Knowledge of Anganwadi Worker about Integrated Child Development Services (ICDS): A Study of Urban Blocks in Sundargarh District of Odisha

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Submitted by

Prasanti Jena (411HS1003)

Under the Guidance of

Dr. Jalandhar Pradhan

DEPARTMENT OF HUMANITIES AND SOCIAL SCIENCES

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ROURKELA – 769008,

ODISHA, MAY 2013

Dr. Jalandhar Pradhan
Department of Humanities and Social Sciences
National Institute of Technology Rourkela
Rourkela – 769008
Odisha, India

CERTIFICATE

This is to certify that **Prasanti Jena** has carried out the research embodied in the present dissertation entitled **"Knowledge of Anganwadi Worker about Integrated Child Development Services (ICDS): A Study of Urban Blocks in Sundargarh District of Odisha"** under my supervision for the award of the master degree in **Development Studies** of the National Institute of Technology, Rourkela. This dissertation is an independent work and does not constitute part of any material submitted for any research degree or diploma here or elsewhere.

Research Supervisor

(DR. JALANDHAR PRADHAN)

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Dept. of Humanities & Social Sciences — Prasanti Jena

NIT, Rourkela — Roll No. 411HS1003

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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 30 Anganwadi workers belonging to three Urban Blocks of Sundargarh Districts. 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. The mean knowledge score about various ICDS services is about 12.83, and the individual score ranging from minimum of 7 to maximum of 19. 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.

Keywords: Anganwadi Centre; Anganwadi worker; ICDS; Children; Awareness; Knowledge; Training.

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 characterised 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 centres, it is known as **"Anganwadi".** The word Anganwadi is devloped 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 Centres

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 centres, 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

1.3.1Supplementary 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 diarrhoea, 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 refer 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 (Behaviour 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 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), 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 diahrrea 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; Chattopadhayay, 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 centres 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 realises 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 centres 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.

1.7 Objectives of the Study

The key objective of the study is to assess the correct knowledge among Anganwadi Worker about Integrated Child Development Services (ICDS). Specific objectives are as follow:

- To examine the socio-economic background of Anganwadi Workers there training service condition.
- To assess the awareness among the Anganwadi Workers regarding the health and nutritional services of ICDS programme.
- To study the problems faces by AWWs while implementing the ICDS programme.

CHAPTER II

DATA AND METHODS

2.1 Study area

The present study was conducted in urban area of Sundargarh District during the year 2012 of December month. The study area was confined to 3 Blocks namely Jagda, Jhirpani and Bonaigarh. All the selected AWCs are belonging to urban areas and the selection of AWCs was purposive.

2.2 Sampling

The sample for the present study comprises of 30 Anganwadi workers belonging to three Blocks of Sundargarh Districts. I have selected 14 AWWs from Jagda, 13 AWWs from Jhirpani and 3 AWWs from Bonaigarh.

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-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.

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 centres. 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 SPSS. Univariate and Multivariate 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,……..30

Total knowledge score: Sum total of individual knowledge score.

Table 2.1 Indicators considered for assessing correct knowledge score about ICDS

Q. No	Question	Response	Correct response
Supplementary nutrition			
q1	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 5. DK	3. 500 cal & 15gm proteins
q2	What amount of calories & proteins given to grade 4 malnourished child?	1.same as others 2. double 3. triple	2. double
q3	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 5. DK	4.600cal; 15 gm proteins
Non-formal preschool education and growth monitoring			
q4	Growth monitoring should start from?	1.from birth 2.3 months 3. 6 months	1.from birth
q5	The red colour in mid arm circumference (MAC) strip means?	1.well nourished 2. under nourished 3. in between 4. Severe malnourished	4. Severe malnourished
q6	Yellow colour on MAC strip means a circumference of?	1.12.5-13.5 2. 13.5-14.5 3. 11.5-12.5	1.12.5-13.5

q7	Flattened growth line on growth card means?	1.weight is declining 2. weight is increasing gradually 3. weight is low for Age	1.weight is declining
q8	At what 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
q9	What is the average weight of a 1 year old child?	1.7kg 2. 10kg 3.12 kg	2. 10kg
Immunization			
q10	What is the gap between 2 successive doses of DPT vaccine?	1.1week 2. 4 weeks 3. 8 weeks	2. 4 weeks
q11	Measles vaccine given at what age ?	1.6 month 2. 9month 3.1 yr	2. 9month
q12	Booster dose of DPT given at what age?	1.1yr 2. 1& ½ months 3.2 yr 4. 2 yrs	2. 1& ½ months
q13	What type of Vaccines given at 5yr age?	1.DPT 2. DT 3. TT	1.DPT
q14	What No. of tetanus toxoids that a pregnant lady should receive?	1.1 2. 2 3. 3	2. 2
Health check-up			
q15	What is the earliest symptom of vitamin A deficiency?	1.inability to read 2. night blindness 3. lacrimation	2. night blindness
q16	Dose of vit. A below 1 yr age?	1.one lakh 2. two lakh 3. 0.5 lakh IU	1.one lakh
q17	Dose of vit. A above 1 yr age?	1.one lakh 2. two lakh 3. 0.5 lakh IU	2. two lakh
q18	First dose of vit. A given at?	1. age of 6 months 2. 9 month. 3. 1yr	2. 9 month.
Q19	Gap between 2 successive doses of vitamin A?	1. 2 month 2.6 month 3. 1 yr	2.6 month
q20	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume?	1.60 2.90 3.200	2.90
Referral services:			
q21	Mention 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
q22	Children who need referral (any four?	1.could mention all correctly 2. only 3 3. only 2	1.could mention all correctly

		4. none	
Nutrition & health education			
q23	Exclusive breast feeding should be continued till?	1. 3 months 2. 6 months 3.1 yr	2. 6 months
q24	What Kind of diet that should be given during diarrhea?	1.only liquids 2. light & nutritious diet 3. diet should be Withheld	1.only liquids
q25	Following are high risk pregnancies?	1.win pregnancy 2. anaemia 3. pre-eclampsia 4. oligohy dramnios	2. anaemia
q26	ORS should be discarded if not used completely after?	1.4hrs 2.24hrs 3.36hrs	2.24hrs

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 Centres. 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-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF ANGANWADI WORKERS

