sex Ratio (Per 1000)	935	932
Child Sex Ratio (0-6 Age)	890	865
Average Literacy	72.30	60.36
Male Literacy	82.90	73.63
Female Literacy	61.05	46.33
Total Child Population (0-6 Age)	184,779	190,192
Male Population (0-6 Age)	97,762	101,968
Female Population (0-6 Age)	87,017	88,224
Literates	837,913	599,082
Male Literates	494,631	375,588
Female Literates	343,282	223,494
Child Proportion (0-6 Age)	13.75%	16.08%
Boys Proportion (0-6 Age)	14.08%	16.66%
Girls Proportion (0-6 Age)	13.40%	15.46%

Description	Rural	Urban
Population (%)	79.08 %	20.92 %
Total Population	1,062,653	281,081
Male Population	548,324	146,073
Female Population	514,329	135,008
Sex Ratio	938	924

Child Sex Ratio (0-6)	896	862
Child Population (0-6)	153,011	31,768
Male Child(0-6)	80,705	17,057
Female Child(0-6)	72,306	14,711
Child Percentage (0-6)	14.40 %	11.30 %
Male Child Percentage	14.72 %	11.68 %
Female Child Percentage	14.06 %	10.90 %
Literates	630,617	207,296
Male Literates	378,570	116,061
Female Literates	252,047	91,235
Average Literacy	69.33 %	83.15 %
Male Literacy	80.96 %	89.96 %
Female Literacy	57.02 %	75.84 %

	Census-2011	
Area (Sq.Km.)	9027	
Total Population	13,43,734	
Rural (%)	79.08	
Urban (%)	20.92	
S.C. Population	123356 (9.18%)	
S.T. Population	13303 (0.99%)	
Sex Ratio (Adult)	935	
Sex Ratio (0-6 Yr. Age Group)	890	
Infant Mortality Rate (IMR)	33	MIS Data 2013
Below Poverty Line (BPL) (%)	40	Planning Comm.
Crude Birth Rate (CBR)	21	DLRHS-2011
Literate (person)	73.47	Census-2011
Death Rate	6.2	CRS-2012

1.2 Administrative Structure :

Taluka	09
Villages above 1000 population	385
Villages < 1000 population	132
Total Revenue Village	517
Nagarpalikas	05
Gram Panchayat	472
Primary, Secondary, H.S.Schools	1901
Colleges	24
Anganwadies	1399
Families	259343 (FHS-2013)
Eligible Couples	201513 (FHS-2013)

GROWTH RATE:-

The district has a population of 1343734. The district has experienced an annual exponential growth rate of 1.20 %. (Census 2011).

LITERACY RATE:-

The literacy rate of the district is 72.30 percent, with 82.90 Percent for males and 61.05 percent for females, which are comparable to the respective rates in the state. Thus, in terms of urbanization, Patan district is at a disadvantageous Position as compared to the state as a whole.

Taluka wise Male-Female literacy rate % of Total Rate:

Sr. No.	Name of Taluka	Total literacy rate	Male	Female
1	Patan (Patan 1 + Saraswati)	76.16	85.56	66.11
2	Sidhpur	81.12	89.81	72.00
3	Chanasma	81.52	90.73	71.71
4	Harij	66.35	78.46	53.38
5	Sami	64.25	77.28	49.99

6	Radhanpur	64.21	76.97	50.82
7	Santalpur	58.34	70.27	45.56
	Total	72.30	82.90	61.05

SEX RATIO:-

The sex ratio of the district is 935 which being higher than the states figures is favorable for the district but not in comparison with Kerala. Taluka wise Sex Ratio shown in table below:

Sr	Taluka	0-6 yr Sex Ratio			Adult Sex Ratio
		1991	2001	2011	2011
1	Patan	893	848	873	927
2	Sidhpur	917	845	882	944
3	Chanasma	914	803	855	930
4	Harij	903	883	914	930
5	Sami	916	908	904	944
6	Radhanpur	890	911	918	947
7	Santalpur	904	919	911	930
	District	903	865	890	935

VITAL RATES:-

The Crude Birth rate & crude death rate of the district is 21 & 6.2 respectively. The infant mortality rate of the district is 33. Neonatal mortality rate is 40.2 & the post neonatal mortality rate 17.07. (MIS 2013)

WORK PARTICIPATION:--

Around 41.29 % of the population is working class out of which 69.04% are males & 30.96 % are females. But district is having 39.46% Male & 60.54 Female unemployed out of 58.71 % of total unemployed population. This shows that it is economically underdeveloped & thus is a matter of concern for the district. (Census 2011) The reason for unemployment can be the low literacy rate of the district.

POPULATION DISTRIBUTION & SEX RATIO:-

Taluka wise population distribution % of Total population and Sex Ratio:

Census 2011

Sr. No.	Name of Taluka	Population	% of Total Population	Male	Female	Sex Ratio
1	Patan	449480	33.45	233211	216269	927
2	Sidhpur	213087	15.86	109587	103500	944
3	Chanasma	130743	9.73	67752	62991	930
4	Harij	94562	7.04	48994	45568	930
5	Sami	182805	13.60	94050	88755	944
6	Radhanpur	144266	10.74	74083	70183	947
7	Santalpur	128791	9.58	66720	62071	930
	Total	1343734	100.00	694397	649337	935

Taluka wise SC / ST population & % of Total population:

Census 2011

#	Taluka	Population	SC	%	ST	%
1	Patan	449480	45301	10.08	5073	1.13
2	Sidhpur	213087	23038	10.81	2034	0.95

3	Chanasma	130743	11879	9.09	347	0.27
4	Harij	94562	8353	8.83	565	0.60
5	Sami	182805	16345	8.94	383	0.21
6	Radhanpur	144266	9947	6.89	3551	2.46
7	Santalpur	128791	8545	6.63	3551	2.76
	Total	1343734	123408	9.18	13303	0.99

3.3 ABOUT THE ORGANIZATION:-

Integrated Child Development Scheme is in force since the existence of Patan District. The scheme is in force in Gujarat state since 2nd. October 1975. Development of human power is an important factor for development of the country. Base of physical and mental development is rooted in early childhood. Most of the children in India are nurtured in poor families deprived of educational, social, economic advantages. If vicious circle of malnutrition, illness, physical handicapped ness and mortality is dismantled, substantial economic, social and all round development may be achieved.

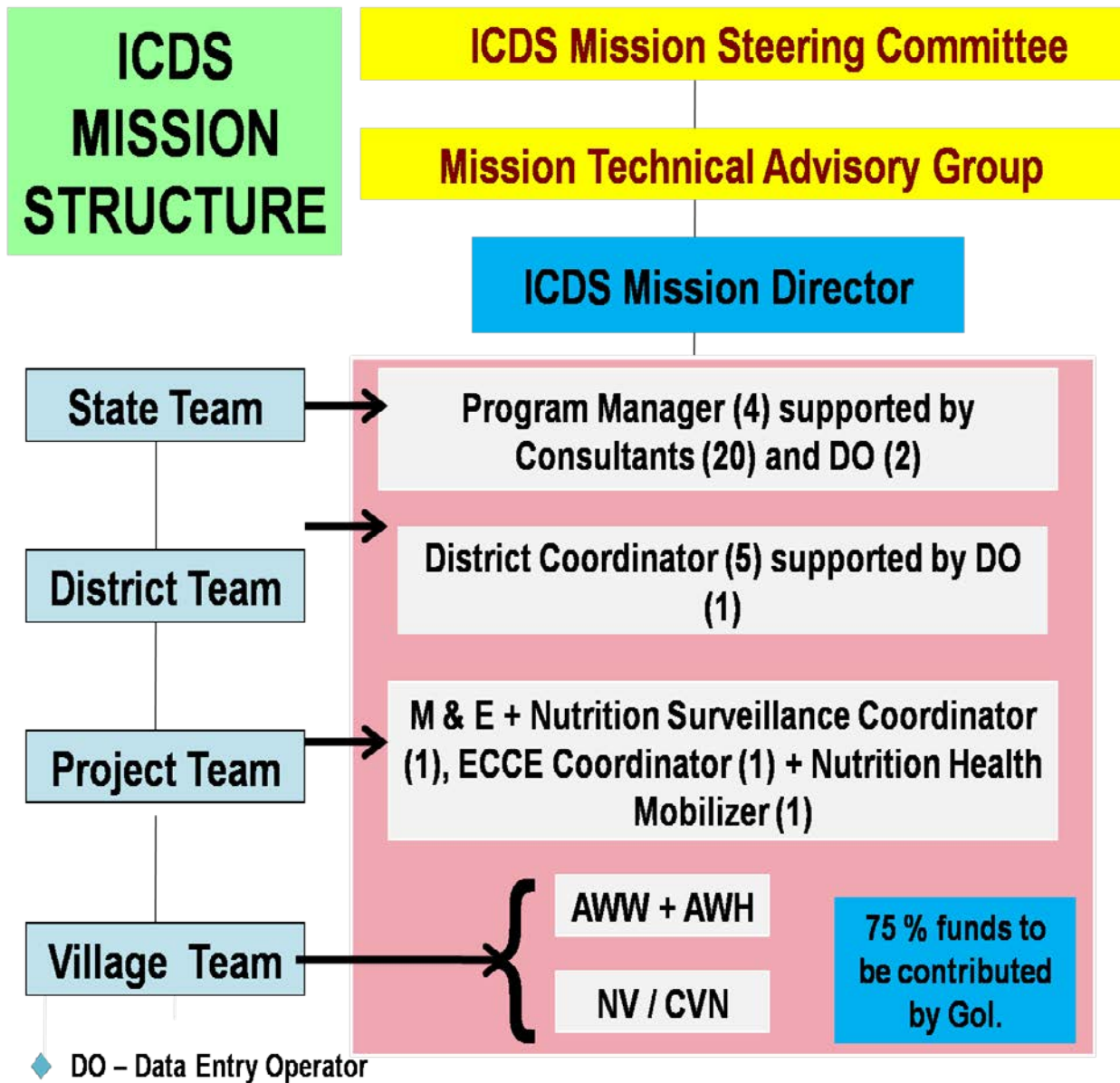
In order to plan integrated child development services, the Minister of Planning government of India made suggestions in the report, on the basis of which integrated Child Development scheme was implemented. 33 units were started on experimental basis in the state in 1975-76. The Scheme was begun first in Vadodara District. Health and nutrition level of children as well as women has improved by this Scheme. Children of backward classes, tribal and poor families have obtained substantial benefits. There are 1427 anganwadi centers working in total 8 (eight) units in Patan District.

