**CHAPTER – I**

**EXECUTIVE SUMMARY**

India is a multicultural nation with high-level of regional inequality, health and nutrition inequality, social hierarchy, which are pervasive and persistent [1] . After Independence Government of India realized the utmost urgency and importance of giving highest priority to develop human resources and found it most essential to evolve a national program for the overall development of our children who constitute the most precious asset of country’s future. The most valuable asset of a nation is its human resource. Countries who have learnt to invest on its human resources are today the most progressive and developed nations. India has also recognized this and has made several efforts to improve the quality of its human resources. The Constitution of India provides a framework for care and protection of women and children and it mentions that states shall make special provisions for children.

The ICDS is the World`s largest community based outreach program running unilaterally all over the country, which offers a package of health, nutrition and education services to children below the age of 6 years, pregnant and nursing mothers

Anganwadi worker (AWW) is a multipurpose worker employed under the Integrated Child Development Scheme, India. They are the community’s primary link with health services and an important agent for behavioral change for improving QoL. The AWW undergo training at the beginning of their career and once in every 3 years, and this training includes various issues regarding the improvement of physical, psychological, social, envi­ronmental, and other aspects of life.

An Anganawadi worker is selected from within the local community. Her responsibility and job function include ensuring key maternal and child services like supplementary nutrition immunization, periodic health check–ups referral, non formalpre school education, giving advice on the nutrition and the common ailments to adolescent girls and pregnant and lactating women. Besides caring the mother and child an Anganwadi worker also has to be involved in the pulse polio Immunization programme the house to house survey etc.

Now their responsibilities and functions include surveys and disease control programs that require door to door visits beyond the working hours which further stress them. Performing and discharging many duties in a limited time may lead to stress and discontent among theAWWs. Stress may lead to dissatisfaction, poor motivation and a decreased efficiency. There is a lack of information on the Anganwadi workers occupational stress. Such information would be important in improving the quality of the service and the optimal utilization of the existing Anganwadi workers by taking measures to address the issues .Thus, in this study an attempt was made to assess the level of job stress and personal efficiency and also to understand the various factors which were associated with job stress which could be responsible for the sub-optimal performance of the Anganwadiworkers (Desai, 2012).

The Anganwadi worker (AWW) is the community based voluntary frontline worker of the ICDS programme. Selected from the community, she assumes a pivotal role due to close and continuous contact with the beneficiaries. The output or the ICDS scheme is to a great extent dependant on the profile of the key functionary i.e. the A WW, her qualification, experience, skills, and attitude. training etc.The rate of rural development in India, is lesser than urban development. By rural development, here, we mean the actions which are mainly taken for the socio – economic development of the rural areas of the country. It is a process of improving the quality of life and economic well being of people living in relatively isolated and sparsely populated areas. Rural development is also characterized by its emphasis on locally produced economic development strategies. India is a country suffering from malnourishment, high mortality rate & poverty. The problem is high in the rural parts of the country. In order to counter the health and mortality issues gripping the rural parts of the country, a need of medical and health care experts was felt by the government of India(Dasgupta ,2013).

A comprehensive and integrated early childhood services were regarded as investment in future economic and social progress of the country for both the urban and the rural areas of our country. Accordingly a scheme for integrated child care services was worked out for implementation in all states.

The major problem faced by AWWs, though they are the basic functionaries of ICDS, are less pay honorarium (administration related), frequent travelling (Infrastructure related) and communication problems for convincing community people as well as employees (man power related). Further, the top most reason for job satisfaction mentioned by AWWs was “they loved working with children” and the most dampening reason was “less number of public holidays”. Further the relationship between problems and job satisfaction faced by AWWs was found as a result that when job related problems decrease the level of job satisfaction increase. Therefore the study suggest that to improve job satisfaction of AWWs the authorities should provide proper honorarium and job security to AWWs for their work. The efficiency of AWWs should be increased by improving their infrastructure facility, reducing reporting work and travelling.

**CHAPTER – II**

**PROBLEM STATEMENT**

**PROBLEM STATEMENT**

The Anganwadi workers (AWW) is community based voluntary frontline workers of the ICDS programme. She assumes a pivotal role due to her close and continuous contact with the beneficiaries children grow and develop amazingly.Anganwadi workers play the most dominant role in providing basic education, nutrition and ensuring health in rural India. ICDS has played an important role in improving health status of the children and women in India at macro level. The study describe the growth and development of Anganwadicentres and their beneficiaries. It is also focus on problems faced by anganwadi workers.

**SIGNIFICANCE OF THE STUDY**

The Anganwadi workers (AWW) is community based voluntary frontline workers of the ICDS programme. She assumes a pivotal role due to her close and continuous contact with the beneficiaries children grow and develop amazingly.Anganwadiworkers play the most dominant role in providing basic education, nutrition and ensuring health in rural India. The study analyse roles and responsibilities of Anganwadi workers and also analyse the problems faced by Angwadi workers and suggest to overcome their problems. it is quite regrettable and sad to note that despite their social commitment and diligence they are very poorly paid and treated worse than the class fourth employers.

**OBJECTIVES OF THE STUDY**

* To study the role and responsibilities of Anganwadi workers
* To understand the personal, social and occupational problems of the Anganwadi workers
* To identify the measures taken by the authorities to improve the ICDS programs and Angwadi
* To study the satisfaction level of Angwadi workers with the benefits provided by the Government.

**HYPOTHESIS OF THE STUDY**

* Anganwadi workers efficiently deliver the ICDS services to the Anganwadi beneficiaries
* Working environment and socio-economic conditions are likely do not support for the prosperous development of Anganawadi workers.
* Social status among Anganwadi workers is likely to be less as compared other class of society.
* Majority of the Angwadi workers pointed out the need for the development of infrastructure facilities of Angawadi.
* Majority of the Anganawadi workers are not satisfied with the financial and benefits provided to their family.

