SOCIO ECONOMIC IMPACT OF INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME ON CHILD DEVELOPMENT: WITH SPECIAL REFERENCE TO MUL TALUKA IN CHANDRAPUR DISTRICT.(2006-2016)

A DISSERTATION PRESENTED BY

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UNDER THE GUIDANCE OF

DR. JYOTI PATIL

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF

MASTER OF PHILOSOPHY

TO

TILAK MAHARASHTRA VIDYAPEETH,

PUNE

JUNE 2018

DECLARATION

I hereby declare that the dissertation entitled **"Socio Economic Impact of Integrated Child Development Services (ICDS) Scheme on Child Development: With Special Reference to Mul Taluka In Chandrapur District." (2006-2016)** completed and written by me has not previously formed the basis for the award of any Degree or other similar title upon me of this or any other Vidyapeeth or examining body.

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CERTIFICATE

This is to certify that the dissertation entitled **"Socio Economic Impact of Integrated Child Development Services (ICDS) Scheme on Child Development: with Special Reference To Mul Taluka In Chandrapur District." (2006-2016)** which is being submitted herewith for the award of the Master of Philosophy (M.Phil) in Economics of Tilak Maharashtra Vidyapeeth, Pune is the result of original research work completed by Smt. Badhe Sonali Hari under my supervision and guidance. To the best of my knowledge and belief the work incorporated in this dissertation has not formed the basis for the award of any Degree or similar title of this or any other University or examining body upon her.

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ABBREVIATIONS

ACDPO-additional Child development officer

ANM-Auxiliary Nurse Midwife

ASHA- Accredited Social Health Activist

AWC- Anganwadi Centre

AWH- Anganwadi Helper

AWW- Anganwadi Worker

CDPO- Child Development Office

ICDS- Integrated Child Development Services

MAM- Moderate Acute Malnourished

MWCD-Ministry of Women and Child Development

PHC-Primary Health Centre

SAM- Severe Acute Malnutrition

SNP-Supplementary Nutrition Programme

THR- Take Home Ration

UT- Union Territory

VCDC- Village Child development Centre

CHAPTER 1

INTRODUCTION

1.1 Introduction:

A healthy child is the foundation of a healthy nation. The process of development of the country mainly depends upon the human resource of the country. Human resource contributes towards growth of any country. The human resource plays crucial role in each and every area and the overall development of the country including economic, social, cultural and political developments. Any physical or financial resource cannot yield its desired results if they are not accompanied by the application of human resources. The success of any country in any field depends, to a larger extent, upon the human resources. The contribution of human resources to the nation or institution building depends upon their education, experience, training, morale, efficiency, attitude, commitment etc. Hence it is necessary to develop the human resources systematically so that they perform their responsibility satisfactorily. For development of human capital of the country it is very essential for the country to invest in its younger generation, which is prerequisite for sustained macroeconomic growth. Science says that first 1000 days /first 6 years of the early life are of critical importance for the child for his/her developmental process. It is apparent that if the child receives proper care and conducive environment for progress it will become productive, successful and well adjusted adults of the nation. India is also not an exception for this. In the ageing world, India is poised for reaping demographic dividends. According to census 2011, out of the total population of India around 158 million are the children between the age group 0 to 6 years. (2011 Census) It shows that children constitute a major part of the population of our country. About 12.8 million young persons are joining the working class every year. It is expected that the labour force in India is likely to increase by 32% over the next 20 years while it will decline by 4% in industrialised nations. India will have a large productive population of 75% by 2025.[1] Over the two decade India will have the youngest and largest working age populations in the world. To capitalise fully on the expected demographic dividend and enrich productive capacity at global level it is very important to invest in its children intensively. Investing in children is not only right

thing to do for their survival and quality of life, it is also vital for creating and sustaining broad based economic growth. (Commission on growth 2008)

India has also initiated several programs for the welfare of the children. Being a developing country India faces several problem likes poverty, health care, higher dropout rate in school education, infant and child mortality, malnutrition etc. It hampers the process if child development and ultimately human resource development of the country. NFHS 4 reveals that overall 58% of the children in India have some degree of anemia.[2] 53% of women have anemia [3] 38% children under age five are stunted (short for their age), 21% are wasted (thin for their height), 36% are underweight (thin for their age) and 2% are overweight (heavy for their height). It also records that stunting and wasting are higher among the children in rural areas (41%) than urban areas (31%). [4] For the development of the country as a whole, it is very important that a country should have healthy children.

1.2 Concept of child and child development

A) Child

Constitution of India defines a child as a person below 14 years.[5]
The census of India also considers a person below 14 years as a child.[6]
Article I of the United Nations Convention on the Rights of the child defines a child as every human being below the age of 18 years" (New Children Policy 2016)

B) Child development

Many people use the term growth and development interchangeably. But there is drastic difference between these two concepts. Growth refers to the increase in size and structure of body and organs. It is always complementary and primary condition which is helpful in the development process of the child. As a result of the growth in brain the child has greater capacity for learning, remembering, and reasoning. He grows mentally as well as physically.[7] On the other hand; development of a child is related to qualitative changes in the child. It can be defined as a progressive series of orderly, coherent changes. Progressive signifies that the changes are directional that they lead forward rather than backward. 'Orderly' and 'coherent' suggest that there is a definite relationship between a given stage and the stages which precede or follow it.[8]

C) Stages of child development

Childhood is divided into four major stages beginning from conception to when the child becomes sexually mature.

i. Prenatal – Conception to birth

ii. Infancy – birth to 2 years

iii. Childhood – 2–12 years

iv. Adolescence – 12–18 years[9]

The process of child development is the process of growth and development of the child over a period of time. Child development extends from the moment of conception to the pubescent comprising changes in all round development of the child at each stage. Child development focuses on the pattern of development and role played by environment and learning experiences.[10]

All round development of a child comprises three major aspects

a) Physical and motor development

b) Cognitive and language development

c) Psychological development

These three concepts can be elaborated as follows:

a) Physical and motor development: Physical development includes changes in body's size, structure, proportion and system. Motor development includes development of control of muscular functions and coordination between various parts of the body.

b) Cognitive and language development: Cognitive development includes ability to think perceive and solve problems including intellectual development i.e. development of language and thinking skills. Language development include ability to communicate and speak

c) Psychological development: Includes development of social and emotional bonds[11]

1.3 Initiatives for Child Development in International context

Various international institutions like UNICEF, World Bank, WHO works for children at an international level. We can take brief look at the initiatives taken for children at the international level.

