**CHAPTER – I**

**EXECUTIVE SUMMARY**

**INTRODUCTION**

Commitment towards the cause of children is as old as India's civilisation. But over the years during the pre-independence era, due to various socioeconomic and cultural reasons, the importance given to the child was substituted by neglect, abuse, and deprivation especially in the poverty-stricken sections of the society. However, India's Independence puts a new hope in the field of child welfare and development. Child Welfare is taken as a social responsibility worldwide. International organizations, including the United Nations Agencies, are making efforts to make the child welfare schemes compatible with their resources and with the assistance of other developed nations. The government of India on its part have initiated and implemented projects such as Integrated Child Development Services (ICDS), Sarva Shiksha Abhiyan (SSA), Midday meal, Mission Indhradhanush, etc. with the corporation of state governments and local bodies, towards the wellbeing of the child. Though the spread of the programme is nationwide and inclusive, the fund allotted and used is not compatible with the demand.

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

Around 158 million of the population of India are children in the age group 0 - 6 years. As per the World Bank, Early Childhood Programs improve the health, nutrition and educational outcomes of children. Integrated Child Development Services (ICDS), an Early Childhood Development Program is one of the largest and oldest social sector schemes of the Government of India. It provides an integrated approach for converging six essential services for improved childcare, early stimulation and learning, health and nutrition, education, primarily targeting young children (0-6 years), expectant and nursing mothers. Besides, nutritional and health services are provided targeting, in general, all women in the age group 15 to 45 years. Anganwadis are the primary delivery points and operational units of ICDS at habitation level managed by an Anganwadi worker (AWW) and an Anganwadi Helper (AWH). ICDS is a people's programme, and its success depends on the participation of the community. In the Report of the Inter-Ministerial Group on ICDS Restructuring, by adopting a lifecycle approach to early childhood care and development, Anganwadi would be transformed to vibrant, child - friendly Early Childhood Development (ECD) centre which will ultimately be owned by the women in the community.

ICDS services are provided a vast network of ICDS centres, it is known as “Anganwadi”. The word Anganwadi is devloped from the Hindi word “Angan” which refers to the courtyard of a house. In rural areas an Angan is where people get together to discuss, meet, and socialize. The Angan is also used occasionally to cook food or for household members to sleep in the open air. This part of the house is seen as the ‘heart of the house’. A network of “Anganwadi Centre (AWC)” literally it is a courtyard play centre, provides integrated services comprising supplementary nutrition, immunization, health check-up, referral services, pre-school education and health and nutrition education. It is a childcare centre located within the village or the slum area itself. It is the central point for the delivery of services at community levels to children below six years of age, pregnant women, nursing mothers and adolescent girls. Under the ICDS scheme, one trained person is selected to focus on the health and educational needs of children age 0-6 years. This person is the Anganwadi worker (AWW). The Anganwadi worker is the most important functionary of the ICDS scheme. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. This service will help the children to get into the right from the pre-school age. The Integrated Child Development Service (ICDS) scheme is utilized to help the family especially mothers to ensure effective health and nutrition care, early recognition and timely treatment of ailments.

In spite of the ongoing direct nutrition interventions like ICDS, India still contributes to about 21% of the global burden of child deaths before their fifth birthday (UNICEF 2007). They also found little evidence of programme impact on child nutrition in villages with ICDS centre. ICDS is the foremost symbol of India’s commitment to her children – India’s response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality. World Bank has also highlighted certain key shortcomings of the programme including inability to target the girl child improvements, participation of wealthier children more than the poorer children and lowest level of funding for the poorest and the most undernourished states of India (World Bank, 2011).

Supplementary Nutrition is one of the important factor for balancing the nutrition status of the children. This includes supplementary feeding and growth monitoring; and against vitamin A shortage and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. Anganwadi workers are advantage of supplementary feeding supports for 300 days in a year. For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day. By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition are two important actions that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to find out the growth flattering and helps in assessing their nutritional status. In addition, highly malnourished children are focused with special supplementary feeding and referred to medical services for the betterment.

The community’s active participation and co-operation is the key to the success of any social and development programs, but not much research has been done to show the extent of community participation and its effectiveness in many of the programs initiated. This research studies the ICDS scheme alone taking into account the Human Resource Development components like education, nutrition, and health and also considers the importance of Early Childhood Development. ICDS, being the largest women and child development program implemented anywhere in the world, having completed 42 years of existence demands a study regarding the achievement of its primary goal through community participation.

The services arc extended to the target community at a focal point ‘Anganwadi’ (AWC) located within an easy and convenient reach of the community. AWC is managed by an honorary female worker ‘Anganwadi Worker'(AWW). who is the key community level functionary. She is a specially selected and trained woman from the local community, educated upto high school. She undergoes 3 months training in child development, immunization, personal hygiene, environmental sanitation, breastfeeding. ante-natal care, treatment of minor ailments and recognition of ‘at risk’ children. She gets a small honorarium as an incentive. The presence of AWW in the community has a synergistic effect as she liaises between health functionaries and the community. Convergence with health helps achieve better maternal and child health, enhances awareness regarding family planning services, treatment of morbidity and reduction of mortality. AWC serves as a central point for immunisation, distribution of vitamin A, iron and folic acid tablets and treatment of minor ailments and first aid. AWC is also the venue for health related activities carried out by auxiliary nurse-midwives (ANM)

The purpose of the study being community participation in ICDS, the people above the age of 14 who constitutes the community (Beneficiary, Functionary, and other Community Stakeholders) are considered as the respondents. The field of the study was Kannur district in the state of Kerala, India. The data collection instruments consisting of both Quantitative (Questionnaires, Interview Schedule), and Qualitative were employed to collect the primary data from the respondents.