3.1 Introduction

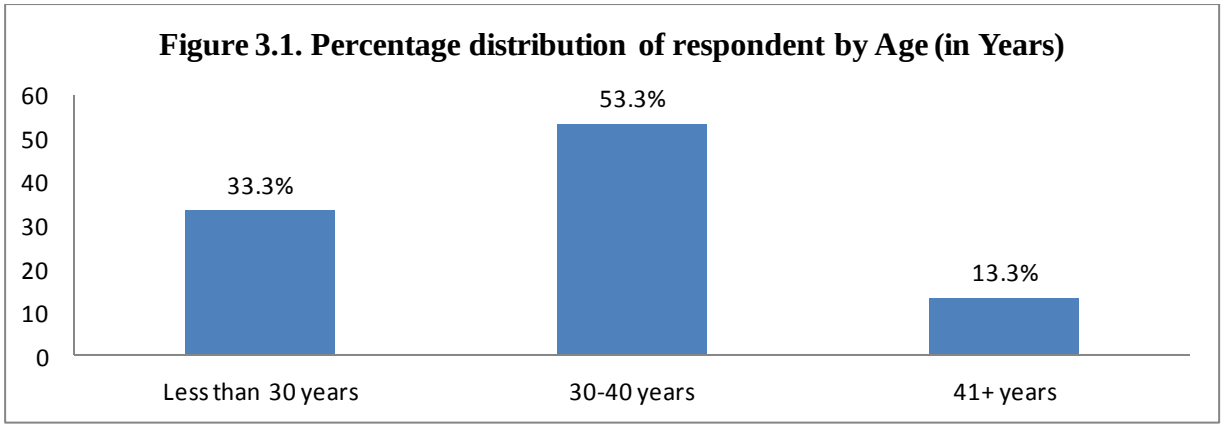
Various studies in recent past clearly highlighted the importance of socio-economic and demographic characteristics of AWWs in implementing the ICDS programmes (Bhasin et al, 2001; Davey and Dutta, 2004). In the present study 30 Anganwadi Workers were interviewed. The Anganwadi Worker and helper are 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 9 A.M to 1P.M and then they go for home visit another 1hour till 2 PM. They visit 5 houses every day. All Anganwadi workers get guidance from Auxiliary Nurse Midwife (ANM). As mentioned by the AWW, it was found that the workers have only 6 days holiday during Christmas. 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 33.3% of Anganwadi workers were less than 30 years, 53.3% of workers were in the age group of 30-40 years and 13.3% were 41 years and above. Results suggest that major portion of AWWs belongs to age group of 30-40 years.

Figure 3.1. Percentage distribution of respondent by Age (in Years)

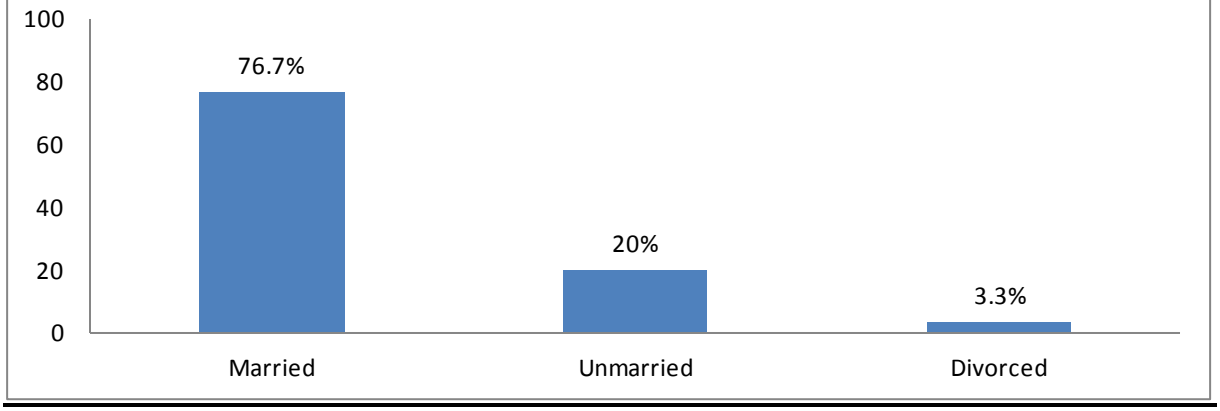


Source: Survey data

3.2.2 Marital Status of respondents

While distributing the respondents by marital status it was found that about 76.7% of the workers are married, 20.0% are unmarried and 3.3% of the workers are divorce (Figure 3.2). So, major portion of workers are married.

Figure 3.2. Percentage distribution of respondent by Marital status

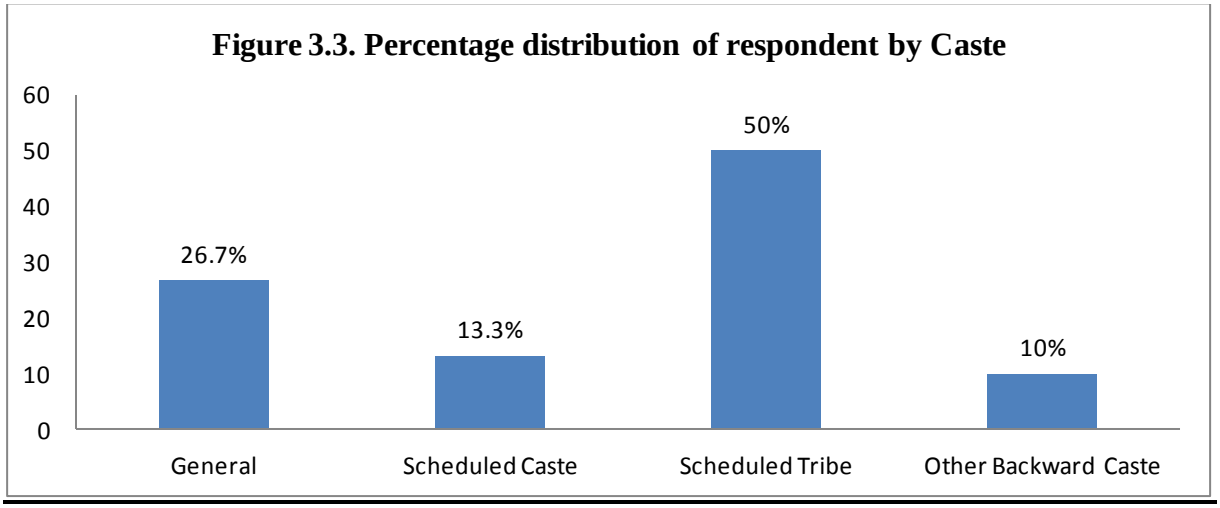


Source: Survey Data

3.2.3 Caste of respondents

It was found that the majority (50.0%) of Anganwadi workers are belonging to ST background. The rest of the workers distributed among OBC, SC, and General Communities. They are respectively 10.0%, 13.0% and 26.7%. It reflects that the studied Anganwadi centre is numerically dominated by Tribal communities.

Figure 3.3. Percentage distribution of respondent by Caste

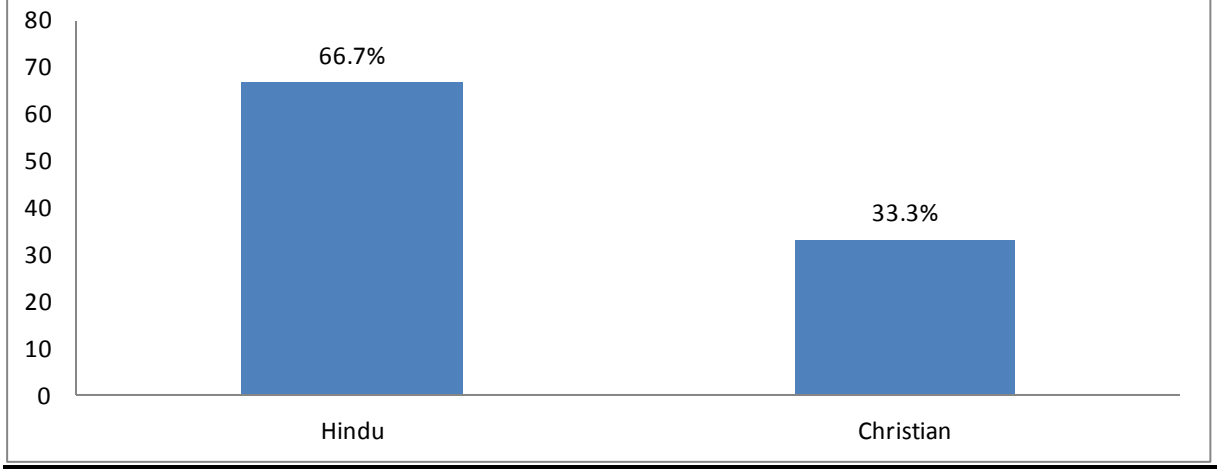


Source: Survey data

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 66.7% of AWWs are Hindu followed by 33.3% for Christian.

