COMMUNITY PARTICIPATION AND PERFORMANCE OF ANGANWADI CENTRES (AWCs) IN AIZAWL, MIZORAM

Ruby Laltlanmawii Bawitlung

Department of Social Work

Supervisor

Dr. Elizabeth H

Submitted in partial fulfillment of the requirement of the Degree of Master of Philosophy in Social Work of Mizoram University, Aizawl.

Mizoram University

December 2015

Declaration

I, Ruby Laltlanmawii Bawitlung, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to the Mizoram University for the degree of Master of Philosophy in Social Work.

Date: (RUBY LALTLANMAWII BAWITLUNG)

Place: Aizawl, Mizoram

Department of Social Work
Mizoram University, Aizawl - 796 004

Mizoram University

December 2015

CERTIFICATE

This is to certify that the thesis of *Community Participation and Performance of Anganwadi Centres (AWCs) in Aizawl, Mizoram* submitted by Ms. Ruby Laltlanmawii Bawitlung for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other university or institute of learning.

Date: 8th December 2015

Place: Aizawl, Mizoram

(Dr. KANAGARAJ EASWARAN)

Head
Department of Social Work
Mizoram University

(Dr. ELIZABETH H)

Research Supervisor
Department of Social Work
Mizoram University

Acknowledgement

First and the foremost, I would like to express my gratitude to the Almighty God who guided and gave me strength, health and courage to complete all the semesters without any hardship.

I acknowledge with deep gratitude to my research supervisor *Dr. Elizabeth H*, Assistant Professor, Department of Social Work, Mizoram University, for her guidance and support and under whose mentorship the thesis took the final shape.

I express my sincere thanks to Dr. Kanagaraj Easwaran, Head of the Department of Social Work and all the faculty members, for giving me an opportunity to undertake a research in the field of my interest.

I also express my deepest gratitude to the office of Urban ICDS and all the respondents in the study - the anganwadi workers, the mothers of the beneficiaries and the community key leaders for sharing their valuable time.

I also thank my fellow M.Phil scholars for their help and support. And my sincere thanks to Mr. Obadia Vanramnghaka Ralte for his help and assistance throughout the study.

Last but not the least, I would like to thank my family who are the source of my inspiration and who encourage me throughout the study.

(RUBY LALTLANMAWII BAWITLUNG)

Department of Social Work,

Mizoram University, Aizawl, 796 004

CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

ANM	:	Auxiliary Nurse Midwife
AWCs	:	Anganwadi Centres
AWH	:	Anganwadi Helper
AWW	:	Anganwadi Worker
AWWTCs	:	Anganwadi Worker Training Centers
CDPO	:	Child Development Project Officer
CO	:	Circle Officer
ICDS	:	Integrated Child Development Service
IMR	:	Infant Mortality Rate
MHIP	:	Mizo Hmeichhia Insuihkhawm Pawl
MO	:	Medical Officer
NHEd	:	Nutrition and Health Education
OPV	:	Oral Polio Vaccine
PEM	:	Protein Energy Malnutrition
PSE	:	Preschool Education
SNP	:	Supplementary Nutrition Program
UNDP	:	United Nations Development Program
YMA	:	Young Mizo Associations

CHAPTER I

INTRODUCTION

CHAPTER I

INTRODUCTION

The present study attempts to assess the community participation and the performance of Anganwadi Centers (AWCs) in Aizawl, Mizoram.

Children in India form a large segment of the population. Children are the future assets of the nation. The census of India treats persons below the age of 14 as “Children”. These are estimated 300 million children between 0 and 14 years of age in India today, representing a little over one-third of India’s population are living in poor economic, social, physical and environmental conditions, which has a detrimental effect on their physical and mental development.

Human resource is a key factor in development. The foundation for physical, psychological and social development has taken place in the early childhood stage. Basically, child care is the responsibility of the family and within the family primarily of the mother but either of the parents or family alone is not sufficient to promote the child development. Therefore, provision of early childhood services in integrated manner is needed to promote and ensure the full physical, mental and social development of the children.

India has made progress in reducing the Infant Mortality Rate (IMR) from a level of 129 deaths per 1,000 live births in 1971 to 79 in 1992. In spite of the fact that 25 million children born every year in India and out of which two million die before reaching their first birthday. A majority of these deaths are due to avoidable infections and malnutrition. In India, the pattern shows that the IMR in rural areas had always exceeded the IMR in urban areas, and the gaps continue to persist. So, nearly 43.8% of children suffer from moderate degree of Protein Energy

Malnutrition (PEM) and 8.7% suffer from extreme forms of malnutrition. Also, 56% of pre-school going children and almost 50% of expectant mothers in the third trimester of pregnancy suffer from iron deficiency and no state in India is free from Iodine deficiency. The Iodine deficiency alone accounts for an estimated 90,000 still births and neo-natal death every year. Further, nearly 2.2 million children are afflicted with cretinism and about 6.6 millions are widely retorted and suffer from various degrees of motor handicaps and around 60,000 children become blind every year due to deficiency of vitamin A coupled with PEM (Government of India's National Nutrition Policy, 1993).

The community participation is visualized as a means of social transformation of culturally and economically diverse and hierarchical groups of people into a more democratic and egalitarian framework. In India, the advent of panchayati raj has been envisaged as a facilitator of the people's participation and thereby advancing the role of communities in their own social and economic advancement. In this context, people's direct participation in the management of anganwadi center (AWC) is felt indispensable and inevitable for materializing long cherished goal for universalizing of AWCs. Specific efforts in various forms are launched to revitalize the AWCs-community relationships that can be gainfully channelized for quantitative as well as qualitative improvement of AWCs.

1.1 Defining Community

The term 'community' is one of the most important concepts. It is commonly used, and given different interpretations. Due to the abstract nature of the term and the nostalgic attachment to the idealized notion of community, the term has been defined in a number of ways. For instance, the encyclopedia of social sciences defined 'community' as a "territorially bonded social system or set of integrated functional sub systems (economic, political, educational, religious, etc.) serving a resident population plus the material culture through which the sub-

system operate". Further, the concept of community includes a minimum of consensus and a normative structure which is either inherited from the past or self-consciously inherited in each sub-system.

The classical perspective on community was provided by Zimmerman (1938) emphasized the four basic characteristics of community such as social fact, specification, association and limited geographical area. Hillary (1955) indicated that of three unifying elements of community such as social interaction, common bonds and territory. According to her, community is a geographic area having common center of interests and activities. Community is also understood essentially as an area of social living which is marked by some degree of social coherence. It includes in itself all the social relationships, a variety of associations and institutions. Within the range of community, the members carry on their economic, religious, political, educational and other activities. For example, global community, urban community, rural community, caste community, religious community may be some of the common references.

MacIver (1945) defines it as an area of social living marked by some degree of social coherence. According to him, 'whenever the members of any group, small or large live together in such a way that they share, not this or that particular interest, but the basic conditions of a common life, we call that group a community'. Further, MacIver (1970) pointed out that society is a web of social relationships, but community consists of a group of individuals living in particular areas with some degree of 'we' - feeling. What he points out is that "to understand the whole reality of community, we must keep in mind the endless unformulated relations into which men enter, relations of infinite variety and of every degree of complexity, by whose means every man is brought into nearer contact with each other, joined in a solidarity and in interdependence which none can ever fully estimate". In other words, MacIver opined that the community is an area of social living marked by some degree of social coherence.

Further, Kingsley Davis (1949) defined community as the "smallest territorial group that can embrace all aspects of social life". Lundberg (1958) pointed out that the community is a human population living within a limited geographic area and carrying on a common interdependent life. Mannheim (1959) defined community as any circle of people who live together and belong together in such a way that they do not share this or that particular interest only, but a whole set of interests. Ogburn and Nimkoff (1950) defined community as the total organization of social life within a limited area. Sutherland (1961) defined community as a local area over which people are using the same languages, conforming to the same mores, feeling more or less the same sentiments and acting upon the same attitudes. Talcott Parsons (1951) pointed out that community is that collectivity the members of which share a common territorial area as their base of operation for daily activities.

Jonassen (1959) pointed out that a community includes six elements and they were: (1) a grouping of people, (2) within a geographic area, (3) with a division of labor into specialized and interdependent functions, (4) with a common culture and a social system which organizes their activities, (5) whose members are conscious of their unity and of belonging to the community and (6) whose members can act collectively in an organized manner.

Thus, an examination of all the foregoing definitions reveals that there are three main approaches to the meaning of community. While some scholars have given emphasis to the geographical aspects, others have adopted socio-psychological emphasis in their thinking about the community, whereas some others have given emphasis to both.

1.2 Understanding Community Participation

It is important to recognize the significance of community participation for the level of achievement. Therefore, the study conceptualized community participation in the context of ICDS. It came to be recognized as a crucial factor in the success of developmental programs. The

significance of community participation lies in the fact that the very foundation of democratic governance depends on people's participation. Development is of the total wellbeing of the people, through implementing various developmental programs, to achieve the desired goals and needs to be identified by the community itself for the betterment and wellbeing of themselves.

Community refers to a village or a group of villages with families inhabiting them, who are dependent on one another in their day to day transactions of mutual advantages. In this sense, community participation is active involvement of people in planning, implementing and monitoring of ICDS program. In fact, community participation is not just utilization of services and being passive users.

The term 'participation' is one of the most important concepts that occupy a central place in the development literature. Over the years participation by the people, in particular, has become a buzz word in the development community. Even though the terms like 'participation', 'community power', 'empowerment', etc., have become part of the discourse of development, they have remained elusive concepts without any clear cut definitions. Different scholars and organizations have defined the terms in different ways.

The word participation can be defined as the "act of being involved in something". Nick Wates (1999) defines the word community "as a group of people sharing common interests and living within a geographically defined area". However, Nabeel Hamdi (2010) points out that the term community has both "social and spatial dimensions" and that generally the people within a community come together to achieve a common objective, even if they have certain differences. Nabeel Hamdi (2010) defines community participation as a powerful idea which "refers to the process by which professionals, families, community groups, government officials, and others get together to work something out, preferably in a formal or informal partnership". He explains

that community participation was initially an outcome of the public pressure demanding “environmental justice”.

In addition, N.J Habraken (1972) has understood that participation has two definitions with opposite meanings. Participation can either represent assigning certain decisive roles to the users, where they share the decision-making responsibility with the professionals. The other type of participation is where there is no shift of responsibilities between the users and professionals but instead only the opinion of the user is considered while making decisions.

Therefore, community participation means some form of involvement of people, with similar needs and goals, in decisions affecting their lives. Charles Abrams (1965) defines community participation as, “the theory that the local community should be given an active role in programs and improvements directly affecting it”. It is only rational to give control of affairs and decisions to people most affected by them. Besides, since no government or authority has the means to solve all the public problems adequately, it is necessary to involve people in matters that affect them.

According to the United Nations Development Program (UNDP) (1993), participation means that people are closely involved in the economic, social, cultural and political processes that affect their lives. Paul (1986) identified participation as an active process by which beneficiaries influence the direction and execution of a development project with a view to enhancing their well-being in terms of income, personal growth, self-reliance or other values they cherish.

In the Indian context, a study undertaken by the Government of India (1999), defined "community participation as an organized process of empowerment by enabling the local community to actively participate in the decision making process in implementation, monitoring and sharing of the resources". Raina (2003) conceptualized community participation as an

experience felt differently by different people in different circumstances even in similar circumstances. This is due to the fact that the deep-rooted socio-economic stratification that characterize our society. Therefore, "community participation would go hand in hand with safeguards for the poor and marginalized, which most often is a political task requiring active and sustained intervention of the state".

Therefore, the foregoing discussion reveals that the term 'community participation' has been used very loosely in the literature. However, for the purposes of practical relevance of the term in the context of the development, the definition by the United Nations appears appropriate. For instance, the United Nations Report on Human Development (1993) defined 'community participation' as sharing by people in the benefits of development and active contribution by people to development and involvement in decision- making at all levels of society'.

1.3 Integrated Child Development Services (ICDS)

Integrated Child Development Services (ICDS) is the largest national program for the promotion of the mother and child health and their development. It is a government sponsored program and is a primary social welfare scheme to tackle the nation-wide incidences of malnutrition and health problems among the children and their mothers. ICDS was launched in 1975 in accordance with The National Policy for Children, 1974 India. It has grown into one of the largest effective and integrated family and community welfare schemes and therefore, the Government of India committed towards ensuring universal availability and accessibility of the program.

The primary responsibility for the implementation of the program lies with the Department of Women and Child Development at the center and nodal department at the states, while maybe Social Welfare, Rural Development, Tribal Welfare or Health Department.

The people of a country are its most valuable asset. The strength and prosperity of a nation lies in its people who are healthy, educated and economically self-reliant. Hence, in fulfilling the directions given in the constitution of India, the government is committed to provide facilities and opportunities to its citizen for education, health and nutrition with a long term goal of ensuring freedom from disease, illiteracy and poverty.

The future of a country is vested in its children. Children of today are the citizens of tomorrow. Hence, it becomes predominantly significant to take adequate steps for the holistic development of the child right from the beginning when he is in the womb of his mother. Such development of child needs adequate facilities for health education and nutrition. Hence, an intervention namely "Integrated Child Development Services (ICDS) was launched in the country.

The Target Population of ICDS includes children below 6 years of age, pregnant and lactating mothers, and adolescent girls. The gender promotion of the girl child by trying to bring her at par with the male child is a key component of the scheme.

Therefore, the ICDS packets of services are Immunization, Supplementary nutrition, Health check-up, Referral services, Non-formal pre-school education and Nutrition and Health education.

The package of services is delivered to beneficiaries at an Anganwadi Centre by a woman volunteer from the local community known as "Anganwadi Worker" (AWW). The anganwadi worker is helped in her efforts by another woman volunteer – the 'Anganwadi Helper' (AWH).

Hence, the ICDS has an approach on holistic development including preparation of to be mothers in future, inside the womb and after birth which focuses on reduction of mortality and

morbidity among the children and pregnant women which also have greater impact on their health status. Apart from nutrition, ICDS continuously emphasize on Education of all the target groups starting with engagement of children in the anganwadi center and enrollment in educational institutions.

The main objectives of (ICDS) program are:

- To lay the foundation for the proper psychological, physical and social development of the child.
- To improve the nutritional and health status of children below the age of six years.
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout.
- To achieve effective coordination of policy and implementation among various departments to promote child development.
- To enhance the capacity of the mother to look after the normal health, nutritional and development needs of the child, through proper community education.

1.4 Integrated Child Development Services (ICDS), Mizoram

Integrated Child Development Services (ICDS) has been operational in Mizoram since 1978-79. The performances of ICDS, Mizoram is revolving around the Anganwadi Center (AWC) and services have been delivered from AWC only. There are 17 ICDS Projects with 2244 AWC per the statistics of June, 2012.

Mizoram has the proud privilege of having one of the best AWC in the country. Most of the centers are beautifully built through the contribution and coordination of the village or individual AWC level between the Project staff and the concerned committees.

There is a considerable progress in the field of women and child development through ICDS Program which has been implemented in the State (Mizoram) since 1978. Health and Nutrition has received adequate attention. More importantly, a general awareness of the need to give a good foundation to children up to the age of 6 years, and care for pregnant and lactating mothers has been generated. In the entire program the community participation in ICDS by donating land and buildings, transporting nutrition food, constructing and repairing of anganwadi buildings were recorded.

1.5 Statement of the Problem

Integrated Child Development Service is a major policy intention at community level to promote the well-being of children below 6 years and pregnant and lactating mothers. Mizoram is one of the states successfully implementing ICDS program in the country. In this context, the present study tries to describe the nature of community participation and its bearing on the performance of AWC in terms of delivery of the package of services to beneficiaries. It partially focuses on the awareness of the beneficiaries and the utilization pattern on the services.

The results of the present study will be significant for improving the functioning of AWC as instruments of delivery of integrated child development service package to the beneficiaries – nursing mothers, pregnant women and children below the age of 6 years living in urban area of Mizoram.