**CHAPTER – II**

**PROBLEM STATEMENT**

**PROBLEM STATEMENT**

Integrated Child Development Services Scheme was conceived as a community-based program . In her study on Efficiency of Anganwadi Centres-A Study in Kannur District, Kerala, Asha, has found a statistically significant association between the efficiency of Anganwadi centres and community participation. Among the states of India, Kerala stands out in the areas of literacy, health, nutrition, etc. but this does not match with the ground reality while considering the status of Anganwadis regarding low utilisation, poor infrastructure quality, new born death due to malnourishment, lack of medical treatment, etc. The news reports (Hindu, 2015 June 2; Bureau, 2012; Mathrubhumi, 2017, 8th February; Indian Express N. , 2017, 9th February; Indian Express T. N., 2017, 8 February); report (Rozario, 2013), and studies (Balsekar, George, Puett, & Dhingra, 2005; Seema, 2001; Tharakan, 2005; Asha, 2014) have reported a gap between the claim and the reality. In spite of various projects implemented and funds provided by the Union and State governments and local bodies, what is understood to be wanting in this area is a proactive community involvement (Sharma A., NIPCCD 1987; Asha, 2014; Jones, Lyytikäinen, Mukherjee, & Reddy, 2007). Though the relevance of community participation in ICDS is established, studies centred on ICDS have ended up giving suggestions or recommendation to augment participation. However, a conceptual clarity for measuring indicators or proper methodology to assess the depth and breadth of community participation in the context of ICDS is not defined. In this scenario, the need arises to define the concepts ‘community', ‘participation,' and the indicators for measuring community participation and developing tools that can appropriately measure the extent and effectiveness of community participation.

**SIGNIFICANCE OF THE STUDY**

ICDS started in the year 1975 gained acceptance in terms of various parameters relating to the objectives envisaged gradually was extended to the whole country. Though universalised, seeing a lack of quality, resources, participation, etc., the programme recently turned to mission mode for restructuring and strengthening the ICDS. One of the new thrust areas in the broad framework of implementation for the strengthening and restructuring of ICDS by Ministry of Women and Child Welfare 2013 is 'greater community participation.' Community Mobilisation is one of the elements in the redesigned service package stated in the framework. Again the five mission mode of ICDS emphasises on building the local capacities and resources. In the report of the inter-ministerial group on the restructuring of ICDS chaired by the member of Planning Commission Dr. Syeda Hameed, the increased ownership of the programme by the community or women by way of participation and contribution is one among the nine themes. The above said emphasises the importance of research in this area. When the government relies on greater community participation, it must be a matter of concern; on what is the knowledge level of the community about the schemes and participation; what is their attitude towards the same, how the community participation is ensured; to what extent community is participating; how is community participation elicited at present and how the participation is benefiting the programme and the intended group. This research concentrates to understand the knowledge attitude and practice of the community towards community participation, the extent of participation and the effectiveness of the present participation in ICDS and to find how the community could be motivated in participating in these schemes.

**OBJECTIVES OF THESTUDY**

* To study the Socio-demographic profile of the respondents.
* To understand the Knowledge, Attitude and Practice of the respondents.
* To assess the Effectiveness of community participation.
* To identify the problems that hinders community participation.
* To develop an appropriate Social work model for effective community participation.

**HYPOTHESIS OF THE STUDY**

* There is no association between the Beneficiary Respondent’s Level of KAP and the Socio-Demographic Profile (Type of project, Location of respondents, Number of years of stay)
* There is no correlation between the dimensions of Knowledge, Attitude, and Practice of Beneficiary respondent.
* There is no difference among the level of Extent of Beneficiaries’ Participation and their location.
* There is no significant difference among the Location of beneficiary respondents with respect to the dimensions of problems.
* There is no relation between the factors of community participation in beneficiary respondents.

**METHODOLOGY**

This empirical study conducted on community participation in ICDS in Kannur district, Kerala have drawn lessons from the review of the literature, framing the conceptual base. Accordingly, the insights and observations received from various researchers have been utilised to explore the variables towards the conduct of research.

**RESEARCH DESIGN**

The researcher has used the Descriptive design for the study which is to provide an accurate and valid representation of the factors or variables that are relevant to the research questions. Here in this descriptive design, the researcher described the socio-demographic, knowledge, attitude, practices as well as the extent and effectiveness of community participation.

**Sampling Design**

The researcher has used the Proportionate Stratified Random Sampling method to collect the Quantitative data.

**Source of Data**

The availability of suitable and sufficient materials enhances the possibilities of in-depth research. The researcher for the present study used the primary sources of information acquired through direct administration of self-prepared interview schedule and questionnaire for quantitative data collection as well as semi-structured interview guide and focus group discussion guide for qualitative data collection. Besides, the secondary sources were also used. The journals were extracted from the search engines like Google Scholar and Inflibnet and their electronic databases. The researcher also visited different libraries, institutions, and the social justice department to find the availability of resource materials, thereby a collection of scholarly journals, magazines, newspapers, academic books, government documents were utilised as the secondary data source.

**LIMITATION OF THE STUDY**

Though the research was adequately planned and executed, there were certain limitations, which were inherent and out of control of the researcher. The outcome of the study should be understood when the results are read along with the limitations and constraints occurred during the study. Following are the certain limitations.

* Since participation is an ongoing process and it may change from time to time over a period, due to various reasons, hence the results of the study cannot be taken as a standard behaviour of the community towards community participation.
* As the study was confined to the geographical area, Kannur, the results cannot be generalised to the other regions of Kerala. Also in this study, only prominent and immediate target population was interviewed, and other groups who also participate at subsequent levels had to be left out for the sake of manageability.

**REVIEW OF LITERATURE**

Review literature gives an insight in to different aspects of the problem under the study. It helps the investigator to design the framework, develop the methodology and tools for data collection and plan the analysis of data.Various studies in recent past has revealed that implementation of services under ICDS are not up to satisfactory standards and still more efforts are needed for improving the quality of services for the successful achievement of expected targets (Barman 2001; Forces New Delhi 2007). In the opinion of some scholars the achievement of ICDS programme goals depends heavily upon the effectiveness of the Anganwadi workers, which in turn, depends upon their knowledge, attitude and practice (Sharma, 1987; Chattopadhayay, 1999). The studies done in past have strongly concluded on the need of improved knowledge and awareness among Anganwadi workers but unfortunately it was found to be the most underrated aspect of their job profile (Kant et al. 1984; Gopaldas et al. 1990; Bhasin et al. 2001).

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

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

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

**CHAPTER – III**

**THE STUDY**

**CHILD WELFARE POLICIES AND PROGRAMMES IN INDEPENDENT INDIA**

The Independent India considered and focussed its attention in the interest of the young child, and adequate provisions were made for the care and protection of children in the Constitution. However, only in 1974, a comprehensive national policy to ensure the welfare of children as envisaged in the constitution was formulated. Today Child Welfare is not limited to the maladjusted delinquents but covers the whole spectrum of the all-round development of the child (Devi, 1998). Relevant Child-centric legislation, institutional frameworks for Child Welfare, and government policies for children.