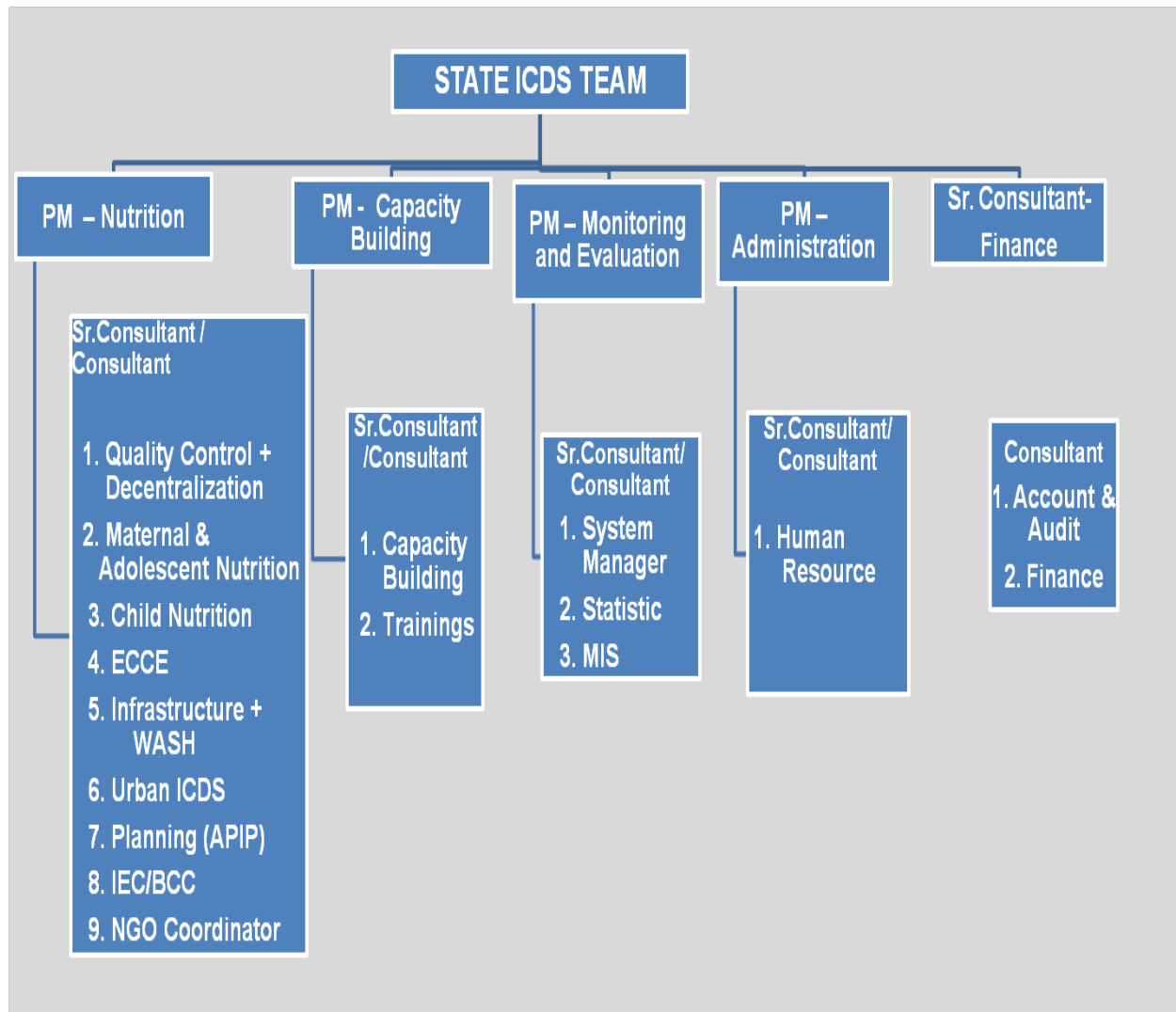
Aanganvadi

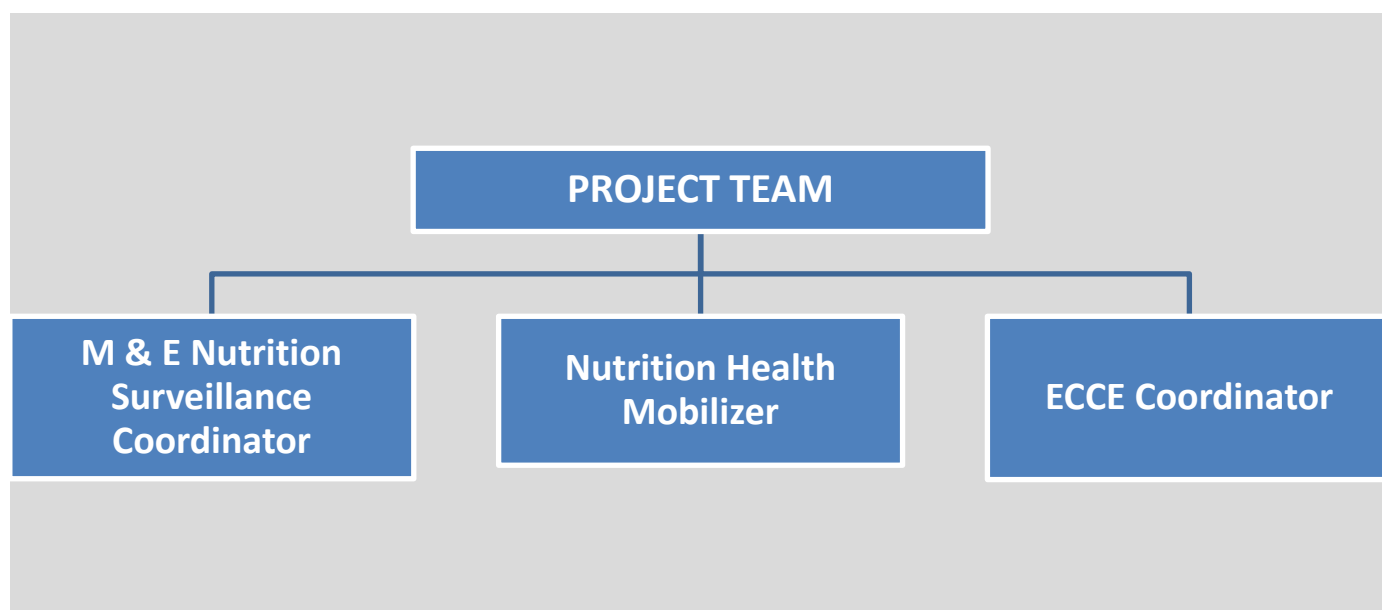
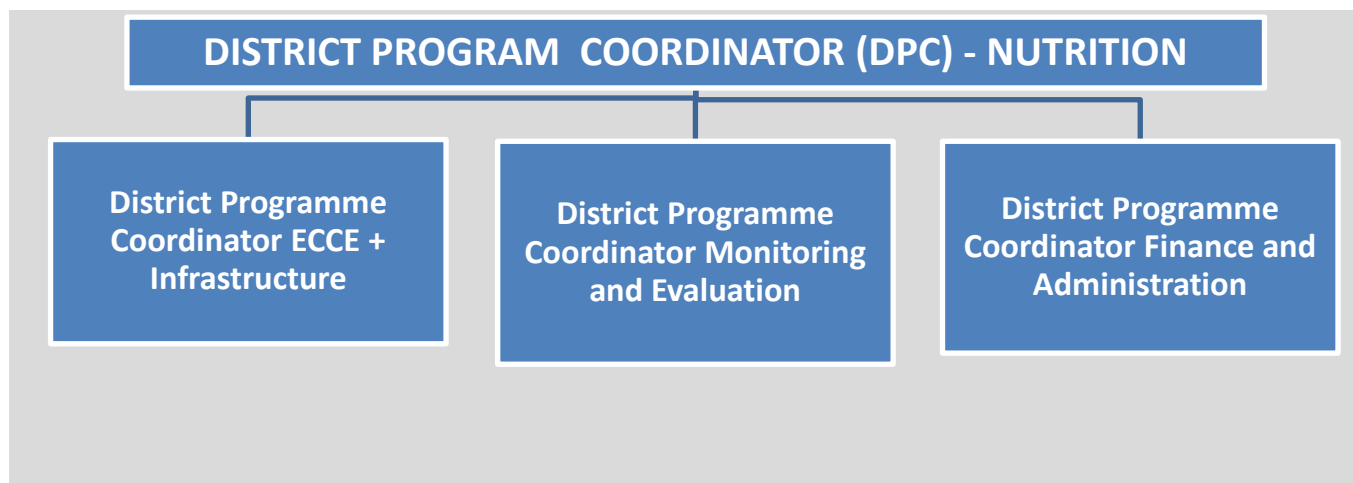
Implementation of Integrated Child Development Scheme is made through anganwadis at village level. Pre-primary education is imparted to children from 3 to 6 years by anganwadi workers. Various services to improve nutrition level are rendered by health team every month from anganwadi level only.

Sr.No	Name of unit	Number of working anganwaid
1	Sami	221
2	Harij	99
3	Chanasmai	178
4	Siddhpur	195
5	Patan-1	209
6	Patan-2	193
7	Radhanpur	137
8	Santalpur	161

ORGANOGRAM:-







Observations and Learning:-

- Interacting and monthly meetings with block coordinators to discuss their field related problems, taking review of the field work done block wise and status of the tour program and tour diary maintained by them.
- Monthly meetings with CDPOs and discussing block wise malnutrition status, enrolled population within the project and beneficiaries who received ICDS services, gaps if any and suggestions and solutions discussed.
- Checking of Monthly Progress Report (MPR) for the indicators and submitting monthly report to State MIS cell.
- Monthly preparing reports of DPC monitoring indicators and sending it to State MIS cell.
- Attending of Baldin, Vatsalya din, Mamta diwas for monitoring, supervision and counseling of beneficiaries.
- Developing coordination with the health department for Mamta diwas, Kishori Shakti Yojna and other health indicators.
- Conducting SA meetings and checking of all the documents to be submitted in SA meeting at Gandhinagar.
- Preparing the anganwadi centers for Delhi visit team for program evaluation organization.
- Conducting surprise field visits at anganwadi centers for the checking the functioning of AWCs and meeting the beneficiaries and their counseling.
- Counseling of Anganwadi workers and beneficiaries especially for IGMSY scheme.
- Doing proceedings on the various official documents and circulars received from State level.
- Patan district has 2% severe malnutrition status, which is mostly due to early child marriages, early marriages, early and repeated pregnancies, lower literacy levels, migratory populations, poverty due to unemployment and poor socio-economic condition (most prevalent in the four blocks of Sami, Harij, Radhanpur and Santalpur).
- Due to geographical and climatic conditions, it is difficult to find trained manpower to work in these four blocks where malnourishment status is highest in the whole district. Here the literacy level of Anganwadi workers and helpers is the lowest (5th -7th standard pass).
- Desert areas with sand dunes and dry hot summer winds blowing in the desert areas, high temperature in summer, lack of availability of drinking water and proper sanitation facilities, lowest amount of rainfall in these regions and hence poor agriculture production, lack of livelihood in desert areas, lack of vegetation for livestock, location of houses of beneficiaries in distant areas from the anganwadi centers, location of houses at great distances from each other, lack of support from community leaders etc. are the various problems faced in the blocks of Sami, Harij, Radhanpur and Santalpur.

CHAPTER I INTRODUCTION

1.1 Integrated Child Development Services (ICDS) scheme

India is the nation with high-level of regional inequality, social hierarchy and multicultural society. With high level of economic and social inequality, health and nutrition inequalities are also pervasive and persistent. According to WHO classification of 14 sub regions, India comes in the region of South East Asian Region (SEAR D), which is characterized as high child and adult mortality (WHO, 2000). In India, mortality for children less than 5 years of age is currently around 74 per 1000 live births (NFHS-3, 2005-06). Poor status of health and nutrition among the children of deprived group challenging to achieve Millennium Development Goals (MDGs) set forth by United Nation. To combat this situation, the Government of India initiated the Integrated Child Development Service (ICDS) scheme on experimental basis from 2nd October 1975 to reduce the level of infant and child mortality rates. Today ICDS represents one of the world's largest programmes for early childhood development (GOI, 2010).

The main objective of this programme is **to cater to the needs of the development of children in the age group of 0-6 years**. Pre-school education aims at ensuring holistic development of the children and to provide learning environment to children, which is helpful for promotion of social, emotional, cognitive development among children. Universalization of the ICDS was originally considered to be achieved by the end of 1995-96, through the development of services all over the country. It is one of the largest child care programmes in the world aiming at child health, hunger, malnutrition and its related issues.

ICDS services are provided a vast network of ICDS centers, it is known as “**Anganwadi**”. The word Anganwadi is developed from the Hindi word “Angan” which refers to the courtyard of a house. In rural areas an Angan is where people get together to discuss, meet, and socialize. The Angan is also used occasionally to cook food or for household members to sleep in the open air. This part of the house is seen as the ‘heart of the house’. A network of “Anganwadi Centre (AWC)” literally it is a courtyard play centre, provides integrated services comprising supplementary nutrition, immunization, health check-up, referral services, pre-school education and health and nutrition education. It is a childcare centre located within the village or the slum area itself. It is the central point for the delivery of services at community levels to children below six years of age, pregnant women, nursing mothers and adolescent girls.