1.6 Objectives

The main objectives of the study are:

1. To understand the nature of community participation in ICDS at the level of anganwadi center.
2. To assess the mother's awareness on ICDS and community participation.
3. To assess the level of utilization of ICDS services by mothers and their children.

4. To assess the performance of AWCs from the perception of mothers.

5. To assess the association between the community participation and performance of AWCs.

1.7 Chapter Scheme

The study will be organized into the following chapters:

Chapter I - Introduction

Chapter II - Review of Literature

Chapter III - Methodology

Chapter IV - Results and Discussions

Chapter V - Conclusion and Suggestions

CHAPTER II

REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Review of literature helps in identifying substantive, theoretical, methodological, conceptual issues and addressing them appropriately in the context of the present study. Hence, in this chapter a critical review of available studies on community participation and performance of anganwadi centers (AWCs) is presented.

Community participation means some form of involvement of people, with similar needs and goals, in decisions affecting their lives. Community participation is not an automatic process. People's active participation and co-operation is the key to the success of social and development program which is aimed at bringing about a change in the life of the people. It is imperative to ensure maximum level of participation since from its inception to achieve the goal of ICDS. Also, the objectives and services of the program are interpreted to perceive the program as their felt needs.

A study conducted by Nicola Jones (2007) on 'Local institutions and social policy for children: opportunities and constraints of participatory service delivery' stated that Mothers' Committees were set up to improve user participation in public services, and there are limited provisions for children's voices to be heard. It is found that the social sector or child related issues were rarely discussed in gram sabha or gram panchayat meeting.

It is also important to assess the mother's awareness on ICDS and community participation and as a result, a study was conducted by Sengupta, Sinha, Sarkar (1998) on the perception and practice regarding pulse polio immunization in an urban community in Calcutta, among mothers having children less than 3 years of age. It was revealed that 91.8% of under 3-year children received PPI on 9-12-1995 and 94.4% on 20-1-1996. Major reasons for not accepting the

services on those two days included 'mother's unawareness' (22%), 'child too small' (30.5%), etc. the major source of first information was television (TV)/radio (57.2%) followed by information from anganwadi workers (AWWs) (33.8%). However, majority of the mothers were finally motivated for PPI by AWWs (58.8%) followed by the role of TV/radio (34.1 percent). The study results shows that 70.7% mothers knew the name of the vaccine correctly and only 3.5% mothers could tell the exact purpose of its administration. Most mothers (73%) opined that 2 drops of oral polio vaccine (OPV) was administered to their children and only 14.6% hoped that such programs will be conducted by the Government in future.

A study conducted by Swaminathan (2007) on knowledge, attitude and practices among mothers regarding immunization covered by Universal immunization program at Madurai, shows that the immunization coverage is good but mothers had poor knowledge and lack of awareness regarding immunization services.

A study conducted by Sangita Banerjee (1999) on the assessment of the awareness level on community participation was conducted among parents of anganwadi going children at North Calcutta, and it was found that out of 15 respondents 7 had mentioned that they came to know from adult family members that they could send their children to AWCs and another 5 respondent mothers of the beneficiary children were encouraged by family members to send their child to the centre, while the remaining 3 respondents were motivated by the Anganwadi Workers (AWW). From the study, it was seen that most mothers were unaware of the various services provided in the ICDS.

In order to see the level of utilization of ICDS services by mothers and their children, A study was conducted by Kanthi S (2005) in two randomly selected villages at Udaipur, Rajasthan to assess the knowledge, attitude of women beneficiaries regarding services provided under ICDS program. The study found that ICDS utilization surveys have shown a wide variation and

the mothers should be provided with necessary education for better utilization of services as education is a highly significant factor for knowledge.

A study was conducted on awareness and utilization of services under ICDS, Tirupati (2007). This aimed to know the awareness and utilization of ICDS service by families in selected slums. The results demonstrate that the ICDS program has indeed had an impact on changing the attitude of mothers but ICDS workers must closely look at what needs to be changed in the program, so as to bring about a positive attitude towards utilization of ICDS services among the mothers.

A study conducted by Anil (2009) aimed to assess the utilization of ICDS services in children of 1 – 6 years of age in the rural ICDS block. A door to door survey was conducted in six anganwadi areas. The study concluded that, three years after implementation of ICDS, the nutritional and immunization status did not improve. Possible reasons include insufficient knowledge and lack of attitude among the mothers.

Moreover, it is important to understand the perceptions of mothers on the performance of AWCs. The AWW is expected to elicit community participation in running the program, not only to minimize the operational cost, but also to make the people aware of the special needs of children and their mothers, and enhance their capabilities in taking care of them in the family environment. Many of the studies on community participation in ICDS emphasize on the relevance of the skills of the anganwadi worker in eliciting community participation, existence of co-ordination committees, frequency of meeting held and the involvement of local organization which is crucial for strengthening and promotion of ICDS.

Therefore, it is relevant to understand the association between community participation and performance of AWCs. A study was conducted by Nayar D, Kapil U, Nandan D (1999) on the Assessment of Community contribution to the ICDS scheme in Agra. The study was conducted

in three selected ICDS rural project within the district. The AWWs were interviewed through a semi-structured questionnaire to assess the community contribution during the previous 6 months. It has shown that about 68% of AWWs had been able to receive assistance in bringing the children to the AWCs, 53.3% had received free accommodation for AWCs, and 42.6% had obtained assistance in implementation of health activities. While, the AWWs reported that there was only 4% community participation in the preparation of nutrition and 12%of community assistance in the distribution of nutritional supplements. The study concluded that the community assistance in bringing children to the AWCs were the most common forms of community contribution to the ICDS program.

Similarly, a study was conducted to assess the community contribution on ICDS program in Agra district by M.M. Thakare, B.M Kurll and M.K Doibale (2011). The study comprises of 74 selected AWCs from three rural projects of ICDS. It was found that the most common form of contribution by the community was bringing children to the AWCs. Thus, gathering children to AWC was the only known community assistance received by ICDS program.

A study on 'Community Participation in Integrated Child Development Scheme (ICDS)' in Chennai conducted by T. Sampath (2008) had found that ICDS staff had inadequate knowledge about the basic concept of community participation, and the community also lacked knowledge on community participation.

Several studies have been conducted to evaluate the ICDS program. They focus on the interrelated aspects of functioning of AWCs (Roy C. Mathew, 2001), the pattern of nutrition supply (Deepali Sharma, 2008), role of AWWs (Darnal, 2005), utilization of services and impact of the ICDS program (Ajay Kumar Ranjan, 2014). However, the major gap in the literature on integrated child development service in India is that there are a few studies on the community

participation and the performance of anganwadi centers. Further, there are a fewer studies on the relation between the performance of AWCs and community participation.

CHAPTER III

METHODOLOGY

CHAPTER III

METHODOLOGY

The present study includes research design, sampling, tools of data collection, data processing and analysis of the present study.

The present study is descriptive in design and cross sectional in nature. It is a mixed approach collected through quantitative and qualitative methods. The study is based on primary data collected mainly through field survey with pre-tested structured interview schedule. The unit of the study is anganwadi center (AWC) and the individual beneficiaries of AWCs - the mothers of the beneficiaries and the community key leaders.

3.1 Sampling

The study used a multi stage sampling procedure to select anganwadi centers and respondents. The sample is drawn with the help of ICDS nodal office, Mizoram. 14 AWCs were purposively chosen. In each of the AWCs, 7 beneficiaries (1 AWW, 4 mothers of the beneficiaries and 2 community key leaders) were selected using simple random sampling. The population of the study included AWW, mothers of the beneficiaries and community key leaders.

The study was conducted in 14 AWCs namely Bungkawn, Dawrpui, Laipuitlang, Ramhlun North, Chanmari, Chaltlang, ITI, College Veng, Republic Venghlun, Chhinga Vengthar, Chanmari West, Saron Veng, Kulikawn and Republic Vengthlang.

3.2 Tools of Data Collection

The tools of data collection for the study included structured interview schedule. Exploration on qualitative dimension was held using Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). The interview schedule comprises of 3 sets of schedule – AWW, mothers of the beneficiaries and community key leaders.

The AWW schedule included the demographic profile, training of AWWs, enrolment in AWCs, infrastructure of AWCs, services of AWC - supplementary nutrition, nutrition and health, non-formal pre-school education and health services.

The schedule of the mothers of the beneficiaries included the demographic profile, the awareness on AWC, the awareness on the functioning of AWC, the services of AWC and the presence of the mother's committee.

The schedule of the community key leaders schedule included the demographic profile, the attitudes towards community participation, the ICDS coordination committee, the awareness on AWC and the indicators of community participation.

Apart from this a pilot study was conducted with one AWC with 10 respondents. Therefore, the tool was constructed in accordance with the prior pilot study. Further, it was pre-tested with one AWC and finally administered it. Then the final survey was conducted on the sample of the selected AWCs.

3.3 Data processing and Analysis

The quantitative data collected through field survey is processed with the help of MS excel and SPSS Packages. For analyzing data, simple statistical methods of averages, proportions and percentages were used.

CHAPTER IV

RESULTS AND DISCUSSIONS

CHAPTER IV

RESULTS AND DISCUSSION

In the present chapter an attempt has been made to present the results of the analysis of data collected through field survey in 14 AWCs. This chapter has been presented in four sections with its sub-sections. The first section consisted of the AWWs, the second section consisted of mothers of the beneficiaries, the third section consisted of the community key leaders and the fourth section consisted of Focus Group Discussion (FGD) and Key Informant Interviews (KIIs).

4.1 Schedule of Anganwadi Workers (AWWs)

The schedule of the AWWs was presented in demographic profile of the respondents, profile of AWCs, training of AWWs, enrolment in AWCs, infrastructure of AWCs, services of AWC - Supplementary Nutrition Program, Nutrition and Health, Non-formal Pre-School Education and Health Services.

4.1.1 Demographic profile

The demographic profile of the anganwadi workers (AWWs) is presented in terms of age, marital status, educational qualification, and family annual income, the type of family and size of family (see table 4.1)

All the respondents were female. There were a total number of 14 respondents who were current AWWs working under ICDS Urban (Aizawl), Aizawl district, Mizoram. More than half (57.1%) of the AWWs were in the age group between 40 years and 50 years which was followed by 21% between the age group of 30 years and 40 years. Another 14% of the AWWs were between 20 years and 40 years and the remaining 7% were between the age of 50 years and 60 years. Therefore, the table shows that there were a maximum number of AWWs falls in the age group of 40 years and 50 years and a minimum number of AWWs falls in the age group between

50 years and 60 years. Also, women below the age of 18 years were not appointed as AWW. The mean age of AWW was 40.78.

The study explores the marital status of the respondents AWWs. More than two-thirds (78.6%) of the AWWs were married while 7% were divorced and the remaining 14% of the respondents were unmarried.

It is important for the AWW to have a certain level of educational qualification as they were to teach not only the children but the mothers in the AWCs. The data shows that 50% of the AWWs have attained an education up to Higher Secondary School (class 11-12) which was followed by 42.9% of AWWs having formal education up to High School (class 8-10) standard. Also another 1 AWW have completed her graduation.

Half of the AWWs were belonging to a family having an annual income between Rs. 25,001 and Rs. 50,000 followed by equal number (21.4%) of AWWs having a family annual income between Rs. 50,001 and Rs. 750,00 and Rs.10,001 and 25,000 respectively. Hence, another 1 AWW respondent decided not to disclose the amount of annual family income.

The type of family of the AWW was shown and more than half of the respondents were a nuclear type of family. 21.4% have a joint family while only 1 respondent have an extended type of family.

The size of family of the AWW was shown and more than half (51.7%) of the AWWs were belonging to a family having members between 5-7 members which was then followed by another 35.7% of AWWs respondents belonging to a family size between 1-4 members. While another 1 respondent is having a family of more than 8 members.

4.1.2 Profile of Anganwadi Centers (AWCs)

The years of establishment of the selected AWCs of the study was shown. Out of a total number of 14 AWCs, more than half (57.1%) were established between the years 1990 and 1995.

Also an equal number of two AWCs (14.3%) were established between the years 2001-2005 and 2006-2010 respectively. Further, another 2 AWCs were established between the years 1996-2000 and 2011-2015 respectively. Thus, more than half of the AWC of the study has 20 years of existence.

The location of the AWC is very important as the location defines the number of enrolled beneficiaries. The numbers of AWCs located within a community was shown. The number of AWC within a locality varies mainly depending upon the total number of beneficiaries. It was observed that 5 of the respondents from 5 localities had reported the existence of 3 AWCs (35.7%) each in their own respective locality to cover the entire population within the community. While, another 3 respondents had reported that there was only one AWC each in their locality which consisted of 21.4% and another 3 respondents had 2 AWCs each while the remaining 3 locality had more than 3 AWCs within the area.

All the respondents of the study were residing in the locality same to that of location of AWC. All the respondents had not faced difficulty in commuting to the AWCs. In every AWC, there were 2 AWWs i.e. 1 AWW and 1 AWH.

The duration of working as AWW in the present AWC was shown. 71.4% of the respondents had been working for more than 3 years and another 14.3% had been working for more than 1 year but less than 2 years. While the remaining 1 AWW had worked for more than 2 years but less than 3 years. And the remaining 7.1 % of the respondents were working for less than 1 year.

4.1.3 Training of Anganwadi Workers (AWWs)

All the AWWs had undergone anganwadi workers training to develop the skills and abilities for effective and efficient functioning. There were 2 types of training which was provided to all the AWWs – anganwadi worker training and refresher course training. It was

mandatory for the AWW to attend training before starting of service. The AWWs were given refresher course training every once in 2 years of service in the Anganwadi Workers Training Centers (AWWTCs) which was located within the state. For attending the refresher course, the office had to issue a call letter to the AWW. Thus, the entire respondents had completed the anganwadi worker training before starting the service. Also, the data had shown that 64.3% of the respondents had undergone refresher course training while the remaining 35.7% have not yet undergone such training. Hence, the entire respondents confirmed the effectiveness and usefulness of the anganwadi worker training which was held before starting of the service.

4.1.4 Enrolment in Anganwadi Centers (AWCs)

The enrollment in AWCs mentioned that 100% of the AWWs had received help from the mothers of the beneficiaries besides the anganwadi helper (AWH). The mothers act as a helping agent to the AWWs as they could assist in the teaching and learning process and they were also very helpful in preparing the supplementary nutrition which was provided to the children in the AWC.

The enrollment rate of the beneficiaries such as children, mothers and pregnant women were varying. The number of enrolled pre-school children in 14 AWCs for the academic period of 2014 -2015 was shown. The data had shown that 42.9% AWCs had registered more than 40 pre-school children each and followed by 28.6% of AWCs having enrollment between 31-40 pre-school children. Equally another two AWCs had an enrollment of 11-20 pre-school children and 21 -30 respectively.

The number of enrollment of pregnant mothers in the 14 AWCs was shown and 35.7% of the AWCs had each registered more than 20 pregnant mothers and another 28.6% had registered between 6-10 numbers of pregnant mothers. While, 14.3% had registered 11-15 pregnant mothers and another 14.3% of the AWCs had registered 1-5 enrolled pregnant mothers. And the

remaining 1 AWC had 16-20 enrolled pregnant mothers. Therefore, it is seen that the services of AWCs were very much utilized by the pregnant mothers.

The numbers of nursing mothers who were enrolled in the AWCs was shown. The data had shown that 5 AWCs were registering more than 20 mothers in each of the center and equally 2 AWCs had enrolled 1-5 mothers and 6-10 mothers. Another 2 AWCs were registering 11-15 mothers. Among the 14 AWCs, only 1 AWC was having a registration of more than 16 and less than 20 numbers of nursing mothers. Besides being one of the objectives of ICDS, it is important for nursing mothers to attend AWCs as they not only taught the new mothers how to look after their babies but also shared their experiences and passed the message on the importance of vaccines.