Numerous programmes or schemes from time to time have been executed for improving the lot of children. The Government is implementing a large number of schemes and programmes for children. Notable among them are Beti Bachao Beti Padhao, Integrated Child Development Scheme (ICDS- 1975), SABLA, Kishori Shakti Yojana, Swachh Bharat Mission (Total Sanitation Campaign- 1999 and Swachh Bharat Mission- 2014), Sarva Shiksha Abhiyan (SSA- 2000), Mid Day Meal, National Health Mission (NHM- 2005), Integrated Child Protection Scheme (ICPS2009), National Skill Development Mission (NSDM-2015), Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram and many others. The National Nutrition Mission (NNM) is soon to be re-launched to address critical issues of under-nutrition comprehensively. The Government is also undertaking gender and child budgeting to ensure adequate resource allocation for women and children.

Child welfare is a broad umbrella encompassing the preventive, developmental, curative and restorative as well as rehabilitative character. The present study, however, focuses on the developmental aspect because of its very nature, and hence the emphasis on the early childhood development and care.

**Early Childhood Development and Care**

Life’s early years have a profound impact on a child’s future. When loved, nourished and cared in safe as well as stimulating environments, the child develops the skills to embrace the opportunity and bounce back from adversity. Care and experiences in the early childhood lay critical foundations for the entire life course (UNICEF, 2017; WHO, 2017) ‘Development is defined as orderly and relatively enduring changes over time in physical and neurological structures, thought process, and behaviour. In the first 20 years of life, these changes usually result in new, improved ways of reacting-that is a behaviour that is healthier, better organised, more complex, more stable, more competent or more efficient’ (Mussen, Coger, Kagar, & Huston, 1990). Advances from creeping to walking, from babbling to talking, or from concrete to abstract thinking are understood as the instances of development. Mussen states that the Child development is also about how and why children develop perception, thought process, emotional reaction and patterns of social behaviour. This also provides knowledge that is crucial for advising parents, forming educational programmes, creating and defending Government programmes and, making legal policies affecting children (Mussen, Coger, Kagar, & Huston, 1990).

The first few years of a child's life is a critical period, concerning physical, cognitive, social and emotional development. Maggie et al. 2005, in their review paper Knowledge Network for Early Child development, have divided the early childhood into two phases to discuss the social determinants. First is the Prenatal and Perinatal Periods (from conception to birth) and second is Preschool and School Age (from birth to 8 years of age) (Maggi, Irwin, Siddiqi, Poureslami, Hertzman, & Hertzman, 2005). The 2007 Lancet series on early childhood development estimated that globally 200 million children aged less than five years are unable to achieve their full potential. Among those, 89 million live in South East Asia Region. Many of these children later will do poorly in school resulting in lowered incomes and productivity (WHO, 2017).

As per the study by Walker et al. in 2007, poverty and associated health, nutrition, and social factors prevent at least 200 million children in developing countries from attaining their developmental potential. ‘Spending one's early years in an un-stimulating emotionally and physically unsupportive environment will affect brain development in adverse ways and leads to cognitive, social and behavioural delays' (Maggi, Irwin, Siddiqi, Poureslami, Hertzman, & Hertzman, 2005). ‘The most frequently assessed social determinant in child health research is socioeconomic status (SES), most notably income.' In another study by Herd et al., it was shown that education was a greater predictor than income at the onset of health problems and then parental unemployment has also been linked with increased prevalence of chronic illness (Victorino & A H, 2009).

As per the World Bank, the ECD (Early Childhood Development) programs improve the health, nutrition, and education outcomes of children. Research shows that ECD interventions benefit the poorest and most disadvantaged children the most even though these children currently are the least likely to have access to them. Children who participate in quality ECD programs, usually the local neighbourhood ‘hub' by which families access quality child care, enables them to participate in primary school tasks more quickly and successfully. There are various studies that points out the importance of the nurturing qualities of family environments which influence the development of a child. These can be enhanced through intervention programmes by involving and improving the parental skills, nutritional supplementation and quality child care arrangements (Maggi, Irwin, Siddiqi, Poureslami, Hertzman, & Hertzman, 2005). Jones and Ramchandini, also states about the developing child and the influences that will shape them which may affect the individual throughout and beyond childhood. Some of them are to the child, such as genetic factors. Other factors such as physical, psychological and family influences, as well as the broader neighbourhood and cultural ones, are from outside.

As per the UNICEF report, about half of all child deaths globally occurred in the year in 2000 were in India, Nigeria, China, Pakistan, Democratic Republic of Congo, and Ethiopia. Jones, Steketee, Black, Bhutta, Morris, & Bellagio, 2003 in their article, point out that ‘though two-thirds of the deaths were preventable, and still it occurred due to the poor implementation of appropriate interventions in these countries'. India is home to the largest number of young children in the world –every fifth child in the world lives in India. Children in the age group 0-6 years constitute around 158 million of the population of India (Census of India 2011). The National Family Health Survey III released the distressing data that almost half of India's children under the age of five were undernourished. Though measures were taken to address the said issue in developing countries, it remains as a matter of concern because of its magnitude and lack of appropriate curbing mechanisms in place. But various organizations like ‘Aga Khan' has demonstrated that community-based approaches to improving child development are feasible and effective in developing countries. As a community-based practice, Integrated Child Development Services (ICDS) Scheme in India, aims at improving nutrition and health status of children.

**Integrated Child Development Services Scheme (ICDS)**

India's Integrated Child Development Services (ICDS) is a holistic early childhood and development program that addresses the interrelated needs of children, adolescent girls, and women from disadvantaged communities'. The scheme was launched in 1975 in pursuance of the National Policy for Children. It is the largest programme for the promotion of maternal and child health and nutrition in the whole world. ICDS provides supplementary nutrition, immunization, health check-up, referral services, pre-school non-formal education and nutrition and health for 0-6 years' children. The scheme is implemented jointly by Ministry of Women and Child Development and Ministry of Health and Family Welfare. It is a multi-sectoral programme and involves several government departments. The programme services are coordinated at the village, block, district, state and central government levels. The primary responsibility for the implementation of the programme lies with Department of Women and Child Development at the Centre and nodal department at the states, which may be Social Welfare, Rural Development, Tribal Welfare or Health Department, Social Justice Department or an Independent Department (Kapil, 2002). This Scheme was organised based on the understanding of the relationship between the intellectual, emotional, social development and the health and nutritional sustainability of the child. ICDS is a multi-dimensional and community-based convergent scheme' (APIP16-17, 2016). Thus it became India’s primary response to the nutritional and developmental needs of the children below six years, pregnant and nursing mothers as well as the adolescent girls.