Under the ICDS scheme, one trained person is selected to focus on the health and educational needs of children age 0-6 years. This person is the **Anganwadi worker (AWW)**. The Anganwadi worker is the most important functionary of the ICDS scheme. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. This service will help the children to get into the right from the pre-school age. The Integrated Child

Development Service (ICDS) scheme is utilized to help the family especially mothers to ensure effective health and nutrition care, early recognition and timely treatment of ailments.

In spite of the ongoing direct nutrition interventions like ICDS, India still contributes to about 21% of the global burden of child deaths before their fifth birthday (UNICEF 2007). They also found little evidence of programme impact on child nutrition in villages with ICDS centre. ICDS is the foremost symbol of India's commitment to her children – India's response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality.

World Bank has also highlighted certain key shortcomings of the programme including inability to target the girl child improvements, participation of wealthier children more than the poorer children and lowest level of funding for the poorest and the most undernourished states of India (World Bank, 2011).

1.2 The main objectives of the Integrated Child Development Services (ICDS)

The basic purpose of the ICDS scheme is to meet the health, nutritional and educational needs of the poor and vulnerable infants, pre-school-aged children, and women in their child-bearing years. Its specific objectives are:

- To develop the nutritional and health status of children in the age-group 0-6 years.
- To put the groundwork for proper psychological, physical and social development of the child.
- To reduce the prevalence of mortality, morbidity, malnutrition and school dropout.
- To achieve effective co-ordination of policy and functioning along with the various departments to promote child development.
- To improve the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

1.3 Services provided by Anganwadi Centers

The above objectives are necessary to be achieved through a package of services. Delivery of services under ICDS scheme is managed in an integrated way through Anganwadi centers, its workers and helpers. The services of Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health and Family and Welfare UNICEF has provided necessary equipment for the ICDS scheme since 1975. World

Bank has also assisted with the financial and technical support for the programme. The cost of ICDS programme averages \$10–\$22 per child a year. The scheme is centrally sponsored with the state governments contributing up to 1.00 (US\$ 0.02) per day per child. Furthermore, the (GOI 2008) adopted the World Health Organization (WHO) standards for measuring and monitoring the child growth and development, both for the ICDS and the National Rural Health Mission (NHRM). These standards were developed by WHO through an intensive study of six developing countries since 1997. They are known as New WHO Child Growth Standard and measure of physical growth, nutritional status and motor development of children from birth to 5 years age.

There are six dimensions or services of ICDS scheme which are provided by AWCs.

1. Supplementary Nutrition
2. Immunization
3. Health check-up
4. Referral services
5. Non-formal Preschool education
6. Nutrition and health education

1.3.1 Supplementary Nutrition

Supplementary Nutrition is one of the important factor for balancing the nutrition status of the children. This includes supplementary feeding and growth monitoring; and against vitamin A shortage and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. Anganwadi workers are advantage of supplementary feeding supports for 300 days in a year. For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day.

By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition are two important actions that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to find out the growth flattering and helps in assessing their nutritional status. In addition, highly malnourished children are focused with special supplementary feeding and referred to medical services for the betterment.

1. 3.2 Immunization

To prevent the child from health related problem, immunization is utmost necessary. Immunization of pregnant women and infants protects children from six vaccine preventable diseases, tetanus, tuberculosis and measles. These are major preventable that helps in preventing the child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces the risk of maternal and neonatal mortality.

1.3.3 Health Check-Up

The health check-up includes children less than six years of age, antenatal care of mothers and postnatal care of nursing mothers. The different health services provided by Anganwadi workers for those children and Primary Health Centre (PHC) staff includes regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhea, and distribution of simple medicines etc.

1.3.4 Referral Services

During health check-ups of malnourished children and timely medical attention are referred to the Primary Health Centre (PHC) or its sub-centre. The Anganwadi workers have also been oriented that the young children are not capable. She enlists all such cases in a special register and refers them to the medical officer of the PHC.

1.3.5 Non-formal Pre-School Education

Non-Formal Pre-School Education (NFPSE) is a part of the ICDS and it is mostly considered as its backbone, because its services basically cover the Anganwadi. Anganwadi Centre (AWC) – a village courtyard is the main platform for delivering of the services. These AWCs have been set up in every village of the country. In its functioning, the commitment to the cause of India's children, present government has decided to set up an AWC in every human occupation / settlement. As a result, total number of AWC would go up to almost 1.4 million. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the Anganwadi centre- an activity that motivates parents and communities. Pre-school education (PSE), as considered in the ICDS, focuses on total development of children chiefly six year olds, mainly from the poor groups or those who are mostly needy. **Its programme for the three-to six years old children in the Anganwadi is directed towards providing and ensuring a natural, joyful and motivating environment, with importance on necessary inputs for most advantageous growth and development.** The early learning component of the ICDS is a significant contribution for providing a sound foundation for increasing lifelong learning and development. It also contributes to the universalization of primary education, by providing the necessary preparation for primary schooling and offering alternative care to younger siblings, thus freeing the older ones especially girls to attend school.

1.3.6 Nutrition and Health Education

Nutrition, Health and Education (NHED) is a key element of the the Anganwadi worker. This is a part of the BCC (Behavior Change Communication) strategy. This has the long term goal of capacity-building of women particularly in the age group of 15-45 years so that they can look after their own health, nutrition and development needs as well as that of their children and families.

1.4 Duties and Responsibility of Anganwadi Worker (AWW)

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.
- Assisting 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 mobilize 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-centers, 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.
- Organizing supplementary nutrition for feeding infants, nursing mothers.
- Organizing counseling 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 are availed by villagers.
- Informing supervisors for villages' health progression, or issues needing attention and intervention.
- To ensure that Kishori Shakti Yojana (KSY), 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 diarrhea and cholera cases to health care division of blocks and districts

1.5 Review of Literature

Review literature gives an insight in to different aspects of the problem under the study. It helps the investigator to design the framework, develop the methodology and tools for data collection and plan the analysis of data. Various studies in recent past has revealed that implementation of services under ICDS are not up to satisfactory standards and still more efforts are needed for improving the quality of services for the successful achievement of expected targets (Barman

2001; Forces New Delhi 2007). In the opinion of some scholars the achievement of ICDS programme goals depends heavily upon the effectiveness of the Anganwadi workers, which in turn, depends upon their knowledge, attitude and practice (Sharma, 1987; Chattopadhyay, 1999). The studies done in past have strongly concluded on the need of improved knowledge and awareness among Anganwadi workers but unfortunately it was found to be the most underrated aspect of their job profile (Kant et al. 1984; Gopaldas et al. 1990; Bhasin et al. 2001).

Correct knowledge and perception for promoting complementary food practices was found to be 40% among the ICDS AWWs (Parikh, 2011). So it leads a critical gap between knowledge and practice of complementary feeding, so equipping the AWWs is the major homework has to be done for betterment of figures (Parikh, 2011). Another study shows that awareness about ICDS services increases with the increased level of education (Thakare, 2011). Also the same study indicates that fewer honorariums with excessive work can be viral to efficiency to AWWs (Thakare, 2011). Another study made in Purmandal block shows that in spite of the fact that most (92.5%) of the Anganwadi workers were trained, it was found that performance as well as awareness among Anganwadi workers regarding the importance of growth charts and growth monitoring was not satisfactory (Manhas and Dogra, 2012).

As the Anganwadi worker is the key person in the programme, her education level and knowledge of nutrition plays an important role related to her performance in the Anganwadi centre. It has also been reported that, in addition to education level, training of Anganwadi workers about growth monitoring plays a valuable role in improving their performance (Das et al., 1990). Nutrition knowledge was the most powerful determinant of performance followed by guidance from the supervisors or health functionaries and education level (Gujral et al. 1992). (Kapil et al 1994) had also mentioned that only 42% Anganwadi workers were able to mention the monthly weight recording of malnourished children. A study conducted (Das Gupta et al. 2004) to assess the level of child malnutrition in India, found that the poor northern states with high level of child malnutrition and nearly half of India's population have the lowest programme coverage. They also found little evidence of programme impact on child nutrition in villages with ICDS centre.

Another study shows that majority of Anganwadi workers (92.71%) could not even tell full form of ICDS. Most of them (90.62%) could not enumerate all the services being provided and none could list out their job responsibilities (Kant et al., 1984). Another study (Davey and Datta, 2004) revealed that Anganwadi centers were not that much popular as expected for this might be poor relationship between Anganwadi worker and community members. According to NFHS-2 of Delhi, 35% of children less than 3 year of age are under weight and 37% are underdeveloped. Anaemia is the most frequent malnutrition among the children from the slum community.

Another study was conducted in Jammu and Kashmir, under the scheme, a total number of 368060 eligible children (6-72 months age) and 90215 pregnant and lactating women are getting benefits for various services (PEO, 2009). But in spite of the ongoing direct nutrition interventions like ICDS, India still contributes to about 21 percent of the global burden of child deaths before their fifth birthday (UNICEF, 2007). The ICDS is perhaps one of the better concerned programmes, yet on travels around country one realizes that there is a huge gap between what is expected of the programme and the ground situation. What is even more

worrying is that even the existing centers do not function effectively and that dishonesty, mismanagement seems to permeate even the ICDS programme (Ramachandran, 2005).

The study revealed that 44 percent children nationally and 29 percent within state but in spite of this huge reach the nutritional status of children under normal category has still attained only up to 54.16 percent children at national level and 68.88 percent children at state level (NIPCCD 2009). Various studies in recent past had reflected the importance of knowledge and awareness of Anganwadi worker in performance of Anganwadi worker (Kant et al. 1984; Udani et al. 1980; Gujral et al. 1992; Bhasin et al. 2001). Various studies in recent past had reflected unsatisfactory implementation of growth monitoring practices by Anganwadi workers under ICDS (Bhasin et al. 1995; Datta 2001).

Another study was found that there are extremes of observations in different studies. On other hand, (B.N Tandon 1997) commented that the knowledge, attitude and practice of Anganwadi Workers with respect to growth monitoring, supplementary nutrition and immunization are satisfactory.

1.6 Need 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). 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.

RESEARCH QUESTION

What are the current levels of knowledge among the Anganwadi workers about the various services under the Integrated Child Development Scheme and the need of training programmes for capacity building of Anganwadi workers?

1.7 Objectives of the Study

The key objective of the study is to assess the current level of knowledge among Anganwadi Workers about Integrated Child Development Services (ICDS) and the need of training programmes for capacity building of Anganwadi workers.

Specific objectives are as follow:

- To study the socio-demographic characteristics of Anganwadi Workers.
- To assess the current level of knowledge among the Anganwadi Workers regarding the services delivered under the ICDS programme.
- To study the need of training programmes for capacity building of Anganwadi workers.

CHAPTER II

DATA AND METHODS

2.1 Study area

The present study was conducted in urban area of Patan District during the year 2014 of February, March, April months. The study area was confined to 3 Blocks namely Patan 1, Patan 2 and Chanasma AWCs are belonging to urban areas and the selection of AWCs was purposive.

2.2 Sampling

The sample for the present study comprises of 150 Anganwadi workers belonging to three Blocks of Patan Districts. I have selected 50 AWWs from Patan 1, 50 AWWs from Patan 2 and 50 AWWs from Chanasma.

2.3 Tools Applied

A face to face interview schedule was used as a tool for data collection with various questions framed on the knowledge among Anganwadi workers regarding the services of ICDS. Major content of the interview schedule were: socio-demographic profiles of AWWs, Knowledge about various ICDS services (like immunization, nutritional and health education, supplementary nutrition, growth monitoring).

2.4 Data Collection

Quantitative study design was followed to collect necessary information on Anganwadi workers awareness regarding child health & nutrition. Data were collected personally by making personal visits to Anganwadi centers. Data was collected both from primary and secondary sources. Primary data was collected from all the Anganwadi workers. The secondary data was collected from official records, published reports of similar projects, journals and literature form social science discipline.

2.5 Data Analysis

The data obtained was complied and tabulated using the Excel program and SPSS. Univariate analysis is performed to address above objectives.

2.6 Assessing Knowledge Score

Twenty six knowledge indicators are considered to estimate the mean knowledge score related to six domains of ICDS services (Table 1). If the response is correct then it is coded as 1 or else equal to 0. So the individual knowledge score will vary from 0 to 26. Total knowledge score is estimated by adding the individual scores of each response.