A) Declaration of the rights of the child/ Geneva Declaration:

In 1959 the United Nations General assembly adopted the Declaration of the rights of the child or Geneva declaration. It marked the first major International consensus on the fundamental principles of children.

B) The convention on the rights of the child:

It is an agreement that identifies the human rights of the children which integrate entire range of international human rights. The article in the convention includes the right of adequate and nutritious food, shelter, clean and safe drinking water, a clean and safe environment, formal education, good quality primary health care, leisure and recreation etc. Article 27 specifies that children have the right to a standard of living that is good enough to meet their physical and mental needs. Government should help families and guardian who cannot afford to provide this. Article 4 specifies that government have the responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. [12]

C) Millennium development goal:

MDG was originated from the Millennium Declaration adopted by the General assembly of the United Nations in September 2000.[13] It aims at reducing child mortality, eradicate poverty and hunger and attain universal primary education and gender equality.

1.4 Child development and Global scenario

In spite of initiatives taken by UNICEF, UN, world bank, WHO for combating the problems of children worldwide there are a lot of challenges to be addressed at global level. The millennium Development Goals Report 2015 reveals that over 800 million people still live in extreme poverty and suffer from hunger. Over 160 million children under age 5 have inadequate height for their age due to insufficient food. In

the developing countries children from poorest 20 percent of households are more than twice as likely to be stunted as those from wealthiest 20 percent. Over 880 million people are estimated to be living in slum like conditions in the developing world's cities. The maternal mortality ration in the developing regions is 14 times higher than the developed regions.[14]

1.5 Intervention programme by Government of India for Child welfare in India

Children are of utmost importance for any nation. Article 15(3) of Indian Constitution makes special provision for protection of women and children. After independence govt of India felt that there should be separate policy for the welfare of the young ones. With the introduction of five year planning, an intended move towards child welfare was initiated by the Government of India. In the first FYP, the planning commission gave precedence to the welfare needs of the young ones. Many child welfare programmes were introduced in the five year plans like Welfare extension projects (1958)**,** Special Nutrition Programme-(1970-71)**,** Balwadi Nutrition Programme-(1959), Applied Nutrition Programme-(1959), Wheat Based Supplementary Nutrition Programme- (1986), Tamil Nadu Integrated Nutrition Programme-(1981), Mid day meal programme-(1956), Goiter Control Programme-(1962), National Diarrheal diseases Control Programme-(1981) etc. Due to the inadequate coverage, inefficient monitoring and limited inputs they came under severe scrutiny and could not make remarkable dent in the field of resolving child problems.[15]

UNICEF started working in India in the year 1949. It supported government of India in various initiatives meant for children to improve nutrition, reduce stunting and improves infant mortality rate for children under six as well as expectant and nursing mothers.[16] Government of India initiated National policy of children for the country. The national policy for children adopted in 1974 has emphasis the need to accord priority to children, in the country's developmental efforts. The policy gives prominence to the fact that the state should provide adequate services to the children in the pre natal and post natal stages of their lives. In addition to that, such services should be provided to the children through the period of their growth which will ensure their survival and consistency in the process development.[17]

Several programmes for child welfare were introduced since then. To fulfil its objectives of child welfare the Government of India has instigated various programs for enhancing access to food through various initiatives like price controls, and public distribution system and fair price shops. Another thrust was through income support, i.e. range of food for work programs and employment guarantee programmes. Over the period of time these programs were reorganised and renamed, for example in 1989 The National Rural employment program and The Rural Landless Employment Program were merged in to the Jawahar Rozgar Yojana and as of 2001 reformulated in to the Sampoorna Grameen Rozgar yojana. A third approach is to feed the eligible beneficiaries directly. The Mid Day Meal Programme for schools going children and supplementary Nutrition Programme through ICDS scheme is an example of it.[18] Government of India adopted the WHO standards for measurement of growth and development of the child in 2008. These are popularly known as new child growth standards. Children admitted to AWC are monitored according to the Child Growth Standards of WHO from 2010. India is signatory to the Millennium Declaration adopted at the United Nations General assembly in September 2000. It consistently reaffirmed its commitment towards the eight development goals which included poverty eradication and hunger, universal primary education, gender equality, women empowerment, reduction of child mortality. [19]

1.6 Introduction of ICDS in India:

ICDS is an ambitious multidimensional program which targets the problem of malnutrition of the children as well as mothers of these children. The ICDS scheme is designed and implemented for providing basic welfare services to all needy segment of the society which encompass children in the age group of 0-6 years, pregnant and lactating mothers and all women in the age group 15-44 years. The integrated package of ICDS scheme includes welfare services of supplementary nutrition, non-formal preschool education for 3 to 6 year children, immunization of the child and mother, health check up services, referral service and health and nutrition education for both children and mothers. The Government of India initiated the Integrated Child Developmental services (ICDS) scheme in 1975 to provide nutrition and educational services for preschool children and pregnant and lactating mothers. Integrated child development scheme (ICDS) was first launched in India on 2nd October 1975. Initially it was introduced at thirty places as a pilot initiative. Afterwards in the succeeding

years it was expanded to cover more areas of the country. Now it has turned out to be one of the biggest integrated family and community welfare schemes in the world.
ICDS is response of India to the challenges for breaking a vicious cycle of malnutrition, impaired development, morbidity and mortality in young children. It tries to fulfil the interrelated needs of children below 6 years, pregnant women, lactating mothers and adolescent girls in comprehensive manner.