**The ICDS was launched with the following Objectives:**

* To improve the nutritional and health status of children in the age group of 0-6 years.
* To lay the foundation for proper psychological, physical and social development.
* To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
* To achieve co-ordination of policy and implementation amongst the various departments to promote child development; and
* To enhance the capability of the mother to look after the normal health and nutrition needs of the child through proper nutrition and health education.

The above objectives are sought to achieve through a package of six services comprising supplementary nutrition, immunization, health check-up, referral services, pre-school non-formal education and nutrition& health education.

**Supplementary Nutrition Programme (SNP)**: The SNP includes feeding, growth monitoring, prophylaxis against Vitamin A deficiency and control of anaemia. All families in the community are surveyed to identify children below the age of six as well as the pre and postnatal mothers, and they can access the supplementary feeding almost 300 days in a year. The supplementary feeding is done to bridge the caloric gap between the recommended and the actual consumption.

**Immunisation:** Immunisation of pre-natal mother (i.e., pregnant women) and infants is to protect them from six preventable diseases like poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis, and measles which lead to mortality, disability, morbidity, and malnutrition. Immunisation of pre-natal mother against tetanus also reduces maternal and neonatal mortality. This is a joint responsibility of ICDS and Health department.

**Health check-ups:** The health care of children less than six years of age and antenatal, postnatal care of mothers is looked after by Anganwadi workers and Primary Health Care (PHC) staff. They conduct regular health check-ups, recording of weight, immunisation, management of malnutrition, treatment of diarrhoea, de-worming and distribution of basic medicine etc.

**Referral Services:** During health check-ups and growth monitoring, the sick or malnourished child in need of immediate medical attention is referred to the Primary Health Care or its sub-centre. The Anganwadi worker (AWW) is also oriented to detect early disabilities in children. She has to enlist such cases in a particular register and refer them to the medical officer in the PHC.

**Non-Formal Pre-School Education (PSE)**: The Non- Formal Pre-School Education (PSE) component of the ICDS, is done at the Anganwadi centre (AWC), a village courtyard, where the children from 3- 6 years of age are being educated.

**Nutrition and Health Education (NHE):** One of the primary responsibilities of the Anganwadi worker is NHE, which is the communication strategy for inducing behavioural change. The capacity building of women, in the age group of 15 to 45 years, to take care of their own as well as their children's health, nutrition, and development needs is achieved thereby (the Barrel, 2013).

ICDS services are provided through a network of Anganwadi centres (AWC). It is the first village or habitation post for health, nutrition and early learning. Each centre is run by an Anganwadi worker (AWW) and a Helper (AWH). The AWW is usually a local woman, who undergoes three months of institutional and four months of community training wherein the importance of health, nutrition, and promotion of child's overall development are inculcated. The responsibilities of the AWW include informal preschool education, supplementary feeding, health, and nutrition education, parenting education through home visits, community support and participation, and primary maternal and child health care coordinating with the concerned departmental staff.

The Anganwadi worker (AWW) is also responsible for maintaining records, motivating the parents and organising immunisation sessions, identifying the pregnant women, antenatal care of expectant mothers (pre-natal mothers). They also ensure their IFA supplies, facilitates safe delivery, actively support and promote exclusive breastfeeding from the time of birth and complementary feeding from six months onwards, health check-up of children under six, postnatal care of nursing mothers (post-natal mothers), recording of weight, management of under nutrition and treatment of minor ailments etc. (Secretariat, 2014; Ghosh, 2006). The purpose of Early Childhood Care and Education (ECCE), in ICDS, is to ensure responsive care, early learning and development (physical, motor, language, cognitive and aesthetic appreciation). Thus, the program encompasses the essential elements of care, health, nutrition, play and early learning within a protective and enabling environment (Ministry of Women and Child development, 2015). Supportive supervision and guidance are provided to the AWW by a Supervisor, and a full-time Child Development Project Officer (CDPO), who is directly responsible for the implementation and management of each ICDS project. The programme is a multidepartmental and inter-sectoral endeavour.

The Government of India also partners with United Nations International Children’s Emergency Fund (UNICEF), Co-operative for Assistance and Relief Everywhere (CARE) and World Food Programme (WFP). UNICEF supports ICDS by providing technical support, organising regional workshops, dissemination of best practices, impact assessment in selected states on nutrition and development, anaemia control, etc., UNICEF-CARE, implements non-food projects, like girl primary education, micro-credit, etc. WFP is extending assistance to enhance the effectiveness and outreach of the ICDS scheme and assists the State Government to start and expand the production of low-cost micronutrient fortified food (the Barrel, 2013). The historical background needs to be examined to have a clear picture about ICDS.

**ICDS Scheme in Kerala In Kerala**

ICDS started on October 2nd, 1975 as a pilot project in Vengara in Malappuram District (APIP16-17, 2016). The ICDS Programme was administered under the Directorate of Social Welfare from the year 1975 to 2012. The Department of Social Welfare renamed as the Directorate of Social Justice from 1st November 2012 onwards (IMG, 2016). In Kerala, there is no separate Women and Child Development Directorate. The State Project Director is holding the office of the ICDS and functioning under the direction of Director of Social Justice Department . The Organisational Structure of ICDS project is in three levels in Kerala. There is a State level Organisational Structure, in which Social Justice Department Director, Addl. Director, Joint Project Coordinator, Programme officer, and other office staffs; In the District Level Functionaries, it is headed by the Programme Officer and the Jr. Statistical Inspector, Jr. Superintendent, Head Accountant and other office staffs, including clerk, typist, driver and peon; and in the Project level organisational structure, it is headed by the CDPO, ACDPO, ICDS Supervisor, Anganwadi Worker and Anganwadi Helper. The Administrative staffs include the Head Accountant/Head Clerk, U D clerk, LD Clerk, Typist, Driver, peon, watchman.