**RESEARCH DESIGN AND METHODOLOGY**

Exploratory research design has been adopted to assess the role and responsibilities of anganwadi workers and effective implementation of anganwadi services to the beneficiaries

**SAMPLE DESIGN**

The sample design is a definite plan for obtaining a sample from given population. The design of samples is a particularly important aspect of survey methodology, and provides a basis for the sound measurement of economic and social phenomena from surveys of businesses.

**SAMPLING TECHNIQUES**

Sampling is the use of subset of the population to represent the whole population. Probability sampling, or random sampling, is a sampling technique in which the probability of getting any particular sample may be calculated.

**SAMPLE SIZE**

Time and cost are the two basic factors influencing each and every research. Taking the above factors into consideration the sample size was determined. In this research work, the researcher collected data from 50 respondents, which is the sample size.

**SAMPLING UNIT**

Sampling unit is a single section selected to research and gather statistics of the whole. The sampling unit taken for the research was limited to Taliparamba Taluk only

**SOURCESOF DATE**

The study relies to great extent on primary data and some extent on secondary data.

**Primary Data**

Primary data consist of data collected from dealers. A structured questionnaire was prepared. And direct interview method was used.

**Secondary Data**

Secondary data was collected from the official record of the organisation. These data are those already gathered having been collected have already originally for some other purpose. These are those which have been collected by someone else and which have already been passed through the statistical process. The secondary data was collected from the company by their booklets, magazines, websites, etc.

**METHOD OF DATA COLLECTION**

The questionnaire is by far the most common instrument in collecting primary data. A structured questionnaire consist of a set of questions presented to respondents to get their answer, For collecting primary data from dealers, set of questions is prepared.

**TOOLS USED FOR STUDY**

The tools used for the study purpose are: PERCENTAGE ANALYSIS

 (Number of respondents)/ (Total number of respondents)\* 100

**LIMITATIONS OF THE STUDY**

* The period of the study was limited to three weeks this was too shot for conducting a broad study.
* The findings of the study are subject to bias and prejudice of the respondents.
* The accuracy of the study is solely based on the information provided by respondents.
* Certain respondents were worried that the management would use the information collected by the researcher against them.
* The qualitative response depends upon the mental frame work of the respondents at the time of interview and hence it is only approximate.
* Due to limitation of the time, the research could not be made detailed.

**REVIEW OF LITERATURE**

**Padma Mohanan et al., (2012)** have worked on ''Are the Anganwadi Workers Healthy and Happy? A Cross Sectional Study Using the General Health Questionnaire (GHQ 12) at Mangalore, India‖ states that Anganwadi Workers (AWWs) are the implement- ers of Integrated Child Development Scheme (ICDS). It is important to obtain the worker‘s viewpoints on their job-description, the problems they face and the levels of stress that they encounter, to address the quality of their services. The stressed AWWs are likely to be unhealthy, poorly motivated, less productive and less efficient in implementing the ICDS scheme. Thus, there is a need to evaluate the stress levels among the anganwadi workers and to understand the factors that influence the stress in this class of the population. This study was planned to study the stress among the anganwadi workers and the factors that are related to the stress.

**Christo (2006)**argued that the cause of occupational stress includes perceived loss of job, security sitting for long hours or heavy lifting , lack of safety ,complexiety and receptiveness ,lack of autonomy in the job. In addition occupational stress caused by lack of resourses and equipment ,work schedules (such as working overtime ) and organisational climate are considered as contributors of occupational stress.Sourses of health care professionals vary with the type of medical practice (private vs public,hospital based vs.community based) and speciality.

**(Cosio 2011)**Several work related factors that contribute to occupational stress include role overload , role conflict, and role ambiguity. These factors are considered as being subjective or objective .

**Shetal.R.Barodia (2011)** evaluated the relation between job satisfaction and problems faced by Anganwadi workers. The result revealed that the anganwadi teachers were performing there basic task .It is found that when job related problems decrease the level of job satisfaction increases.Therefore the study suggested that to improve job satisfaction of anganwadi teachers the authorities should provide proper honaorarium and job security to them, for their work .The effiency of teacher should be increased by improving their working condition.

**Clemence (1990)** found that role conflict affected job-satisfaction of women teachers but social tension of value influenced their job-satisfaction .

**Agarwal (1991)** in a study on job satisfaction of primary and secondary school teachers concluded that caste, place of work and mother tongue were significantly related to job satisfaction. Male graduate trained teachers, single family teachers, more experienced and government school teachers were more satisfied than others; age and marital status, however,had no relationship with job satisfaction. Economic and political values were found to be correlates of job satisfaction.

**Rani Et Al. (2004)** This study was conducted in the state of Andhra Pradesh to evaluate the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects. Three districts, namely Hyderabad (urban), Anantpur (rural) and Visakhapatnam (tribal) were covered. Majority of AWWs in Hyderabad urban projects were Muslims who couldnot write in Telugu language and they were not able to fill up records and registers. In rural projects there were many vacant posts of Supervisors, and the Supervisors inposition were supervising about 30 AWWs or even more. In tribal projects all the Supervisors mentioned that their major concern was the selection of uneducated women as AWWs who were not able to fill up the records and registers. There is an urgent need to select educated women as AWWs. AWWs in urban projects need to be trained intensively in filling up the records and registers. Urban Supervisors also mentioned thatthere was no crèche facility available where they could leave their children and they were not getting loans for owning vehicles. They suggested that these facilities should be extended to them. Necessary training may be imparted to Supervisors and AWWs to utilize the locally available material for preparation of toys, because in tribal projects AWWs were unable to attract and hold the attention of children during PSE due to lack of proper play material and teaching aids, and the children just took their food and ran away. Provision of the required facilities can divert Supervisors and AWWs efforts towards the effective management of ICDS scheme activities.