1.7 ICDS and child rights:

ICDS addresses basic child rights which are essential for survival, protection, participation and development of the children. They can be stated as follows:

A) Right to Survival:

Rights for survival include rights related to life, health, nutrition, water, sanitation, environment, adequate standard of living, right to a name from birth, right to acquire nationality, right to know and be cared by his or her parents

B) Right to Protection:

Rights for protection include rights related to protection of children from all forms of discrimination, exploitation, abuse, inhuman or degrading treatment and neglect, disability, right to special protection in situations of emergency and armed conflicts.

C) Right to Participation:

Rights for participation include rights related to respect for the views of the child, right to freedom of expression, thoughts, conscience and religion; freedom of association and peaceful harmony; access to appropriate information and awareness.

D) Right to Development:

All rights related to early childhood development and care, social security, education, right to leisure, recreation and cultural activities are included here .[20]

All above rights addressed by ICDS leads to a better environment for children in the country. Based on these objects for child welfare ICDS has following objectives.

1.8 Objectives of ICDS:

i) To improve the nutritional and health status of children in the age-group 0-6 years;

ii) To lay the foundation for proper psychological, physical and social development of the child;

iii) To reduce the incidence of mortality, morbidity, malnutrition and school dropout;

iv) To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development

v) To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.[21]

1.9 Expansion of ICDS

In the beginning ICDS scheme was introduced with 33 Projects. At the time of inception it had 4891 AWCs which increased to 5652 Projects with nearly 6 lakh AWCs by the end of 9th Five Year Plan. In the year 2016-17 India has7073 operational ICDS projects and 13,49,563 operational AWCs. The country have 14 lakh approved AWCs.[22]

1.10 Services provided under ICDS:

ICDS scheme offers package of services. The services are provided through the network of community level of anganwadi centers. The services provided under the scheme are as follows:

1) Supplementary nutrition
2) Non formal preschool education
3) Nutrition and health education
4) Immunisation
5) Health heck ups
6) Referral services

First 3 services are provided at anganwadi centre by AWW, rest of the three services i.e. immunization, health checkups and referral services are imparted in convergence with health ministry by health department. The services can be explained in brief as follows:

1) Supplementary nutrition:

Under supplementary nutrition programme, ICDS attempts to bridge the gap between standard requirement of daily intake and actual intake of the beneficiary. Children falling under malnourishment category are also focused with special supplementary nutrition feeding. Supplementary feeding is provided at AWC at least 25 days in a month and 300 days in a year. The food is served either in the form of meal cooked at AWC or ready to eat snacks. The food is procured by state and provided by Mahila Mandals or Self Hep groups. Supplementary feeding is also provided to all beneficiaries under the periphery of anganwadi like children of sugarcane workers, brick workers, construction and other workers. [23]

2) Non formal preschool education-

Non formal preschool education under ICDS aims at providing learning environment to the children between 3 to 6 years. This service is imparted through play way method. It helps the child for their overall development and prepares them for formal education.

3) Nutrition and health education

Health and Nutrition education is an important service given at AWC. Parents specifically mothers are given information about health factors and guidance about intake of the beneficiaries which creates awareness among the parents. They also educate parents to reduce expenses on unhealthy outside food and purchase healthy eating items like fruits, green vegetables, milk and milk products, eggs and healthy food with saved money. Along with they are given information about the frequency of food a child should be given and a tentative schedule about the intake of the child. They are also educated about the ill effects of the traditional beliefs and practices about feeding practices at home, health care and nurturing the child.

4) Immunization:

Immunization is one of the major strategies to prevent mortality. With convergence to health department AWC provides immunisation facility to the children. Immunisation facility is arranged once in a month

5) Health Check up:

Health checkups services are provided at the AWC in convergence with department of health. Health check-up of the children between 0 to 6 years is done quarterly. Vaccinations are given according to the immunisation schedule of the child. Check up of severely underweight children is done once in a month. The service is provided by ANM and ASHA worker at AWC. They also provide health check up service to pregnant mothers and ensure that they give birth to their child at hospitals.

6) Referral services:

Under referral services provided under ICDS, AWW detects the problems, recognises severity and refers them to medical officers for further treatment. During regular health check- ups and home visits if sick or malnourished children or at risk pregnant mothers are found they are provided referral services through ICDS.

1.11 Beneficiaries of ICDS:

ICDS provides services to following categories. The group beneficiaries of ICDS comprises, children between 0 to 6 years, Expectant and Nursing mothers, other women who are between the age group of 15 to 45 years and adolescent girls in the age group 11 to 18 years.

1.12 ICDS TEAM:

Though AWW are frontline functionaries, services under ICDS are provided with co ordination of a team who is responsible for overall performance of the ICDS.