4.1.5 Infrastructure of Anganwadi Centers (AWCs)

The construction of the AWC was shown. AWCs were mainly constructed in pucca, semi-pucca and kucha building depending upon the place. It was observed that half of the AWC was constructed in a pucca manner; which was constructed using bricks and cement. And another 35.7% of the AWC was semi-pucca, the roof was constructed using tin with brick walls and the remaining 14.3% was constructed in a kucha manner, where both the walls and the roof were constructed using both tin and tiles.

The infrastructure of the AWC was shown and this reveals the satisfaction level of the AWWs on the infrastructure provided to them. The study attempts to explore the level of satisfaction of AWW on the infrastructure provided to the AWC. The infrastructure included electricity, fan, water supply, etc. which was available in the AWC. 85.7% of the AWW respondents were satisfied with the present infrastructure while the remaining 14.3% AWCs were unsatisfied with the infrastructure mainly due to unavailability of water provision, inadequate space with no separate rooms for kitchen and classrooms, improper wash rooms and

others. However, it was observed that the availability of electricity supply was good in all the AWCs.

It is compulsory for the AWC to have certain logistics for delivering the services. This included the attendance registers, weighing scale, educational kits like books, color, charts, posters and other materials which were necessary for the AWW to effectively perform the task. The available logistics of the AWC was shown. Majority of the respondents were satisfied with the provided logistics while, 1 respondent was unsatisfied with the provision because of the unavailability of weighing scale.

Further, it is important to explore the availability of medicines and medical service in the AWC. All the respondents were satisfied with the availability of the supply of medicines in the AWCs and an arrangement was made with the medical personnel who came to organize the health check-ups on regular intervals.

Supervision by the Child Development Project Officer (CDPO) and circle officers in the functioning of ICDS – AWC was another important aspect on the satisfaction level of the AWW. All the respondents were satisfied with the supervision given to the AWC by the CDPO and the circle officers.

Some of the scholarly articles cited that the successful functioning of AWC depended upon community participation. The achievement of the AWC is an important indicator of the AWWs satisfaction level. The existence of AWC is for the well-being of the children, pregnant women and lactating mothers in the community. It was observed that participation of the community in terms of location of AWC is relevant to the understanding of community participation in AWC. Therefore, it was reported that all the respondents were satisfied with the participations received from the community.

4.1.6 Services of Anganwadi Centers (AWCs)

a) Supplementary Nutrition Program (SNP)

The Supplementary Nutrition Program (SNP) of ICDS was launched in the year 1975-76 in the entire country and the beneficiaries included children of 0 years – 6 years, pregnant and lactating mothers. It now became one of the 6 services provided by the AWCs and the details of utilization by the 14 AWCs were shown. The exploration on the regularity of the nutrition supply received by the AWC had shown that three-fourth of the respondents received the supplementary nutrition ration in time and another 21.4% of the respondents claim that there was a usual delay in the delivery of ration to their centers. The observations on the reasons for delay in the receiving of the supplementary nutrition by the AWCs includes transportation and road communication problems and also due other reasons.

The acceptability in terms of the quality of the food item supply under supplementary nutrition program was that the entire respondents agreed with the quality of the food items received and it was acceptable for distribution to the children.

The pattern of distribution of supplementary nutrition to the enrolled children in the AWC was shown. The modes of serving supplementary nutrition in the AWC may be cooked, raw and take home. 85.7% of the respondents served the supplementary nutrition in the center itself. The required preparation was also done in the AWC. In spite of the fact that similar kind of food had been distributed in all the AWCs, 7.1% of the respondents usually served it raw due to limitation of gas supply for cooking and or limitation of time for preparation of food during the anganwadi working hours. While another 7.1% served food that was to be taken home. This was done mainly due to the fact that many of the AWCs were closed early and no separate time could be spared for cooking and for serving the supplementary nutrition.

It is important to understand the utilization pattern of the supplementary food provided in the AWC. The enrolled children who had received the supplementary nutrition from their respective AWC were shown. Nearly half of the respondents (42.9%) mentioned that 50% of the enrolled children regularly receive the supplementary nutrition every day. And another 28.6% of the respondents had more than 50% of enrolled children who regularly received the nutrition. Further, another 28.6% of the respondents reported that the entire enrolled children came regularly to the AWCs to receive the supplementary nutrition. Therefore, the SNP was greatly impetus for the children of the AWCs.

b) Nutrition and Health

It is important to know the nutrition and health status of the children. In examining the ability of the respondents to monitor the growth of all the registered children in the center, more than two-third of the respondents had reported that they were unable to monitor the growth of all the children in the AWC which was mainly due to disproportionate of the numbers of workers to that of registered children in the center. The inadequacy of workers to perform each and every task was highlighted. 7.1% of the respondents revealed the unavailability of weighing scale in the AWC. On the other hand, another 21.4% of the respondents had regularly monitored the growth chart and had filled the growth chart within the center itself.

The organization of Nutrition and Health Education (NHEd) by the AWWs was shown. It is compulsory to organized NHEd in the center mainly for the mothers of the beneficiaries. 92.9% of AWW respondents regularly organized NHEd and the remaining 7.1% of the respondents do not organize NHEd at all. The reasons for not organizing NHEd were that majority of the beneficiaries do not understand the local language (medium of instructions) and the AWWs were also incapable of using English to deliver the NHEd. So, there was a communication barrier between the AWWs and the beneficiaries.

Further, the frequency of organization of NHEd among the respondents was explored. More than half of the respondents had regularly organized NHEd once a month followed by 14.3% who had organized once in two months and another 14.3% of the respondents had organized often without having proper intervals.

The study also probes the content or focus area of the NHEd. More than two-third of the respondents focused mainly in the area of breast feeding, immunization, supplementary nutrition, use of health services, health and hygiene, family planning and family planning (birth spacing). The other 14.3% of the respondents talked solely on breast feeding in the NHEd and 7.1% of the respondents talked on the utilization of health services. It was observed that the remaining 7.1 % of the respondents never organize NHEd basically due to communication barriers as mentioned earlier.

It is important to know the methods and technique adopted in NHEd. This is because the success of the program is largely depending upon the feasibility and friendliness of the methods to the beneficiaries. Therefore, the methods for adopting NHEd were shown and more than half of the respondents had organized focus group discussions (FGD) on selected topics. In addition, all the participants were taking part in one way or the other and every one of them were well participated. While, another 35.7% of the respondents reported that a subject matter experts delivered talked on the selected topics and discussions were held. Moreover, apart from the coming-up comments, queries and doubts are also clarified. Overall, the NHEd program organized in the AWCs were well respond by the target group of beneficiaries.

In addition, the problem faced by the AWWs in organizing the NHEd was explored and majority of the respondents do not face any kind of problems in terms of methods or topics. While, another 7.1% of the respondents did not mention any problems as the concern AWC have never organize NHEd programs.

c) Non-formal Pre-School Education (PSE)

The participation on the Pre-School Education (PSE) organized by AWC was shown. The PSE is a compulsory program to be held in AWC. The main aim and purpose of PSE is to prepare the children of anganwadi for formal schooling. In connection to the composition of the age group among the enrolled children of the AWC, more than two-third of the AWW respondents reported that the PSE were mainly attended by children between the age of 3 years to 6 years who were registered in the AWCs and another 28.6% of the respondents reported that the PSE organized in their AWC were mainly attended by children between the age group of 1 year and 2 years. It was also observed that the PSE were regularly attended by all the enrolled children regardless of their age group and the activities were varying depending upon the age of the participants. However, all the AWW respondents had taught Alphabets, Nursery Rhymes, Numbers and Colors in the PSE program.

The circle officer (CO) of ICDS was designated as a supervisor in the PSE program. The participation of the supervisor in organizing the PSE activities was shown. More than two-third of the respondents received tremendous participation and involvement of the supervisor from planning of the PSE and more than 70% of the respondents mentioned that they were helped by the supervisor in demonstration of new activities. Further, another 7.1% of the respondents reported that the circle officer helped in the planning of the program. While, another 14.3% of respondents did not received participation from the supervisor in the PSE program and the supervisor carefully examine the performance of the activities and was involved unless it was absolutely necessary.

d) Health Service

It is significant to understand the provisions of health care services provided at the AWC. The services included immunization to children and pregnant mothers, health check–up and health referral services to all the beneficiaries who were registered in the AWC.

The immunization program is a globally accepted mechanism against childhood infections and diseases. It was also a way of decreasing the alarming rate of IMR. The pattern of delivery of immunization to the children and pregnant women was shown. All the respondents could provide effective immunization to all the children and pregnant mothers in the AWCs. The level of public awareness on immunization and vaccination was reflected in the people's readiness and participation in the service. This was done under the supervision of health service providers and also after completion of training provided to the AWW. It was observed that the efficiency and participation of AWWs was notable in the immunization service.

Further, health check-up of children and the other beneficiaries was a compulsory component of ICDS and was highlighted in the main objectives. The target population was the registered beneficiaries who were enrolled in the AWC. The respondents had reported the presence of regular health check-up to the women beneficiaries and to the children and the health check-up were done in the nearest health sub-center within the locality. However, any new health complaints which may occur were also attended immediately. Majority of the respondents reported that health check-up was being done by the medical officer (MO) and another 7.1% of the respondents also reported that health check-up were done by the auxiliary nurse midwife (ANM) for the particular AWC.

It is an important aspect to understand the health referral services which was provided in the AWC. More than two-third of the respondents had refer the women and children as necessary to the medical doctors and out of which 42.9% of the respondents usually referred them to

government hospitals and another 28.6% had referred them to the health sub centers. While, another 28.6% of the respondents do not at all provide referral services because the children and the other beneficiaries directly went to the doctors themselves without the involvement of the AWWs.

In connection to this, the organization of health check-ups by the AWCs was explored. The entire respondents did not face any problems in organizing health check-ups. However, in regards to referral service, more than half of the AWW respondents did not face any problems and another 7.1% had attendance problem due to the lack of awareness on the importance of health check-up among the mothers of the beneficiaries. Thus, the remaining 28.6% of the respondents did not disclose the information.

4.2 Schedule of Mothers of the Beneficiaries

The schedule of the mothers of the beneficiaries was presented in demographic profile of the respondents, awareness on Anganwadi Center (AWC), awareness on the functioning of Anganwadi Center (AWC), awareness on Anganwadi Center (AWC) services and awareness on mother's committee.

4.2.1 Demographic profile

The demographic profile of the mothers of the beneficiaries was presented in terms of age, marital status, educational qualification, and family annual income, the type of family and size of family (see table 4.7)

The age of the respondents were classified into five categories such as 20 years to 25 years, 26 years to 30 years, 31 years to 35 years, 36 years to 40 years and 41 years to 45 years. There were a total number of 56 respondents. It was seen that 41.1% of the respondents were in the age group between 26 years and 30 years which was followed by 23.2% between 31 years and 35 years. Another 21.4% of the respondents were between 20 years and 25 years and another

12.5% between 36 years and 40 years and the remaining 1.8% were between the age of 41 years and 45 years. Therefore, the maximum numbers of respondents were between the age group of 26 years and 30 years and a minimum between the age group of 41 years and 45 years.

The marital status of the respondents were classified into Married, Unmarried, Divorce and Widow. Out of the 56 respondents, the study shows that 96.4% were married while 3.6% were unmarried. Therefore, the study had a maximum number of respondents who were married while there were no divorce and widow among the respondents.

The educational status of the respondents were classified into illiterate, middle school education (up to class 7), high school education (class 8-10), higher secondary school education (class 11 and 12), and graduate and post-graduation and above. The data highlighted that a maximum number of the respondents (35.7%) had received an education up to higher secondary school and 33.9% of the respondents had attained graduate degree and another 19.6% had completed high school and another 7.1% of the respondents had attained an education up to middle school level. The least among them were 3.6% of the mother respondents who had attained an education up to middle school level and another 3.6% of the respondents had an education of post-graduation and above. Overall, the educational background of the respondents shows that there was no illiterate among the respondents.

It is significant to know the occupation of the respondents. The occupation of the respondents was classified into government servant, self-employed, housewife/homemaker, petty shop owners and farmers/cultivators. It was shown that 83.9% of the respondents were engaging in household work which was followed by 7.1% of the respondents who were self-employed engaging in activities like small business owners and poultry farmers and another 5.4% of the respondents were engaging in government work such as teachers and clerical staff and the remaining 3.6% decided not to disclose their occupation. Therefore, the study shows that

maximum numbers of the respondents were engaging in household activities (home maker) while the minimum number of respondents were engaging in government work.

The annual income of the respondent's family was classified into 6 categories which were below Rs. 5,000, between Rs. 5,001 and Rs. 10,000, between Rs. 10,001 and Rs. 25,000, between Rs. 25,001 and Rs. 50,000, between Rs. 50,001 and Rs. 750,000, Rs.750, 001 and above. The data highlighted that 32.1% of the respondents were belonging to a family having an annual income between Rs. 25,001 and Rs.50, 000 followed by 26.8% having a family annual income between Rs. 10,001 and Rs. 25,000 and 21.4% between Rs. 50,001 and Rs. 750,000. While, 10.7% of the respondents had an annual income between Rs. 5,001 and Rs. 10,000 and another 5.4% had an income of Rs.750, 001 and above. The remaining 3.6% respondents decided not to disclose the amount of annual family income. It was observed that maximum number of respondents had an annual income between Rs. 25,001 and Rs. 50,000 and the minimum number of respondents had an annual income of Rs. 750,001 and above.

The types of family were classified into nuclear family, joint family and extended family. The study restricted that nuclear family consisted of a pair of adults and their children living in the same household. Joint family composed of parents, their children and the children's spouses and their grandchildren living in the same household. And, extended family consisted of parents, their children and all the children's spouses and their grandchildren living in the same household. Nearly half of the respondents belonged to a nuclear family and more than one-third of the respondents were belonging to a joint family. Thus, the remaining 16.1% of the respondents had an extended family. Therefore, the study shows that maximum number of the respondents were belonging to nuclear family while the minimum number of the respondents were belonging to extended family.

Meanwhile, the size of the family of the respondents was classified into 1-4 members, 5-7 members and 8-10 members. Half of the respondents were having a family size between 5-7 members which was followed by an equal number of 21.4% of the respondents having a family member between 8-10 members and between 1-4 members. Therefore, either large size (1-8 members) or small size (1-4 members) of family was a common practice among the respondents.

4.2.2 Awareness on Anganwadi Center (AWC)

The respondents were asked on the presence of a child below 6 years of age in the family and 100% of the respondents replied that they were living with children below the age of 6 years in their family. Further, the number of children had by the respondents showed that majority of the respondents had children between 1 and 3 and another 5.4% of the respondents had children between 3 and 5.

The respondent's awareness level on ICDS was explored. Majority of the respondents had heard of ICDS or AWC and the other 5.4% have not heard about ICDS or AWC.

The respondents were then asked if they were familiar with the purpose of ICDS or AWC and the data shows that majority of the respondents understood the purpose of ICDS and the remaining 8.9% of the respondents were unaware of the purpose of ICDS. Further, 14.3% of the respondents agreed that the main purpose of ICDS was to improve the nutritional and health status of children below the age of six years while, 8.9% agreed that the existence of ICDS was to achieve effective coordination of policy and implementation among various departments on child development. On the other hand, equally 5.4% of the respondents believed that the main aim of ICDS was to lay the foundation for the proper psychological, physical and social development of the child and to enhance the capacity of the mother to look after the health and nutritional needs of the child, and another 3.6% believed that ICDS was to reduce the incidence

of mortality, morbidity, malnutrition and school dropout. While, 53.6% of the respondents believed that the main purpose of ICDS is to ensure all the enlisted reasons that was mentioned.

The respondents were asked if they have sent their children to AWC before the study was conducted and it was observed that majority of the respondents had sent their children to AWC and another 3.6% did not send their children to AWC before as they have never heard about it and was only familiarized with it only recently.