**CHAPTER – III**

**THE STUDY**

**ABOUT ANGANWADI WORKERS**

Anganwadi worker (AWW) is a multipurpose worker employed under the Integrated Child Development Scheme, India. They are the community’s primary link with health services and an important agent for behavioral change for improving QoL. The AWW undergo training at the beginning of their career and once in every 3 years, and this training includes various issues regarding the improvement of physical, psychological, social, envi­ronmental, and other aspects of life.

An Anganawadi worker is selected from within the local community. Her responsibility and job function include ensuring key maternal and child services like supplementary nutrition immunization, periodic health check–ups referral, non formalpre school education, giving advice on the nutrition and the common ailments to adolescent girls and pregnant and lactating women. Besides caring the mother and child an Anganwadi worker also has to be involved in the pulse polio Immunization programme the house to house survey etc.

Now their responsibilities and functions include surveys and disease control programs that require door to door visits beyond the working hours which further stress them. Performing and discharging many duties in a limited time may lead to stress and discontent among theAWWs. Stress may lead to dissatisfaction, poor motivation and a decreased efficiency. There is a lack of information on the Anganwadi workers occupational stress. Such information would be important in improving the quality of the service and the optimal utilization of the existing Anganwadi workers by taking measures to address the issues .Thus, in this study an attempt was made to assess the level of job stress and personal efficiency and also to understand the various factors which were associated with job stress which could be responsible for the sub-optimal performance of the Anganwadiworkers

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A comprehensive and integrated early childhood services were regarded as investment in future economic and social progress of the country for both the urban and the rural areas of our country. Accordingly a scheme for integrated child care services was worked out for implementation in all states.

The major problem faced by AWWs, though they are the basic functionaries of ICDS, are less pay honorarium (administration related), frequent travelling (Infrastructure related) and communication problems for convincing community people as well as employees (man power related). Further, the top most reason for job satisfaction mentioned by AWWs was “they loved working with children” and the most dampening reason was “less number of public holidays”. Further the relationship between problems and job satisfaction faced by AWWs was found as a result that when job related problems decrease the level of job satisfaction increase. Therefore the study suggest that to improve job satisfaction of AWWs the authorities should provide proper honorarium and job security to AWWs for their work. The efficiency of AWWs should be increased by improving their infrastructure facility, reducing reporting work and travelling.

**ANGANWADI SYSTEM**

The Anganwadi system in one village/ area is managed by a single Anganwadi worker, who is chosen from the community and has been trained for four months in areas such as health, nutrition and childcare. Each Anganwadi worker covers a population of about 1000 people.

It is heartening to know that there more than a million Anganwadi centres in India, employing more than 2 million workers, who are mostly female and intuitive to the health needs of the region. For a country where illness, child mortality, illiteracy and poverty co-exist, this comes as a refreshing statistic.

India is home to over-population, mal nutrition, poverty, unemployment, low literacy levels and more, with a target to make healthcare accessible and affordable for everyone. Given the urgency of healthcare issues, child mortality, mal nutrition, etc., our country needs high number of medical and healthcare professionals to cater to the population that is now running into billions. Faced with acute shortage of skilled professionals, the Government’s ICDS scheme is using the local population to help meet its grand goals

The Anganwadi worker hails from the village where she works and has her finger on the pulse of the health of the village, its people and children. Apart for the healthcare knowledge that she possesses and gained over a period of time, the Anganwadi worker is so entrenched in the general affairs of the household that she is in a better position to understand the real malady behind the healthcare issues. These latent problems of the household or community could range from relationship issues, daily hassles, sanitation, nutrition, social, peer pressure, and much more. Given the definition of health – the physical, metal, social, spiritual wellbeing of an individual, the Anganwadi worker perhaps has the best insight into the people’s health of her region.

While educated doctors, learned nurses and seasoned professionals are excellent in their work and skills, they mostly lack the social skills and expertise which is more than necessary in interacting with the rural folk. An Anganwadi worker is well versed in the ways of the village, knows the people by their names, interacts with them on regular basis and may also havea personal relationship with the people.

Anganwadi workers need to have good communication skills. They are usually adept in using the right language, metaphors and allusions for convincing people to act in a certain way. Religious customs and sentiments work best for them. Here is an [interesting account](http://www.thefreelibrary.com/The%2BKaur%2Bof%2Bthe%2Bmatter%3A%2BHygiene%2B%28Health%29-a0204641554%29) of how the Anganwadi worker convinced the villagers from defecating on open land. From shaming the defecators, convincing the women of the house, to citing the sacred texts that emphasized cleanliness and took the sanitary hygiene of the village to much higher level than one can imagine. Such is the power of the Anganwadi worker

Some Anganwadi workers are very enterprising. Like the ones in Tamil Nadu, they have taken the[initiative of growing kitchen gardens](http://www.thehindu.com/2010/01/06/stories/2010010653410300.htm) to help meet the nutritional needs and achieve the objectives of reducing mal nutrition of 0-6 year olds. So far 200 kitchen garden initiatives have been undertaken where Anganwadi workers will be trained in laying the gardens and growing crops, on one cent of land allotted to them.

With minimum qualification to boot, an Anganwadi worker is deemed wise in the ways of the village and in the duties that she performs. Their understanding, communication skills and approach is needed to implement the grand projects of the state and central Governments, making them the most vital link in delivering the ‘health for all’ mission.

In the state there is a Welfare Fund for the welfare of Anganwadi Workers and Helpers All permanent Anganwadi Workers and Helpers are members of this welfare fund. Contribution of Anganewadi worker is Rs.30 per month and contribution of Anganwadi help is Rs.15 per month.