Figure 3.4. Percentage distribution of respondent by religion

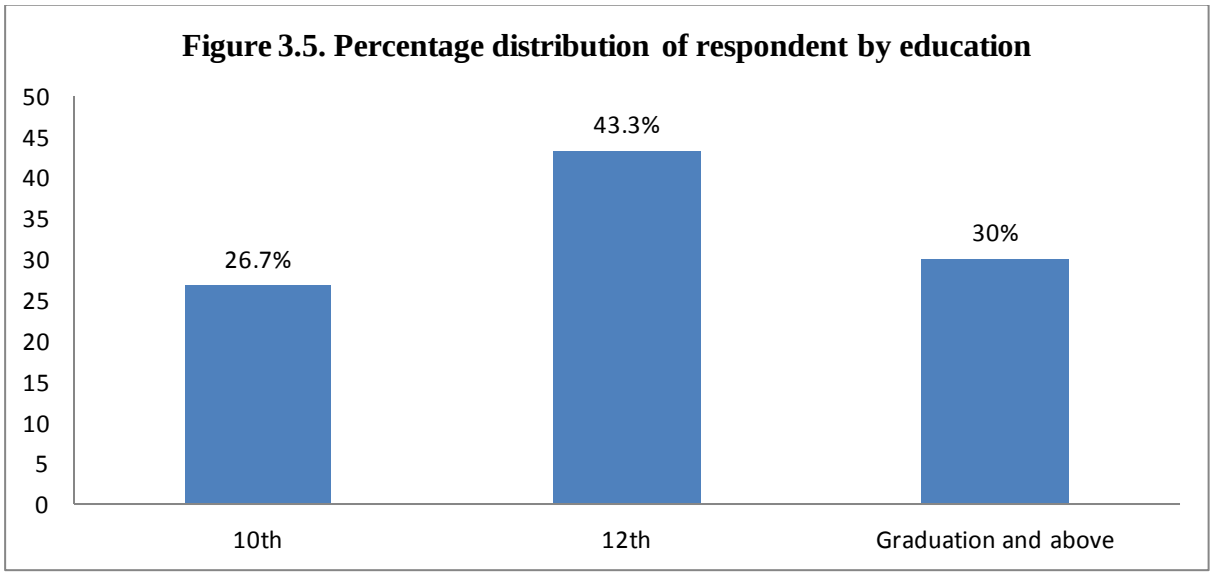


Source: Survey Data

3.2.5 Education of respondents

In the present study 30 Anganwadi workers were interviews and it is evident from the Figure.5 that 26.7% of the Anganwadi workers were 10^{th} passed, 43.3% were 12^{th} passed, 30% had education up to graduation level and above.

Figure 3.5. Percentage distribution of respondent by education

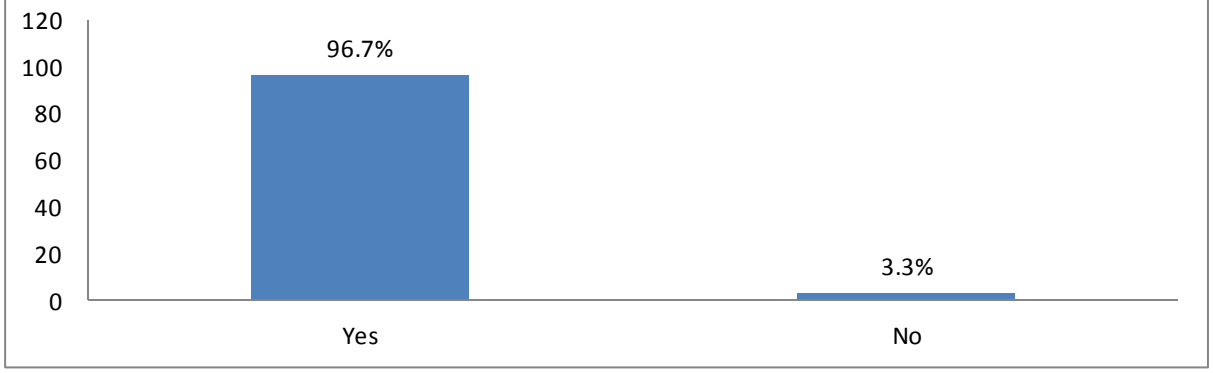


Source: Survey data

3.2.6 Residence Status of respondents

Figure 6 highlighted that all most all the Anganwadi workers, 96.7% were resident within the same area where the Anganwadi centre is located and only 3.3% were staying outside the village.

Figure 3.6. Percentage distribution of respondent by residence status within the same area