In the context of universalisation of ICDS with focus on improved quality in the delivery of services and also proposed strengthening and restructuring of ICDS, it is proposed to put in place a five-tier monitoring and review mechanism at the central level and up to the AWC level

**Five-Tier Monitoring committee**

1. National Level Monitoring and Review Committee (Secretaries of various dept. in the Centre)
2. State Level Monitoring and Review Committee (Secretaries of different State Departments)
3. District Level Monitoring and Review Committee (Directors of various Departments)
4. Block Level Monitoring committee (Block Panchayat President, BDO, CDPO, MO, AEO, Agricultural Officer, Supervisor (2)
5. Anganwadi Level Monitoring and Support Committee (below-given table is the constitution of ALMSC)

**COMMUNITY PARTICIPATION**

Introduction The famous philosopher, Bertrand Russell, had rightly said that the only thing that will redeem mankind is cooperation (Russell, 1954). The essence of what Russell noted was that cooperation is a must for people in a community to achieve a common goal, which is nothing but the participation of the community in various ways. Internationally resources for social welfare are shrinking resulting in the deprivation, further affecting the course of social welfare. It was during the 1950s that the concept of community development and community participation emerged (Mathbor, 2008). Participation as one of the outcomes of community development can be a value, principle, method or strategy. It can be a means or an end in itself. Most of the familiar phrases used in community development like bottom-up development, people-centred development, community-driven development, etc. refer to participation.

Often the term participation is modified with adjectives, resulting in terms such as community participation, citizen participation, people's participation, public participation, and popular participation, electoral participation, etc. While the terms citizen participation, public or civic participation, electoral participation is understood as participation relating to political aspects, the terms such as community participation, people's participation deal with participation in developmental projects and programmes. Unlike in the case of people's participation, where it usually means a limited engagement of people in one or other phase of a development project, in the context of community participation, it connotes widespread participation by the members of a community in the various stages of its development project. It includes formation, execution, supervision, and evaluation. In its literal sense also, it connotes comprehensive participation of a self-help group or a social action group in all phases of its development endeavour (Sharma, 2007). People's participation stands for the involvement of people in a given project, whereas in community participation it connotes people's engagement with their development project. Here in this study, the researcher deals with community participation.

**TABLE NO 4.1**

**AGE WISE CLASSIFICATION**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of respondents** | **Percentage** |
| 20 – 30 | 8 | 16 |
| 31 – 40 | 20 | 40 |
| 41 – 50 | 16 | 32 |
| 51 – 60 | 6 | 12 |
| **Total** | **50** | **100** |

**Source: primary data**

**INTERPRETATION**

The above table show that 40% of the respondents are comes under the age group of 31-40, 32% are comes under 41-50, 16% are comes under 20-30 and 12% of them are comes under the age group of 51-60

**TABLE NO 4.2**

**EDUCATIONAL QUALIFICATION**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No of respondents** | **Percentage** |
| SSLC | 15 | 30 |
| HSE | 23 | 46 |
| Diploma/Degree | 7 | 14 |
| PG | 5 | 10 |
| **Total** | **50** | **100** |

**Source: primary data**

**INTERPRETATION**

The above table shows that 46% of the respondents have SSLC qualification, 30% of them have HSE qualification, 14% are completed diploma/degree and 10% of them are post graduates.

**TABLE NO 4.3**

**WORK EXPERIENCE OF AWW IN ICDS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No of respondents** | **Percentage** |
| Below 5 years | 15 | 30 |
| 5 – 10 years | 25 | 50 |
| More than 10 years | 10 | 20 |
| **Total** | **50** | **100** |

**Source: primary data**

**INTERPRETATION**

The above table shows that 50% of the respondents have a working experience of 5-10 years of AWW in ICDS, 30% HAVE below 5 years experience and 20% of them have more than 10 years work experience.

**TABLE NO 4.4**

**BELONGING TO THE SAME VILLAGE WHERE ANGANWADI LOCATED**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Yes | 38 | 76 |
| No | 12 | 24 |
| **Total** | **50** | **100** |

**Source: primary data**

**INTERPRETATION**

The above table shows that 76% of the respondents belong to the same village where the anganwadi located and 24% are not belonging to the same village where anganwadi located.

**TABLE NO 4.5**

**UNDERGONE TRAINING FOR AWW IN ICDS**

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

**Source: primary data**

**INTERPRETATION**

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

**TABLE NO 4.6**

**LOCATION OF ANGANWADI**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Panchayath/Municipality/Corporation Building | 16 | 32 |
| School building | 10 | 20 |
| Building provided by the community free of rent | 24 | 48 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.1**

**NO. OF YEARS HAVE BEEN WORKING**

**INTERPRETATION**

The above table and chart shows that 48% of the anganwadi are located in the building provided by the community free of rent, 32% of the anganwadi located in panchayath/ municipality/corporation building and 20% are located in school building.

**TABLE NO 4.7**

**OPINION WITH THAT THE NUTRITIONAL AND HEALTH OF CHILDREN (0-6YEARS) IS IMPROVED THROUGH PROPER UTILIZATION OF AWC SERVICE**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 13 | 26 |
| Agree | 17 | 34 |
| Neutral | 4 | 8 |
| Disagree | 11 | 22 |
| Strongly disagree | 5 | 10 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.2**

**OPINION WITH THAT THE NUTRITIONAL AND HEALTH OF CHILDREN (0-6YEARS) IS IMPROVED THROUGH PROPER UTILIZATION OF AWC SERVICE**

**INTERPRETATION**

The above table shows that 34% of the respondents agreed that the nutritional and health status of children (0-6 yrs.) is improved through proper utilization of AWC services, 26% are strongly agreed, 22% are disagreed, 10% are strongly disagreed and 8% of them are neutral.

**TABLE NO 4.8**

**RESPONDS THAT THE AWCS HELP FOR SCHOOL READINESS IN CHILDREN**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 15 | 30 |
| Agree | 20 | 40 |
| Neutral | 3 | 6 |
| Disagree | 7 | 14 |
| Strongly disagree | 5 | 10 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.3**

**RESPONDS THAT THE AWCS HELP FOR SCHOOL READINESS IN CHILDREN**

**INTERPRETATION**

The above table shows that 40% of the respondents are agreed that AWCS help for school readiness in children, 30% are strongly agree, 14% are disagree, 10% are strongly disagree and 6 % of them have no opinion.

**TABLE NO 4.9**

**PARENT INVOLVEMENT IS AN IMPORTANT COMPONENT FOR THE AWC FUNCTIONING**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 23 | 46 |
| Agree | 18 | 36 |
| Neutral | 2 | 4 |
| Disagree | 4 | 8 |
| Strongly disagree | 3 | 6 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.4**

**DURATION OF VISITS TO THE HOUSEHOLD**

**INTERPRETATION**

The above table shows that 46% of the respondents are strongly agreed that Parent involvement is an important component for the AWC functioning, 36% are agreed, 8% are disagreed, 6% are strongly disagreed and 4% of them are neutral.