**ROLE AND RESPONSIBILITIES OF AN ANGANWADI WORKER.**

* To elicit community support and participation in running the programme.
* To weigh each child every month, record the weight graphically on the growth card, use these referral cards for referring cases of mothers / children to public health centers / sub centers.
* To maintain health cards for children below six years and produce them before visiting medical/ paramedical personnel.
* To carry out a quick survey of all families especially mother and children in those families. In their respective areas of work. Once in a year.
* To organize non formal pre-school activities in the Anganwadi of children 3 to 6 years of age.& help in designing and making of toys and play equipment of indigenous origin for use in the Anganwadi.
* To organize supplementary nutrition feeding for children (0 -6) years, and expectant and nursing mothers by planning the menu based on locally available food and local recipes.
* To provide health, nutrition, education and counseling on breast feeding / infant and young feeding practices to mothers. Anganwadi worker being close to local community can motivate married women to adopt family planning / birth control measures.
* Anganwadi workers shall share the information regarding / relating to births that took place during the month with the panchayat secretary/ gram sabha sewak/ANM, who so ever has been notified as registrar of births/deaths in that village.
* To make home visits for educating parents to enable mothers to plan an effective role in child’s growth and development, with special emphasis in new born children.
* To maintain files and records as subscribed.
* To assist PHC staff in implementation of health component of the programmes such as immunization , health check up etc.
* To assist ANM in administration of IFA and vitamin A by keeping stock of both medicines.
* To share information collected under ICDS scheme with ANM.
* To bring into notice of supervisors /CDPO any development in the village which requires their attention.
* To maintain liaison with other institutions (mahila mandals) & involve lady school teachers which have relevance to their functionaries.
* To guide Accredited Social health Activist (ASHA) engaged under National Rural Heath Mission (NHRM) in delivery of health services.
* To assist the implementation of Kishori Shakti Yogana( KSY)and motivate and educate adolescent girls / their parents by organizing awareness campaigns.
* AWW would also assist in implementation of Nutrition Programme for Adolescent girls ( NPAG) as per guidelines of the scheme .
* To identify disability among children during home visit & refer the case immediately to nearest PHC or district disability rehabilitation center.
* To support in organizing Pulse Polio Immunization ( PPI) drives.
* To inform the ANM in case of emergency cases viz..Diarrhea, cholera etc (Desai ,2012).

**ICDS TRAINING PROGRAMME**

The training component of the Integrated Child Development Services Programme has now been recognized as the most important key to achieve the aims and objectives of Integrated Child Development Services scheme with the ultimate aim of moulding the functionaries into "Agents of social and behavioural change.”

  The Southern Regional Centre of the National Institute of Public Co-operation and Child Development (NIPCCD) located at Bangalore is an apex body catering to the training needs of senior level Integrated Child Development Services functionaries like Deputy Directors/Programme Officers/ CDPOs/ACDPOs etc., besides undertaking Research and Evaluation studies. .

 At present there is one Middle Level Training Centre (MLTC) at Ujire (Dakshina Kannada) which is catering to the training needs of ICDS supervisors. The state has 19 Anganwadi Workers Training Centres (AWTCs) which are runby NGOs for training Anganawadi workers and helpers. The rates of honorarium as well as course grants as per GOI guidelines have been sanctioned by the State Government to implement various training programmes.

During 2006-07 an amount of Rs 216.29 lakhs was released and Rs. 196.73 lakhs was incurred under the ICDS training programme to train 595 supervisors, 6658 Anganwadi Workers and 8595 Anganwadi Helpers (Job/Refresher training /orientation training).

**STATE TRAINING TASK FORCE**

  For regular monitoring and evaluation of the training component of Integrated Child Development Services scheme, the state Government has constituted the State TrainingTask Force.

 The basic function of this Task Force is to integrate and co-ordinate all aspects of ICDS training at all levels and to recommend changes in the curriculum, strategies and methodology. The ultimate goal is to reorient and re-utilise ICDS training to turn it into a dynamic, responsive and human resource development programme (Ram Mohan, 2011).

**ADVANTAGES**

Ideal and health care experts. Unfortunately India has a shortage of skilled professionals. Therefore, through the Anganwadi system, the country is trying to meet its goal of enhanced health facilities that are affordable and accessible for local populations. In many ways an Anganwadi worker is better equipped than a physician in reaching out to the rural population. Since the worker lives with the people she is in a better position to identify the cause of health problems and hence counter them. She has a very good insight of the health status in her region. Secondly though Anganwadi workers are not as skilled or qualified as professionals they have better social skills thus making it easier to interact with the people.

 Moreover, since these workers are from the village, they are trusted which makes it easier for them to help the people. Last but not the least, Anganwadi workers are well aware of the ways of the people, are comfortable with the language, know the rural folk personally etc. This makes it very easy for them to figure out the problems being faced by the people and ensure that they are solved.

## CHALLENGES

There have been public policy discussions over whether to make Anganwadies universally available to all eligible children and mothers. This would require significant increases in budgetary allocation and a rise in Anganwadies centres to over 16 lakh.

Anganwadies are staffed by officers and their helpers, who are typically women from poor families. The workers do not have permanent jobs with comprehensive retirement benefits like other government staff. Worker protests (by the All India Anganwadi Workers Federation) and public debates on this topic are ongoing. There are periodic reports of corruption and crimes against women in some Anganwadi centres. There are legal and societal issues when Anganwadi-serviced children fall sick or die.