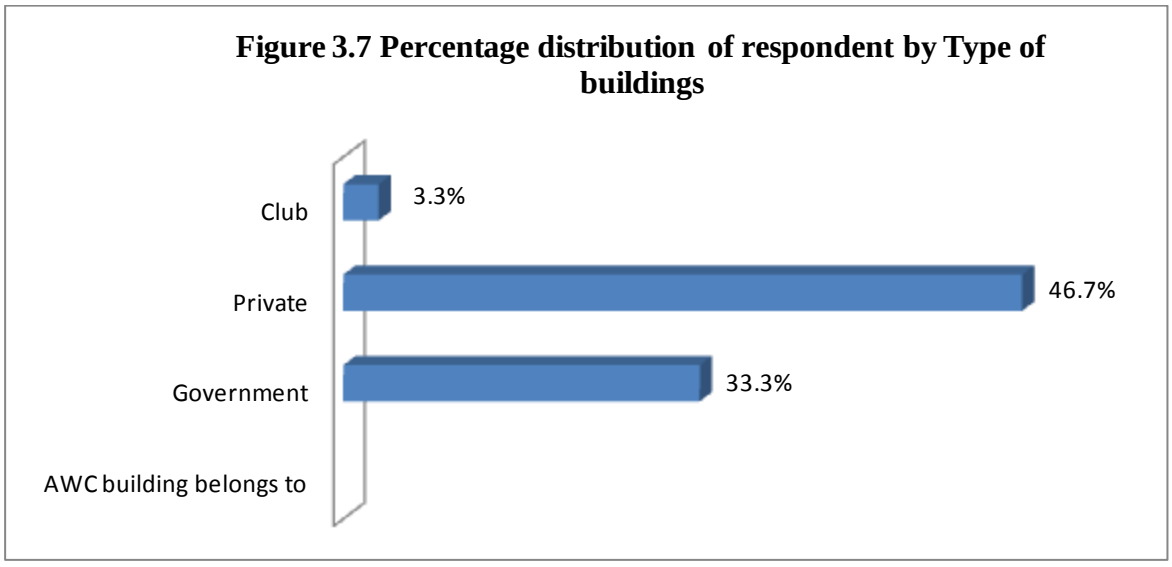


Source: Survey data

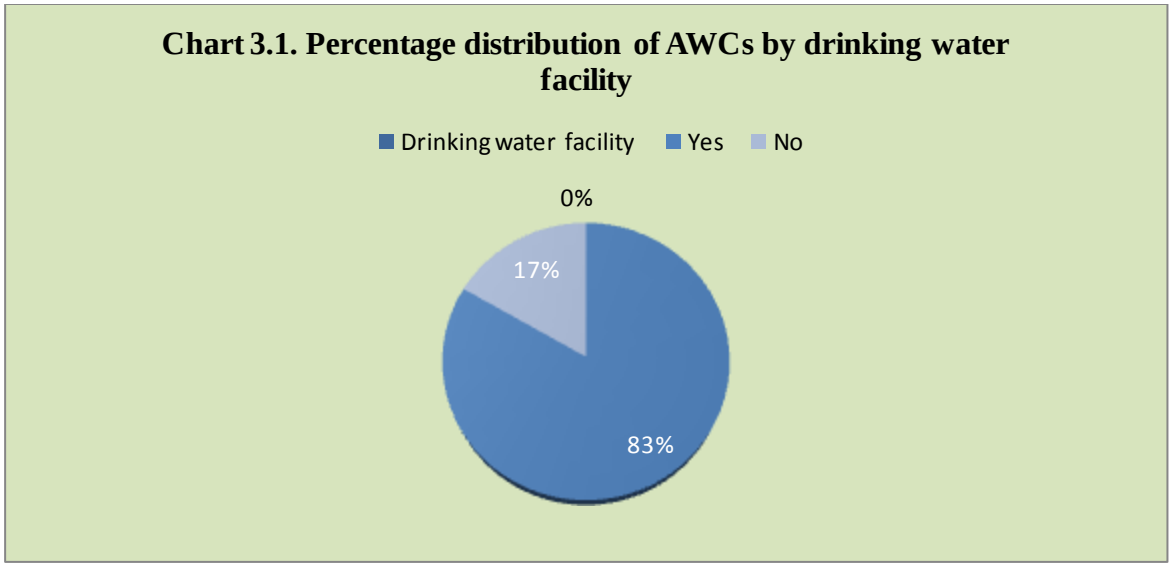
3.3 General Information about the Anganwadi Centre (AWC)

Thirty three percent of Anganwadi centre buildings belong to government quarters. About 46% of Anganwadi centre belongs to the private quarters followed by 3% established in club building (Figure 3.7). Results show that most of the AWCs have inadequate level of infrastructure facility in terms of availability of electricity, toilet, and drinking water facility (Chart 3.1, 3.2 and 3.3).

Figure 3.7 Percentage distribution of respondent by Type of buildings



Source: Survey data



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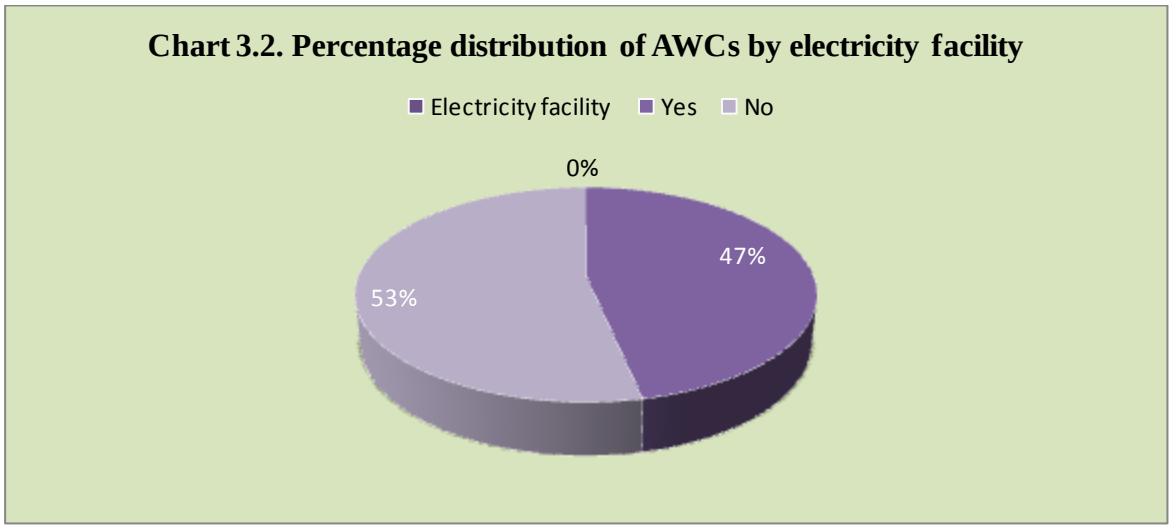
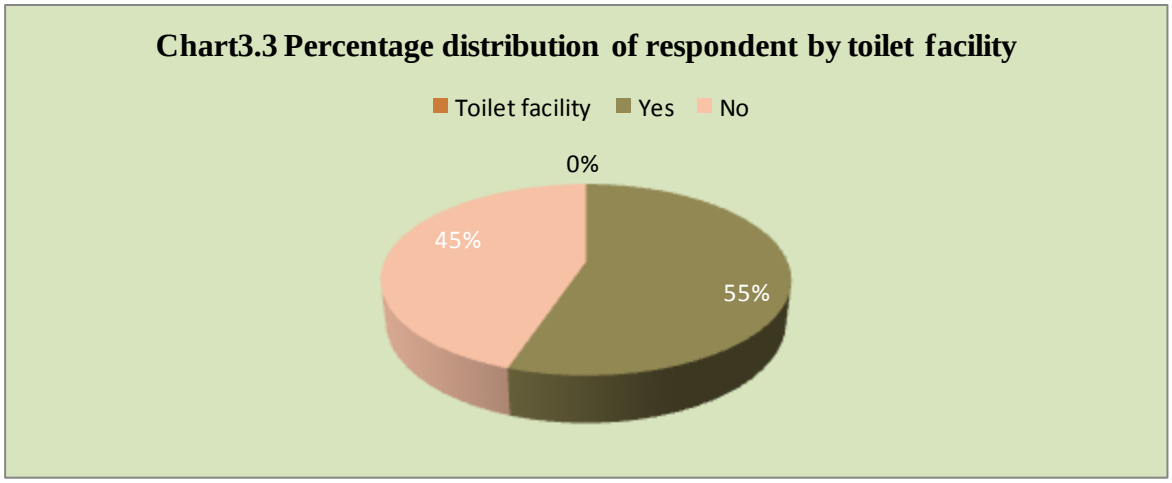