**TABLE NO 4.10**

**ANGANWADI LEVEL MONITORING AND SUPPORT COMMITTEE (ALMSC) IN AWC**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 12 | 24 |
| Agree | 16 | 32 |
| Neutral | 5 | 10 |
| Disagree | 10 | 20 |
| Strongly disagree | 7 | 14 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.5**

**ANGANWADI LEVEL MONITORING AND SUPPORT COMMITTEE (ALMSC) IN AWC**

**INTERPRETATION**

The above table shows that 32% of the respondents are agreed that there is an Anganwadi Level Monitoring and Support Committee (ALMSC) in their AWC, 24% are strongly agreed, 20% are disagreed, 14% are strongly disagree and 10% have no opinion.

**TABLE NO 4.11**

**RESPONDS WITH THAT THE CHILD NEED TO BE GIVEN MORE OPPORTUNITIES AND GOOD ENVIRONMENT IN THE INITIAL YEARS (0-6 YEARS)**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 22 | 44 |
| Agree | 15 | 30 |
| Neutral | 4 | 8 |
| Disagree | 5 | 10 |
| Strongly disagree | 4 | 8 |
| **Total** | **50** | **100** |

**Source: primary data**

**CHART NO 4.6**

**RESPONDS WITH THAT THE CHILD NEED TO BE GIVEN MORE OPPORTUNITIES AND GOOD ENVIRONMENT IN THE INITIAL YEARS (0-6 YEARS)**

**INTERPRETATION**

The above table shows that 44% of the respondents are strongly agreed that the child need to be given more opportunities and good environment in the initial years (0-6 years), 30% are agreed, 10% are disagreed, 8% of them are strongly disagreed and 8% of them are neutral.

**TABLE NO 4.12**

**OPINION ABOUT CONSIDERING THE INTAKE OF FOLIC ACID & IRON SUPPLEMENTS DURING PRE NATAL PERIOD AS NECESSARY**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 16 | 32 |
| Agree | 20 | 40 |
| Neutral | 2 | 4 |
| Disagree | 8 | 16 |
| Strongly disagree | 4 | 8 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.7**

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

**INTERPRETATION**

The above table shows that 40% of the respondents are agreed that considering the intake of Folic acid & iron supplements during pre natal period as necessary, 32% are strongly agree, 16% are disagreed, 8% are strongly disagreed and 4% of them have no opinion.

**TABLE NO 4.13**

**INFORMATION RECEIVED FROM THE HEALTH EDUCATION CLASS ARE PRACTICED IN DAILY LIFE**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 13 | 26 |
| Agree | 17 | 34 |
| Neutral | 5 | 10 |
| Disagree | 10 | 20 |
| Strongly disagree | 5 | 10 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.8**

**INFORMATION RECEIVED FROM THE HEALTH EDUCATION CLASS ARE PRACTICED IN DAILY LIFE**

**INTERPRETATION**

The above table shows that 34% of the respondents are agreed that information received from the health education class are practiced in daily life, 26% are strongly agree, 20% are disagreed, 10% are strongly disagreed and 10% of them have no opinion.

**TABLE NO 4.14**

**DISSEMINATING INFORMATION ABOUT THE VARIOUS PROGRAMMES& SERVICES OF ICDS FROM THE MOTHERS' MEETINGS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 22 | 44 |
| Agree | 19 | 38 |
| Neutral | 2 | 4 |
| Disagree | 4 | 8 |
| Strongly disagree | 3 | 6 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.9**

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

**INTERPRETATION**

The above table shows that 44% of the respondents are strongly agreed that disseminating information about the various programmes& services of ICDS from the mothers' meetings, 38% are agreed, 8% are disagreed, 6% are strongly disagreed and 4% of them have no opinion.

**TABLE NO 4.15**

**ENSURING THE ADEQUACY OF FACILITIES IN AWC**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 15 | 30 |
| Agree | 19 | 38 |
| Neutral | 5 | 10 |
| Disagree | 9 | 18 |
| Strongly disagree | 2 | 4 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.10**

**ENSURING THE ADEQUACY OF FACILITIES IN AWC**

**INTERPRETATION**

The above table shows that 38% of the respondents are agreed that they trying to ensure the facilities in AWC are adequate, 30% are strongly agreed, 18% are disagreed, 10% of them are neutral and 4% strongly disagreed.

**TABLE NO 4.16**

**PASSING OF RECEIVED INFORMATION ABOUT AWC TON OTHER RELATIVES/FRIENDS/NEIGHBOURS**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 20 | 40 |
| Agree | 12 | 24 |
| Neutral | 3 | 6 |
| Disagree | 10 | 20 |
| Strongly disagree | 5 | 10 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.11**

**PASSING OF RECEIVED INFORMATION ABOUT AWC TON OTHER RELATIVES/FRIENDS/NEIGHBOURS**

**INTERPRETATION**

The above table shows that 40% of the respondents are strongly agreed that they are passing the information received about AWC to other relatives/friends/ neighbours, 24% are agreed, 20% are disagreed, 10% strongly disagreed and 6% of them are neutral.

**TABLE NO 4.17**

**GIVING FEEDBACK/ SUGGESTION FOR THE IMPROVEMENT OF THE AWC**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 18 | 36 |
| Agree | 15 | 30 |
| Neutral | 5 | 10 |
| Disagree | 8 | 16 |
| Strongly disagree | 4 | 8 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.12**

**GIVING FEEDBACK/ SUGGESTION FOR THE IMPROVEMENT OF THE AWC**

**INTERPRETATION**

The above table shows that 36% of the respondents are strongly agreed that they are have given feedback / suggestion for the improvement of the AWC, 30% are agreed, 16% are disagreed, 10% have no opinion and 8% of them are strongly disagreed.

**TABLE NO 4.18**

**SHARING PROBLEMS TO THE AWW**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 18 | 36 |
| Agree | 25 | 50 |
| Neutral | 2 | 4 |
| Disagree | 3 | 6 |
| Strongly disagree | 2 | 4 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.13**

**SHARING PROBLEMS TO THE AWW**

**INTERPRETATION**

The above table shows that 50% of the respondents are agreed that they sharing their problems to the AWW, 36% are strongly agreed, 6% are disagreed, 4% have no opinion and 4% of them are strongly disagreed.