Knowledge score for individual (i) = Score of (q1+ q2+ q3+.....+q25+q26)

Where i=1, 2,.....150

Total knowledge score: Sum total of individual knowledge score.

Table 2.1 Indicators considered for assessing correct knowledge score about ICDS

Supplementary nutrition

No.	Topics/Issues	Options	Correct Answer
1	Amount of calories & proteins given to each child through supplementary nutrition	1.200 cal & 5 gm proteins 2. 300 cal & 10gm proteins 3. 500 cal & 15gm proteins 4. 600 cal & 20 gm proteins 5. DK	3. 500 cal & 15gm proteins
2	Amount of calories & proteins given to grade 4 malnourished child	1.same as others 2. double 3. triple	2. double
3	Calories & proteins a pregnant woman receive from AWC	1.400:40 gm proteins 2. 300:10 gm proteins 3. 500 cal:20 gm Proteins 4. 600 cal: 15 gm proteins 5. DK	4.600cal:15 gm proteins

Non-formal preschool education and growth monitoring

4	Growth monitoring starts from	1. from birth 2. 3 months 3. 6 months	1. from birth
5	The significance of red color in mid arm circumference (MAC) strip	1. well nourished 2. under nourished 3. in between 4. Severe malnourished	4. Severe malnourished
6	Yellow color on MAC strip indicates a circumference of	1. 12.5-13.5 2. 13.5-14.5 3. 11.5-12.5	1. 12.5-13.5
7	Flattened growth line on growth card indicates	1. weight is declining 2. weight is increasing gradually 3. weight is low for Age	1. weight is declining
8	Level of weight gain per year between age group 3	1. 5 yrs- 1kg 2. 2 kg 3. 3 kg per year	3. 3 kg per year
9	The average weight of a 1 year old child	1. 7kg 2. 10kg 3. 12 kg	2. 10kg

Immunization

10	The gap between 2 successive doses of DPT vaccine	1. 1 week 2. 4 weeks 3. 8 weeks	2. 4 weeks
11	Measles vaccine given at the age of	1. 6 month 2. 9 month 3. 1 yr	2. 9 month
12	Booster dose of DPT given at the age of	1. 1 yr 2. 1 & ½ months 3. 2 yr 4. 2 yrs	2. 1 & ½ months
13	Vaccines given at 5 yr age	1. DPT 2. DT 3. TT	1. DPT
14	Tetanus toxoids that a pregnant lady should receive	1. 1 2. 2 3. 3	2. 2

Health Check up

15	the earliest symptom of vitamin A deficiency	1.inability to read 2. night blindness 3. lacrimation	2. night blindness
16	Dose of vit. A below 1 yr age	1.one lakh 2. two lakh 3. 0.5 lakh IU	1. one lakh
17	Dose of vit. A above 1 yr age	1.one lakh 2. two lakh 3. 0.5 lakh IU	2. two lakh
18	First dose of vit. A given at	1. age of 6 months 2. 9 month. 3. 1yr	2. 9 month.
19	Gap between 2 successive doses of vitamin A	1. 2 month 2.6 month 3. 1 yr	2. 6 month
20	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume	1.60 2.90 3.200	2. 90

Referral services:

21	any four high risk pregnancies which need referral	1.could mention all correctly 2. only 3 3. only 2 4. none	1. could mention all correctly
22	Children who need referral	1.could mention all correctly 2. only 3 3. only 2 4. none	1.could mention all correctly

Nutrition & health education

23	Exclusive breast feeding to be continued till	1. 3 months 2. 6 months 3. 1 yr	2. 6 months
24	The Kind of diet to be given during diarrhea	1. only liquids 2. light & nutritious diet 3. diet should be Withheld	1. only liquids
25	Following are the high risk pregnancies	1. twin pregnancy 2. anaemia 3. pre-eclampsia 4. oligohydramnios	2. anaemia
26	ORS to be discarded if not used completely after	1. 4hrs 2. 24hrs 3. 36hrs	2. 24hrs

While conducting the face to face interview it is observed that 100% of the Anganwadi workers have mentioned all the records and registers need to maintain but during the study it was found that majority of Anganwadi workers were not aware of the importance of growth chart instead they were maintaining the growth charts as per the requirement of their job profile only. About 33.3% of the Anganwadi workers have knowledge about the flattened growth line on growth chart. The present study found that 16.7% of Anganwadi workers have correct knowledge about the calories and proteins given to grade4 malnourished child, 10.6% had correct knowledge about weight gain per year between age group 3 and 70% had correct knowledge about the average weight of a 1year old child, 10% knew the correct red color mid arm circumference (MAC) strip means and they don't have knowledge about the yellow color of MAC strip means. As expected, about 65.3% of workers knew the minimum number of IFA (iron, folic acid) tablets that a pregnant woman should consume and only 30% knew the number of tetanus toxoid that a pregnant lady should receive. None of the Anganwadi worker was familiar with the energy and protein requirement of the targeted age group and was unaware of the fact as how much caloric food they are providing to children.

It was revealed that during the study that no one have the correct knowledge about the amount of calories and proteins given to each child through supplementary nutrition. Fifty percent knew the

correct knowledge of calories and proteins a pregnant woman should receive from Anganwadi Centre. There were 100% of workers who stated that growth monitoring should start from birth.

The present study revealed that around 66.5% workers had correct knowledge about ORS (Oral Rehydration Solutions/salts). Knowledge of Anganwadi workers regarding child care components, it was observed that the earliest symptom of vitamin A deficiency, gap between 2 successive doses of vitamin A, the first dose of vitamin A, dose of vitamin A below 1year and vitamin A above 1year were known to 33.9%, 63.7%, 66.1%, 60.5% and 60.3% Anganwadi workers respectively. Only 13.3% could mention the type of vaccines given at 5year age.

Most of the Anganwadi workers have best knowledge about the component of Immunization. 83.5% were knew the correct knowledge about the measles vaccine, 68% were knew about the doses of DPT vaccine and 74.6% booster dose of DPT. The awareness regarding the provision of referral services was 30 percent workers were only having the knowledge about the children who need referral. The study revealed the fact that although the large section of Anganwadi workers were aware about the importance of provision of supplementary nutrition but in favor of the malnutrition and referral services, the result on implementation part was not satisfactory. The knowledge was rather incomplete and not up to the mark. As depicted in (Table 4.2), Anganwadi workers were highly aware regarding health check-up facility for children.

The present study revealed that the correct knowledge related to antenatal care, post-natal care, family welfare services, management of diarrhea and prevention of vitamin A deficiency and nutritional anemia was not up to mark and not satisfactory.

2.7 Chapterization Plan

The study was consists of 5 chapters. The first chapter deals with the introduction and literature review. It explains about the concept of ICDS scheme and their services. Besides it deals with the needs of the study and objective of the study. The second chapter deals with the data and methods including the study area, sampling, data collection, data analysis and assessing correct knowledge score. The third chapter deals with the socio-economic and demographic characteristics of Anganwadi Workers and general information about the Anganwadi Centers. The fourth chapter deals with the knowledge and awareness of Anganwadi workers about ICDS scheme. The fifth chapter provides a brief summery and conclusion of the study.

CHAPTER III

SOCIO- DEMOGRAPHIC CHARACTERISTICS OF ANGANWADI WORKERS

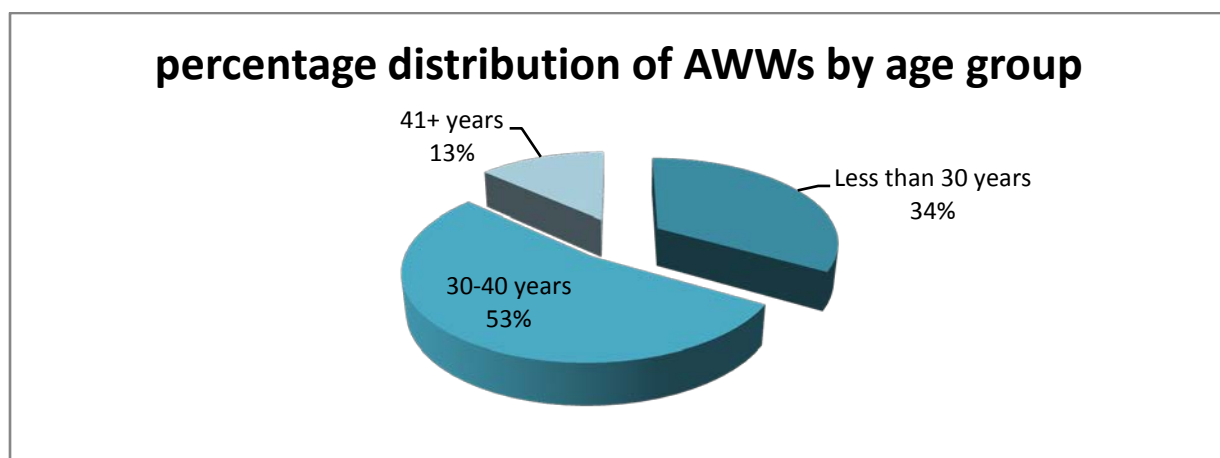
3.1 Introduction

Various studies in recent past clearly highlighted the importance of socio-demographic characteristics of AWWs in implementing the ICDS programmes (Bhasin et al, 2001; Davey and Dutta, 2004). In the present study 150 Anganwadi Workers were interviewed. The Anganwadi Worker and helper are the basic functionaries of the ICDS. They are not government employees, but are called "social workers" or "voluntary workers". All the Anganwadi workers get about Rs.3500 as payment per month. The working hours are from 8 A.M to 2P.M and then they go for home visit another 1hour till 3 PM. They visit 5 houses every day. All Anganwadi workers get guidance from Auxiliary Nurse Midwife (ANM). The back ground characteristics of all selected AWWs are given in the following sections.

3.2 Socio demographic characteristics of Anganwadi Workers

3.2.1Age of respondent

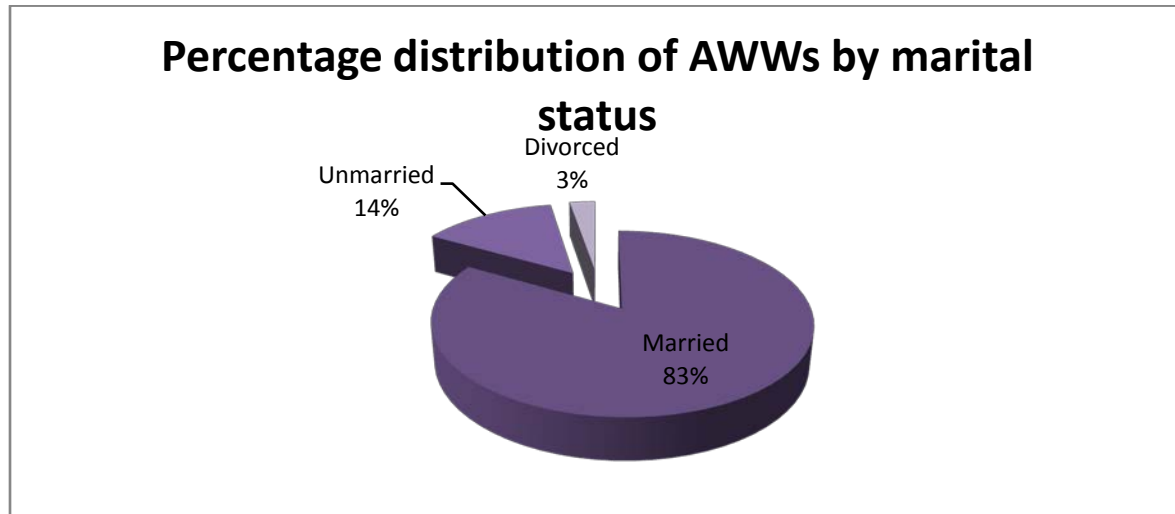
Figure 3.1 shows that 34% of Anganwadi workers were less than 30 years, 53% of workers were in the age group of 30-40 years and 13% were 41 years and above. Results suggest that major portion of AWWs belongs to age group of 30-40 years.