4.2.3 Awareness on the functioning of Anganwadi Center (AWC)

The respondents were asked if they believed that ICDS was good for their community. Majority of the respondents believed that ICDS helped in developing their community by uplifting the educational status of the community and another 1.8% of the respondents did not disclose their opinion.

The respondents were asked on the awareness level on the presence AWCs in their community. 85.7% of the respondents were aware of the presence of AWCs in their community. However, 14.3% of the respondents were unaware of the existence of the AWC in their community before.

The respondents were asked on the awareness of the functioning of AWCs. Majority of the respondents were aware of the AWC's functioning while 7.1% did not have any awareness on the functioning of the AWCs.

4.2.4 Awareness on Anganwadi Center (AWC) services

The awareness on the services of ICDS was mentioned. Majority of the respondents were aware on the services of the ICDS while the remaining 10.7% were unaware on the services of ICDS. Half (53.6%) of the respondents were familiar with the main services of ICDS which included supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services. 19.6% of the respondents were

aware familiar with the non-formal pre-school education while 7.1% on the health check-up which was followed by 5.4% on supplementary nutrition and an equal number of respondents (1.8%) on immunization, nutrition and health education.

To understand the services of AWC, the respondents were asked on the regularity and punctuality of the AWC. Majority of the respondents had mentioned that the AWC was regularly open and another 1.8% of the respondents reported that the AWC in their community was not regularly open.

An exploration on the utilization of AWC by the pregnant women was made. The respondents were asked if they had visited AWCs during pregnancy and it was observed that 89.3% of the respondents had visited AWCs during pregnancy. But, 8.9% of the respondents did not visit the AWCs and the remaining 1.8% did not disclose the information.

The study had made an attempt on the source of referral. In connection to the advice received for health check up by the pregnant women shows that more than half of the respondents were suggested by the family members and equally 14.3% of the respondents were suggested by the government health staff and the private health practitioner. While, nearly half of the respondents get health check-up in private hospital followed by 30.4% of the respondents in health sub-center and the remaining 25% in government hospitals.

The entire respondents were very much keen on taking vaccination during pregnancy. More than half of the respondents got vaccinated from health sub-center followed by one third of the respondents who had received from private hospitals and the remaining less than 10 % of the respondents received from government hospitals.

On the other hand, the respondents were asked on their participation in the NHEd which was held at the AWC. More than two third of the respondents had attended the NHEd at the

AWC and another 25% of the respondents had never attended the NHEd. The remaining 1.8% of the respondents did not disclose the information.

The attempt made on the exploration of problems faced by the respondents in utilization of ICDS services shows that majority of the respondents do not have problem while the remaining 3.6% have a problem on distance of the AWC from their place. This has affected their utilization of the service. Apart from this, all the respondents and their children benefitted out of the child welfare services which were provided by the ICDS.

Child feeding is an important aspect and it is necessary for every mother to understand the proper directions in child feeding. It was seen that majority of the respondents had received advice on child feeding while the remaining 3.6% did not receive any advice on child feeding due to unavailability of time on the part of the AWW.

The PSE which was provided under the ICDS services was greatly benefitted by all the children of the respondents. And it was also observed that 100% of the respondent's children did receive the supplementary nutrition which was provided in the AWCs.

The quantity and quality of the supplementary nutrition was shown and it was observed that the respondent's opinion on the quantity of the supplementary nutrition was that majority of the respondents felt that the quantity on the supplementary nutrition was adequate while 1.8% felt that it was not adequate. While, on the quality of the supplementary nutrition provided, it was observed that majority of the respondents felt that the quality of the supplementary nutrition provided was acceptable while 1.8% of the respondents felt that the quality was unacceptable mainly due to the improper way of cooking.

The preference in serving the supplementary nutrition was shown and 39.3% of the respondents prefer the supplementary nutrition to be served in a way which can be had at home

which was followed by 26.8% who preferred it in a way in which it was ready to eat and another 17.9% preferred it in a raw manner while the remaining 16.1% preferred it cooked.

4.2.5 Awareness on Mother's Committee

The presence of mother's committee in the AWCs was explored. 57.1% of the respondents have mother's committee in their AWC and another 42.9% of the respondents do not have mother's committee in their AWC. Thus, the data shows that mother's committee does not exist in all the AWC. Further, duration on the existence of mothers committee shows that an equal number of respondents (21.4%) had an established the mother's committee in the AWC between the years 2000 and 2005 and between 2011 and 2015 respectively. The other 14.3% of the respondents reported that the establishment of the mother's committee was between the years 2006 and 2010 while, the remaining 42.9% of the respondents reported the absence of mother's committee in their AWC.

The number of members in the mother's committee was then asked and an equal number of respondents (21.4%) were having members between 11 and 15 members and between 16 and 20 members while the remaining had members between 6 and 10 members while the other 42.9% did not have a mother's committee.

The topic discussed during the mother's committee was asked and 48.2% of the respondents replied saying that the committee usually discussed on how to help the children to get a good education, how to take the children on educational field trips and how to have harmony between the mothers which was followed by 8.9% saying that the main topic discussed during the mother's committee was on how to help the children to get a good education. While, 42.9% of the respondents did not attempt the question since they did not have a mother's committee in their respective AWCs.

The respondents were then asked the kind of issues the mother's committee usually dealt with. 21.4% of the respondents usually dealt with issues like regularity in opening the AWC which was followed by 17.9% in solving the various problems faced by the mothers and their children and an equal number (8.9%) on ensuring the participation of the community and on the proper supply on the supplementary nutrition to the beneficiaries of the AWCs and the remaining 42.9% of the respondents did not have mother's committee in the AWCs respectively.

The helpfulness of the mother's committee was then asked and 55.4% of the respondents found the committee to be very helpful while the remaining 1.8% did not find it helpful mainly because the committee did not solve any problems faced.

4.3 Schedule of Community key leaders

The schedule of the community key leaders was presented into five sections such as the demographic profile of the respondents, attitudes towards community participation, perception on ICDS coordination committee, perception on Anganwadi Center (AWC) and the indicators of community participation.

4.3.1 Demographic profile

The demographic profile of the community key leaders was presented in terms of age, marital status, educational qualification, and family annual income, the type of family and size of family (see table 4.12)

The age groups of the respondents were classified into four categories such as 30 years and 40 years, 41 years to 50 years, 51 years to 60 years and 61 years to 70 years. There were a total number of 28 respondents who were current leaders in their respective community. Nearly half of the respondents were in the age group between 51 years and 60 years which was followed by 42.9% between the age group of 41 years and 50 years. Another 7.1% of the community key leaders were between 30 years and 40 years and a minimal of 3.6% comprises between the age of

61 years and 70years. Therefore, the study had a maximum number of respondents between the age group of 51 years and 60 years and a minimum of 3.6% of the respondents were in the age group of 61 years and 70 years.

The marital status of the respondents were classified into Married, Unmarried, Divorce and Widow. Out of the 28 respondents, the study shows that 89.3% of the respondents were married while 7.1% of the respondents were widow and the remaining 3.6% of the respondents were unmarried. Therefore, the study had a maximum number of respondents who were married while there was no divorce among the respondents.

The educational status of the respondents were classified into illiterate, middle school education (up to class 7), high school education (class 8-10), higher secondary school education (class 11 and 12), and graduate and post-graduation and above. The data shows that 39.3% of the respondents had attained an education up to higher secondary school and 28.6% of the respondents had completed high school education and another 28.6% of the respondents had graduated. The least among them were 3.6% of the respondents who had attained an education up to middle school level. Overall, the educational background of the respondents shows that there was no illiterate among the respondents and all the respondents had obtained an education minimum to middle school standard.

It is significant to know the occupation of the respondents. The nature of work, the type of work in which the respondents were engaging in and even the financial capabilities of the respondents were connected to an individual's level of participation in the community. So, the occupations of the respondents were classified into government servant, self-employed, housewife/homemaker, petty shop owner and farmer/cultivator. Half of the respondents were petty shop owners which was followed by more than one-fourth of the respondents who were government employees such as teachers and clerical staff and another 10.7% were self-employed

engaging in activities like business owners and poultry farmers and 3.6% of the respondents were women community leaders confining into household chores. Here, the participation of the women community leaders was noticeable in the ICDS scheme. Meanwhile, the remaining 7.1% of the respondents did not disclose their occupation. Therefore, the study shows that maximum number of the respondents were petty shop owners while the minimum number of respondents were engaging in household chores.

Another relevant aspect on the profile of the respondents was the annual income of the respondent's family. The annual income is an important part of the economic background of the respondents. The annual income of the respondent's family were classified into six categories such as - below Rs. 5,000, between Rs. 5,001 and Rs. 10,000, between Rs. 10,001 and Rs.25,000, between Rs. 25,001 and Rs. 50,000, between Rs. 50,001 and Rs. 750,000, Rs.750,001 and above. It was shown that nearly half of the respondents were belonging to an annual family income of Rs.25,001 and Rs.50, 000 and nearly one-third of the respondents were having an annual family income of Rs.50,001 and Rs.750,000. While, 14.3% of the respondents were having an income between Rs. 10,001 and Rs. 25,000 and the remaining 7.1% were having an annual family income of Rs. 750,001 and above. It was observed that more than two-third of the total respondents had an annual family income of not less than Rs, 25001 and not more than Rs.750000

The respondent's types of family were classified into nuclear family, joint family and extended family. The study restricted that nuclear family which consists of parents and their children living in the same household. Joint family composed of parents, their children and the children's spouses and their grandchildren living in the same household. And an extended family consisted of the parents, their children and the all children's spouses and their grandchildren living in the same household. Majority of the respondents were having a nuclear family while

7.1% of the respondents were belonging to joint family. The remaining 3.6% of the respondents were having an extended family. Therefore, the study shows that maximum number of family of the respondent's was nuclear family while the minimum number of the type of the respondent's family was extended family.

The respondent's size of family was classified into 1-4 members, 5-7 members and 8-10 members. More than half of the respondents were having a family size between 5-7 members while 17.9% of the respondents were having a member of 8-10 and the remaining 17.9% of the respondents were having 1-4 family members. The above classification on the numbers of the family members was based on small family, medium size family and large size of family. Hence, the medium size of family is commonly practice by the respondents in the community where study had been conducted.

4.3.2 Attitudes towards Community Participation

The attitudes of the respondents on community participation in AWC functioning was shown. It was observed that the entire respondents gave importance to the involvement of the local people/local leaders/local groups in the activities of the AWCs.

The exploration on the reasons for the involvement in the AWC functioning as a local people/local leaders/local groups mentioned by the respondents were that in ICDS the required resources such as sites of AWC, infrastructures, beneficiaries and others could not be met by the government alone. Secondly, ICDS as a community program, it is necessary to be involved because later this particular program would be taken up by the community alone independently and the success of the program was largely depending upon the rate of community participation. The data shows that 28.6% of the respondents were involving in the AWC activities because they strongly agreed that all the resources required in the functioning of ICDS cannot be met by the government alone and the program was designed to have community involvement. Another

28.6% of the respondents agreed that the beneficiaries of the program were the people of the community. So, success of the ICDS program highly depended on the rate of community participation. While, another 25% of the respondents had an opinion that it was the duty of the people to participate and be involved in a program which was functioning for the benefit of the community. Also, 14.3% of the respondents believed that community key leaders should have better understanding because the program would be taken over at some point and they needed to have certain preparations. Hence, the remaining 3.6% of the respondents did not mention any other reasons for the need of involvement of the local leaders/people/groups in the activities of the AWCs.

The need for the community participation in the ICDS programs was shown and two-thirds of the respondents agreed to participate in the ICDS program in order to have a sustainable ICDS program and obviously the functioning of AWC. While, 14.3% of the respondents agreed that the accountability in-term of success or failure of the program depended entirely on the hands of the community which provoked the community participation. Another 10.7% of the respondents believed that the community participation in the ICDS program was important in order to reduce the government's intervention. Further, some minimal part of the component could be sorted-out within the community. Also 7.1% of the respondents believed that the community participation was a way of ensuring the smooth functioning of the ICDS program within the locality. However, the remaining 3.6% of the respondents were of the opinion that the community participation would increase the utilization of the services to every possible way.

4.3.3 Perception on ICDS coordination committee

Coordination committee consisted of a group of people who were engaged in looking after the AWCs and provided all the necessary materials which the AWCs required. The

existence of ICDS coordination committee in the community was shown and the entire respondents had reported the existence of coordination committee in their own locality.

The years of establishment of ICDS coordination committee in the locality was shown. The year wise distributions show the differences in existence of ICDS coordination committee and it was also connected to the establishment of AWC in the particular locality. 57.1% of the ICDS coordination committee was set-up between the years 1990-1995 which was followed by the establishment of 14.3% of ICDS coordination committees during the years 2001-2005 and an equal number had established between the years 2001-2005 and between 2011-2015. Also, the data had shown that there were an equal number of establishments of 7.1% in the years 1996-2000 and 2006-2010 respectively.

The functions of the ICDS coordinating committee was shown and the main functions included providing site for AWC, supporting ICDS program through cash and kind and helping AWW in identification of beneficiaries and in the delivery of services . 7.1% of the respondents mentioned that the main function of the ICDS coordinating committee was the provision of site for the location of AWC. In addition, the respondents agreed that resource mobilization from government and within the community for the construction of AWC was another preview of the committee. While, 3.6% of the respondents had an opinion that the main function was to support the ICDS program in terms of cash and or kind. Also these respondents focused on monitoring and supervision of the financial matters. Equally another 3.6% of the respondents believed that the responsibility of the ICDS coordination committee was helping the AWW in the identification of beneficiaries such as children 0-6 years, pregnant women and nursing mothers. They also included the mode of delivery of ICDS services such as health package, supplementary nutrition and immunization. However, most of the respondents mentioned that the

main functions of the ICDS coordinating committee cover the above three roles and responsibilities including motivation of parents to send their children to AWC.

4.3.4 Perception on Anganwadi Center (AWC)

The awareness of the community leaders on the services that should be provided by the AWCs was shown and majority of the respondents believed that the community were aware of the services that should be provided by the AWCs while the remaining 3.6% believed that the community people were not at all aware of the services which were being provided by the AWCs.

The types of services which were being provided by the AWCs were shown and 21.4% of the respondents believed that the community people were familiar with only the non-formal pre-school education and nutrition which was then followed by 7.1% who believed that the people were only aware on the supplementary nutrition and another 7.1% on the health education while 60.7% of the respondents believed that the community people were aware of all the services which were being provided by the AWCs which included the supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services.

4.3.5 Indicators of community participation

The indicators of the community participation were shown and more than two-third of the respondents shows that the community participation could be seen through the visits of the AWCs and helping in solving the problems of the AWW followed by 14.3% in supporting the maintenance of AWCs and 10.7% of the respondents pointed out that the community brought and collected children from the AWCs while the remaining 3.6% respondents showed that the community people helped the AWW in cooking and serving food in the AWCs.

The frequency of the participation of the community people was shown and all the respondents pointed out that the community was regularly participating in the different activities of the AWCs.

The nature of support provided by the community to the AWCs were shown and nearly one-third of the respondents shows that the nature of support given to the AWC was by ensuring the proper supply of nutrition followed by 25% in monitoring the activities of the AWCs and the community was able to provide support and an equal number (17.9%) pointed out that by ensuring the participation of the target group and by ensuring the availability of AWW/AWH the community was able to provide support. While the remaining 3.6% showed that by ensuring the availability of health care services the community was able provide support to the AWC.

The need for inclusion of the community in decision making of the AWCs was shown and it was pointed out and all the respondents were in agreement that the community needed to be included in the decision making of the AWCs.