Source: Survey data

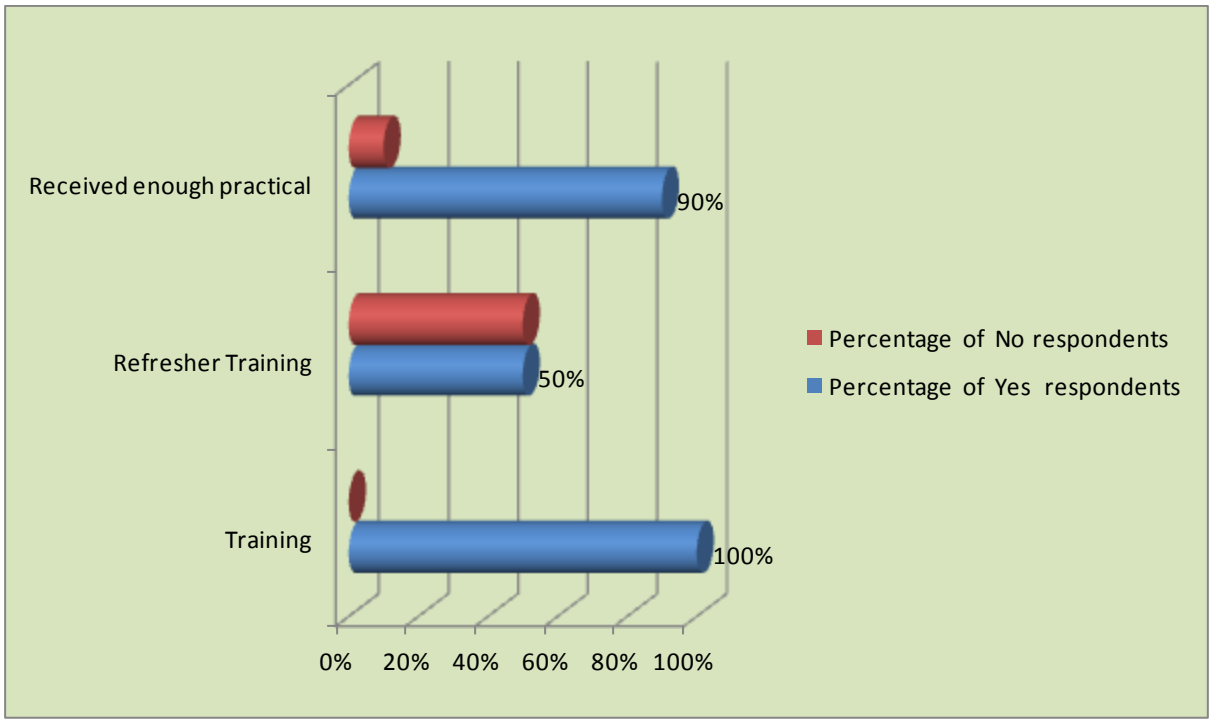


Source: Survey data

3.4 Training and Refresher Training

As for as training status Anganwadi worker was concerned, it was found that majority of Anganwadi workers 100% were trained and have attended the ICDS training programme but among all 30 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 received enough practical experience during training sessions.

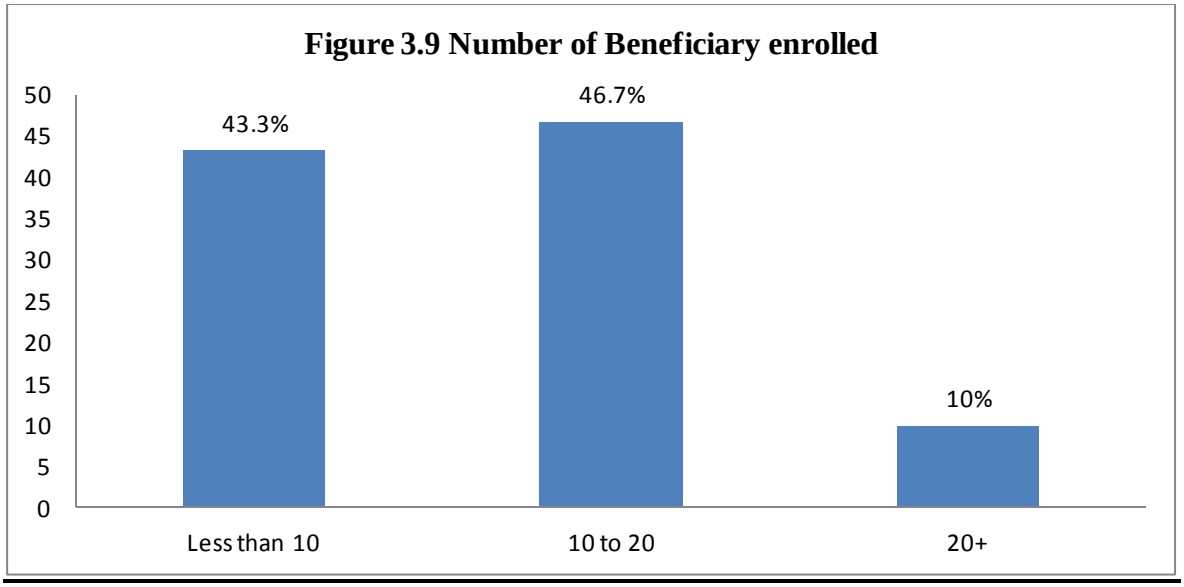
Figure 3.8 Percentage distribution of respondent by Training and Refresher training



Source: Survey data

3.5 Beneficiary Enrolled

Result suggest that about 43.3% centres have less than 10 children, 46.7% centres have 10 to 20 children and only 10% of Anganwadi centres have 20 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.



Source: Survey data

3.6 Types of problem faced by Anganwadi workers

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 10^{th} 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 56.7% are complained of inadequate salary while only 16.7% complained of lack of logistic supply related problems (Table 3.1). 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. Forty three percent of workers not happy because of overload of work. And 40% 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 conducted by Municipal Corporation.

Table 3.1. Problems faced by Anganwadi workers

Types of problem	Number of AWWs with the problem
Inadequate salary	17 (56.7)
Infrastructure related	15 (50.0)
Logistic supply related	5 (16.7)
Work overload	13 (43.3)
Excessive record maintenance	12 (40.0)
Total (N)	30

A figure in parentheses is indicating percentages.

Source: Survey data

(Picture 3.1 and 3.2) was taken during our field visit and this Anganwadi centre is located in Jagda Block. It is the main Anganwadi centre of Jagda Block and this Centre is given by Government of India. While our interaction with Anganwadi woker of this centre, she told that though this Anganwadi building is given by Government but it is worthless because it is a very small room and lack of space, more than 10 children at a time they can't seat also 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 equipments also. It is also observed that because of no safe drinking water in this Anganwadi centre, the helper is gone to another place to take drinking water for cooking and also for children.

Picture: 3.1 Anganwadi Centre Jagda.1

Picture: 3.2 Anganwadi Centre Jagda.1

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.

4.2 Correct knowledge about ICDS scheme

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 4.1 Correct Knowledge Score

	Mean Score	Min	Max	SD
Correct Knowledge score (N=30)	12.83	7	19	2.71

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 23.3% of the Anganwadi workers have knowledge about the flattened growth line on growth chart. The present study found that 26.7% of Anganwadi workers have correct knowledge about the calories and proteins given to grade4 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, 20% knew the correct red colour mid arm circumference (MAC) strip means and they don't have knowledge about the yellow colour of MAC strip means. As expected, about 73.3% 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 26.7% of Anganwadi workers were knew the correct knowledge of the amount of calories and proteins given to grade4 malnourished child and no one have the correct knowledge about the amount of calories and proteins given to each child through supplementary nutrition. Sixty 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.