Source: Survey data

3.2.2 Marital Status of respondents

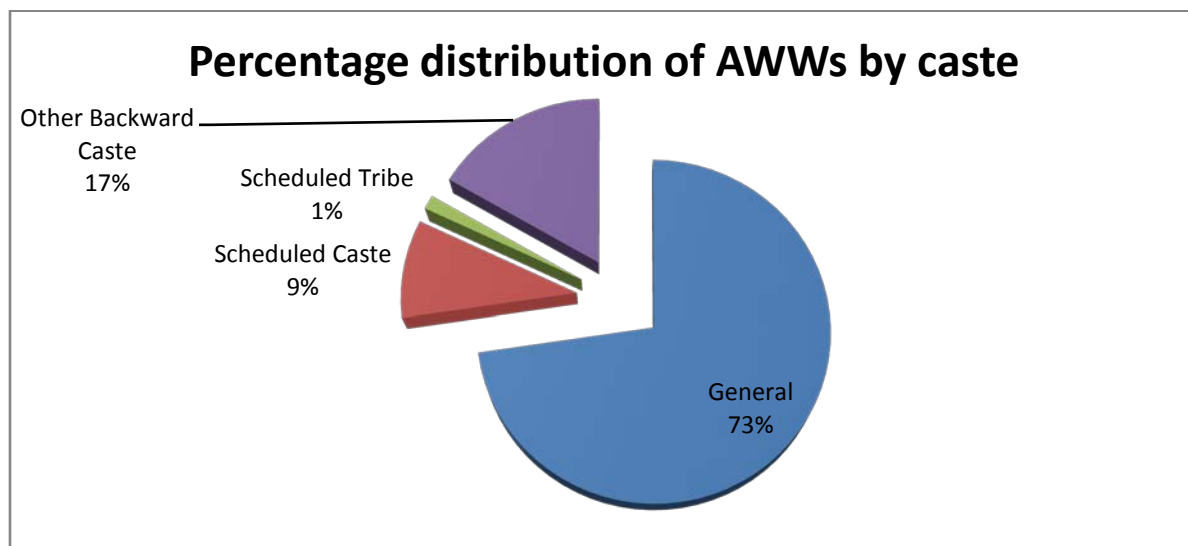
While distributing the respondents by marital status it was found that about 83% of the workers are married, 14% are unmarried and 3% of the workers are divorce (Figure 3.2). So, major portion of workers are married.



Source: Survey Data

3.2.3 Caste of respondents

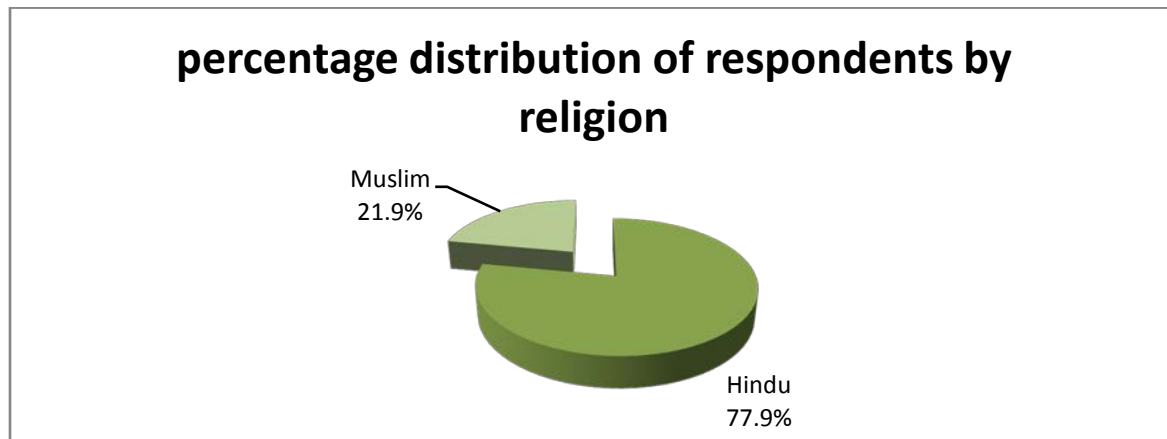
It was found that the majority (73%) of Anganwadi workers are belonging to general category. The rest of the workers distributed among OBC, SC, and ST communities. They are respectively 17%, 9% and 1%. It reflects that the studied Anganwadi centre is numerically dominated by general categories.



Source: Survey Data

3.2.4 Religion of respondents

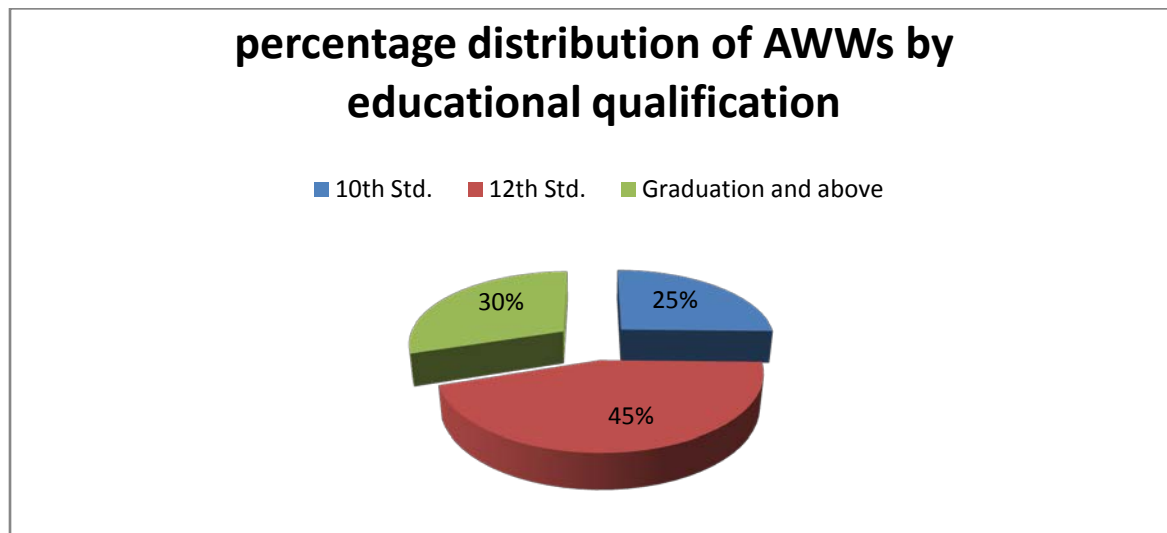
The ideological differences based on various religions influence the implementation process of any project. This study shows that about 77.9% of AWWs are Hindu followed by 29.1% for Muslim.



Source: Survey Data

3.2.5 Education of respondents

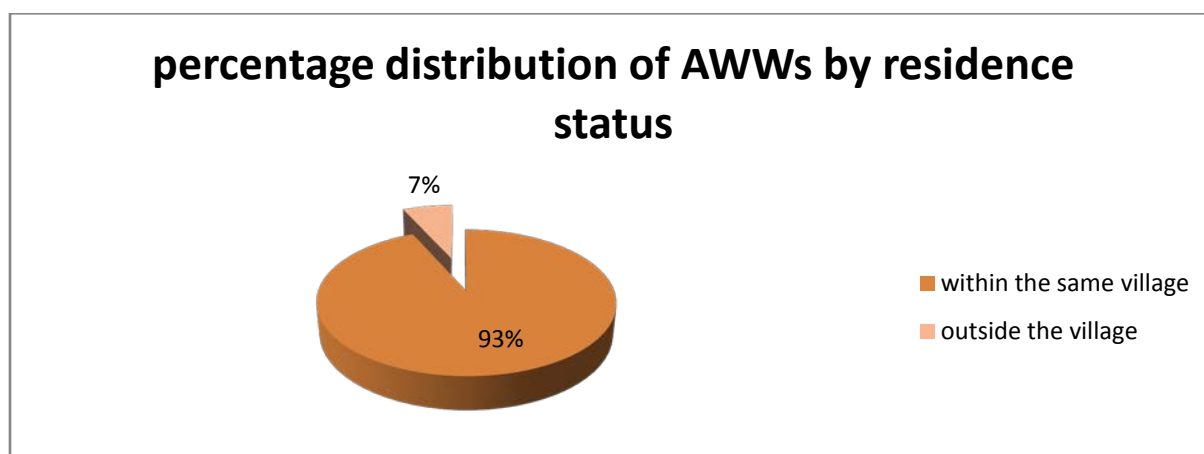
In the present study 150 Anganwadi workers were interviewed and it is evident from the Figure.5 that 25% of the Anganwadi workers were 10th passed, 45% were 12th passed, 30% had education up to graduation level and above.



Source: Survey data

3.2.6 Residence Status of respondents

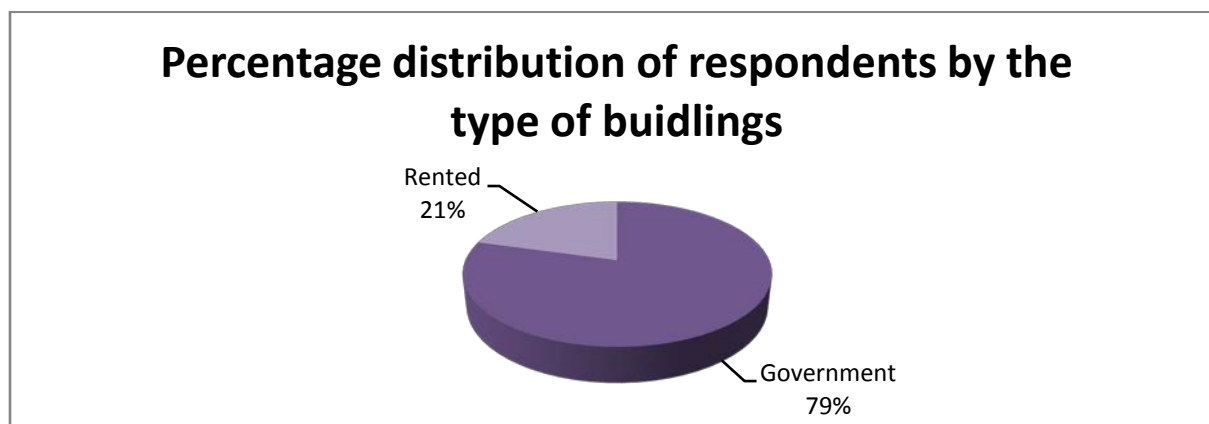
Figure 6 highlighted that all most all the Anganwadi workers, 93% were resident within the same area where the Anganwadi centre is located and only 7% were staying outside the village.



Source: Survey Data

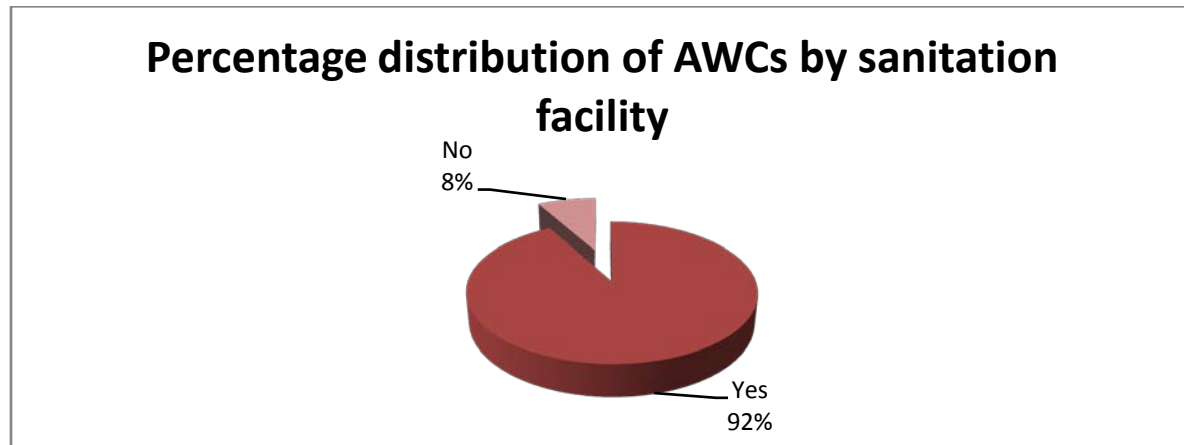
3.3 General Information about the Anganwadi Centre (AWC)

Seventy nine percent of Anganwadi centre buildings belong to government buildings and twenty one percent belongs to rented buildings.