4.4 Qualitative Information

4.4.1 Focus Group Discussions (FGDs) with Mother's committee

Profile of the Participants:

Sl.no	Marital Status	Age	Educational Qualification	Occupation
1.	Married	25	HSSLC	Housewife
2.	Married	27	Graduate	Housewife
3.	Married	27	HSSLC	Housewife
4.	Married	24	HSSLC	Housewife
5.	Married	26	Graduate	Housewife
6.	Married	22	HSSLC	Housewife
7.	Married	25	HSLC	Housewife

Source: Compile

A Focus Group Discussions (FGDs) was conducted among the Mother's Committee in AWC. The FGD was held on the 23th November 2015 and the discussion was held for a period of 30 minutes. The criteria of participation were voluntary and the participants were the mothers of the anganwadi beneficiary who were currently attending the AWC. The main topic of discussion was on the performance of the AWC.

Firstly, the level of satisfaction in providing the various services was discussed among the mothers. The discussion showed that the mothers were fully satisfied with the current service which was provided. It was seen that the AWW was very helpful as she help the mothers to understand the importance of regular health check-up of not only their children but their selves as well. The mothers also exclaimed that the supplementary nutrition which was provided in the AWC was very helpful in motivating the children as this made them excited to return to the AWC each day.

The discussion on the matters of Pre-School Education (PSE) was held. All the participants were very satisfied with the current methods of teaching under PSE. It was claimed that the AWW was very good in handling the children as they could give attention during class due to the adoption of different methods during teaching and this made them more excited for the next class. It was also discussed that the children learned more from practical rather than theory. On that note, the children were made to learn by using their own hands as they were made to draw on the boards and also learned from the various educational toys.

Another discussion on the benefit out of the existing AWC in the locality was discussed by the participants. It was observed that the community had greatly benefitted from the AWC as they were now able to send their children at free of cost for pre-school education which they believed that they could have never afford. They also felt that the different services of the ICDS was very helpful for them as they were able to learn more from it each day and realized the

importance on regular health check-up and especially on immunization. It was also felt that the AWC was performing at its best given the condition of their locality and they were glad to be a part of the so called 'the AWC family'.

Thus, the discussion clearly highlighted that the beneficiary mothers were satisfied with the performance of the AWC in carrying out the different services and in the routine of the AWC as well. It was also seen that the mothers were impressed with the PSE as they could send their children to attend pre-school which they believed they could have never afford. They were grateful with all the services which were provided by the ICDS as these services were now available to them at their doorstep.

4.4.2 Key Informant Interviews (KIIs)

Two KIIs were conducted and the main results were presented below.

a) Interview 1 - Anganwadi Worker (AWW)

Name	:	Ms. R (*Fictitious)*
Venue	:	Anganwadi Center (AWC)
Duration	:	20 minutes
Dated	:	25th, September, 2015

The Key Informant Interview (KII) was held with Ms. R, an anganwadi worker (AWW) under ICDS Urban Project. The objective of the interview was to understand the challenges faced by the AWW in running the AWC. The AWW was asked about the roles and responsibilities in running the AWC and the issues and challenges faced by the respondent. A KII outlines was prepared to get the required information.

An exploration was made on the availabilities of study materials to be use by the AWW in the AWC. The informant had reported that all the necessary teaching materials for an effective learning including IEC materials such as educational posters for the children on parts of body,

animals, fruits, numerical numbers, boards to write on, charts, crayons and the alphabetical letters were adequately provided to the AWC. The informant's expressed the usefulness of such materials as the children learn more from seeing then from listening. In addition, the educational toys provided were also importantly use because the children were more efficient in leaning through playing. Also, the informant's had mentioned that by using such materials the creativity of both the AWW and the children was chalked-out and increasing the attendance rate too.

The informant then exclaimed that since there were no proper toilets in the AWC they face a lot of problems. It was also exclaimed that the supply of water was insufficient as they need water for cooking and for cleaning and it was impossible for them to do all that with just little amount of water.

Further, the interview had probed on the community participation received by the AWC. It was reported that the community had participated immensely in providing sites for AWC, in the construction of AWC buildings, in the contribution on play toys and in cooperating with the AWC even in times of resource mobilization.

Lastly, the informant was asked to have examination on her performance. It was reported that the AWW performance till date was very satisfactory within the materials provided. The main limitation was the absence of weighing scale for the children which was a compulsory provision to be made to AWC-ICDS.

b) Interview 2 - Community Key Leader

Name : Mr. O (*Fictitious)*
Venue : Residence of Mr. O
Duration : 20 minutes
Dated : 16th September 2015

The second key informant interview was held with Mr. O, the President of Young Mizo Association (YMA) who was also a member of the ICDS coordination committee.

The first enquiry was made on the utilization of ICDS-AWC in the locality. The informant reported the benefit from the presence of ICDS since the inception of AWC in the locality. It was mentioned that the health status of the children, pregnant women and lactating mothers was greatly improved. This had increased the concerns for the smooth functioning of AWC within the locality.

Secondly, the way of community participation in the functioning of AWC was explored. The informant had mentioned the contributions of the community in terms of providing sites for AWC and mobilization of majority of the materials required for construction of the AWC buildings. These resources were met within the community itself. Further, apart from these, the community extended physical help during the construction of the AWC buildings and continues till date as the matter arises.

Hence, another interesting part of community participation was that the payment for pipe water bill and electricity bill of AWC was regularly made by the community from the community fund and or through contributions.

Another important aspect of community participation was the arrangement for delivery of supplementary nutrition to the AWC. The community key leaders did not directly brought the goods to the AWC but ensures in the necessary transportations and labors arrangements and the due payments were made by the anganwadi coordination committee.

Lastly, the informant had mentioned the effectiveness of NHEd program and PSE program which were regularly carried out in the AWC. These programs had tremendous implications on the well-being of the mothers and children of the community. As a means of community participation, the community key leaders could often participate in those programs

depending upon their convenient. It was concluded by informing the interviewer that ICDS-AWC was one of the major tools for health promotion and development in the community.

In this chapter an attempt has been made to present a discussion of the results of analysis of primary data collected with structured interview schedule. The conclusions drawn from these discussions will be presented in the next chapter.

Table 4.1: Demographic profile of Anganwadi Workers (AWWs)

Sl.no	Variable	Age	No. of respondents
1.	**Age**	20-30	2 (14.3)
		30-40	3 (21.4)
		40-50	8 (57.1)
		50-60	1 (7.1)
		Total	**14 (100)**
	The mean age for AWW is 40.78		
2.	**Marital Status**	**Marital Status**	**No. of respondents**
		Married	11 (78.6)
		Unmarried	2 (14.3)
		Divorced	1 (7.1)
		Total	**14 (100)**
3.	**Educational Qualification**	**Education**	**No. of respondents**
		High School	6 (42.9)
		Higher Secondary School	7 (50.0)
		Graduate	1 (7.1)
		Total	**14 (100.0)**
4.	**Family Annual Income**	**Income**	**No. of respondents**
		Nil	1 (7.1)
		Rs.10,001>25,000	3 (21.4)
		Rs.25,001>50,000	7 (50.0)
		Rs.50,001>750,000	3 (21.4)
		Total	**14 (100)**
5.	**Type of Family**	**Family**	**No. of respondents**
		Nuclear family	10 (71.4)
		Joint family	3 (21.4)
		Extended family	1 (7.1)

		Total	**14 (100)**
6.	**Size of Family**	**Family**	**No. of respondents**
		1-4	5 (35.7)
		5-7	8 (57.1)
		8-10	1 (7.1)
		Total	**14 (100)**

Source: Computed

Table 4.2: Profile of Anganwadi Centers (AWCs)

Sl.no.	Variable	Years	No. of respondents
1.	**Year of AWC establishment**	1990-1995	8 (57.1)
		1996-2000	1 (7.1)
		2001-2005	2 (14.3)
		2006-2010	2 (14.3)
		2011-2015	1 (7.1)
		Total	**14 (100)**
2.	**Number of AWCs in a community**	**No. of AWC**	**No. of respondents**
		1	3 (21.4)
		2	3 (21.4)
		3	5 (35.7)
		Above 3	3 (21.4)
		Total	**14 (100)**
3.	**Residence where the AWC is located**	**Characteristic**	**No. of respondents**
		Yes	14 (100)
		No	0 (0)
		Total	**14 (100)**
4.	**Difficulty in commuting to the anganwadi**	**Characteristic**	**No. of respondents**
		Yes	0 (0)
		No	14 (100)
		Total	**14 (100)**
5.	**Number of workers in AWC**	**Characteristic**	**No. of respondents**
		2	14 (100)
		Total	**14 (100)**
6.	**Duration of working as an AWW (year)**	**Characteristic**	**No. of respondents**
		Less than 1 year	1 (7.1)
		1-2 year	2 (14.3)
		2-3 years	1 (7.1)
		3 years and above	10 (71.4)
		Total	**14 (100)**

Source: Computed

Table 4.3: Training of Anganwadi Workers (AWWs)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**AWWs training**	Yes	14
		No	0 (0)
		Total	**14** **(100)**
2.	**Attended Refresher course training**	**Characteristic**	**No. of respondents**
		Yes	9 (64.3)
		No	5 (35.7)
		Total	**14** **(100)**
3.	**Effectiveness of the Training AWW**	**Characteristic**	**No. of respondents**
		Yes	14 (100)
		No	0 (0)
		Total	**14** **(100)**
4.	**Practicality of Training**	**Characteristic**	**No. of respondents**
		Yes	14 (100)
		No	0 (0)
		Total	**14** **(100)**

Source: Computed

Table 4.4: Enrolment in Anganwadi Centers (AWCs)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Assistance provided in the AWC**	Mothers of beneficiaries	14 (100)
		Total	**14 (100)**
2.	**Enrollment of Pre-school children in AWCs (2014 -2015)**	**Characteristic**	**No. of respondents**
		11-20	2 (14.3)
		21-30	2 (14.3)
		31-40	4 (28.6)
		More than 40	6 (42.9)
		Total	**14 (100)**
3.	**Enrollment of pregnant mothers in AWCs (2014 -2015)**	**Characteristic**	**No. of respondents**
		1-5	2 (14.3)
		6-10	4 (28.6)
		11-15	2 (14.3)
		16-20	1 (7.1)
		More than 20	5 (35.7)
		Total	**14 (100)**
4.	**Enrollment of nursing mothers in AWC(2014 -2015)**	**Characteristic**	**No. of respondents**
		1-5	3 (21.4)
		6-10	3 (21.4)
		11-15	2 (14.3)
		16-20	1 (7.1)
		More than 20	5 (35.7)
		Total	**14 (100)**

Source: Computed

Table 4.5: Infrastructure of Anganwadi Centers (AWCs)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Construction of AWC building**	Pucca	7 (50)
		Semi-Pucca	5 (35.7)
		Kucha	2 (14.3)
		Total	14 (100)
2.	**Infrastructure (electricity, fan, water supply, etc)**	**Characteristic**	**No. of respondents**
		Satisfactory	12 (85.7)
		Unsatisfactory	2 (14.3)
		Total	**14 (100)**
3.	**Logistic (register, weight scale, etc)**	**Characteristic**	**No. of respondents**
		Satisfactory	13 (92.9)
		Unsatisfactory	1 (7.1)
		Total	**14 (100)**
4.	**Availability of medicine**	**Characteristic**	**No. of respondents**
		Satisfactory	14 (100)
		Unsatisfactory	0 (0)
		Total	**14 (100)**
5.	**Supervision (CDPO and other officers)**	**Characteristic**	**No. of respondents**
		Satisfactory	14 (100)
		Unsatisfactory	0 (0)
		Total	**14 (100)**
6.	**Community Participation**	**Characteristic**	**No. of respondents**
		Satisfactory	14 (100)
		Unsatisfactory	0 (0)
		Total	**14 (100)**

Source: Computed

Table 4.6.1: Supplementary Nutrition Program (SNP)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Supply of Supplementary Nutrition ration in time**	Yes	11 (78.6)
		No	3 (21.4)
		Total	**14 (100)**
2.	**Acceptability of the quality**	**Characteristic**	**No. of respondents**
		Yes	11 (78.6)
		No	3 (21.4)
		Total	**14 (100)**
3.	**Pattern of served**	**Characteristic**	**No. of respondents**
		Cooked	12 (85.7)
		Raw	1 (7.1)
		Take home	1 (7.1)
		Total	**14 (100)**
4.	**Receive supplementary nutrition**	**Characteristic**	**No. of respondents**
		Up to 50%	6 (42.9)
		More than 50%	4 (28.6)
		All the enrolled children	4 (28.6)
		Total	**14 (100)**

Source: Computed

Table 4.6.2: Nutrition and Health

Sl.no.	Task	Characteristic	No. of respondents
1.	**Monitoring the growth of children**	Yes	3 (21.4)
		No	11 (78.6)
		Total	**14 (100.0)**
2.	**Organizing Nutrition and Health Education (NHEd)**	**Characteristic**	**No. of respondents**
		Yes	13 (92.9)
		No	1 (7.1)
		Total	**14 (100)**
3.	**Content of NHEd**	**Characteristic**	**No. of respondents**
		Breast feeding	2 (14.3)
		Use of Health Services	1 (7.1)
		Nil	1 (7.1)
		All the above	10 (71.4)
		Total	**14 (100)**
4.	**Methods adopted for NHEd**	**Characteristic**	**No. of respondents**
		Discussions	8 (57.1)
		Talks by experts	5 (35.7)
		Nil	1 (7.1)
		Total	**14 (100)**

Source: Computed

Table 4.6.3: Non-formal Pre-School Education

Sl.no.	Task	Characteristic	No. of respondents
1.	**Participants of Pre-School Education (PSE) program**	1-2 years	4 (28.6)
		3-6 years	10 (71.4)
		Total	**14 (100)**
2.	**Activities of PSE**	**Characteristic**	**No. of respondents**
		Alphabets, Nursery Rhymes, Numbers and Colors	14 (100)
3.	**Supervision in PSE**	**Characteristic**	**No. of respondents**
		Yes	12 (85.7)
		No	2 (14.3)
		Total	**14 (100)**

Source: Computed

Table 4.6.4: Health Services

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Provision of effective immunization facilities**	Yes	14 (100)
		No	0 (0)
		Total	**14 (100)**
2.	**Health check-up of children and women**	**Characteristic**	**No. of respondents**
		Sub-centers	14 (100)
		Total	14 (100)
3.	**Health check-up performed**	**Characteristic**	**No. of respondents**
		Medical Officer	13 (92.9)
		Auxiliary Nurse Midwife(ANM)	1 (7.1)
		Total	**14 (100)**
4.	**Problems faced during health check-up**	**Characteristic**	**No. of respondents**
		Yes	0 (0)
		No	14 (100)
		Total	**14 (100)**
5.	**Referral services of children and women**	**Characteristic**	**No. of respondents**
		Yes	10 (71.4)
		No	4 (28.6)
		Total	**14 (100)**
6.	**Reasons**	**Characteristic**	**No. of respondents**
		Govt. Hospitals	6 (42.9)
		Sub Center	4 (28.6)
		Nil	4 (28.6)
		Total	**14 (100)**
7.	**Problems faced during referral services**	**Characteristic**	**No. of respondents**
		Yes	1 (7.1)
		No	9 (64.3)
		Nil	4 (28.6)
		Total	**14 (100)**

Source: Computed

Table 4.7: Demographic profile of Mothers of the Beneficiaries

Sl.no.	Variable	Age	No. of respondents
1.	**Age**	20-25	12 (21.4)
		26-30	23 (41.1)
		31-35	13 (23.2)
		36-40	7 (12.5)
		41-45	1 (1.8)
		Total	**56 (100)**
2.	**Marital Status**	**Marital Status**	**No. of respondents**
		Married	54 (96.4)
		Unmarried	2 (3.6)
		Total	**56 (100)**
3.	**Educational Qualification**	**Education**	**No. of respondents**
		Middle School	4 (7.1)
		High School	11 (19.6)
		Higher Secondary School	20 (35.7)
		Graduate	19 (33.9)
		Post-graduation and above	2 (3.6)
		Total	**56 (100)**
4.	**Occupation**	**Occupation**	**No. of respondents**
		Housewife/Homemaker	47 (83.9)
		Self-employed	4 (7.1)
		Govt.-servant	3 (5.4)
		Nil	2 (3.6)
		Total	**56 (100)**
5.	**Family Annual Income**	**Income**	**No. of respondents**
		Nil	2 (3.6)
		Rs.5,001>10,000	6