1) Child development Project Officer

2) Assistant child Development Officer (where more than 150 AWCs are in the project)

3) Supervisor

4) Anganwadi Worker

5) Anganwadi Helper

6) For health services –team of health functionaries- medical officer, lady health officer, ANM, female health worker from primary health centre.[24]

1.13 Administrative set up of ICDS:

Table 1.1 Administrative set up of ICDS

Sr. no	Administration level	Implementing Authority
1	Central level	Ministry of Women and Child Development
2	State level	Department of Social Welfare/ Rural Dev. / Community Dev./Tribal Welfare/ Women & Child Development
3	District level-	District Welfare Office / District ICDS Cell
4	Block level	Child development Project Officer
5	Sector level	Supervisor
6	Village level	Anganwadi Worker

(Source: Guidelines for Monitoring & Supervision of the Scheme, Central Monitoring Unit, ICDS)

1.14 Funding pattern of ICDS:

Prior to 2005-06 administration cost of the project was provided as central assistance by government of India. Provision of supplementary nutrition under this programme was responsibility of the state, but it was found that due to resource constraint states were not able to provide adequate fund for supplementary nutrition. Afterward this system was changed in 2005-06 and centre started providing support to state and union territories up to 50% of financial norms or 50% of expenditure incurred by them on SNP whichever is less. Afterwards Government of India modified the funding pattern time to time. From 2009-10 for supplementary nutrition, the sharing ratio between centre and state was 50:50 and 90:10 for North East states. For ICDS General it was 90:10. Again it was revised in 2015-16 and was made 50:50 between central and state, the same was 90:10 for North East states and 3Himalayan states. For ICDS general it was made 60:40 between centre and state and 90:10 for North East states and 3 Himalayan States. 100% funds will be provided by the Central Government for Union Territories without Legislature.[25]

1.15 Role of ICDS

ICDS scheme has experienced consummate growth over the last more than forty years. Larger i.e. more than 50% of this growth has taken place in the post 2005 period.[26] There are 7073 ICDS projects and 1349153 AWC all over India. This programme targets the group in the society which is really in need of the services. Children and women is the main target group of this scheme. It provides nutrition, health and education services in an integrated manner so that the overall needs of this segment of the society can be catered. The services provided under the umbrella of ICDS are provided through Anganwadi centre, which is the first contact point for beneficiaries. Angan means courtyard. The name itself suggests that these centre are the service points for the beneficiaries. We can understand the concept and functioning of anganwadi as follows.

1.15.1 Anganwadi:

The services of ICDs are delivered through anganwadi centres in an integrated manner. Each anganwadi centre is run by one anganwadi worker and one anganwadi helper. Anganwadi worker and helper are selected from the community. Each anganwadi covers population of about 1000 people. For every 10 anganwadi there is an anganwadi supervisor which is also known as Mukhya Sewika. Her responsibility is to provide on job guidance to the AWWs.

1.15.2 Functioning of AWC:

Anganwadi centre is the focal point which actually provides the services of ICDS. Anganwadi worker runs the AWC with the help of anganwadi helper who is also a lady from local community and receives honoraria for her work. It is expected that all the activities at AWC should be conducted in a manner so that all the services of ICDS are reached to all eligible beneficiaries. The activities at AWC can be classified as daily activities, monthly, quarterly and periodic activities. These activities can be explained as follows:

a) Daily activities at AWC:

An anganwadi centre is expected to conduct certain activities on daily basis. It includes various activities like inspection of children for cleanliness, Organising Supplementary Nutrition for children and expectant and nursing mothers, washing

hands of children before and after taking Supplementary Food, organising Preschool Education activities, treatment of common childhood illnesses & minor ailments, referral Services as and when required, conducting Home Visits and updating records for the activities conducted at the centre.[27]

b) Monthly, quarterly and periodic activities conducted at AWC:

Anganwadi centre conducts certain activities on monthly, quarterly or periodic basis. These activities include health checkups of children and mothers, immunisation of beneficiaries according to the schedule of vaccination, weighing of children and growth monitoring every month, distribution of Vitamin a and Iron folic Acid tablets, mother's meetings, preparation of monthly Progress report and updating family survey register [28]

c) Time allotted for daily activities at AWC

A tentative time schedule is provided to anganwadi centres by ICDS for the activities to be conducted at AWC. A review of this schedule can give us idea about the activities of AWC and time allotted to each activity.

Table 1.2: Time allotted for daily activities at AWC

Sr. no	Name of the service / activity	Time allotted
1	Preschool Education	2 Hours (120 min.)
2	Preparation and Distribution of Supplementary Nutrition	1/2 Hour (30 min.)
3	Treatment of Common Childhood Illnesses/ Ailments & Referral	1/2 Hour (30 min.)
4	Filling up Records and Registers	1/2 Hour (30 min.)
5	Making 2-3 home visits	1 Hour (60 min.)
	Total	4 ½ hours (270 minutes)

(Source: Handbook for Anganwadi Workers, page 23)

Above table gives us information about the daily time schedule for the activities to be conducted at anganwadi centres. It is expected that activities mentioned in the column no 2 of the given table should be conducted daily. The AWC is expected to be open for 4 ½ hours a day. The schedule includes indoor as well as outdoor activities like home visits. The daily indoor activities include

supplementary nutrition, preschool education, common health services, filling up registers of records etc.

1.16 ICDS projects in India:

Integrated Child Development Scheme was introduced in India in 1975 as a programme to combat the problem of malnutrition and give required services to eligible beneficiaries in an integrated manner. Started with only 33 projects the programme extended its area of operation in rural, tribal as well as urban areas of the country and today in the year 2016-17 it has 7073 projects spread all over the country. Following table gives us a brief idea about the growth of ICDS programme in India for the period 2006 to 2016.