In announcing the 2008-2009 budgets, Indian Finance Minister P Chidambaram stated that salaries would be increased for Anganwadi workers to Rs 1500 per month and helpers to Rs 750 per month. In March 2008 there was debate about whether packaged foods (such as biscuits) should become part of the food served. Detractors, including Nobel Prize winner [Amartya Sen](https://en.wikipedia.org/wiki/Amartya_Sen), disagreed saying it will become the only food consumed by the children. Options for increasing partnership with the private sector are continuing.

In a major initiative, the centre is set to digitise the work of Anganwadies starting with 27 most-backward districts in Uttar Pradesh: Bihar, Madhya Pradesh, Rajasthan, Orissa and Andhra Pradesh. Anganwadies will be provided with tablet computers to record data that will be integrated with the health ministry which is involved in carrying out immunisation, health check-ups, and nutrition education under the Integrated Child Development Scheme (ICDS).

Stress is a term which has got great prominence in the modern world now days. Every person wants to achieve new heights in their personal and professional life, which leads to stressful days and nights, declining physical and mentalhealth and formation of new variety of diseases. Occupational stress plays a key role in the work environment of an organization .When thinking about stress and its solutions field of medicine arises into our mind first. But the real fact is that the health care industry was identified as one of the major where this occupational stress is highly prevailing. Major studies on stress related to the medical field always revolve aroundnurse’s population due to their long work hours, night duties and shift work. But here we are knowingly or unknowingly ignoring the person who occupied a prominent place in relation to job stress when compared with other professionals in health care industry, Doctors. The researchers found negative relationship between job stressors and job involvement that is employees whose job involvement is high respond more negatively to job involvement is high respond more negatively to job stressors.

Community health workers are an important channel for delivery of services to the community in developing countries. Anganwadi worker (AWW) is a woman who works at grass- root level under the Integrated Child Development Services (ICDS) scheme which is one of the largest and most unique community based outreach program for women and child development. Apart from various services of ICDS such as supplementary nutrition, health education, health checkups, referrals etc. AWW are involved in national health programs such as Pulse Polio Immunization, integrated disease control programs for dengue, malaria, etc . Her work also includes doing house to house survey, visits beyond working hours, maintenance of registers, records, reporting etc. AWW play a crucial role in broadening coverage of health services and contributes significantly to improve the health outcomes .

Anganwadi workers are the real providers of many basic services for the poor across India but they are not treated on a par with other government employees and considered as "social workers" or "voluntary workers". They are not paid "wages" but only an "honorarium". Also other resources and facilities provided for undertaking all this work are minimal. As working women, AWW have dual responsibility of their own household chores as well as program activities. These underpaid AWW performing and discharging duties and accomplishing targets in a limited time may lead to stress and discontent among them. Stress may affect their health and also may lead to dissatisfaction, poor motivation and a decreased efficiency. They are responsible to take care of health of the community but their own health has been neglected.

There is a lack of information on psychosocial condition and occupational stress and their impact on health of Anganwadi workers. Stressed AWW can affect programme performance. So such information would be important in improving the quality of the service and the optimal utilization of the existing Anganwadi workers by taking measures to address these issues. Thus, in this study, an attempt was made to assess the level of job stress and understand the various factors associated with job stress, which could be responsible for their adverse health status and the sub-optimal performance of the Anganwadi workers.

**CHAPTER – IV**

**DATA ANALYSIS AND INTERPRETATION**

**TABLE NO 4.1**

 **AGE WISE CLASSIFICATION**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of respondents** | **Percentage** |
| Lee than 25 years | 7 | 14 |
| 25-40 years | 28 | 56 |
| Above 40 years | 15 | 30 |
| **Total** | **50** | **100** |

 **Source: primary data**

**CHART NO 4.1**

**AGE WISE CLASSIFICATION**

**INTERPRETATION**

The above table show that 56% of the respondents are comes under the age group of 25-40, 30% comes under above 40 years and 14% of the respondents come under the age of less than 25 years.

**TABLE NO 4.2**

**EDUCATIONAL QUALIFICATION**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No of respondents** | **Percentage** |
| Up to V std  | 10 | 20 |
| V-X std | 15 | 30 |
| Higher secondary | 12 | 24 |
| Graduate  | 8 | 16 |
| PG | 5 | 10 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.2**

**EDUCATIONAL QUALIFICATION**

**INTERPRETATION**

The above table shows that 24% of the respondents have an educational qualification of V-X std, 24% of them completed higher secondary education, 20% have an qualification of up to V std, 16% of them are graduates and 10% of the respondents are post graduates.

**TABLE NO 4.3**

**LIVING IN THE SAME PANCHAYATH AS ANGANWADI LOCATED**

|  |  |  |
| --- | --- | --- |
| **Particulars**  | **No of respondents** | **Percentage** |
| Yes  | 40 | 80 |
| No  | 10 | 20 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.3**

**LIVING IN THE SAME PANCHAYATH AS ANGANWADI LOCATED**

**INTERPRETATION**

The above table shows that 80% of the respondents are living in the same panchayath where anganwadi located and 20% are not living in the same panchayath as anganwadi located.

**TABLE NO 4.4**

**UNDERGONE TRAINING FOR DOING THE JOB**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 42 | 84 |
| No  | 8 | 16 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.4**

**UNDERGONE TRAINING FOR DOING THE JOB**

**INTERPRETATION**

The above table shows that 84% of the respondents are undergo training for doing the job and 16% of them never gone for training.

**TABLE NO 4.5**

**NO. OF YEARS HAVE BEEN WORKING**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Less than 1 year | 12 | 24 |
| 1 – 3 years | 13 | 26 |
| 3 – 5 years | 18 | 36 |
| More than 5 years | 7 | 14 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.5**

**NO. OF YEARS HAVE BEEN WORKING**

**INTERPRETATION**

The above table and chart shows that 36% of the respondents have been working for 3-5 years, 26% of them working for 1-3 years, 24% are worked less than 1 year and 14% of the respondents have been working for more than 5 years.