**TABLE NO 4.19**

**ATTENDING TO THE NEEDS OF AWC AS AND WHEN REQUIRED**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 9 | 18 |
| Agree | 19 | 38 |
| Neutral | 3 | 6 |
| Disagree | 13 | 26 |
| Strongly disagree | 6 | 12 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.14**

**ATTENDING TO THE NEEDS OF AWC AS AND WHEN REQUIRED**

**INTERPRETATION**

The above table shows that 38% of the respondents are agreed that they attended to the needs of AWC as and when required, 26% are disagreed, 18% are strongly agreed, 12% are strongly disagreed and 6% of them have no opinion.

**TABLE NO 4.20**

**RESPONDS WITH THAT IT IS IMPORTANT TO INVOLVE LOCAL PEOPLE/LOCAL LEADERS/ LOCAL GROUPS IN AWC ACTIVITIES**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 10 | 20 |
| Agree | 10 | 20 |
| Neutral | 5 | 10 |
| Disagree | 20 | 40 |
| Strongly disagree | 5 | 10 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.15**

**RESPONDS WITH THAT IT IS IMPORTANT TO INVOLVE LOCAL PEOPLE/LOCAL LEADERS/ LOCAL GROUPS IN AWC ACTIVITIES**

**INTERPRETATION**

The above table shows that 40% of the respondents disagreed that it is important to involve local people/local leaders/local groups in AWC activities, 20% are strongly agreed, 20% are agreed, 10% have no opinion and 10% of them are strongly disagreed.

**TABLE NO 4.21**

**CHILD'S WEIGHT SHOULD BE MONITORED AND GRAPHICALLY RECORDED EVERY MONTH**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 15 | 30 |
| Agree | 24 | 48 |
| Neutral | 4 | 8 |
| Disagree | 5 | 10 |
| Strongly disagree | 2 | 4 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.16**

**CHILD'S WEIGHT SHOULD BE MONITORED AND GRAPHICALLY RECORDED EVERY MONTH**

**INTERPRETATION**

The above table shows that 48% of the respondents are agreed that the child's weight should be monitored and graphically recorded every month, 30% are strongly agreed, 10% are disagreed, 8% of them are neutral and 4% of them are strongly disagreed

**TABLE NO 4.22**

**RESPONDS WITH THE STATEMENT THAT AWW NEED NOT ORGANISE THE NUTRITION AND HEALTH EDUCATION PROGRAMME REGULARLY**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 4 | 8 |
| Agree | 10 | 20 |
| Neutral | 2 | 4 |
| Disagree | 20 | 40 |
| Strongly disagree | 14 | 28 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.17**

**RESPONDS WITH THE STATEMENT THAT AWW NEED NOT ORGANISE THE NUTRITION AND HEALTH EDUCATION PROGRAMME REGULARLY**

**INTERPRETATION**

The above table shows that 40% of the respondents disagreed with the statement that the AWW need not organise the Nutrition and Health Education programme regularly, 28% are strongly disagreed, 20% are agreed, 8% are strongly agreed and 4% of them have no opinion.

**TABLE NO 4.23**

**THE INFRASTRUCTURE OF ANGANWADI NEED BE IMPROVED WITH THE HELP OF LOCAL SELF GOVERNMENT**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 20 | 40 |
| Agree | 15 | 30 |
| Neutral | 4 | 8 |
| Disagree | 9 | 18 |
| Strongly disagree | 2 | 4 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.18**

**THE INFRASTRUCTURE OF ANGANWADI NEED BE IMPROVED WITH THE HELP OF LOCAL SELF GOVERNMENT**

**INTERPRETATION**

The above table shows that 40% of the respondents are strongly agreed that the infrastructure of Anganwadi need be improved with the help of Local Self Government, 30% are agreed, 18% are disagreed, 8% of them are neutral and 4% of them are strongly disagreed

**TABLE NO 4.24**

**RESPONDS WITH THAT THE INCREASE IN THE WORKLOAD OF AWW MAY COMPROMISE WITH THE QUALITY**

|  |  |  |
| --- | --- | --- |
| **Particulars** | **No. of Respondents** | **Percentage** |
| Strongly agree | 10 | 20 |
| Agree | 8 | 16 |
| Neutral | 2 | 4 |
| Disagree | 18 | 34 |
| Strongly disagree | 12 | 24 |
| **Total** | **50** | **100** |

**Source: Primary data**

**CHART NO 4.19**

**RESPONDS WITH THAT THE INCREASE IN THE WORKLOAD OF AWW MAY COMPROMISE WITH THE QUALITY**

**INTERPRETATION**

The above table shows that 34% of the respondents disagreed that the increase in the workload of AWW may compromise with the quality, 24% are strongly disagreed, 20% are strongly agreed, 16% are agreed and 4% of them are neutral.

**CHAPTER – V**

**FINDINGS, SUGGESTIONS AND CONCLUSION**

**5.1 FINDINGS**

* 40% of the respondents are comes under the age group of 31-40.
* 46% of the respondents have SSLC qualification.
* 50% of the respondents have a working experience of 5-10 years of AWW in ICDS.
* 6% of the respondents belong to the same village where the anganwadi located.
* 84% of the respondents are undergo training for AWW in ICDS.
* 48% of the anganwadi are located in the building provided by the community free of rent.
* 34% of the respondents agreed that the nutritional and health status of children (0-6 yrs.) is improved through proper utilization of AWC services.
* 40% of the respondents are agreed that AWCS help for school readiness in children.
* 46% of the respondents are strongly agreed that Parent involvement is an important component for the AWC functioning.
* 32% of the respondents are agreed that there is an Anganwadi Level Monitoring and Support Committee (ALMSC) in their AWC.
* 44% of the respondents are strongly agreed that the child need to be given more opportunities and good environment in the initial years (0-6 years).
* 40% of the respondents are agreed that considering the intake of Folic acid & iron supplements during pre natal period as necessary.
* 34% of the respondents are agreed that information received from the health education class is practiced in daily life.
* that 44% of the respondents are strongly agreed that disseminating information about the various programmes & services of ICDS from the mothers' meetings.
* 38% of the respondents are agreed that they trying to ensure the facilities in AWC are adequate.
* 40% of the respondents are strongly agreed that they are passing the information received about AWC to other relatives/friends/ neighbors.
* 36% of the respondents are strongly agreed that they are have given feedback / suggestion for the improvement of the AWC.
* 50% of the respondents are agreed that they sharing their problems to the AWW.
* 38% of the respondents are agreed that they attended to the needs of AWC as and when required.
* that 40% of the respondents disagreed that it is important to involve local people/local leaders/local groups in AWC activities.
* 48% of the respondents are agreed that the child's weight should be monitored and graphically recorded every month.
* 40% of the respondents disagreed with the statement that the AWW need not organize the Nutrition and Health Education programme regularly.
* 40% of the respondents are strongly agreed that the infrastructure of Anganwadi need be improved with the help of Local Self Government.
* 34% of the respondents disagreed that the increase in the workload of AWW may compromise with the quality.