			(10.7)
		Rs.10,001>25,000	15 (26.8)
		Rs.25,001>50,000	18 (32.1)
		Rs.50,001>750,000	12 (21.4)
		Rs.750,001 and above	3 (5.4)
		Total	**56** **(100)**
6.	**Type of Family**	**Family**	**No. of respondents**
		Nuclear family	26 (46.4)
		Joint family	21 (37.5)
		Extended family	9 (16.1)
		Total	**56** **(100)**
7.	**Size of Family**	**Family**	**No. of respondents**
		1-4	12 (21.4)
		5-7	32 (57.1)
		8-10	12 (21.4)
		Total	**56** **(100)**

Source: Computed

Table 4.8: Awareness on Anganwadi Center (AWC)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Children below the age of 6 years**	Yes	56 (100)
		No	0 (0)
		Total	**56 (100)**
2.	**Number of children**	**Characteristic**	**No. of respondents**
		1-3	53 (94.6)
		3-5	3 (5.4)
		Total	**56 (100)**
3.	**Aware of ICDS or AWC**	**Characteristic**	**No. of respondents**
		Yes	53 (94.6)
		No	3 (5.4)
		Total	**56 (100)**
4.	**Aware of Purpose of ICDS or AWC**	**Characteristic**	**No. of respondents**
		Yes	51 (91.1)
		No	5 (8.9)
		Total	**56 (100)**
5.	**List of ICDS purpose**	**Characteristic**	**No. of respondents**
		To improve the nutritional and health status of children below the age of six years	8 (14.3)
		To achieve effective coordination of policy and implementation among various departments to promote child development	5 (8.9)
		Nil	5 (8.9)
		To lay the foundation for the proper psychological, physical and social development of the child	3 (5.4)
		To enhance the capacity of the mother to look after the normal health, nutritional and development needs of the child, through proper community	3 (5.4)

		education	
		To reduce the incidence of mortality, morbidity, malnutrition and school dropout	2 (3.6)
		All the above	30 (53.6)
		Total	**56 (100)**
6.	**Sending children to AWC**	**Characteristic**	**No. of respondents**
		Yes	54 (96.4)
		No	2 (3.6)
		Total	**56 (100)**
7.	**Reasons for not sending**	**Characteristic**	**No. of respondents**
		Lack of awareness	54 (96.4)
		Others (specify)	2 (3.6)
		Total	**56 (100)**

Source: Computed

Table 4.9: Awareness on the functioning of Anganwadi Center (AWC)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**ICDS is good for the community**	Yes	55 (98.2)
		Nil	1 (1.8)
		Total	**56 (100)**
2.	**Awareness on the presence of AWC**	**Characteristic**	**No. of respondents**
		Yes	48 (85.7)
		No	8 (14.3)
		Total	**56 (100)**
3.	**Awareness on the functioning of AWC**	**Characteristic**	**No. of respondents**
		Yes	52 (92.9)
		No	4 (7.1)
		Total	**56 (100)**

Source: Computed

Table 4.10: Awareness on Anganwadi Center (AWC) services

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Services of ICDS**	Yes	50 (89.3)
		No	6 (10.7)
		Total	**56 (100)**
2.	**List of services**	**Characteristic**	**No. of respondents**
		Non-formal pre-school education	11 (19.6)
		Nil	6 (10.7)
		Health check-up	4 (7.1)
		Supplementary Nutrition	3 (5.4)
		Nutrition and health education	1 (1.8)
		Immunization	1 (1.8)
		All the above	30 (53.6)
		Total	**56 (100)**
3.	**Regularityof AWC**	**Characteristic**	**No. of respondents**
		Yes	54 (96.4)
		No	1 (1.8)
		Nil	1 (1.8)
		Total	**56 (100)**
4.	**Visit of AWCs by pregnant women**	**Characteristic**	**No. of respondents**
		Yes	50 (89.3)
		No	5 (8.9)
		Nil	1 (1.8)
		Total	**56 (100)**
5.	**Source of advised for health check-up**	**Characteristic**	**No. of respondents**
		Family members	39 (69.6)
		Govt. Health Staff	8

			(14.3)
		Private Practioner	8 (14.3)
		Nil	1 (1.8)
		Total	**56** **(100)**
6.	**Place of health check-ups**	**Characteristic**	**No. of respondents**
		Private Hospitals	24 (42.9)
		Sub-center	17 (30.4)
		Govt. Hospitals	14 (25)
		Nil	1 (1.8)
		Total	**56** **(100)**
7.	**Place of vaccinations during pregnancy**	**Characteristic**	**No. of respondents**
		Sub-center	34 (60.7)
		Private Hospitals	19 (33.9)
		Govt. Hospitals	3 (5.4)
		Total	**56** **(100)**

Source: Computed

Table 4.11: Awareness on Mother's Committee

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Attended Nutrition and Health Education (NHEd) in AWC**	Yes	41 (73.2)
		No	14 (25)
		Nil	1 (1.8)
		Total	**56 (100)**
2.	**Problems in utilization of ICDS services**	**Characteristic**	**No. of respondents**
		Yes	2 (3.6)
		No	54 (96.4)
		Total	**56 (100)**
3.	**Reasons**	**Characteristic**	**No. of respondents**
		Nil	55 (98.2)
		Distance of anganwadi center	1 (1.8)
		Total	**56 (100)**

Source: Computed

Table 4.12: Demographic profile of Community Key Leaders

Sl.no.	Variable	Age	No. of respondents
1.	**Age**	30-40	2 (7.1)
		41-50	12 (42.9)
		51-60	13 (46.4)
		61-70	1 (3.6)
		Total	**28 (100)**
2.	**Marital Status**	**Marital Status**	**No. of respondents**
		Married	25 (89.3)
		Widow	2 (7.1)
		Unmarried	1 (3.6)
		Total	**28 (100)**
3.	**Educational Qualification**	**Education**	**No. of respondents**
		Middle School	1 (3.6)
		High School	8 (28.6)
		Higher Secondary School	11 (39.3)
		Graduate	8 (28.6)
		Total	**28 (100)**
4.	**Occupation**	**Occupation**	**No. of respondents**
		Petty shop owner	14 (50)
		Govt.-servant	8 (28.6)
		Self-employed	3 (10.7)
		Nil	2 (7.1)
		Housewife/Homemaker	1 (3.6)
		Total	**28 (100)**
5.	**Family Annual Income**	**Income**	**No. of respondents**
		Rs.10,001>25,000	4 (14.3)
		Rs.25,001>50,000	13 (46.4)

		Rs.50,001>750,000	9 (32.1)
		Rs.750,001 and above	2 (7.10)
		Total	**28** **(100)**
6.	**Type of Family**	**Family**	**No. of respondents**
		Nuclear family	25 (89.3)
		Joint family	2 (7.1)
		Extended family	1 (3.6)
		Total	**28** **(100)**
7.	**Size of Family**	**Family**	**No. of respondents**
		1-4	5 (17.9)
		5-7	18 (64.3)
		8-10	5 (17.9)
		Total	**28** **(100)**

Source: Computed

Table 4.13: Attitudes towards community participation

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Need for community leaders to participate in AWC functioning**	Yes	28 (100)
		No	0 (0)
		Total	**28 (100)**
2.	**Reasons**	**Reasons**	**No. of respondents**
		Resources cannot be met by Govt. alone	8 (28.6)
		Success of the program depends on the community participation	8 (28.6)
		It is a community program	7 (25)
		The community has to take over the program later	4 (14.3)
		Any other	1 (3.6)
		Total	**28 (100)**
3.	**Need for the community to participate in ICDS program**	**Characteristic**	**No. of respondents**
		Sustainability of ICDS program	18 (64.3)
		Accountability for success or failure of the program	4 (14.3)
		Reduce Govt. intervention	3 (10.7)
		Smooth functioning of ICDS program	2 (7.1)
		Increase utilization of ICDS services	1 (3.6)
		Total	**28 (100)**

Source: Computed

Table 4.14: Perception on ICDS coordination committee

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Presence of AWC coordination committee**	Yes	28 (100)
		No	0 (0)
		Total	**28 (100)**
2.	**Year of Establishment**	**Characteristic**	**No. of respondents**
		1990-1995	16 (57.1)
		1996-2000	2 (7.1)
		2001-2005	4 (14.3)
		2006-2010	2 (7.1)
		2011-2015	4 (14.3)
		Total	**28 (100)**
3.	**Functions of AWC coordination committee**	**Characteristic**	**No. of respondents**
		Providing site for AWC	2 (7.1)
		Supporting ICDS program through cash and kind	1 (3.6)
		Helping AWW in identification of beneficiaries and delivery of services	1 (3.6)
		All the above	24 (85.7)
		Total	**28 (100)**

Source: Computed

Table 4.15: Perception on Anganwadi Center (AWC)

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Awareness on anganwadi**	Yes	27 (96.4)
		No	1 (3.6)
		Total	**28 (100)**
2.	**Service of AWC**	**Characteristic**	**No. of respondents**
		Non-formal pre-school education and Nutrition	6 (21.4)
		Supplementary nutrition	2 (7.1)
		Health education	2 (7.1)
		Nil	1 (3.6)
		All the above	17 (60.7)
		Total	**28 (100)**

Source: Computed

Table 4.16: Indicators of community participation

Sl.no.	Variable	Characteristic	No. of respondents
1.	**Indicators of community participation**	Visits AWC and help in solving the problems of AWW	20 (71.4)
		Supports in maintaining AWC	4 (14.3)
		Community brings and collects children from AWC	3 (10.7)
		Helps in cooking and serving food at AWC	1 (3.6)
		Total	**28 (100)**
2.	**Frequency of participation of the community**	**Characteristic**	**No. of respondents**
		Regular	28 (100)
		Irregular	0 (0)
		Total	**28 (100)**
3.	**Support provided to AWC by the community**	**Characteristic**	**No. of respondents**
		Ensuring of nutrition supply	9 (32.1)
		Monitoring of activities	7 (25)
		Ensuring participation of target group	5 (17.9)
		Ensuring availability of AWW/AWH	5 (17.9)
		Ensuring availability of health care services	1 (3.6)
		Nil	1 (3.6)
		Total	**28 (100)**
4.	**Participation of the community in AWC decision making**	**Characteristic**	**No. of respondents**
		Yes	28 (100)
		No	0 (0)
		Total	**28 (100)**

Source: Computed

CHAPTER V

CONCLUSION AND SUGGESSTIONS

Chapter V

Conclusions and Suggestions

In this chapter an attempt has been made to present the conclusions and suggestions for social work intervention.

5.1.1 Anganwadi Worker (AWW)

In this study, we can see that all the respondents were female AWWs and the maximum number of AWWs falls in the age group of 40 years and 50 years and a minimum between the age group of 50 years and 60 years. While, two-third of the AWW were married and half had received education up to higher secondary school. It was observed that more than half of the AWCs were established during the years 1990 and 1995 and 35.7% of the respondents had 3 AWCs in their localities. It was also observed that the respondents of the study were residing in the locality same to that of the location of the AWC. This increases the performance of AWC by reducing the turn-over rate of AWW as they have better knowledge on the community and it was more likely to be influential than a person who came from outside.

All the respondents had undergone training before starting the service as an AWW and only 64.3% of the respondents had undergone refresher course training. It was observed that 100% of the AWWs had received help from the mothers of the beneficiaries besides the anganwadi helper (AWH) as the mothers act as a helping agent to the AWWs as they assisted in the teaching and learning process and they were also very helpful in preparing the supplementary nutrition which was served ready to eat to the children.

The study revealed that nearly half of the AWCs had registered more than 40 pre-school children each for the academic period of 2014 -2015 and 35.7% of the AWCs also registered more than 20 pregnant mothers and another 5 AWCs had registered more than 20 nursing

mothers. It was important for the nursing mothers to attend AWCs as they were not only taught how to look after their babies but also on the importance of taking vaccines.

The findings revealed that half of the AWCs were constructed in a pucca building and the remaining half of the AWC building was semi-pucca and kucha. In connection to the level of satisfaction of AWW on the infrastructure provided to the AWC, more than two-third of the AWW respondents were satisfied with the present infrastructure and the remaining 14.3% AWCs were not satisfied with the infrastructure mainly due to the unavailability of water provision and inadequate space. However, it was observed that there was good electricity supply in all the AWCs.

The Supplementary Nutrition Program (SNP) which was one of the 6 services provided by the AWCs was regularly received by three-fourth of the AWCs and another 21.4% AWCs claimed that there was a usual delay in the delivery of ration to the centers. The study then enquired on the acceptability of the received supplementary nutrition in terms of the quality of the food items. The entire respondents agreed that the food items were acceptable for distributions. It was also observed that majority of the respondents served the supplementary nutrition in the center itself and nearly half of the respondents mentioned that 50% of the enrolled children regularly came to the center to receive the supplementary nutrition.

The study also revealed the ability of the respondents to monitor the growth of all the registered children in the center and more than two-third of the respondents were unable to monitor the growth of all the children. It was also compulsory for the AWW to organize Nutrition and Health Education (NHEd) in the AWCs and the study showed that majority of the respondents regularly organized NHEd and these education mainly focuses on the areas of breast feeding, immunization, supplementary nutrition, the use of health services, health and hygiene, family planning and birth spacing.

The Pre-School Education (PSE) organized by AWC was a compulsory program which aims to prepare the children of anganwadi for formal schooling. It was observed that the PSE were regularly attended by all the enrolled children in the AWC and the content of the activities varies upon the age group of the participants.

The study revealed that it was significant to understand the provisions of health care services provided at the AWC and such services included immunization to children and pregnant mothers, health check–up and health referral service to all of the beneficiaries registered in the AWC. It was observed that the respondents had provided regular health check-up and referral services to the women beneficiaries and to the children of anganwadi center and it was done in the health sub-center within the locality.

5.1.2 Mothers of the Beneficiaries

In this study, it was observed that all the respondents were female and the maximum number of the respondents were in the age group between 26 years and 30 years and a minimum number was in the age group between 41 years and 45 years. The study highlighted that a maximum number of the respondents had received education up to higher secondary school and it was also observed that there were no illiterate among the respondents. Maximum number of the respondents were belonging to nuclear family while the minimum number of the respondents were belonging to an extended type of family with 1-8 members and a small size (1-4 members) family was a common practice among the respondents.

The study shows that 100% of the respondents were living with children below the age of 6 years and it was also observed that 5.4% of the respondents had no awareness on ICDS or AWC but majority of the respondents were aware of the main purpose of ICDS. And all the respondents were in agreement that the ICDS was indeed good for their community. The study

also revealed that majority of the respondents had awareness on the services of ICDS while the remaining 10.7% were unaware.

Majority of the respondents had mentioned that the AWC was regularly opened and it was also utilized by the pregnant women and it was also observed that majority of the respondents regularly utilized the AWC during pregnancy as well. The study revealed that nearly half of the respondents received health check-up in private hospital which was then followed by sub-center and government hospitals. It was then observed that the respondents had taken vaccines mainly from the health sub-center in the locality. Also, majority of the respondents had attended the NHEd programs at the AWC.

The study revealed that all the respondents and their child benefitted from the child welfare services which were provided by the ICDS and all the respondents agreed with the services of the PSE program and the supplementary nutrition program (SNP) which was provided in the AWCs.

Mother's committee was expected to exist in the entire anganwadi center and the study revealed that nearly half of the respondents did have mother's committee in the AWC. The member of the mother's committee was varying between 10 and 20 members. The mother's committee of AWC dealt with issues such as regularity in opening of the AWC, ensuring the participation of the community and on the proper delivery of the supplementary nutrition to the beneficiaries. Majority of the respondents felt that the presence of the mother's committee was helpful.