**TABLE NO 4.6**

**PARTICIPATED IN COMMUNITY SURVEY UNDER ICDS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 30 | 60 |
| No  | 20 | 40 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.6**

**PARTICIPATED IN COMMUNITY SURVEY UNDER ICDS**

**INTERPRETATION**

The above table shows that 60% of the respondents are participated in a community survey under ICDS and 40% of them are not participated.

**TABLE NO 4.7**

**VISITING BENEFICIARY’S HOUSE**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 35 | 70 |
| No  | 15 | 30 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.7**

**VISITING BENEFICIARY’S HOUSE**

**INTERPRETATION**

The above table shows that 70% of the respondents are visiting the beneficiary’s house and 30% of them are not visiting.

**TABLE NO 4.8**

**DURATION OF VISITS TO THE HOUSEHOLD**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Regularly  | 10 | 20 |
| Sometimes | 15 | 30 |
| Never | 5 | 10 |
| When necessary | 20 | 40 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.8**

**DURATION OF VISITS TO THE HOUSEHOLD**

**INTERPRETATION**

The above table shows that 40% of the respondents visiting the beneficiary’s house when necessary, 30% of them sometimes visiting, 20% are regularly visiting and 10% of them are never visiting the households.

**TABLE NO 4.9**

**TYPE OF GUIDANCE PROVIDING**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Guidance regarding nutrition food and health care education of pregnant women | 12 | 24 |
| Regarding vaccination for both mother and child | 15 | 30 |
| Regarding care of children | 14 | 28 |
| Information of malnourished children to the parents and necessary guidance | 9 | 18 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.9**

**TYPE OF GUIDANCE PROVIDING**

**INTERPRETATION**

The above table shows that 30% of the respondents opined that they providing the guidance regarding vaccination for both mother and child, 28% of them providing the guidance regarding care of child, 24% provide guidance regarding nutrition food and health care education of pregnant women and 18% of the respondents provides information of malnourished children to the parents and necessary guidance.

**TABLE NO 4.10**

**AWARENESS ABOUT SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP)**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 40 | 80 |
| No  | 10 | 20 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.10**

**AWARENESS ABOUT SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP)**

**INTERPRETATION**

The above table shows that 80% of the respondents are aware of supplementary nutritional programme (SNP) and 20% of the respondents are not aware about it.

**TABLE NO 4.11**

**PROVIDING KINDS OR CASH FOR SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP) BY THE GOVERNMENT**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of respondents** | **Percentage** |
| Kinds  | 33 | 66 |
| Cash  | 17 | 34 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.11**

**PROVIDING KINDS OR CASH FOR SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP) BY THE GOVERNMENT**

**INTERPRETATION**

The above table shows that 66% of the respondents said that the government providing kinds for supplementary nutritional programme and 34% of them said as cash.

**TABLE NO 4.12**

**MAINTAINING OF MENU AS PER GOVERNMENT RULES**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes | 39 | 78 |
| No | 11 | 22 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.12**

**MAINTAINING OF MENU AS PER GOVERNMENT RULES**

**INTERPRETATION**

The above table shows that 78% of the respondents opined that they maintain the menu as per the government rules and 22% of them are not maintaining the menu as per the government rules.

 **TABLE NO 4.13**

**OPINION REGARDING THE QUALITY OF SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP)**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Excellent | 14 | 28 |
| Good | 20 | 40 |
| Average | 9 | 18 |
| Poor | 7 | 14 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.13**

**OPINION REGARDING THE QUALITY OF SUPPLEMENTARY NUTRITIONAL PROGRAMME (SNP)**

**INTERPRETATION**

The above table shows that 40% of the respondents opined that the quality of supplementary nutritional programme is good, 28% of them opined as excellent, 18% are opined as average and 14% of the respondents opined as poor.

**TABLE NO 4.14**

**FREQUENCY OF ORGANIZING IMMUNIZATION CAMP**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Regularly | 19 | 38 |
| Sometimes | 15 | 30 |
| Never | 2 | 4 |
| When necessary | 14 | 28 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.14**

**FREQUENCY OF ORGANIZING IMMUNIZATION CAMP**

**INTERPRETATION**

The above table shows that 38% of the respondents said that they regularly organizing immunization camps, 30% opined as sometimes, 28% opined as when necessary and 4% of the respondents opined that they never organizing the immunization camp.

**TABLE NO 4.15**

**FREQUENCY OF ORGANIZING HEALTH CHECK UP CAMPS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Regularly | 15 | 30 |
| Sometimes | 18 | 36 |
| Never | 4 | 8 |
| When necessary | 13 | 26 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.15**

**FREQUENCY OF ORGANIZING HEALTH CHECK UP CAMPS**

**INTERPRETATION**

The above table shows that 36% of the respondents opined that they sometimes organizing health check up camps, 30% of them are opined as regularly, 26% opined as when necessary and 8% of the respondents opined as never.

**TABLE NO 4.16**

**RESPONDS ABOUT THE COORDINATION OF HEALTH DEPARTMENT**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Excellent | 18 | 36 |
| Good | 15 | 30 |
| Average | 10 | 20 |
| Poor | 7 | 14 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.16**

**RESPONDS ABOUT THE COORDINATION OF HEALTH DEPARTMENT**

**INTERPRETATION**

The above table shows that 36% of the respondents responded that the coordination of health department were excellent, 30% responded as good, 20% responded as average and 14% of the respondents responded as poor.

**TABLE NO 4.17**

**MAINTAINING OF REGISTER FOR REFERRAL SERVICE AND MEDICAL ITEMS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 45 | 90 |
| No  | 5 | 10 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.17**

**MAINTAINING OF REGISTER FOR REFERRAL SERVICE AND MEDICAL ITEMS**

**INTERPRETATION**

The above table shows that 90% of the respondents said that they are maintaining register for referral service and medical items and 10% of them are not maintaining registers.