Most of the Anganwadi workers have best knowledge about the component of Immunization. 93.3% were knew the correct knowledge about the measles vaccine, 76.7% were knew about the doses of DPT vaccine and 73.3% booster dose of DPT. The awareness regarding the provision of referral services was 20 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 favour 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 around 76.6% 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 43.3%, 73.3%, 86.7%, 70% and 70% Anganwadi workers respectively. Only 13.3% could mention the type of vaccines given at 5year age.

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

Table 4.2Correct knowledge about ICDS scheme

Q. No	Question	Correct Response (%)
q1	What amount of calories & proteins given to each child through supplementary nutrition?	0.0
q2	What amount of calories & proteins given to grade 4 malnourished child?	26.7
q3	How much Calories & proteins a pregnant woman should receive from AWC?	60.0
q4	Growth monitoring should start from?	100.0
q5	The red colour in mid arm circumference (MAC) strip means?	20.0
q6	Yellow colour on MAC strip means a circumference of?	0.0
q7	Flattened growth line on growth card means?	23.3
q8	At what level of weight gain per year between age group 3?	16.7
q9	What is the average weight of a 1 year old child?	60.0
q10	What is the gap between 2 successive doses of DPT vaccine?	76.7
q11	Measles vaccine given at what age?	93.3
q12	Booster dose of DPT given at what age?	73.3
q13	What type of Vaccines given at 5yr age?	13.3
q14	What No. of tetanus toxoids that a pregnant lady should receive?	30.0
q15	What is the earliest symptom of vitamin A deficiency?	43.3
q16	Dose of vit. A below 1 yr age?	70.0
q17	Dose of vit. A above 1 yr age?	70.0
q18	First dose of vit. A given at?	86.7
Q19	Gap between 2 successive doses of vitamin A?	73.3
q20	Minimum no. of tab. of iron & folic acid that a pregnant woman should consume?	73.3
q21	Mention any four high risk pregnancies which need referral?	23.3
q22	Children who need referral (any four)?	20.0
q23	Exclusive breast feeding should be continued till?	100
q24	What Kind of diet that should be given during diarrhea?	80.0
q25	Following are high risk pregnancies?	43.3
q26	ORS should be discarded if not used completely after?	76.7

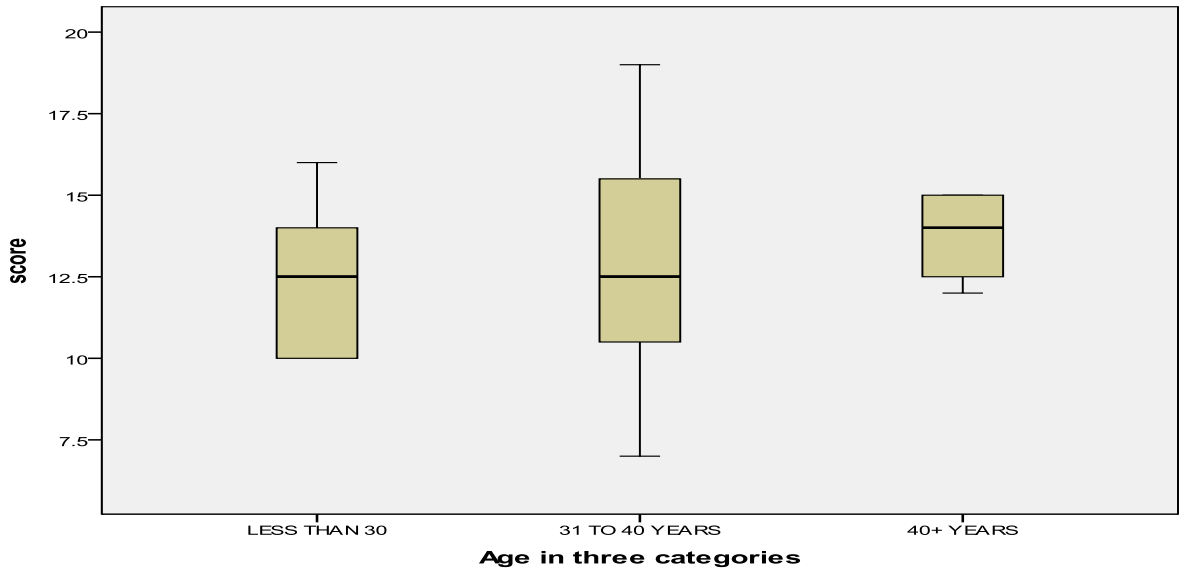
4.2.1 Knowledge differentials by Age

Results from the following table highlight that the knowledge score is higher for older women compare the younger women (Table 4.3). 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) (Figure 4.1). This evidence suggests that older women are much more aware about various ICDS services compared to their younger counterpart.

Table 4.3. Mean Knowledge score by age

Age group	Mean Score	95% CI	
		Lower bound	Upper Bound
Less than 30	12.30	10.83	13.77
31-40 Years	12.94	11.18	14.69
41+ Years	13.75	11.36	16.14

Figure 4.1: Knowledge differential by age



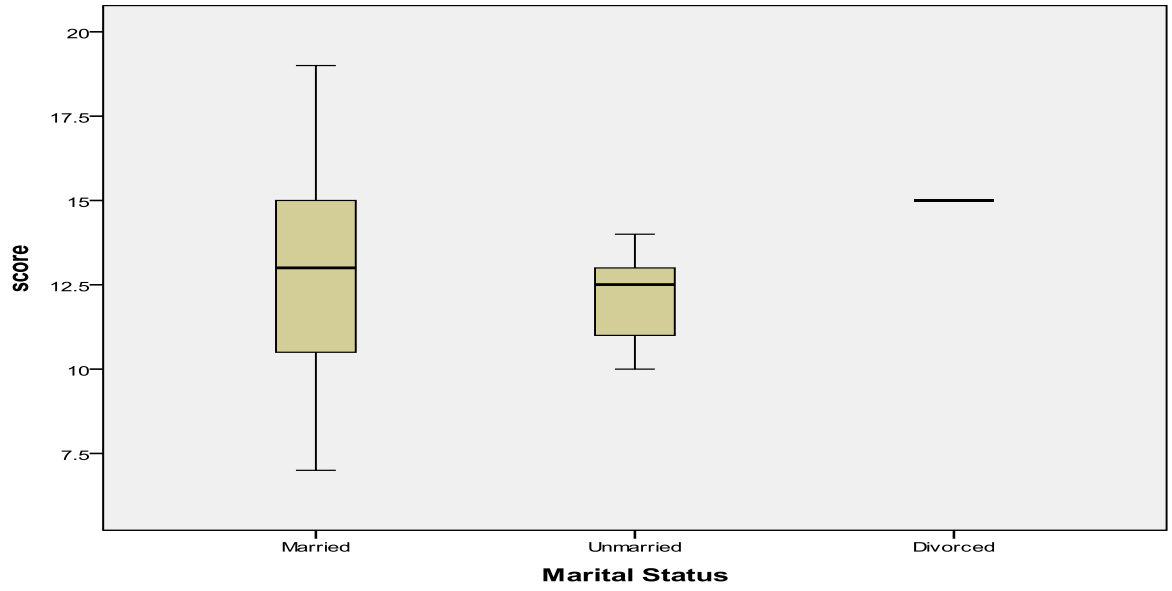
4.2.2 Knowledge differentials by Marital Status

Table 4.4 shows that 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.