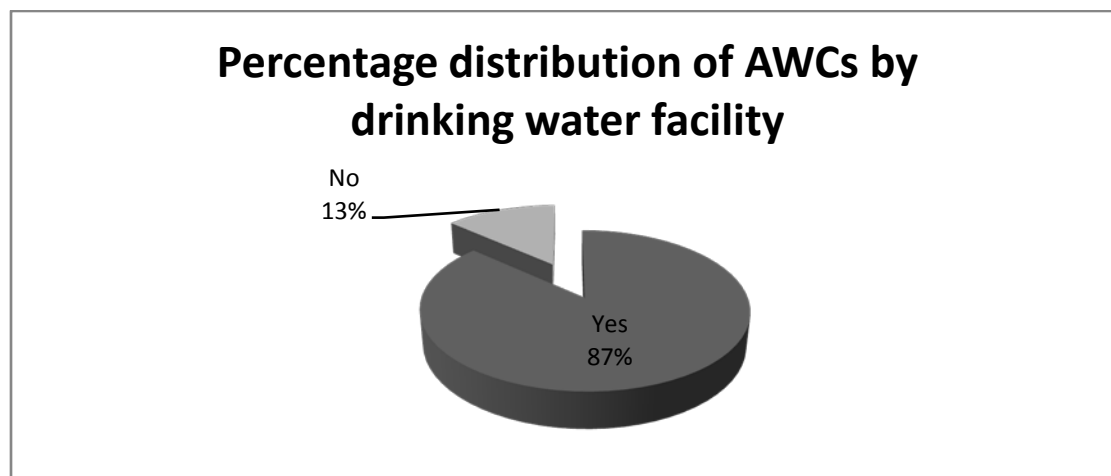
Source: Survey data

Ninety two percent anganwadi centers have sanitation facility while eight percent anganwadi centers do not have sanitation facility.



Source: Survey data

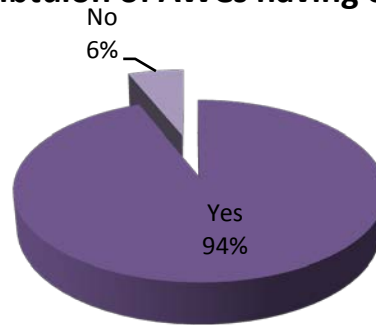
Eighty seven percent of anganwadi centers have drinking water facility and thirteen percent anganwadi centers do not have drinking water facility.



Source: Survey data

Ninety four percent of anganwadi centers have electricity facility and six percent of anganwadi centers do not have electricity facility.

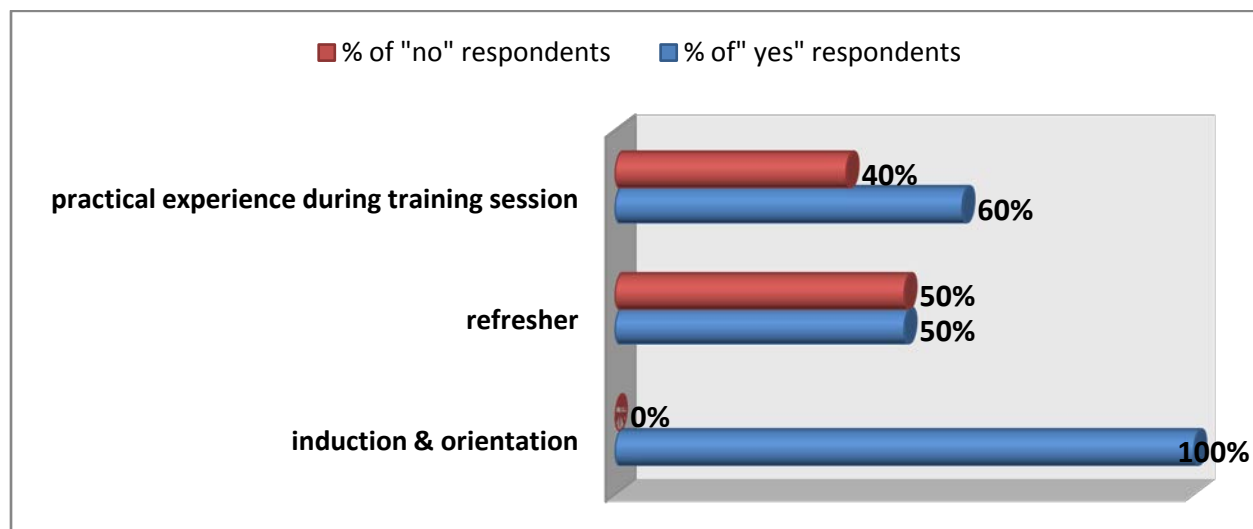
Percentage distribtuion of AWCs having electricity facility



Source: Survey data

3.4 Training and Refresher Training

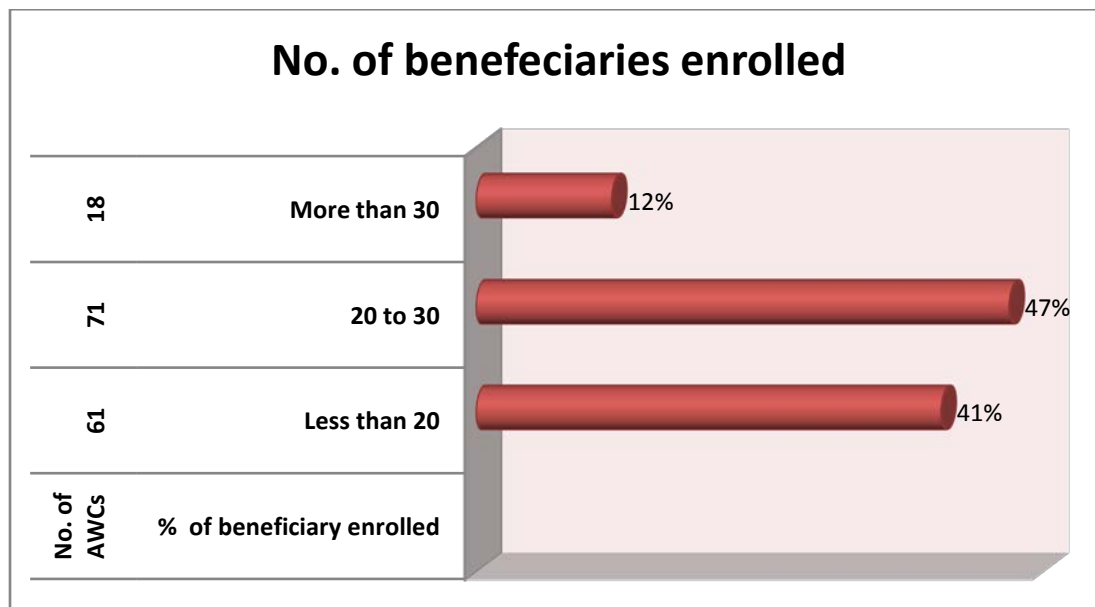
As for as training status Anganwadi workers was concerned, it was found that majority of Anganwadi workers 100% had received training about induction and orientation and have attended the ICDS training programme but among all 150 workers, only 50% of them attended the refresher training (Figure 3.8). Result also suggests that majority of the AWWs those who received training had opinion that they had not received enough practical experience during training sessions. They desired to have more practical sessions during their training programmes for proper implementation of growth monitoring and supplementary nutrition.



Source: Survey Data

3.5 Beneficiary Enrolled

Result suggest that about 41% centers have less than 20 children, 47% centers have 20 to 30 children and only 12% of Anganwadi centers have 30 above children (Figure 3.9). During interview it was observed that most of the children are not coming into the AWC because those children's parents are more preferred for private school rather than AWC. In urban centers, people prefer play groups more than AWC.



Source: Survey data

CHAPTER IV

KNOWLEDGE AND AWARENESS OF ANGANWADI WORKERS ABOUT ICDS SERVICES

4.1 Introduction

Although much of the researches have been done on the nutritional status of the beneficiaries of ICDS, evaluation of nutrition and health services rendered by Anganwadi centers but very less focus has been shifted over to knowledge and awareness among the Anganwadi workers, who are actually the main resource person of the programme and whose knowledge and skills do have a direct impact on the implementation of the programme. As the Anganwadi workers play an important role due to their close and continuous contact with the people of community, especially the children and women, so there is an utmost need to assess the level of awareness in Anganwadi workers regarding services provided by them in Anganwadi centers.

As the Anganwadi worker is the key person in the programme, her education level and knowledge of nutrition plays an important role related to her performance in the Anganwadi centre (AWC). It has also been reported that, in addition to education level, training of Anganwadi workers about growth monitoring plays a beneficial role in improving their performance (Gopaldas et al., 1990). Nutrition knowledge was the most powerful determinant of performance, followed by guidance from the supervisors or health functionaries and education level (Gujral et al., 1992). Most of the Anganwadi workers were performing mechanically and were not clear with the basic concepts of their working. The national evaluation of ICDS by NIPCCD (1992) also shows that about 36.3 percent Anganwadi workers were not able to monitor the growth of children. The main reason that was pointed out was the lack of skills among Anganwadi workers in filling up growth charts.

Since the success rate of this nationwide integrated programme solely depends upon the fact as to how we are preparing our ground workers to combat with the problem of malnutrition, it becomes really important to upgrade our ground worker i.e. Anganwadi worker with quality training and enhanced and advanced nutrition knowledge as nutrition knowledge was the most powerful determinant of performance (Gujral et al., 1992). The Integrated Child Development Services (ICDS), the nationwide programme of the Government of India offers the most

important interventions for addressing the nutrition and health problems and promoting early childhood education among the disadvantaged population of the country.

As mentioned in the methodology section, 26 variables are considered to estimate the total knowledge score of correct responses. Table 4.1 clearly highlights that the mean correct knowledge score is about 12.83 and the range varies from 7 to 19. Though Government of India putting lot of money to enhance the health status of both mother and children through AWCs, the results suggest to relook the operational aspects of AWCs across the country.

Table 4.2 Correct and current knowledge about ICDS scheme among anganwadi workers

No	Topics	Percentage of Correct Responses obtained from AWWs on the various topics (%)
1	Amount of calories & proteins given to each child through supplementary nutrition	0.0
2	Amount of calories & proteins given to grade 4 malnourished child	16.7
3	Calories & proteins a pregnant woman receives from AWC	50.0
4	Growth monitoring starts from	100.0
5	The red color in mid arm circumference (MAC) strip indicates	10.0
6	Yellow color on MAC strip indicates a circumference of	0.0
7	Flattened growth line on growth card indicates	33.3
8	Level of weight gain per year between age group 3	10.6
9	The average weight of a 1 year old child	70.0
10	The gap between 2 successive doses of DPT vaccine	68.0
11	Measles vaccine given at the age of	83.5
12	Booster dose of DPT given at the age of	74.6
13	Vaccines given at 5yr of age	13.3
14	No. of tetanus toxoids a pregnant lady receives	30.0
15	The earliest symptom of vitamin A	33.9

	deficiency	
16	Dose of vit. A below 1 yr age	60.5
17	Dose of vit. A above 1 yr age	60.3
18	First dose of vit. A given at	66.1
19	Gap between 2 successive doses of vitamin A	63.7
20	Minimum no. of tab. of iron & folic acid a pregnant woman consumes	65.3
21	Four high risk pregnancies needing referral services	23.3
22	Children needing referral services (any four)	30.0
23	Exclusive breast feeding continues till	100
24	The Kind of diet that to be given during diarrhea	80.0
25	High risk pregnancies	43.3
26	ORS to be discarded if not used completely after	66.5

Table 4.2 shows all the correct responses of the Anganwadi workers. While conducting the face to face interview it is observed that 100% of the Anganwadi workers have mentioned all the records and registers need to maintain but during the study it was found that majority of Anganwadi workers were not aware of the importance of growth chart instead they were maintaining the growth charts as per the requirement of their job profile only. About 33.3% of the Anganwadi workers have knowledge about the flattened growth line on growth chart. The present study found that 16.7% of Anganwadi workers have correct knowledge about the calories and proteins given to grade4 malnourished child, 10.6% had correct knowledge about weight gain per year between age group 3 and 70% had correct knowledge about the average weight of a 1year old child, 10% knew the correct red color mid arm circumference (MAC) strip means and they don't have knowledge about the yellow color of MAC strip means. As expected, about 65.3% of workers knew the minimum number of IFA (iron, folic acid) tablets that a pregnant woman should consume and only 30% knew the number of tetanus toxoid that a pregnant lady should receive. None of the Anganwadi worker was familiar with the energy and protein requirement of the targeted age group and was unaware of the fact as how much caloric food they are providing to children.