**TABLE NO 4.18**

**FREQUENCY OF ORGANIZING MOTHER’S MEETING**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Regularly | 9 | 18 |
| Sometimes | 16 | 32 |
| Never | 3 | 6 |
| When necessary | 22 | 44 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.18**

**FREQUENCY OF ORGANIZING MOTHER’S MEETING**

**INTERPRETATION**

The above table shows that 44% of the respondents said that they organizing mother’s meeting when necessary, 32% said as sometimes, 18% said as regularly and 6% of the respondents said that they are never organizing mother’s meeting.

**TABLE NO 4.19**

**ORGANIZING OF COMMUNITY COUNSELLING MEETING**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Regularly | 10 | 20 |
| Sometimes | 20 | 40 |
| Never | 5 | 10 |
| When necessary | 15 | 30 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.19**

**ORGANIZING OF COMMUNITY COUNSELLING MEETING**

**INTERPRETATION**

The above table shows that 40% of the respondents opined that they sometimes organizing community counseling meetings, 15% are opined as when necessary, 20% are opined as regularly and 10% of them opined as never.

**TABLE NO 4.20**

**RESPONDS REGARDING THE ADEQUACY OF AWC EQUIPMENT IN TERMS OF ENABLING TO THEM TO PERFORM THE WORK EFFECTIVELY**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Adequate | 30 | 60 |
| Inadequate | 12 | 24 |
| Unclear | 8 | 16 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.20**

**RESPONDS REGARDING THE ADEQUACY OF AWC EQUIPMENT IN TERMS OF ENABLING TO THEM TO PERFORM THE WORK EFFECTIVELY**

**INTERPRETATION**

The above table shows that 60% of the respondents opined that there is adequate AWC equipment in terms of enabling to them to perform their work effectively, 24% are opined as inadequate and 16% are opined as unclear.

**TABLE NO 4.21**

**OPINION ABOUT THE QUALITY OF EQUIPMENT PROVIDED TO AWC**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Excellent | 14 | 28 |
| Good | 25 | 50 |
| Average | 6 | 12 |
| Poor | 5 | 10 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.21**

**OPINION ABOUT THE QUALITY OF EQUIPMENT PROVIDED TO AWC**

**INTERPRETATION**

The above table shows that 50% of the respondents opined that good quality of equipments are provided to AWC, 28% of them opined as excellent quality, 12% opined as average and 10% of the respondents opined as poor quality of equipments.

**TABLE NO 4.22**

**RESPONDS WITH THAT SOME OF THE WORK IS QUITE COMFORTABLE TO MAINTAIN THE DUAL ROLES IN BOTH WORK PLACE AND HOME**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 25 | 50 |
| No  | 25 | 50 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.22**

**RESPONDS WITH THAT SOME OF THE WORK IS QUITE COMFORTABLE TO MAINTAIN THE DUAL ROLES IN BOTH WORK PLACE AND HOME**

**INTERPRETATION**

The above table shows that 50% of the respondents opined that some of the work is quite comfortable to maintain the dual roles in both work place and home and 50% of the respondents opined that it is not possible.

**TABLE NO 4.23**

**FEELING OF TIREDNESS AFTER RETURNING FROM WORK PLACE**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes  | 36 | 72 |
| No  | 14 | 28 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.23**

**FEELING OF TIREDNESS AFTER RETURNING FROM WORK PLACE**

**INTERPRETATION**

The above table shows that 72% of the respondents feel tired after returning from work place and 28% of them not feeling tiredness.

**TABLE NO 4.24**

**SATISFACTION WITH THE PROFESSION**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Highly satisfied | 14 | 28 |
| Satisfied | 24 | 48 |
| Neutral | 8 | 16 |
| Dissatisfied | 4 | 8 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.24**

**SATISFACTION WITH THE PROFESSION**

**INTERPRETATION**

The above table shows that 48% of the respondents are satisfied with their profession, 28% are highly satisfied, 16% are neutral and 8% of them are dissatisfied with the profession.

**TABLE NO 4.25**

**OPINION REGARDING PUBLIC PERCEPTIONS TOWARDS THE JOB**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Excellent | 15 | 30 |
| Good | 22 | 44 |
| Average | 10 | 20 |
| Poor | 3 | 6 |
| **Total** | **50** | **100** |

 **Source: Primary data**

**CHART NO 4.25**

**OPINION REGARDING PUBLIC PERCEPTIONS TOWARDS THE JOB**

**INTERPRETATION**

The above table shows that 44% of the respondents opined that the public perceives as good towards the job, 30% are opined as excellent, 20% opined as average and 6% of them opined as poor.