5.1.3 Community Key Leaders

In the study, the maximum numbers of respondents were in the age group between 51 years and 60 years and a minimum number of the respondents were in the age group between 61 years and 70 years. The study then highlighted that the maximum number of respondents were

married while there were no divorce among the respondents. The educational background of the respondents showed that there were no illiterate among the respondents and all the respondents had obtained education minimum to middle school standard. The study revealed that the main occupation of the respondents was petty shop while the minimum number of respondents were engaging in household chores. The study then shows that the maximum number of the respondents belonged to nuclear family while the minimum number of the respondents belonged to an extended family and the medium size of family was commonly practiced by the respondents in the community where the study was conducted. The study also revealed that more than two-third of the total respondents had an annual family income of not less than Rs. 25,001 and not more than Rs. 750,000.

The study on the attitudes of the respondents towards community participation in AWC shows that the entire respondents gave importance to ICDS and the involvement of the local people/local leaders/local groups in the activities of the AWCs was important because the required resources of AWC such as sites for AWC, building of AWC, infrastructures, beneficiaries and others could not be met by the government alone. Further, ICDS is a community program and later this particular program would have been taken–up by the community independently and the success of the program largely depended upon the rate of the community participation. While, one-fourth of the respondents were involving in the AWC activities because it was strongly agreed that all the resources required in the functioning of ICDS cannot be met by the government alone and the program was designed to have community involvement.

The need for the community participation in the ICDS programs was shown in the study and two-third of the respondents agreed to participate in the ICDS program in order to have a sustainable ICDS program and functioning of AWC.

The study confirmed the presence of ICDS coordination committee in all the community. The functions of the ICDS coordinating committee was mainly in providing site for AWC, supporting ICDS program through cash and kind and also helping AWW in identification of beneficiaries and in assisting of delivery of the services.

The awareness of the community leaders on the services was revealed in the study and it was observed that majority of the respondents believed that the community were aware of the ICDS services that should be provided by the AWCs. In regard to the types of services provided by the AWCs, most of the community understood only the non-formal pre-school education and supplementary nutrition which was then followed by the other package of services of ICDS.

The indicators of the community participation were shown in the study and more than two-third of the respondents showed that the community participation could be seen through the visits of the AWCs and all the respondents frequently participated in the different activities of the AWCs.

The need for inclusion of the community in decision making of the AWCs was shown in the study and it was pointed out that all the respondents were in agreement that the community needed to be included in the decision making of the AWCs. Moreover, the respondents assumed that the involvement in the decision making of ICDS would obviously increase the community participation.

5.2 Suggestions

From the study, the following suggestions were given:

1. The study shows that, there was limited space in the AWCs as there were no separate rooms for kitchen and the class room. From the study it was suggested to have separate rooms in order to have an effective learning process which was already mentioned in the scheme.

2. It was mandatory for the AWW to weigh and measure the children as indicated in the AWW guidelines. However, most of the AWW respondents were unable to perform the activity due to the lack of time within the AWC working hours. So, the social worker suggested that it might be possible for the AWWs to take the necessary measurements by performing it 3-5 children in a day and not all at once.
3. The study revealed that there were no proper toilets in most of the AWCs and therefore, it was necessary for the ICDS coordination committee to provide proper toilets to the AWCs.
4. It was compulsory for the AWW to attend the orientation and refresher course training. According to the rules, AWWs were supposed to have refresher course training in the interval of 2 years of service. However, the study showed that more than one-third of the AWW had attended refresher course training. Moreover, one-fourth of the AWW respondents have not attended the refresher course training due to the unavailability of opportunity. Thus, it is important for all the AWWs to attend the refresher course training for efficient and effective performance of their service.
5. The community key leaders were holding the office through election. The tenure of office may vary from 3 years – 5 years. Therefore, it is important to sensitize the community leaders on ICDS and highlight the importance of community participation.
6. The AWCs provided the different services of the ICDS but it was impossible for the AWW to have a follow-up service to the beneficiaries. In this way, the women group (MHIP – Mizo Hmeichhia Insuihkhawm Pawl) could enhance the performance by arranging such follow-up services like health education program, awareness on hygiene and adopted the role of the mother in building the community.

7. The study revealed that 35.7% of the respondents had 3 AWCs each in their localities and in some localities there was only 1 AWC. In order to increase the number of AWC in their locality, the community needed to participate more in the ICDS activities.
8. Majority of the AWCs have more than 20 pre-school children, pregnant women and lactating mothers. Therefore, it is impossible for the AWW and AWH alone to manage all the enrolled persons. To ensure the responsibilities to each and every individual, the social worker would suggest placement of additional helper depending upon the enrollment rates.
9. The study revealed that half of the AWCs were constructed in pucca buildings and the remaining half of the AWCs buildings were semi-pucca and kucha. Since a pucca building is much safer for the children, it is important for the remaining half of the AWCs to take measures in constructing the buildings to pucca buildings as well.
10. The study revealed that 14.3% of the AWCs were unsatisfied with the infrastructure mainly due to the unavailability of water provision. Therefore, it is necessary for the AWCs to have proper water supply which was used mainly for cooking of the supplementary food which was given in the AWC and also for the toilet purpose.

From the study, it was observed that community participation was very much necessary for the better functioning of the anganwadi center and a good participation from the community could be observed in all the AWC which were selected for the study. The study had shown that the community participated in the various AWC activities and they were the backbone in the construction of the AWCs. The study clearly shows that the community participated physically as well as through cash and kind. Besides generating awareness to the public, the community had mobilized children and mothers to attend the AWCs. It also

provided an opportunity in catering to the every needs of the AWC. They also help the AWW in making the various decisions concerning the AWC. The performance of the AWC was also measured in terms of services which were provided by ICDS. The study shows that majority of the AWC could successfully perform the various services. It was also observed that the mothers of the beneficiaries were very helpful to the AWW as they motivated each other in making the AWC the best place for their children. Further, all the mothers of the beneficiaries were satisfied with the performance of the AWC in each of their locality as their children learn from the AWCs and they themselves also learn in looking after their children and their selves as well.

APPENDICES

BIBLIOGRAPHY

Abrams, Charles (1965). : *The City is the Frontier.* New York: Harper and Row.

Almad, Arix. (1999). : *Good governance through transparency in Management in government – Advanced Public Administration.* New Delhi: Rawat Publications.

Anil K. (2011, November 6) : Research on ICDS an Overview 2. National Institute of Public Co-operation and Child Development. Retrieved from: http://nipccd.nic.in/reports/icdsvol3.pdf

B. P.Chattarjee. : *I.C.D.S, Encyclopedia of Social Work: Vol III.* New Delhi.

Davis, Kingsley, (1949). : *Human Society*, Mac Millan Company: London.

D. Chowdhery, Paul. (1984). : *Community Participation in the 1984 context of ICDS manual for ICDS.* Page 88-89.

Encyclopaedia : of Social Sciences, Vol. 5.

Goel, SK and Jain, RK. (2000) : *Social Welfare Administration.*

Goel, SK. (2003) : *Advanced Public Administration.* U.K: Oxford University Press.

Government of India. (1985). : *Seventh Five Year Plan (1985-90).* New Delhi, Planning Commission.

Government of India. (1991). : *Eight Five Year Plan*.New Delhi, Planning Commission.

Government of India (1992). : *Census on India*. New Delhi.

Government of India (1993). : *National Nutrition Policy*. New Delhi.

Government of India, (1999). : *A study on community mobilization and empowerment for universalisation of Primary Education- A Synthesis Report*, Educational Consultants India Ltd., New Delhi.

Habraken, N. J. (1972). : *Supports: An Alternative to Mass Housing.* New York: Praeger Publishers.

Hamdi, Nabeel. (2010). : *The Placemaker's Guide to Building Community*. New York: Earthscan.

Hillary George A., (1955). : *Definitions of Community: Areas of Agreement*, Rural Sociology. Page 111-123.

Integrated Child Development Scheme. (2011, November 15). : Retrieved from: http://en.wikipedia.org/../Integrated_Child_Development_Services_(India)

Kanthi S. (2011, December 3). : Annual Report - annex. pmd. Retrieved from: http://nipccd.nic.in/annrepe/2004-05/ann.pdf

Kumar, Somesh. (2002). : *Methods for Community Participation*. New Delhi: Vistaar Publications.

Lundberg, G.A., Schrag, C.C, Larsen and Otto N., (1958). : *Sociology*, Harper and Brothers: New York.

Mac Iver R.M., (1970). : *Community, A Sociological Study*, Frank Class & Co. London.

Mannheim Karl, (1959). : *Systematic Sociology*, Routledge & Kegan Paul: London

Mathew, C. Roy. (2001). : *A Critical Analysis of the Problems and Prospects of Integrated Child Development Services (ICDS) Scheme on Women and Children in Kottayam District.*

Metzger, U. (2001) : *Dezentralisierung in Entwicklungsländern*. Finanzielle Dezentralisierung und Sustainable Human Development.Würzburg: Ergon.

Mishra, G. P and Bajpai, Brijesh K. (2001). : *Community Participation in Natural Resource Management.* New Delhi: Rawat Publications.

Nayar D, Kapil U, Nandan D. (1999). : *Assessment of community contribution to the ICDS scheme in district Agra: a case study*

Ogburn & Nimkoff, (1950). *A Handbook of Sociology*, Routledge and Kegan Paul, London.

Parsons Talcott, (1951). : *The Social System*, Free Press, New York.

Parsons Talcott, (1953), *A revised analytical approach to the theory of social Stratification in R. Bendix & S.M. Lipset (ed.) Class, States & Power: A reader in social stratification*, Glencoe, Free Press.

Parsons, Talcott and Bales, Robert, (1955). *Family Socialization and Interaction Process*, Free Press: Illinoise.

Raina, V., (2003). *Making Sense of Community Participation, Comparing School Education and Watershed Development, in: Govinda, R. Rashmi D. (eds.), Community Participation and Empowerment in Primary Education*, Sage Publications, New Delhi, India/ Thousand Oaks, USA/ London, UK

Research Abstracts on ICDS 1998 – 2009 (2011, October 30. : Retrieved from: http://nipccd.nic.in/reports/raicds.pdf

Sengupta B, Sinha RN, Sarkar GN. (1998). : *An perception and practice regarding pulse polio immunization in an urban community of Calcutta*.

Sharma, Abha and Mistry, Veena. (1986). : *Refresher Training of Anganwadi Worker: A Special Encounter.*

Sutherland, Woodward and Maxwell, (1961), *Introductory Sociology*, Oxford and IBH Publishing Co.: Bombay.

Swaminathan C. Directory of NVA Fellows. : Retrieved from: http://www.mission2007.in/iec-pub/pubfile/Fellows-Jul%202005%20-%20Feb%202007,%20vol%201.pdf

(2011, Nov16).

Thakare MM, Kurll BM, Doibale MK. (2011). : Knowledge Of Anganwadi Workers and Their Problems In: An Urban ICDS Block. *Journal of Medical College Chandigarh* .Retrieved from: http://www.gmch.nic.in/ nayar

UNDP (1993) *Human Development Report*, (New York: United Nations Press). Page 21-22.

Verhagen, Koenraad. (1987). : *Self-Help Promotion: A Challenge to the NGO Community, CEBEMO.* The Netherlands.

Wates, Nick. (1999). : *The Community Planning Handbook: How People Can Shape Their Cities, Towns and Villages in Any Part of the World.* London: The Urban Design Group.

Zimmerman C., (1938) : *The Changing Community*, Harper Publication, New York.

Zimmerman, Carle C., (1949). : *Family and Civilization*, Harper and Brothers: New York.

APPENDIX I

COMMUNITY PARTICIPATION AND PERFORMANCE OF ANGANWADI CENTERS (AWCs) IN AIZAWL, MIZORAM

*Interview Schedule for **Anganwadi Worker (AWW)***
(Confidential & Research Purpose only)

Research Scholar
Ruby Laltlanmawii Bawitlung
M. Phil

Research Supervisor
Dr. Elizabeth H
Assistant Professor

Department of Social Work
Mizoram, University
Tanhril, Aizawl

Schedule No. Date:

I. Personal Identification

Sl. no.	Personal Identification		
1.	Name	:	
2.	Address	:	
3.	Age	:	a) 20 years – 30 years ☐, b) 31 years – 40 years ☐, c) 41 years – 50 years ☐, d) 51 years – 60 years ☐
4.	Marital status	:	a) Married ☐, b) Unmarried ☐, c) Divorce ☐, d) Widow ☐
5.	Educational Qualification	:	a) Class 8 ☐, b) High School ☐, c) Higher Secondary School ☐, d) Graduate ☐, e) Post Graduate and above ☐
6.	Family Annual Income	:	a)Rs. 0>5,000 ☐, b) Rs. 5,001>10,000 ☐, c) Rs.10,001>25,000 ☐, d)Rs.25,001>50,000 ☐, e) Rs. 50,001>750,000 ☐, f) Rs. 750,001 and above☐
7.	Type of Family	:	a) Nuclear family ☐, b) Joint family ☐,c)Extended Family ☐
8.	Size of Family	:	a)1-4 ☐, b) 5-7 ☐, c) 8-10 ☐

II. Performance of AWCs

9.	When was your AWC established?	a) 1990 – 1995 ☐, b) 1996 – 2000 ☐, c) 2001 – 2005 ☐, d) 2006 – 2010 ☐, e) 2011 – 2015 ☐
10.	How many AWCs are there in your community?	a) 1☐, b) 2 ☐, c) 3 ☐, d) More than 3 ☐
11.	Do you reside in the village in which the AWC is located?	a) Yes ☐, b) No ☐
12.	a)Do you find it difficult to commute to the anganwadi?	a) Yes ☐, b) No ☐
	b) If yes, why?	
13.	How many workers are there in your AWC?	a) 1☐, b) 2 ☐, c) 3 ☐, d) More than 3 ☐
14.	How long have you worked as an AWW?	a) Less than 1 year ☐, b) 1-2 year ☐,

		c) 2-3 years ☐, d) 3 years and above ☐
15.	Have you undergone training?	a) Yes ☐, b) No ☐
16.	Have you undergone refresher course?	a) Yes ☐, b) No ☐
17.	Do you think that training is mandatory and helpful for AWW?	a) Yes ☐, b) No ☐
18.	Do you feel that the training that you have received was practice oriented?	a) Yes ☐, b) No ☐
19.	Who have helped you in running the AWC?	a) Mothers of beneficiaries ☐, b) Women group☐, c) Youth groups ☐, d) Adolescent girls ☐, e) Community Leaders ☐, f) School teachers ☐, g) Others ☐
20.	How many pre-school children are enrolled in your AWC?	a) 1-10 ☐, b) 11-20 ☐, c) 21-30 ☐, d) 31-40 ☐, e) More than 40 ☐
21.	How many pregnant mothers are enrolled in your AWC?	a) 1-5 ☐, b) 6-10 ☐, c) 11-15 ☐, d) 16-20 ☐, e) More than 20 ☐
22.	How many nursing mothers are enrolled in your AWC?	a) 1-5 ☐, b) 6-10 ☐, c) 11-15 ☐, d) 16-20 ☐, e) More than 20 ☐
23.	How is your AWC building constructed?	a) Pucca ☐, b) Semi-Pucca ☐, c) Kucha ☐
24.	Are you satisfied with the facilities of AWC? a) Infrastructure(electricity, fan, water supply, etc) b) Logistic(register, weight scale, medicines, etc) c) Availability of medicine d) Supervision(CDPO and other officers) e) Community participation	 a) Satisfactory ☐, b) Unsatisfactory ☐ a) Satisfactory ☐, b) Unsatisfactory ☐ a) Satisfactory ☐, b) Unsatisfactory ☐ a) Satisfactory ☐, b) Unsatisfactory ☐ a) Satisfactory ☐, b) Unsatisfactory ☐