Table 1.3: Trends in coverage of ICDS in India

Sr. no	Year	No of operational ICDS projects	% Growth in ICDS projects	No of operational AWCs	% Growth in number of AWCs
1	2006	5659	-	748229	-
2	2007	5829	3.00	844743	12.90
3	2008	6070	4.13	1013337	19.96
4	2009	6120	0.82	1044269	3.05
5	2010	6509	6.36	1142029	9.36
6	2011	6722	3.27	1262267	10.53
7	2012	6908	2.77	1304611	3.35
8	2013	7025	1.69	1338732	2.62
9	2014	7067	0.60	1342146	0.26
10	2015	7072	0.07	1346186	0.30
11	2016	7073	0.01	1349563	0.25

(Source: Annual Report, Ministry of Women and Child Development (2016-17), Government of India, Table 3.3)

Above given table reveals the trend in the growth of operational ICDS projects and AWCs for the period of ten years i.e. 2006 to 2016 in India. We can

observe that there is consistent increase in the number of ICDS projects as well as anganwadi centres in India from the year 2006 to 2016. Initially in the year 2007 the percentage growth was 3 percent for ICDS projects and 12.90 percent for AWCs, which increased considerably in the year 2008 i.e. for ICDS projects 4.13 percent and for AWCs 19.96 percent. In 2009 the rate of growth decreased to 0.82 percent for ICDS projects and 3.05 percent for AWC. Again in 2011 the growth rate increased and we find that the number of both i.e. ICDS projects and AWCs are increasing but at a decreasing rate.

Table 1.4: Growth of beneficiaries of SNP and PSE under ICDS Programme in India

Sr. no	Year	SNP beneficiaries (lakh)	% Growth in SNP beneficiaries	PSE beneficiaries (lakh)	% Growth in PSE beneficiaries
1	2006	562.18	-	244.92	-
2	2007	705.43	25.48	300.81	22.82
3	2008	843.26	19.54	339.11	12.73
4	2009	873.43	3.58	340.6	0.44
5	2010	884.34	1.25	354.93	4.21
6	2011	959.47	8.50	366.23	3.18
7	2012	972.49	1.36	358.22	-2.19
8	2013	956.12	-1.68	353.29	-1.38
9	2014	1045.09	9.31	370.71	4.93
10	2015	1022.33	-2.18	365.44	-1.42
11	2016	1021.31	-0.10	350.35	-4.13

(Source: Annual report, Ministry of Women and Child Development 2016-17, Government of India, Table 3.3, pp 30)

We can observe from table 1.5 that the number of beneficiaries of ICDS services has increased from the year 2006 to 2016. The above given table contains information about the beneficiaries who have taken advantage of Supplementary Nutrition Programme and Pre School Education under ICDS scheme in India. In 2006 the number of children benefitting from SNP was 562.18 lakh and for non formal preschool education it was 244.92 lakh. The number of these beneficiaries increased

in further years till 2012. From the year 2012 onwards we can observe fluctuations in the rate of growth in the percentage of beneficiaries of SNP and PSE. In further years we find negative growth in the number of beneficiaries.

We can also observe that there is huge difference in the number of beneficiaries of Supplementary Nutrition Programme and Preschool education. The reason behind this is, beneficiaries of SNP include the children of age 0 to 6 years, whereas the beneficiaries of PSE include the children from 3 to 6 years. It means that the number of beneficiaries of SNP include the beneficiaries of PSE too.

1.17 ICDS in Maharashtra

Maharashtra is one of the progressive states in the country. In spite of this, the state has considerable percentage of malnourished children. Rural areas of Maharashtra suffers from several social and economic issues like illiteracy, unemployment, lack of health services, sanitation, infrastructural bottlenecks and low standard of living. People belonging to such families cannot provide proper care to their children. It leads to several problems in the process of the development of a child. The Integrated Child Development Services Scheme launched by Government of India is a commitment of the government towards its young generation. The central Government as well as State Government plays important role in this area of overall child development. At state level Ministry of Women and Child Development is responsible for the successful implementation and execution of the programme. Following table gives us information about district wise number and percentage of anganwadi centres in Maharashtra.

Table 1.5: District wise number of AWC in Maharashtra

Sr. no	District	Anganwadi	Percentage
1	Ahmednagar	5782	5.00
2	Akola	1616	1.40
3	Amravati	3384	2.93
4	Aurangabad	5678	4.91
5	Beed	3302	2.86
6	Bhandara	1073	0.93
7	Buldhana	3322	2.87

8	Chandrapur	3058	2.64
9	Dhule	2289	1.98
10	Gadchiroli	2528	2.19
11	Gondia	1821	1.57
12	Hingoli	1208	1.04
13	Jalgaon	4245	3.67
14	Jalna	3723	3.22
15	Kolhapur	4541	3.93
16	Latur	2580	2.23
17	Mumbai	5713	4.94
18	Nagpur	3668	3.17
19	Nanded	4157	3.59
20	Nandurbar	2394	2.07
21	Nashik	5967	5.16
22	Osmanabad	2010	1.74
23	Palghar	3196	2.76
24	Parbhani	1970	1.70
25	Pune	6085	5.26
26	Raigad	3278	2.83
27	Ratnagiri	2980	2.58
28	Sangli	3149	2.72
29	Satara	4957	4.29
30	Sindhudurg	1579	1.37
31	Solapur	4973	4.30
32	Thane	3711	3.21
33	Wardha	1573	1.36
34	Washim	1171	1.01
35	Yavatmal	2952	2.55
	Total	115633	100

(Source: Dy. CEO ZP office, Chandrapur as on 20/03/2018)

Above table shows district wise number of anganwadi in the state of Maharashtra. We can see that Pune district has maximum number of anganwadi i.e.

5.26 percent followed by Ahmadnagar district which has 5 percent of the total AWCs in the state.. Among the districts of rest of the Maharashtra Nashik, Mumbai, Satara, Solapur, Aurangabad districts have considerable number of AWCs after Pune and Ahmadnagar districts, whereas the district of Bhandara has the lowest number of anganwadi i.e. 0.93 percent.