Table 4.4 Knowledge differential by Marital Status

Marital Status	Mean Score	95% CI	
		Lower Bound	Upper Bound
Married	12.91	11.62	14.20
Unmarried	12.17	10.62	13.71

Figure 4.2: Knowledge differential by Marital Status



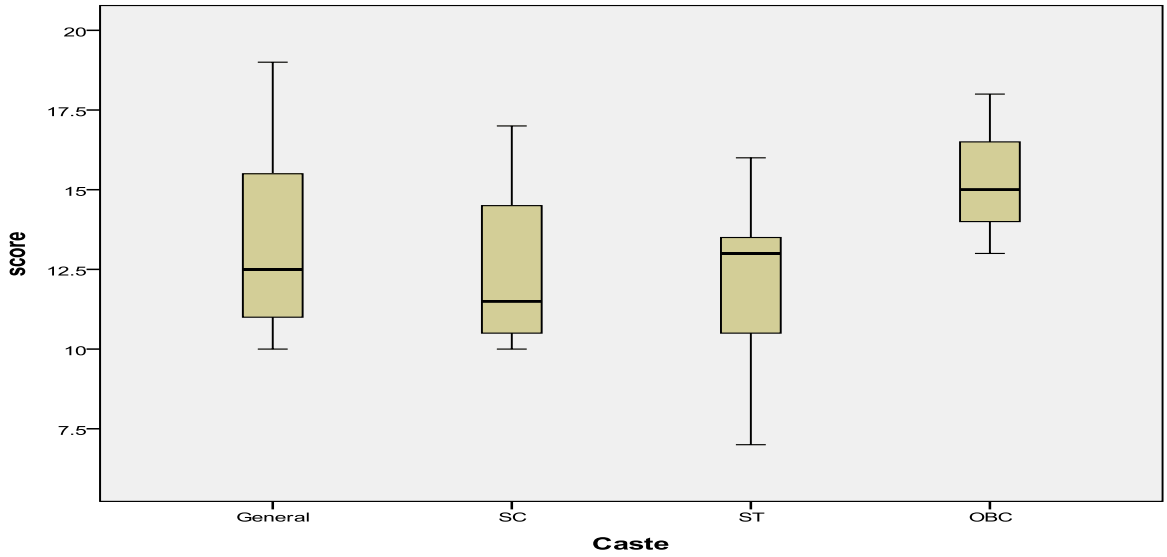
4.2.3 Knowledge differentials by Caste

It clearly shown that the knowledge score is higher for OBC compare the other caste. The knowledge score for women ST is about 12.13 which is lower than the knowledge score for OBC women (mean score 15.33). It suggests that OBC women are more knowledgeable about the ICDS scheme than other caste (Figure 4.3).

Table 4.5 Knowledge differentials by Caste

Caste	Mean score	95% CI	
		Lower bound	Upper bound
General	13.38	10.77	15.98
SC	12.50	7.55	17.45
ST	12.13	10.85	13.42
OBC	15.33	9.08	21.58

Figure 4.3 Knowledge differentials by Caste



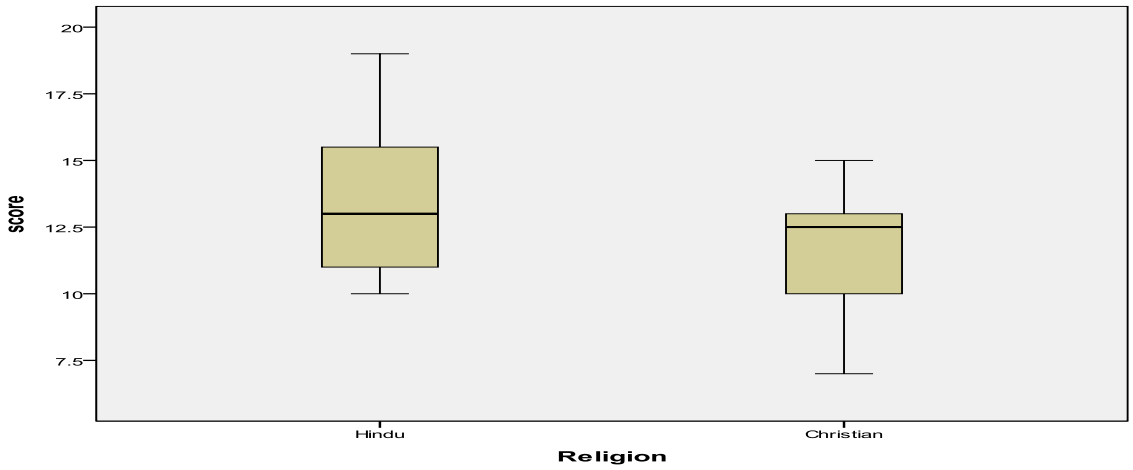
4.2.4 Knowledge differential by Religion

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

Table 4.6 Knowledge differentials by Religion

Religion	Mean score	95% CI	
		Lower bound	Upper bound
Hindu	13.30	12.00	14.60
Christian	11.90	10.13	13.67

Figure 4.4 Knowledge differentials by religion



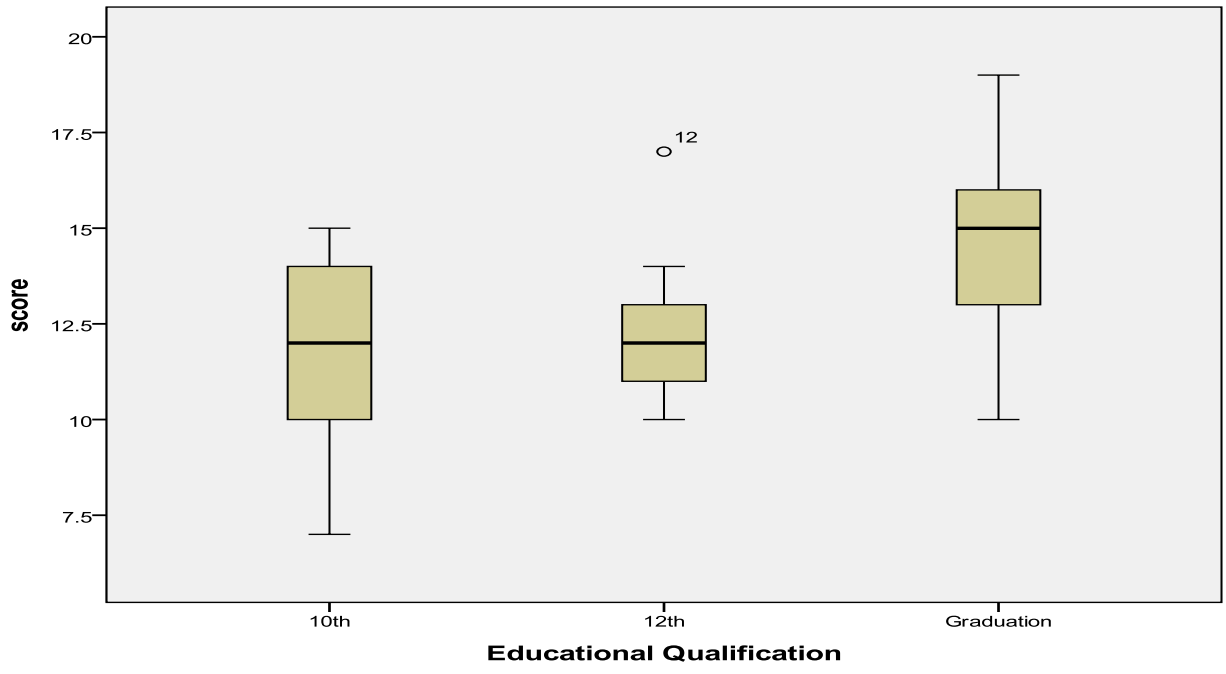
4.2.5 Knowledge differentials by Education