It was revealed that during the study that no one have the correct knowledge about the amount of calories and proteins given to each child through supplementary nutrition. Fifty percent knew the

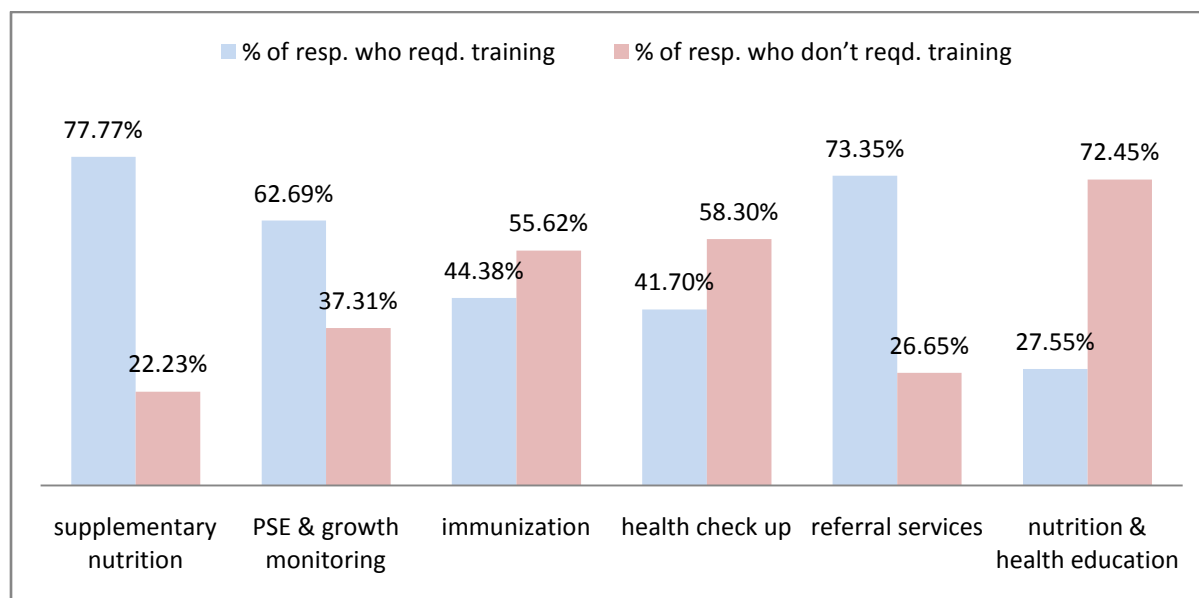
correct knowledge of calories and proteins a pregnant woman should receive from Anganwadi Centre. There were 100% of workers who stated that growth monitoring should start from birth.

The present study revealed that around 66.5% workers had correct knowledge about ORS (Oral Rehydration Solutions/salts). Knowledge of Anganwadi workers regarding child care components, it was observed that the earliest symptom of vitamin A deficiency, gap between 2 successive doses of vitamin A, the first dose of vitamin A, dose of vitamin A below 1year and vitamin A above 1year were known to 33.9%, 63.7%, 66.1%, 60.5% and 60.3% Anganwadi workers respectively. Only 13.3% could mention the type of vaccines given at 5year age.

Most of the Anganwadi workers have best knowledge about the component of Immunization. 83.5% were knew the correct knowledge about the measles vaccine, 68% were knew about the doses of DPT vaccine and 74.6% booster dose of DPT. The awareness regarding the provision of referral services was 30 percent workers were only having the knowledge about the children who need referral. The study revealed the fact that although the large section of Anganwadi workers were aware about the importance of provision of supplementary nutrition but in favor of the malnutrition and referral services, the result on implementation part was not satisfactory. The knowledge was rather incomplete and not up to the mark. As depicted in (Table 4.2), Anganwadi workers were highly aware regarding health check-up facility for children.

The present study revealed that the correct knowledge related to antenatal care, post-natal care, family welfare services, management of diarrhea and prevention of vitamin A deficiency and nutritional anemia was not up to mark and not satisfactory.

Topic wise training required by anganwadi workers:-



The anganwadi workers felt the need of more training programmes to be conducted regarding the topics of supplementary nutrition, referral services and growth monitoring and PSE for capacity building. They felt the requirement of more extensive and practical training in the above mentioned three topics. They had good knowledge about nutrition and health education, health check-up and immunization comparatively as mentioned to the above three topics.

4.2.1 Knowledge differentials by Age

Results from the following table highlight that the knowledge score is higher for older women compare the younger women. The mean knowledge score for women less than 30 years is about 12.30 which is lower than the knowledge score for 41+ years women (mean score 13.75). This evidence suggests that older women are much more aware about various ICDS services compared to their younger counterpart.

4.2.2 Knowledge differentials by Marital Status

The knowledge score is higher for married women compare the unmarried women. The mean knowledge score for married women is about 12.92 which is higher than the knowledge score for unmarried women (mean score 12.17). It suggests that married women are much more about various services compared to their unmarried.

4.2.3 Knowledge differentials by Caste

The knowledge score is higher for general category compared to the other castes. The knowledge score for women OBC is about 12.13 which is lower than the knowledge score for general category women (mean score 15.33). It suggests that general category women are more knowledgeable about the ICDS scheme than other caste.

4.2.4 Knowledge differential by Religion

The mean knowledge score for Hindu workers (13.30) is higher compared to their Muslim counterpart (11.90).

4.2.5 Knowledge differentials by Education

Result from the following table highlight that the knowledge score is higher for graduated women compare the other qualified women. The mean knowledge score for women who passed 10th is about 11.75 which is lower than the knowledge score for Graduated women (mean score 14.67). This evidence suggest that Graduated women are much more aware about various ICDS scheme compared

to the 10th qualified workers. So, the level of education positively associated with the knowledge score about the ICDS scheme knowledge also increases.

4.2.6 Knowledge differentials by Training Status

Results from the following table suggest that those women were received the refresher training, they are more knowledgeable than other trained women. All AWWs had opinion that there is improvement in their knowledge and practice after getting the induction training or refresher training. Those who are attended the refresher training they feel the training received was enough practical oriented.

CHAPTER V

RESULTS AND FINDINGS:-

Today ICDS represents one of the world's largest programmes for early childhood development. Pre-school education aims at ensuring holistic development of the children and to provide learning environment to children, which is helpful for promotion of social, emotional, cognitive development of the child. As the Anganwadi worker is the key person in the programme, her education level and knowledge of nutrition plays an important role related to her performance in the Anganwadi centre. It has also been reported that, in addition to education level, training of Anganwadi workers about growth monitoring plays a beneficial role in improving their performance (Gopaldas et al. 1990).

In our study 150 Anganwadi Workers were interviewed and majority (53%) of the workers is in the age group of 30-40 Years. About 45% of Anganwadi workers were inter-mediate. Only (25%) are matriculate and (30.0%) were completed Graduation.

Present study shows that only 33.3% of the Anganwadi workers have knowledge about the flattened growth line on growth chart. Similarly about 26.7% of Anganwadi workers have correct knowledge about the calories and proteins given to grade 4 malnourished child, 16.7% had correct knowledge about weight gain per year between age group 3 and 60% had correct knowledge about the average weight of a 1year old child, and 20% knew the correct red color mid arm circumference (MAC) strip means. The study also revealed that the correct answers related to antenatal care, post-natal care, family welfare services, management of diarrhea and prevention of vitamin A deficiency and nutritional anaemia were not up to mark and not satisfactory.

While estimating the correct knowledge score about ICDS schemes result clearly states suggests that older women are much more aware about various ICDS services compared to their younger counterpart. Result also suggests that the mean knowledge score is higher for women who have completed graduation compare to their counterparts. This evidence suggests that Graduated women are much more aware about various ICDS scheme compared to the 10th and 12th qualified workers. So, education is positively associated with the correct knowledge score about ICDS scheme among Anganwadi workers. Majority of the AWWs were trained and had received in service job training and 50% of the workers had received refresher training. It was found that all the Anganwadi workers maintaining all the recommended registers and also maintaining monthly weight register and growth chart records. About half of the Anganwadi workers complained that they have Infrastructure 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 recreational activities like outdoor activities, irritation by animals entering into Anganwadi centre.

Though all the workers were trained; but it was found that performance as well as awareness among Anganwadi workers regarding the importance of growth charts and growth monitoring was not satisfactory. Their nutritional knowledge regarding the role of supplementary nutrition and ICDS norms was also not up to the mark as expected from a trained worker. So, regular qualities training as well as on spot training programme are strongly needed.

Thus, we can understand from these hard revealing facts that these unpolished training programmes are not going to help to fight against the alarming existing rate of malnutrition (43%) in our country (UNICEF 2007) and thus making ICDS an ongoing success story. Since the success rate of this nationwide integrated programme solely depends upon the fact as to how we are preparing our ground workers to combat with the problem of malnutrition, it becomes really important to upgrade our ground worker i.e. Anganwadi worker with quality training and enhanced and advanced nutrition knowledge as nutrition knowledge was the most powerful determinant of performance (Gujral et al. 1992, Manhas et al., 2012).

It can be concluded that partly Anganwadi workers were familiar with the various services of ICDS but their importance for the programme was not clear to them. The quality of knowledge was one of the neglected features among Anganwadi workers. Anganwadi workers are the key person who will promote the good practices of services related to ICDS to enhance the health and nutritional status among mothers and children; hence they should be equipped with better knowledge through regular and quality training program.

RECOMMENDATIONS

- The present study strongly felt the need of improving the quality of knowledge and awareness among Anganwadi workers about various ICDS schemes especially growth monitoring and supplementary nutrition.
- There is a strong and intense need for improving the training quality provided to Anganwadi workers to enhance their knowledge regarding various ICDS schemes.
- Frequent interactions among Anganwadi workers and supervisors should be introduced for imparting information and awareness.
- Coordination with health department and referral services training for referring malnourished children to VCNC, CMTC and NRC centers and proper follow up of those children.