1.18 Some basic issues regarding functioning of AWC:

It is conspicuously observed that the problem of malnutrition is an acute problem in the developing countries like India. Though government is taking tremendous efforts to fight with it, it is still persisting. Government provides funds for anganwadi infrastructure, educational equipments, supplementary nutrition, health care and immunization, designs policies and is trying to reach the needy unreached areas, but the efforts are somewhere lagging behind the actual problems. The funds provided by the state are found to be too inadequate to meet the requirements. Consequently it affects the services rendered by AWCs on the behalf of ICDS. This phenomenon gives rise to number of issues, which need urgent attention.

As one takes close view of the functioning of ICDS, more particularly AWCs, it become necessary to examine some of the apparent issues which are closely related to the present study:

1) How does AWCs function at grass root level?
2) How do the AWW monitor the development of the child admitted to AWC?
3) How do the beneficiaries perceive the services rendered by AWC?
4) What are the feeding practices at home for the beneficiaries?
5) As the AWCs receive funding from government, it constitutes their source of expenditure for beneficiaries. In which form they receive these funds?
6) Since AWC rely on the Government funding to meet their requirements, in case of delay how do they cope with the problem which arise due to such delay in funds?

Present study tries to seek answer for such questions. The focus of the study is on assessment of the effects of ICDS services on health and pre-school non formal education of 0-6 year children admitted in Anganwadi centers, understanding the socio-economic background of the beneficiaries of services and to understand opinion of beneficiaries regarding Anganwadi facilities and Anganwadi workers.

1.19 Conceptual Framework:

This research is a study of public expenditure on welfare facilities, in this case on health and education of children. It, therefore, draws on various concepts and theories from the areas of Development Economics, Welfare Economics and Public Economics.

The concept of child development (as described in Section 1 in Chapter I) can be regarded as part of the broader concept of Human Development. Bringing about human development is an important part of the welfare function of the government. A government that is committed to improving the welfare of its citizen is known as a welfare state. Such governments provide those services to their people whom the private sector is unable or unwilling to provide, at least not in the required quantities. These services are known as public goods and merit goods in the economics literature. Health and education are prime examples of merit goods.

In order to provide these services, the welfare state is required to undertake public expenditure. Thus public expenditure contributes directly to improving welfare of the society and hence must be done effectively. This study is an attempt to discover the impact of the expenditure made by the government in India on one welfare programme known as the Integrated Child Development Services (ICDS) Scheme in one particular taluka in the State of Maharashtra.

There are several theories about each of the issues mentioned above in the Development Economics, Welfare Economics and Public Economics literature, which are briefly explained in the remaining part of this section.

1.19.1 Human Development:

The concept of Human Development, introduced by Dr. Amartya Sen in the late 1980s, maintains that development is a process of 'expansion of capabilities'. By capabilities he meant the potential that exists in each individual. A society is developed only when every individual can fully exploit and realize his own potential, thus the freedom to choose the life one wants is capability. If this choice is expanding, then society is developing. Dr. Sen further clarified five different 'freedoms' those are instrumental in bringing about development. They are:

1) Political freedom, which allows people to choose their government.

2) Social opportunities, which refer to levels of education, healthcare, etc., in a particular society that determine the quality of life of an individual.

3) Transparency guarantees that refer to openness in social transactions.

4) Protective security, that is, social security programmes like unemployment insurance.

5) Economic facilities, which refer the resources owned or available for use with an individual.[29]

Of all these 'freedoms', Dr. Sen emphasized the role of education and health facilities in expanding a person's capabilities and hence in rapidly improving the quality of life of a society. The provision of these facilities, according to Sen, can either come about as a result of economic growth i.e. an increase in the income of the society, or they can be publicly provided i.e. through the government budget. Although the private sector will provide these services, Dr. Amartya Sen felt that their growth would be too slow. Therefore, the government needs to provide healthcare and education in order to quickly improve the quality of life of the people. Sen emphasized that although governments in poor countries typically have less money to spend on providing these services, they actually need less money since services like healthcare and basic education are labour intensive and hence relatively inexpensive given the low wage rates in these countries. He therefore concluded that governments in poor countries need to invest in health and education since this would result in high rates of human development as well as high rates of economic growth through increases in productivity and efficiency. Thus investment in health and education cause economic development to take place, and not vice versa. This underlines clearly the role of the state in initiating the process of economic development.[30]

1.19.2. Merit Goods:

Dr. Amartya Sen's argument for the provision of healthcare and education by the government is supported by the concept of merit goods in economic theory. When goods are classified based on the joint criteria of rivalry and excludability, they can be divided into private goods (those that are rival and excludable) and public goods

(those that are non-rival and non-excludable). Private goods are normally supplied by the private sector and public goods by the public sector. A third category includes the goods that are rival and excludable and are supplied at a price. However, they are considered meritorious or desirable from the point of view of the society. Such goods are considered as merit goods. This category include goods such as public services schools, school lunch, subsidized low cost housing, free or subsidised health facilities etc. Merit goods are provided by the government. If considered so meritorious that they are provided through the public budget, over and above what is provided through the market and paid for by private consumers.[31]

Richard Musgrave, who introduced the concept of merit goods argued that the demand for such goods is usually low, because consumers are either unaware of the benefits from the consumption of these goods or because consumer's tastes are inappropriate. Musgrave gave the example of education where those lacking education are incapable of understanding its benefits. This makes it necessary for government to make education compulsory. Since both private demand and private supply of such goods is less than what is socially desirable, government is required to provide merit goods.[32]

1.19.3 Welfare and Welfare State:

The term 'welfare', sometimes also called 'social welfare' has become a very broad concept over a period of time. It now includes income security, health, housing, education and personal social services.[33] A government that provides these social services with the objective of improving the welfare of its people is known as a welfare state. The state in almost all countries at present is a welfare state, whatever may be their political system. Myrdal describes a democratic welfare state as one whose broad goals are economic development, full employment, and equality of opportunity for the young, social security and protected minimum standards of living as regards not only income but nutrition, housing, health and education for all people of all regions and social groups.[34]

The New Palgrave Dictionary of Economics defines the welfare state as follows : 'The welfare state comprises two types of government spending arrangements: (a) cash benefits to households (transfers, including mandatory income

insurance) and (b) subsidies or direct government provision of human services (such as child care, pre schooling, education, healthcare and old-age care). [35]

From the above definitions it is clear that education and healthcare are some of the most important services included in welfare and the government that provides such services is known as a welfare state.