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.

Table 4.7 Knowledge differential by Education

Educational Qualification	Mean score	95% CI	
		Lower bound	Upper bound
10th	11.75	9.48	14.02
12th	12.23	12.99	13.56
Graduation	14.67	12.43	16.91

Figure 4.5 Knowledge differentials by educational qualification



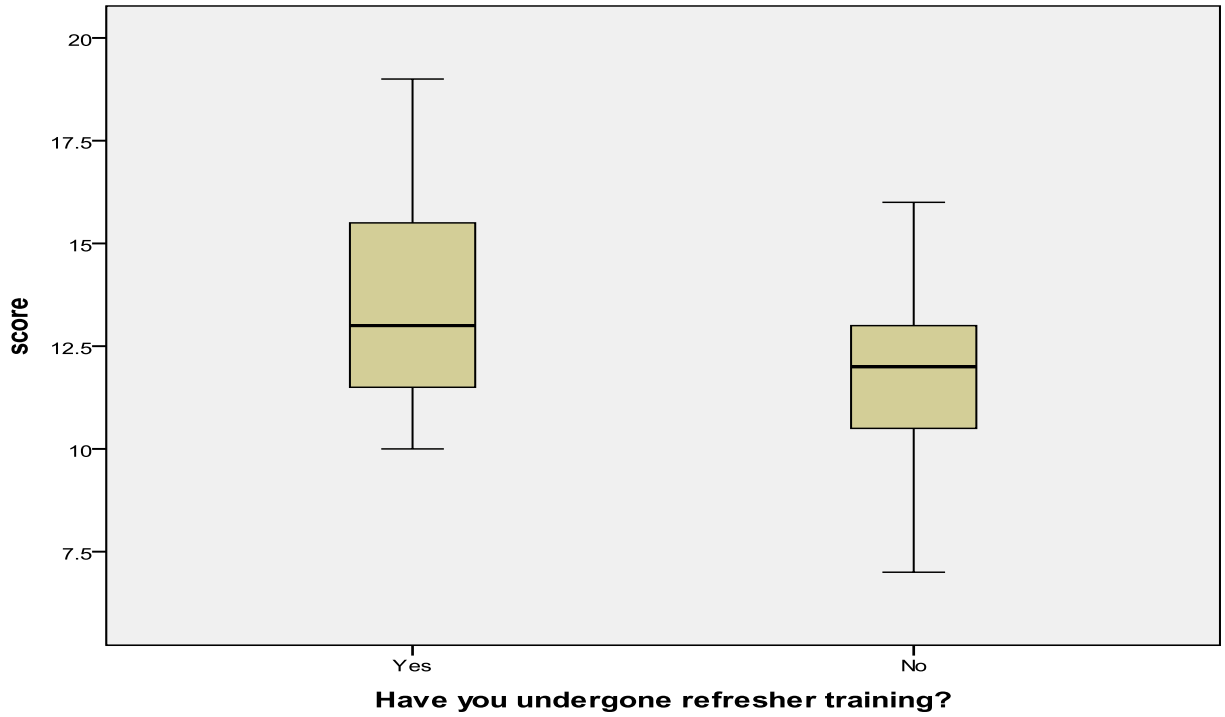
4.2.6 Knowledge differentials by Training Status

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.

Table 4.8 Knowledge differential by Training status

Refresher training	Mean score	95% CI	
		Lower bound	Upper bound
Yes	13.73	12.09	15.37
No	11.93	10.72	13.14

Figure 4.6 Knowledge differentials by Training status



CHAPTER V

SUMMARY AND CONCLUSION

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 30 Anganwadi Workers were interviewed and majority (53%) of the workers are in the age group of 30-40 Years. About 43% of Anganwadi workers were inter-mediate. Only (26.7%) are matriculate and (30.0%) were completed Graduation.

Present study shows that only 23.3% 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 colour 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 highlights that the mean correct knowledge score is about 12.83 and the range varies from minimum of 7 to maximum of 19. 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. Result also suggests that the mean knowledge score is higher for women who have completed graduation compare to their counterparts. The mean knowledge score for women with 10^{th} qualification 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 10^{th} and 12^{th} 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. Results suggest that 56.7% are complained of inadequate salary while only 16.7% complained of lack of logistic supply related problems. 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. Forty three percent of workers not happy because of overload of work. And 40% 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 conducted by Municipal Corporation.

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.

RECOMMENDATION

- The present study strongly felt the need of improving the quality of knowledge and awareness among Anganwadi workers about various ICDS schemes.
- 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.
- Also infrastructure facilities should be improved for better implementation of ICDS scheme.

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APPENDIX

National Institute of Technology, Rourkela

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

QUESTIONNIRE 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 resident of this village?	1.Yes	

		2.No	
10.	Have you undergone training?	1.Yes 2.No	
10a	If yes, when		
11.	Have you undergone refresher training?	1.Yes 2.No	
11a	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. Private 3.Rent 4.Club	
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 3. 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 & GROWTH MUNITERING			
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 colour code for growth monitoring?	1.Yes 2.No	
30.	The red colour in mid arm circumference (MAC) strip means?	1.well nourished 2. under nourished 3. in between	
31.	Yellow colour 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&1 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?		
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 whobecome	

		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 mon. 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	
REFERAL 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 & HEALTH EDUCATION			
60.	Exclusive breast feeding should be continued till?	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.win pregnancy 2. anemia 3. pre-eclampsia 4. oligohydramnios	
68.	ORS should be discarded if not used completely after?	1.4hrs 2.24hrs 3.36hrs	
PROBLEM FACED BY AWW			
69.	What are problems you facing? **<u>TYPES OF PROBLEMS</u>**	1. YES/ 2. NO	
70.	Inadequate salary		
71.	Infrastructure related		
72.	Logistic supply related		
73.	Work overload		
74.	Excessive record maintenance		
75.	Lack of help from community		
76.	In accessibility of superiors'		
77.	Other if any		
78.	Do you want to give any suggestion?		
79.	If yes, please give your suggestion?		