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APPENDIX

TOPIC: KNOWLEDGE OF ANGANWADI WORKER ABOUT INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) QUESTIONNAIRE ON ANGANWADI WORKER

Q. No	Questions	Response	Skip
1	What is your name?		
2	What is your age?		
3	Sex:	1.Male 2.Female	
4	Marital status:	1.Married 2.Unmarried 3.Widowed 4.Divorced 5.Other (specify)	
5	Caste:	1.General 2.SC 3.ST 4.OBC 5.Other(specify)	
6	Religion:	1.Hindu 2.Muslim 3.Christian 4.Sikh 5.Other(specify)	
7	What is your educational qualification		
GENERAL INFORMATION			
8	What is your salary?		
9	Are you a resident of this village?	1. Yes 2. No	
10	Have you undergone training?	1. Yes 2. No	
10 a	If yes, when		
11	Have you undergone refresher training?	1.Yes 2.No	
11 a	If yes, when		
12	What do you feel that about the training you received was enough practical oriented?	1.Yes 2.No	

13	Where did you get your training?		
14	The AWC building is belongs to?	1.Government 2. Rent	
15	Do you have toilet facility in your AWC?	1.Yes 2.No	
16	Do you have safe drinking water in your AWC?	1.Yes 2.No	
17	Do you have electricity facility in your AWC?	1.Yes 2.No	
18	How much beneficiary has enrolled in your AWC?		
19	At what time you open & close the AWC?		
Supplementary Nutrition			
20	Do you maintain nutrition register?	1.Yes 2.No	
21	If yes, what is the information you maintain there?		
22	What amount of calories & proteins given to each child through supplementary nutrition?	1.200 cal & 5 gm proteins 2. 300 cal & 10gm proteins 3. 500 cal & 15gm proteins 4. 600 cal & 20 gm proteins	
23	What amount of calories & proteins given to grade 4 malnourished child?	1.same as others 2. double 3. triple	
24	How much times, Grade 3 malnourished child should get supplementary food from AWC?	1.once in a day 2. 2 times 3. 3 times 4. 4 times	
25	How much Calories & proteins a pregnant woman should receive from AWC?	1.400:40 2. 300:10 3. 500 cal:20 gm Proteins 4. 600 cal: 15 gm proteins	
Non-formal preschool education and growth monitoring			

26	Growth monitoring should start from?	1.from birth 2.3 months 3. 6 months	
27	Do you have preschool education register?	1. Yes 2. No	
28	What do you do if the beneficiary crosses six years of age while you maintain the growth monitoring register?		
29	Do you use color code for growth monitoring?	1. Yes 2. No	
30	The red color in mid arm circumference (MAC) strip means?	1.well nourished 2. under nourished 3. in between 4. Severe malnourished	
31	Yellow color on MAC strip means a circumference of?	1.12.5-13.5 2. 13.5-14.5 3. 11.5-12.5	
32	Flattened growth line on growth card means?	1.weight is declining 2. weight is increasing gradually 3. weight is low for Age	
33	At what level of weight gain per year between age group 3?	1.5 yrs- 1kg 2. 2 kg 3. 3 kg per year	
34	What is the average weight of a 1 year old child?	1.7kg 2. 10kg 3.12 kg	
Immunization			
35	Do you have a register on Immunization, Iron & Folic Acid and Vitamin A Supplementation?	1. Yes 2. No	
36	What is the gap between 2 successive doses of DPT vaccine?	1.1week 2. 4 weeks 3. 8 weeks	
37	Any Side effects of DPT vaccination?	1.fever& soreness 2.abscess & convulsions 3. others if any 4. no side effects	
38	Measles vaccine given at what age ?	1.6 month 2. 9month 3.1 yr	
39	Booster dose of DPT given at what age?	1.1yr 2. 1& ½ months	

		3.2 yr 4. 2 yrs	
40	What type of Vaccines given at 5yr age?	1.DPT 2. DT 3. TT	
41	What No. of tetanus toxoids that a pregnant lady should receive?	1.1 2. 2 3. 3	
Health Check up			
41	Do you have medicine distribution register?	1. Yes 2. No	
42	Do you maintain birth and death register?	1. Yes 2. No	
43	From whom you get the information about any birth and death that take place in the village?	1.Community people 2.ASHA 3.Self help group 4.Neighbour 5.Other (specify)	
44	How do you collect information about the place of delivery?	If the delivery is not conducted in hospital/PHC/sub centre institution, how do you collect the birth weight?	
45	If the delivery is not conducted in hospital/PHC/sub centre institution, how do you collect the birth weight?		
46	Do you know how to identify children “at risk”?	1. Yes 2. No	
47	If yes, how?	1.Infant with low birth 2.Children having repeated infection 3.When breast feeding has not been established 4.Illness of parents	
48	Do you know how to identify ‘AT RISK’ pregnant woman?	1. Yes 2. No	
49	If yes, how?	1.Women who are under weight 2.women who had abortion during previous pregnancies 3.Women who become	

		Pregnant before the age of 18 years or after 35 years	
50	What is the earliest symptom of vitamin A deficiency?	1.inability to read 2. night blindness 3. lacrimation	
51	The Earliest sign of vitamin A deficiencies?	1.cojunctival xerosis 2. Bitot's spot 3. corneal ulcer	
52	Dose of Vit. A below 1 yr age?	1.one lakh 2. two lakh 3. 0.5 lakh IU	
53	Dose of Vit. A above 1 yr age?	1.one lakh 2. two lakh 3. 0.5 lakh IU	
54	First dose of Vit. A given at?	1. age of 6 months 2. 9 month. 3. 1yr	
55	Gap between 2 successive doses of vitamin A?	1. 2 month 2.6 month 3. 1 yr	
56	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume?	1. 60 2. 90 3. 200	
Referral services			
57	Mention any four high risk pregnancies which need referral?	1.could mention all correctly 2. only 3 3. only 2 4. none	
58	Children who need referral (any four?	1.could mention all correctly 2. only 3 3. only 2 4. none	
59	During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to what place?	1.Primary health Centre 2.Sub centre 3.Other(specify)	
Nutrition and Health Education			
60	Exclusive breast feeding should be continued till?	1. 3 months 2. 6 months 3.1 yr	
61	What care should be taken while feeding the child?		

62	Nutrition & health education especially in what age group of?	1.15 to 25 2.15 to 35 3.15 to 45 4.15 to 55 5.Other(specify)	
63	At what age can a child begin to eat from the family pot or meal?		
64	For how long breastfeeding should be continued with complementary feeding?		
65	What Kind of diet that should be given during diarrhea	1.only liquids 2. light & nutritious diet 3. diet should be Withheld	
66	The sources of vit. A?	1.dal 2.rice 3.fruits	
67	Following are high risk pregnancies?	1.twin pregnancy 2. anaemia 3. pre-eclampsia 4. oligohydramnios	
68	ORS should be discarded if not used completely after?	1. 4hrs 2. 24hrs 3. 36hrs	
69	Do you feel the need of further training programmes in supplementary nutrition for capacity building??	1. Yes 2. No	
69a	If yes, why and what more components should be included in the training programme		
70	Do you feel the need of further training programmes in Non-formal preschool education and growth monitoring for capacity building??	1. Yes 2. No	
70a	If yes, why and what more components should be included in the training programme		
71	Do you feel the need of further training programmes in immunization for capacity building??	1. Yes 2. No	
71a	If yes, why and what more components should be included in the training		

	programme		
72	Do you feel the need of further training programmes in health check-ups for capacity building??	1. Yes 2. No	
72a	If yes, why and what more components should be included in the training programme		
73	Do you feel the need of further training programmes in referral services for capacity building??	1. Yes 2. No	
73a	If yes, why and what more components should be included in the training programme		
74	Do you feel the need of further training programmes in health and nutrition education for capacity building??	1. Yes 2. No	
74a	If yes, why and what more components should be included in the training programme		

Table 2.1 Indicators considered for assessing correct knowledge score about ICDS

Supplementary nutrition

1	Amount of calories & proteins given to each child through supplementary nutrition	1.200 cal & 5 gm proteins 2. 300 cal & 10gm proteins 3. 500 cal & 15gm proteins 4. 600 cal & 20 gm proteins 5. DK	3. 500 cal & 15gm proteins
2	Amount of calories & proteins given to grade 4 malnourished child	1.same as others 2. double 3. triple	2. double
3	Calories & proteins a pregnant woman receive from AWC	1.400:40 gm proteins 2. 300:10 gm proteins 3. 500 cal:20 gm Proteins 4. 600 cal: 15 gm proteins 5. DK	4.600cal:15 gm proteins

Non-formal preschool education and growth monitoring

4	Growth monitoring starts from	1.from birth 2.3 months 3. 6 months	1.from birth
5	The significance of red color in mid arm circumference (MAC) strip	1.well nourished 2. under nourished 3. in between 4. Severe malnourished	4. Severe malnourished
6	Yellow color on MAC strip indicates a circumference of	1.12.5-13.5 2. 13.5-14.5 3. 11.5-12.5	1. 12.5-13.5
7	Flattened growth line on growth card indicates	1.weight is declining 2. weight is increasing	1. weight is declining

		gradually 3. weight is low for Age	
8	Level of weight gain per year between age group 3	1.5 yrs- 1kg 2. 2 kg 3. 3 kg per year	3. 3 kg per year
9	The average weight of a 1 year old child	1.7kg 2. 10kg 3.12 kg	2. 10kg

Immunization

10	The gap between 2 successive doses of DPT vaccine	1.1week 2. 4 weeks 3. 8 weeks	2. 4 weeks
11	Measles vaccine given at the age of	1.6 month 2. 9month 3.1 yr	2. 9month
12	Booster dose of DPT given at the age of	1.1yr 2. 1& ½ months 3.2 yr 4. 2 yrs	2. 1& ½ months
13	Vaccines given at 5 yr age	1.DPT 2. DT 3. TT	1. DPT
14	Tetanus toxoids that a pregnant lady should receive	1.1 2. 2 3. 3	2. 2

Health Check up

15	the earliest symptom of vitamin A deficiency	1.inability to read 2. night blindness 3. lacrimation	2. night blindness
16	Dose of vit. A below 1 yr age	1.one lakh 2. two lakh 3. 0.5 lakh IU	1. one lakh
17	Dose of vit. A above 1 yr age	1.one lakh 2. two lakh 3. 0.5 lakh IU	2. two lakh
18	First dose of vit. A given at	1. age of 6 months 2. 9 month. 3. 1yr	2. 9 month.

19	Gap between 2 successive doses of vitamin A	1. 2 month 2. 6 month 3. 1 yr	2. 6 month
20	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume	1. 60 2. 90 3. 200	2. 90

Referral services:

21	any four high risk pregnancies which need referral	1. could mention all correctly 2. only 3 3. only 2 4. none	1. could mention all correctly
22	Children who need referral	1. could mention all correctly 2. only 3 3. only 2 4. none	1. could mention all correctly

Nutrition & health education

23	Exclusive breast feeding to be continued till	1. 3 months 2. 6 months 3. 1 yr	2. 6 months
24	The Kind of diet to be given during diarrhea	1. only liquids 2. light & nutritious diet 3. diet should be Withheld	1. only liquids
25	Following are the high risk pregnancies	1. twin pregnancy 2. anaemia 3. pre-eclampsia 4. oligohydramnios	2. anaemia
26	ORS to be discarded if not used completely after	1. 4hrs 2. 24hrs 3. 36hrs	2. 24hrs

Table 4.2 Correct and current knowledge about ICDS scheme among anganwadi workers

No	Topics	Percentage of Correct Responses obtained from AWWs on the various topics (%)
1	Amount of calories & proteins given to each child through supplementary nutrition	0.0
2	Amount of calories & proteins given to grade 4 malnourished child	16.7
3	Calories & proteins a pregnant woman receives from AWC	50.0
4	Growth monitoring starts from	100.0
5	The red color in mid arm circumference (MAC) strip indicates	10.0
6	Yellow color on MAC strip indicates a circumference of	0.0
7	Flattened growth line on growth card indicates	33.3
8	Level of weight gain per year between age group 3	10.6
9	The average weight of a 1 year old child	70.0
10	The gap between 2 successive doses of DPT vaccine	68.0
11	Measles vaccine given at the age of	83.5
12	Booster dose of DPT given at the age of	74.6
13	Vaccines given at 5yr of age	13.3
14	No. of tetanus toxoids a pregnant lady receives	30.0
15	The earliest symptom of vitamin A deficiency	33.9
16	Dose of vit. A below 1 yr age	60.5
17	Dose of vit. A above 1 yr age	60.3
18	First dose of vit. A given at	66.1
19	Gap between 2 successive doses of vitamin A	63.7
20	Minimum no. of tab. of iron & folic acid a pregnant woman consumes	65.3
21	Four high risk pregnancies needing referral services	23.3
22	Children needing referral services (any four)	30.0
23	Exclusive breast feeding continues till	100

24	The Kind of diet that to be given during diarrhea	80.0
25	High risk pregnancies	43.3
26	ORS to be discarded if not used completely after	66.5