The concept of Welfare State in India: The establishment of a welfare state has been accepted as the ultimate objective of the socio-economic policies in India from the time before Independence. Some basic principles leading to its establishment have been included in the constitution, particularly is the Preamble and Directives of State Policy. The Preamble guarantees, among other things, economic and social justice and equality of status and opportunity for all members of the society. The Directive Principles of State Policy require the government to promote the welfare of the people by creating and maintaining a social order in which all institutions in the country are based on the principle of economic, political and social justice. In short, the Directive Principles aim at establishing an economic and social order based on equality of opportunity, full employment, and provision of adequate means of livelihood and social security benefits for all citizens. In order to fulfil these objectives, the Government of India and its constituent State Governments have accepted the role of the Welfare State.[36] As far as education is concerned, the Constitution of India resolved to provide elementary education for every child. It stated 'The state shall endeavour to provide, within a period of ten years from the commencement of this constitution, for free and compulsory education for all children until they complete the age of fourteen years. (Article 45)

1.19.4 Public Expenditure Theory

The provision of public goods by the government, whether at the central, state or local level, involves some expenditure. Public expenditure refers to the expenditure made by the government through its budget. It includes expenditure on social welfare, defence, public sector investment, provision of public services and expenditure for the growth and development or the economy. It was believed by the traditional economics that government spending should be kept at a minimum level, in keeping with the restricted role assigned to the government by classical economists. There are various theories related

to public expenditure which through light on the views of various economist regarding public expenditure by the government.

A) Adam Smith's views on public expenditure

Smith believed in the effectiveness of the 'invisible hand' and the supremacy of the market process over any government action. Smith believed in a very minimal role to the government, although he was aware that some government functions were extremely important. Smith believed that according to the law of natural liberty there were three duties of the government:

1. Protection of the society from violence and invasion by other independent societies.
2. Protection of every member of society from injustice or oppression by establishing a mechanism for administration of justice, that is, establishment of a legal system.
3. Erecting and maintaining public works and certain public institutions, like roads, bridges, canals, etc., which private individuals would not find profitable enough.[37]

Given these limited functions of the state, public expenditure for providing these services was also limited. Smith was aware of the 'publicness' of certain goods, but he recommended only the use of public finance and not actual public production of such goods. Even where public production becomes inevitable, he felt that efforts needed to be made to simulate market conditions in order to prevent inefficiency[38]

B) Wagner's Theory of Public Expenditure

In his 'law of increasing expansion of public, and particularly state, activities', Adolph Wagner, a German economist tried to explain the growth of public expenditure. He anticipated that the development of modern industrial society would give rise to increasing political pressure for social progress and increasing importance to social considerations in industry. As a result, the public sector would also need to expand its activities.

According to Wagner, the main cause of the growth in public expenditure was the growth of the economy. As the economy grows, the public sector also expands. Wagner's hypothesis of increasing state activity holds that, as per capita income and output increase, especially in industrialising countries, the public sector or government expenditure in these countries will also grow as a proportion of total

economic activity. This will increase relative share of government expenditure in the economy and will be more than proportionately to the growth in output.

Wagner gave the following reasons for this growth of state activity:

1. Growing complexities of public life – With economic development and growing division of labour the gap between the rich and the poor would increase and with this, the causes of friction between different sections of society would increase. The state, therefore, would have to spend more on maintaining law and order, through a larger police force and more legal services.

2. Need for larger investments – New technology would create the need for large amounts of capital, which could only be provided by joint stock corporations or public corporations. Wagner favoured the public corporations, especially where technical conditions like large size of operation and no competitors created a monopoly.

3. Welfare expenditure – Wagner foresaw the expansion of the traditional functions of the government. With the progress of society, it becomes necessary for the government to provide needed infrastructure as well as health and education services, which are services having large positive externalities. A positive externality occurs when there is a benefit to a party not directly involved in an economic transaction, often from the use of a public good. The social benefits of such services cannot be measured in economic terms.

4. War and preparation for war – Although this was not a desirable activity, it was unavoidable, as every country is required to defend itself. The defence expenditure has also to be borne by the government.

Wagner not only affirmed the growing role of the central government, but he also further emphasised on the growing role of local governments in his book Finanzwissenschaft, published in 1883. According to him, increasing public expenditure would also lead to increasing demand for resources at all levels of government.[39]

C) Theory of Public Goods

This theory explains the need for public expenditure in terms of the characteristics of certain products that make government provision necessary. These

goods are called public goods. It was well known even before Samuelson that goods like infrastructure need to be provided by the government. Samuelson for the first time distinguished between private and public goods. The concept of a 'public good' was first put forward by Paul Samuelson in his 1954 article, 'The Pure Theory of Public Expenditure'[40] Samuelson classified goods into two types, 'private consumption goods' and 'collective consumption goods', which later became popularly known as private goods and public goods.