**5.2 SUGGESTIONS**

* Necessary development may be done by the local bodies from their plan fund, or through cooperation from the public, or as a corporate social responsibility from companies.
* The standard set for Anganwadi building needs to be ensured and necessary provisions for storage, water supply, electricity, in-door and out-door equipment to be made.
* Supplementary Nutrition Programme (SNP) can be given based on local acceptability with attractive, nutritious recipes.
* Provision of adequate rent/revision of rent needs to be ensured for AWC.
* Audio-visual aid and Information Education and Communication (IEC) materials need to be provided.
* The welfare committee and monitoring committee can be merged to avoid multiplicity, and the purpose and role of the members must be stipulated.
* Programmes need to be organised with the help of social workers towards the attitudinal and behavioural change in the community level.
* There should be motivation by way of introducing awards to the welfare committee.
* There should be LSG level action plans for the promotion and up-gradation of the AWC under their jurisdiction

**5.3 CONCLUSION**

The Early Childhood Development (ECD) initiatives help in ensuring a better environment for early childhood and adulthood. It addresses the malnutrition and malnourishment prevailing in developing countries. Any child development drive will be meaningful and feasible only by a proactive and effective participation of the community, that comprises of beneficiary parents, related department of government (like health, water, sanitation, agriculture, public works, local self government etc.) along with various self help groups, NGOs, corporate institutions etc. Taking these facts into consideration, the Government of India following the National policy on children (1974), established the ICDS programme that offers variety of services like Immunisation, Pre-School Education (PSE), Supplementary Nutrition Programme (SNP), Nutrition Health Education (NHE), Health check-up and Health referral. ICDS programme was framed on similar lines of the ‘Head Start Programme' of US cofoundered by Bronfenbrenner, based on his theory of ecological development. The unit level ICDS centres are called as ‘Anganwadi' (courtyard garden), from where these package of six services are rendered.

Healthy children are the greatest resource of any country. In a developing country like India, children form a wide base of the population pyramid. The most crucial period in a child's life is the first five years during which 40 percent of physical and 80 percent of mental growth and development happen. The malnutrition and subsequent survival threats do happen in a country like India. The child centred development in the ecological context is well established in the literature. Both heredity and environment have an equal role in the development of a child. And the overlapping community plays an important role. The significance of early childhood development centre, which is a major social determinant of the health of children, cannot be overstated. ICDS is an ECD programme in India, catering to this need and the research shows the importance of participation by way of both ‘extent' and ‘effectiveness' for the fruitful result. As an outcome of the study which was done by way of quantitative and qualitative methods, a reliable participation model was worked out. And it was understood, that an intervention is needed inorder to tackle the problems related to child development. There is no doubt about the role of social workers who are trained enough (who are equipped with professional values and scientific body of knowledge) to motivate the community by using their social work techniques and methods and facilitate their role either independently or through a collective action. The researcher believes that these findings and suggestions if taken properly would deliver definite benefit in the ICDS functioning throughout India and this could also be applicable for similar childcare settings throughout the world, especially in developing countries. This research work also will give few insights for the better utilisation of the Community Participation concept towards the welfare of children. This research study was carried out by utilising data from secondary sources and primary data collected through quantitative and qualitative method conducted by the researcher.

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**WEBSITES**

<https://www.academia.edu/40391466/Adoloscence_girls_development_and_ICDS_A_case_study_of_anganwadi_centres_in_Kannur_District_Kerala>

**APPENDIX**

A Study On Community Participation In Integrated Child Development Services Icds Scheme In Kannur District Kerala

Name :

1. Age :

20 – 30 [ ]

31 – 40[ ]

41 – 50[ ]

51 – 60[ ]

1. Level of education:

SSLC [ ]

HSE [ ]

Diploma/Degree [ ]

PG [ ]

1. Work experience of AWW in ICDS

Below 5 years [ ]

5 – 10 years [ ]

Ore than 10 years [ ]

1. Do you belong to the same village/are where Angwadi is located?

Yes [ ]

No [ ]

1. Have you undergone the training for AWWs in ICDS?

Yes [ ]

No [ ]

1. Where is the anganwa located?

Panchayath/Municipality/Corpn Building [ ]

School building [ ]

Building provided by the community free of rent [ ]

5. Strongly Agree (SA); 4. Agree (A); 3. Neutral (N); 2. Disagree (DA); 1. Strongly Disagree (SD); 0. Not Applicable (NA) Statements/ Items Level of Agreement

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Sl. | Statement | SA | A | N | D | SD |
|  | The nutritional and health status of children(0-6 yrs.) is improved through proper utilisation of AWC services |  |  |  |  |  |
|  | AWCs help for School Readiness in Children. |  |  |  |  |  |
|  | Parent involvement is an important component for the AWC functioning |  |  |  |  |  |
|  | There is an Anganwadi Level Monitoring and Support Committee (ALMSC) in your AWC |  |  |  |  |  |
|  | You think the child need to be given more opportunities and good environment in the initial years (0-6 years) |  |  |  |  |  |
|  | You consider the intake of Folic acid & iron supplements during pre natal period as necessary. |  |  |  |  |  |
|  | Information received from the health education class are practiced in daily life |  |  |  |  |  |
|  | Disseminating information about the various programmes& services of ICDS from the mothers' meetings |  |  |  |  |  |
|  | You try to ensure that the facilities in AWC are adequate |  |  |  |  |  |
|  | You have passed on the information you received about AWC to other relatives/friends/neighbours |  |  |  |  |  |
|  | You have given feedback / suggestion for the improvement of the AWC. |  |  |  |  |  |
|  | You have shared your problems to the AWW. |  |  |  |  |  |
|  | . You have attended to the needs of AWC as and when required. |  |  |  |  |  |
|  | It is important to involve local people/local leaders/ local groups in AWC activities |  |  |  |  |  |
|  | The child's weight should be monitored and graphically recorded every month |  |  |  |  |  |
|  | AWW need not organise the Nutrition and Health Education programme regularly |  |  |  |  |  |
|  | The infrastructure of Anganwadi need be improved with the help of Local Self Government |  |  |  |  |  |
|  | Increase in the workload of AWW may compromise with the quality |  |  |  |  |  |