**CHAPTER – V**

**FINDINGS, SUGGESTIONS AND CONCLUSION**

**FINDINGS**

1. 56% of the respondents are comes under the age group of 25-40.
2. 24% of the respondents have an educational qualification of V-X std.
3. 80% of the respondents are living in the same panchayath where anganwadi located.
4. 84% of the respondents are undergo training for doing the job.
5. 36% of the respondents have been working for 3-5 years.
6. 60% of the respondents are participated in a community survey under ICDS.
7. 70% of the respondents are visiting the beneficiary’s house.
8. 40% of the respondents visiting the beneficiary’s house when necessary.
9. 30% of the respondents opined that they providing the guidance regarding vaccination for both mother and child.
10. 80% of the respondents are aware of supplementary nutritional programme (SNP).
11. 66% of the respondents said that the government providing kinds for supplementary nutritional programme.
12. 78% of the respondents opined that they maintain the menu as per the government rules.
13. 40% of the respondents opined that the quality of supplementary nutritional programme is good.
14. 38% of the respondents said that they regularly organizing immunization camps.
15. 36% of the respondents opined that they sometimes organizing health check up camps.
16. 36% of the respondents responded that the coordination of health department were excellent.
17. 90% of the respondents said that they are maintaining register for referral service and medical items.
18. 44% of the respondents said that they organizing mother’s meeting when necessary.
19. 40% of the respondents opined that they sometimes organizing community counseling meetings.
20. 60% of the respondents opined that there is adequate AWC equipment in terms of enabling to them to perform their work effectively.
21. 50% of the respondents opined that good qualities of equipments are provided to AWC.
22. 50% of the respondents opined that some of the work is quite comfortable to maintain the dual roles in both work place and home.
23. 72% of the respondents feel tired after returning from work place.
24. 48% of the respondents are satisfied with their profession.
25. 44% of the respondents opined that the public perceives as good towards the job.

**SUGGESTIONS**

* Majority of the respondents have more than 5 years of association with ICDS. So they are quite experienced and such employees can be involved in the training or mentoring of newly joined or learners in the association
* Authorities can provide transportation facility to the employees, in particular to those coming from far areas.
* Authorities should also consider involving the workers in the decisions so that they can freely express their problems and contribute ideas.
* Authorities should provide training and development programs to the workers on regular basis so they can efficiently and increase productivity.
* Majority of respondents are quite happy with their present pay but still the company should revise

**CONCLUSION**

Anganwadi workers were also found to result in higher job satisfaction. The reason is that the workers working with the children in public service will earn respectability from society. Similar the workers have reported that holding this service as women (especially gendered related work) tends to produce a high level of job satisfaction compared to those who work in other department and this service is the best service for women employees. In conclusion, except for their salary/ honourarium and over work load, Anganwadi workers of ICDS project under Social Welfare Department of Assam were generally satisfied with their job. Anganwadi centres are considered as the best place for children to get good nutrition, health care and formal education economically. However, quality of service still needs to be evaluated. Thus, present study recommends that improvement in anganwadi centre’s infrastructures and logistic facilities are inevitable components in delivering services to beneficiary. Yet another factor is the educational qualification of anganwadi worker. For the assessment of growth and minor health issues of the children, anganwadi worker must have basic educational qualification. Lastly, community participation and coordinated work with other departments also help in accomplishing the objectives of ICDS.

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* https://www.academia.edu/37507841/KNOWLEDGE\_AND\_PRACTICE\_OF\_ORAL\_HEALTH\_CARE\_AMONG\_ANGANWADI\_WORKERS\_IN\_A\_COMMUNITY\_BLOCK\_PANCHAYATH\_IN\_KERALA

**APPENDIX**

**QUESTIONNAIRE**

Name

1. Age

Les s than 25 years [ ]

25 – 40 years [ ]

Above 40 years [ ]

1. Educational qualification

Upto V std [ ]

V – X std [ ]

Higher secondary [ ]

Graduate [ ]

PG [ ]

1. Do you live in the same Panchyath as Angan wadi located?

Yes [ ]

Noo [ ]

1. Did you undergo training for doing this job?

Yes [ ]

No [ ]

1. For how long have you been working?

Less than 1 year [ ]

1 – 3 years [ ]

3 – 5 years [ ]

More than 5 years [ ]

1. Have you participated in a community survey under ICDS?

Yes [ ]

No [ ]

1. Are you visiting the beneficiary’s house?

Yes [ ]

No [ ]

1. If yes duration of visits to the household?

Regularly [ ]

Sometimes [ ]

Never [ ]

When necessary [ ]

1. What type of guidance do you provide?

Guidance regarding nutrition food and health care education of pregnant women [ ]

Regarding vaccination for both mother and child [ ]

Regarding care of children [ ]

Information of malnourished children to the parents and necessary guidance

 [ ]

1. Are you aware of Supplementary Nutritional Programme (SNP)

Yes [ ]

No [ ]

1. For SNP Govt. provides kinds or cash?

Kinds [ ]

Cash [ ]

1. Do you maintain the menu as per Govt. rule?

Yes [ ]

No [ ]

1. What is your view regarding quality of SNP?

Excellent [ ]

Good [ ]

Average [ ]

Poor [ ]

1. How often do you organize immunization camp?

Regularly [ ]

Sometimes [ ]

Never [ ]

When necessary [ ]

1. How often do you organize health check up camps?

Regularly [ ]

Sometimes [ ]

Never [ ]

When necessary [ ]

1. What is your view about the coordination of health department?

Excellent [ ]

Good [ ]

Average [ ]

Poor [ ]

1. Do you maintain register for referral service and medical items?

Yes [ ]

No [ ]

1. How often do you organize mothers’ meeting?

Regularly [ ]

Sometimes [ ]

Never [ ]

When necessary [ ]

1. Do you organize community counseling meeting?

Regularly [ ]

Sometimes [ ]

Never [ ]

When necessary [ ]

1. How would you describe the adequacy of the AWC equipment, in terms of enabling you to perform your work effectively?

Adequate [ ]

Inadequate [ ]

Unclear [ ]

1. How do you rate the quality of equipment provided to AWC?

Excellent [ ]

Good [ ]

Average [ ]

Poor [ ]

1. Do you think that some of the work is quite comfortable to maintain the dual roles in both work place and home?

Yes [ ]

No [ ]

1. Do you feel tired after returning from your work place?

Yes [ ]

No [ ]

1. Are you satisfied with your profession?

Highly satisfied [ ]

Satisfied [ ]

Neutral [ ]

Dissatisfied [ ]

1. . What is your opinion regarding public perceptions towards your job ?

Excellent [ ]

Good [ ]

Average [ ]

Poor [ ]