III. Services

25.	a) Are you getting Supplementary Nutritionration in time?	a) Yes ☐, b) No ☐

	b) If no, why?	a) Transportation problems ☐, b) Weather conditions ☐, c) AWW not available ☐, d) Food items were spoiled ☐, e) Any other (specify) ☐
26.	a) Is the food item given acceptable to distribute?	a) Yes ☐, b) No ☐
	b) If no, why?	a) Poor quality ☐, b) Not cooked properly ☐, c) Not fit for consumption by children ☐
27.	How is the supplementary nutrition served?	a) Cooked ☐, b) Raw ☐, c) Ready to eat ☐, d) Take home ☐
28.	What percentage of enrolled children comes to receive supplementary nutrition from AWC?	a) Less than 50% ☐, b) 50% ☐, c) More than 50% ☐, d) All the enrolled children ☐
29.	a) Are you able to monitor the growth of all children?	a) Yes ☐, b) No ☐
	b) If no, why?	a) Growth charts are not available ☐, b) Weighing scale has not been supplied ☐, c) No time to monitor all children ☐, d) Parents do not cooperate ☐,
30.	Who fills up the growth charts?	a) Anganwadi Worker (AWW) ☐, b) Auxiliary Nurse Midwife (ANM) ☐, c) Supervisor ☐
31.	Do you organize Nutrition and Health Education (NHEd)?	a) Yes ☐, b) No ☐
32.	How frequently do you organize NHEd?	a) Once in a month ☐, b) Twice in a month ☐, c) Once in two months ☐, d) Any other (Specify)
33.	On what messages NHEd was given?	a) Breast feeding ☐, b) Immunization ☐, c) Supplementary Nutrition ☐, d) Use of Health services ☐ , e) Health and hygiene ☐, f) Family Planning-spacing the children ☐, g) All the above ☐
34.	What methods have you adopted for NHEd?	a) Film shows ☐, b) Discussions ☐, c) Demonstrations ☐, d) Talks by experts ☐
35.	a) Do you ever face problems while organizing NHEd?	a) Yes ☐, b) No ☐
	b) If yes, what are they?	a) Lack of time ☐, b) Lack of resources ☐, c) Lack of interest among mothers ☐, d) Lack of time among the mothers ☐
36.	Who have attended the Pre-School Education (PSE)?	a) 1-2years ☐,

		b) 3-6years ☐
37.	How often do they attend the PSE?	a) Regularly☐, b) Not regular☐
38.	What is taught in the PSE?	a) Alphabets ☐, b) Rhymes ☐, c) Numbers ☐, d) Colors ☐, e) All the above ☐
39.	a) Does the supervisor help you in organizing PSE activities?	a) Yes ☐, b) No ☐
	b) If yes, how?	a) Demonstrate new activities ☐, b) Planning the program ☐, c) Help in preparation of aids/play material ☐
40.	a) Were you able to provide immunization effectively?	a) Yes ☐, b) No ☐
	b) If no, why?	a) Parents did not cooperate ☐, b) Vaccine not available ☐, c) Health functionaries did not come for immunization ☐
41.	a) Do you refer children and women to doctors?	a) Yes ☐, b) No ☐
	b) If yes, where?	a) Sub Centre ☐, b) Govt. Hospitals ☐, c) Private Hospitals ☐
42.	a) Do you face any problems in referral services?	a) Yes ☐, b) No ☐
	b) If yes, what are they?	a) Parents do not take children to hospitals ☐, b) Lack of transport facilities ☐, c) Parents do not undertake follow-up visits ☐
43.	Where does the health check-up of children and women take place?	a) Anganwadi Center (AWC) ☐, b) Sub-centers ☐
44.	Who does the health check-up?	a) Medical Officer ☐, b) Lady Health Visitor (LHV) ☐, c) Auxiliary Nurse Midwife (ANM) ☐
45.	a) Are you facing any problems while organizing health check-ups?	a) Yes ☐, b) No ☐
	b) If yes, what are they?	a) Shortage of medical staff ☐, b) Unwillingness of medical staff to come to AWC ☐, c) Lack of awareness on the part of community on the visits of health staff ☐, d) Reluctance of people to come forward for health check-up ☐, e) Lack of awareness about the importance of health check-up ☐

APPENDIX II

COMMUNITY PARTICIPATION AND PERFORMANCE OF ANGANWADI CENTERS (AWCs) IN AIZAWL, MIZORAM

Interview Schedule for ***Mothers of the Beneficiaries***
(Confidential & Research Purpose only)

Research Scholar
Ruby Laltlanmawii Bawitlung
M. Phil

Research Supervisor
Dr. Elizabeth H
Assistant Professor

Department of Social Work
Mizoram, University
Tanhril, Aizawl

Schedule No. Date:

I. Personal Identification

Sl. no.	Personal Identification		
1.	Name	:	
2.	Address	:	
3.	Age	:	a) 20 years – 25years ☐, b) 26years – 30 years ☐, c) 31 years – 35 years ☐, d) 36 years – 40 years ☐, e) 41 years – 45 years ☐
4.	Marital status	:	a) Married ☐, b) Unmarried ☐, c)Divorce ☐, d)Widow ☐
5.	Educational Qualification	:	a) Illiterate ☐, b) Middle school ☐,c) High school ☐, d) Higher secondary school ☐, e) Graduate ☐, f) Post graduation and above ☐, g) Any other ☐
6.	Occupation	:	a) Govt.-servant ☐,b) Self-employed ☐, c) Housewife/ Homemaker ☐ ,d) Petty shop owner☐, e) Farmer/cultivator ☐
7.	Family Annual Income	:	a)Rs. 0>5,000 ☐, b) Rs. 5,001>10,000 ☐, c) Rs.10,001>25,000 ☐, d)Rs.25,001>50,000 ☐, e) Rs. 50,001>750,000 ☐ f) Rs. 750,001 and above ☐
8.	Type of Family	:	a) Nuclear family ☐, b) Joint family ☐,c) Extended Family ☐
9.	Size of Family	:	a)1-4 ☐, b) 5-7 ☐, c) 8-10 ☐

II: Respondent's Family Background

Sl. no.	Name	Relationship	Occupation	Education	Annual Personal Income
1.					

2.					
3.					
4.					
5.					
6.					
7.					

10.	a) Is there any child below the age of 6 years in your family?	a) Yes ☐, b) No ☐
	b) If yes, how many?	a)1-3 ☐, b) 3-5 ☐, c) More than 5 ☐
11.	Have you ever heard of ICDS or AWC?	a) Yes ☐, b) No ☐
12.	a) Do you know the purpose of ICDS or AWC?	a) Yes ☐, b) No ☐
	b) If yes, what are they?	a) To lay the foundation for the proper psychological, physical and social development of the child ☐ b) To improve the nutritional and health status of children below the age of six years ☐ c) To reduce the incidence of mortality, morbidity, malnutrition and school dropout ☐ d) To achieve effective coordination of policy and implementation among various departments to promote child development ☐ e) To enhance the capacity of the mother to look after the normal health, nutritional and development needs of the child, through proper community education ☐ f) All the above ☐
13.	a) Do you ever send your child/children to AWC?	a) Yes ☐, b) No ☐
	b) If no, what is the reason?	a)Lack of time ☐, b) Not satisfied with the location ☐, c) Due to unqualified AWW ☐, d) Unsafe AWC building ☐, e) Poor sanitation ☐, f) Inadequate or low quality of food ☐, g) Others (specify) ☐
14.	a) Do you think that ICDS is good for your community?	a) Yes ☐, b) No ☐
	b) If no, why?	a) Unsatisfied with AWC functioning ☐, b) Unsatisfied with the non-formal education provided ☐, c) Unskilled worker ☐, d) Irregular delivery of services ☐, e) The community people do not gain actual benefit out of ICDS ☐

III. General Awareness

15.	Are you aware of the presence of AWC in your community?	a) Yes ☐, b) No ☐
16.	Are you aware of AWC functioning?	a) Yes ☐, b) No ☐
17.	a) Are you aware on the services of ICDS?	a) Yes ☐, b) No ☐
	b) If yes, to what extent?	a) Supplementary Nutrition ☐, b) Non-formal pre-school education ☐, c) Nutrition and health education ☐, d) Immunization ☐, e) Health check-up ☐, f) Referral services ☐, g) All the above ☐
18.	Is the AWC in your community regularly open?	a)Yes ☐, b) No ☐, c) Not Know ☐
19.	During your pregnancy, do you visit AWCs?	a)Yes ☐, b) No ☐
20.	Who advised you to go for a health checkup?	a) Family members ☐, b) Govt. Health Staff ☐, c) AWW ☐
21.	Where did you usually get your health checkups?	a)Sub-center ☐, b) Govt. Hospitals ☐, c) Private Hospitals ☐
22.	From where did you receive vaccines during pregnancy?	a) Sub-center ☐, b) Govt. Hospitals ☐, c) Private Hospitals ☐
23.	Do you attend any sessions on Nutrition and Health Education in AWC?	a)Yes ☐, b) No ☐
24.	a) Do you have any problems utilizing ICDS services?	a)Yes ☐, b) No ☐
	b) If yes, what are they?	a) Distance of anganwadi centre ☐, b) Location of AWC Limited activities ☐, c) Indifferent behaviors of AWW ☐, d) Lack of time of the mother ☐
25.	Do you agree with the Child Welfare benefit provided by the ICDS?	a)Yes ☐, b) No ☐
26.	Do you think you and your child benefit from it?	a)Yes ☐, b) No ☐
27.	Have you received any advice on child feeding?	a) Received ☐, b) Not received ☐
28.	Do you think the Pre-School Education (PSE) provided in AWC benefit your child?	a)Yes ☐, b) No ☐, c) Not Know ☐
29.	Do you and your child receive the Supplementary Nutrition (SN) provided in the AWC?	a)Yes ☐, b) No ☐
30.	What is your opinion on the quantity of the SN provided?	a)Adequate ☐, b) Not adequate ☐
31.	a) What about the quality of SN provided?	a)Acceptable ☐, b) Not acceptable ☐

	b) If not acceptable, what is the main reason?	a)Poor quality of the ingredient ☐, b) Bad taste ☐, c) Improper cooking ☐, d) Limited variety ☐
32.	How would you prefer to serve the SN?	a) Cooked ☐, b) Raw ☐, c) Ready to eat ☐, d) Take home ☐
33.	a) Is there any Mother's Committee in your AWC?	a)Yes ☐, b) No ☐
	b) If yes, when was it established?	a) 2000 – 2005 ☐, b) 2006 – 2010 ☐, c) 2011 – 2015 ☐
34.	How many members are there in the committee?	a) 1-5 ☐, b) 6-10 ☐, c) 11-15 ☐, d) 16-20 ☐
35.	What was the topic discussed in the mother'scommittee?	a) To help the children to get a good education ☐, b) To take the children on field trips ☐, c) To have harmony between the mothers ☐, d) All the above ☐
36.	What kind of issues does the mother's committee usually deal with?	a) Regular opening of AWC ☐, b) Ensuring the participation of the community ☐, c) Proper supply of SN ☐, d) Solving the various problems faced by the mothers and their children ☐
37.	a) Do you find the committee helpful?	a) Yes ☐, b) No ☐
	b) If no, what is the main reason?	a) Not allowed to join the committee ☐, b) Not listening to all the members of the committee ☐, c) The committee do not solve any problems faced ☐

APPENDIX III

COMMUNITY PARTICIPATION AND PERFORMANCE OF ANGANWADI CENTERS (AWCs) IN AIZAWL, MIZORAM

*Interview Schedule for **Community Key Leaders***
(Confidential & Research Purpose only)

Research Scholar Research Supervisor

Ruby Laltlanmawii Bawitlung
M. Phil

Dr. Elizabeth H
Assistant Professor

Department of Social Work
Mizoram, University
Tanhril, Aizawl

Schedule No. Date:

I. Personal Identification

Sl.no.	Personal Identification		
1.	Name	:	
2.	Address	:	
3.	Age	:	a) 30 years – 40 years ☐, b) 41 years – 50 years ☐, c) 51 years – 60 years ☐, d) 61 years – 70 years ☐
4.	Marital status	:	a) Married ☐, b) Unmarried ☐, c) Divorce ☐, d) Widow ☐
5.	Educational Qualification	:	a) Illiterate ☐, b) Middle school ☐,c) High school ☐, d) Higher secondary school ☐, e) Graduate ☐, f) Post graduation and above ☐, g) Any other ☐
6.	Occupation	:	a) Govt.-servant ☐,b) Self-employed ☐, c) Housewife/ Homemaker ☐, d) Petty shop owner ☐, e) Farmer/cultivator ☐
7.	Family Annual Income	:	a)Rs. 0>5,000 ☐, b) Rs. 5,001>10,000 ☐, c) Rs.10,001>25,000 ☐, d)Rs.25,001>50,000 ☐,e) Rs. 50,001>750,000 ☐, f) Rs. 750,001 and above ☐
8.	Type of Family	:	a) Nuclear family ☐, b) Joint family ☐,c)Extended Family ☐
9.	Size of Family	:	a)1-4 ☐, b) 5-7 ☐, c) 8-10 ☐

II. Community Participation

10.	a) Do you think that it is important to involve the local people/local leaders/local groups in AWC activities?	a) Yes ☐, b) No ☐
11.	a) If yes, why?	a) It is a community program ☐, b) The community has to take over the program later ☐, c) Resources cannot be met by Govt. alone ☐, d) Success of the program depends on the community participation ☐, e) Any other (Specify)
12.	What is the need for the community to participate in ICDS program?	a) Smooth functioning of ICDS program ☐, b) Reach and increase in utilization of ICDS services ☐, c) Accountability for success or failure of the program ☐, d) Reduce Govt. intervention ☐, e) All the above ☐
13.	a) Is there any coordinating committee?	a) Yes ☐, b) No ☐
	b) If yes, when was it established?	a) 1990 – 1995 ☐, b) 1996 – 2000 ☐, c) 2001 – 2005 ☐, d) 2006 – 2010 ☐, e) 2011 – 2015 ☐
14.	What are the main functions of the coordinating committee?	a) Providing site/building for AWC ☐, b) Bringing children to AWC ☐,

		c) Supporting ICDS program through cash and kind ☐, d) Arranging safe drinking water ☐, e) Preparation and distribution of supplementary food ☐, f) Motivating parents to send children to AWC ☐, g) Helping AWW in identification of beneficiaries and delivery of services ☐, h) Organizing meeting of AWW with local village leaders ☐, i)All the above ☐
15.	a) Are the community people aware of the services that should be provided by the AWCs?	a) Yes ☐, b) No ☐
	b) If yes, what are they?	a) Immunization ☐, b) Supplementary nutrition ☐, c) Health check-up ☐, d) Referral services ☐, e) Non-formal pre-school education and Nutrition ☐, f) Health education ☐, g) All the above ☐
16.	What are the indicators of community participation?	a) Community brings and collects children from AWC ☐, b) Helps in cooking and serving food at AWC ☐, c) Supports in maintaining AWC ☐, d) All the above ☐
17.	a) What is the frequency of participation of the community?	a) Regular ☐, b) Irregular ☐
	b) If irregular, reasons for irregularity	a) Lack of interest ☐, b) Engagement of work elsewhere ☐, c) No effort given by the AWW regarding the assistance required ☐, d) Govt. is responsible, not the community ☐
18.	What is the nature of support provided by the community to the AWC?	a) Monitoring of activities ☐, b) Ensuring participation of target group ☐, c) Ensuring availability of AWW/AWH ☐, d)Ensuring of nutrition supply ☐, e) Ensuring availability of health care services ☐
19.	a) Do you think the community needs to be included in AWCs decision making?	a) Yes ☐, b) No ☐
	b) If No, why?	a) Lack of confidence ☐, b) Unaware about agenda ☐, c) Other reasons ☐