Samuelson defined private goods as those that can be 'parcelled out' i.e., divided between different individuals so that each person's quantity of consumption is known and each can be charged a price for what he consumes. It is possible to exclude individuals from consuming such a good, either by charging a price or through some other means, thereby making consumption excludable.

On the other hand, Samuelson identified some goods that are both non-rival and non-excludable in consumption. He called such goods 'pure' public goods. The consumption of such goods by one individual does not reduce the amount of the good available for consumption by others and no one can be effectively excluded from using such goods. In this away the quantity of the pure public good available for consumption is the same for everyone and collective or joint consumption of such goods is possible. Because the good can be consumed jointly, the exact quantity consumed by any one individual is not known and hence it becomes impossible to charge a price. This results in what Samuelson called the 'free rider problem', i.e., everyone tries to consume the good without paying for it, since in a situation of collective consumption, the free rider cannot be isolated. Samuelson pointed out that in such a situation, when consumption of a good is joint (non-rival) and because it is difficult to exclude free riders (non-excludable), private sector would not be interested in providing such goods. Therefore, such 'pure public goods' need to be provided by the government.

Public goods have positive externalities and if they are produced in less quantity, total social benefit will be reduced. Thus there will be a loss of social welfare if the provision of such a good is left to the market. Samuelson, therefore, concluded that an organisation other than the market is required to provide such public goods. He felt that the government is the most appropriate agency for the provision of

such goods, as they can be supplied out of public revenue. In this case there is no need to charge individuals separately for each unit consumed.

This theory emphasises that public expenditure is necessary for provision of public goods because of the very nature of public goods. The market cannot provide such goods, or if provided by the market, output will be less than the optimum.

D) Market Failure Theory

Market failure theory, first put forward by Francis Bator, contends that there are some areas where the private sector would not produce at all if left to itself. More importantly, there are some goods that the private sector can produce, but they may not always be of the desired quality, quantity and price. Another significant role of the public sector is in providing merit goods, that is, goods that are private in nature (i.e., rival and excludable) but that have large positive externalities. The prices charged for such goods by a private producer would not be able to capture the wider social benefits and hence may not be supplied in adequate quantities, thus reducing total welfare of the society.[41]

1.20 Conclusion:

This chapter introduces basic concepts related to the present study. In the very first part it elaborates the concept of child and various aspects of the process of child development. It gives us brief introduction of various initiatives for child welfare taken at national as well as international level. ICDS scheme was launched in India in the year 1975. It is world's largest initiative which works in an integrated manner for welfare of the society. This chapter gives brief introduction of ICDS scheme working in India. The scheme has its 7073 projects and

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CHAPTER-2

REVIEW OF LITERATURE

2.1 Introduction:

This chapter reviews the literature related to the present study. The review includes report surveys, research studies, and research articles. Since its commencement ICDS programme has been a subject of considerable research and evaluation. Various institutes like government, NGOs, individual researchers, research scholars from social sciences, social work, medical sciences, and home science colleges have conducted research on different aspects of ICDS. The present review is an attempt to understand the research undertaken related to various aspects of ICDS and resultant outcomes.

2.2 Review of Literature:

A) Reports:

2.2.1. Rural development sector Unit, South Asia Region (2001)[1]: Assessment of pre-school education component of ICDS Scheme in Jammu district: Non-formal preschool education is an important component of ICDS scheme. Currently this scheme is operational in more than 6506 projects in India. This paper is based on an investigation of this component of ICDS centers of Jammu district of Jammu Kashmir states. Using observations and interview schedules, the infrastructural facilities available and the conduct of preschool education activities were evaluated. Anganwadi center is the focal point for delivery of ICDS services which is one of the largest programs in India for welfare of children. There is distinct relationship between the availability of infrastructure in the AWCs and the quality of services. The results have revealed that inadequate infrastructure and teaching and learning material is available in the sampled AWCs and it was found that this acted as a deterrent for conduct of preschool education activities. It indicates that AWCs are lacking in basic facilities, infrastructure and space etc.

2.2.2. Impact assessment of ICDS in Madhya Pradesh (2009-10)[2]: The study was undertaken by Centre for advanced research & Development & Sambodhi Research & Communication. The intention of the study was to ascertain the perception of

various stakeholders to understand the existing status of all six components of ICDS in MP and to identify constraints and bottlenecks and suggest ways to improve the implementation of ICDS. The study reveals that the incidence of malnutrition is not only a function of poverty and deprivation but factors such as feeding behaviour, sanitation and vaccination are also key determinants of malnutrition. Hence in order to reduce malnutrition in a sustained manner a strategic shift is required which focus on behaviour change of the targeted group. This behavioural change stresses two components strongly-changing household level feeding behaviour and reducing incidence of infection. For this paradigm shift in following is the prerequisite-1) increase in the home visits by AWW with strong quality counselling components 2) supportive supervision by AWW by supervisor specifically for counselling during home visit 3) Focused monitoring and consultative discussion about the results at sector and block level meeting 4) Ensuring essential new born care through home visit during the time of delivery and first week of delivery 5) Increased home visits in late pregnancy and new born period.

2.2.3. Final report, Impact Assessment if ICDS in Madhya Pradesh (2009-2010)[3]: The Poverty Monitoring and Policy Support Unit (PMPSU) conducted the study for impact assessment of the ICDS in Madhya Pradesh to ascertain the perception of various stakeholders, component and scheme wise impact of ICDS in M.P., to assess contribution of ICDS and identify constraints and bottlenecks and suggest ways to improve the implementation of ICDS. For the study 5582 households were covered among which 1360 were urban, 2278 were rural and 1444 were tribal households. More than half of the total household respondents were found to be illiterate. More than 60% households were living in the low standard of living conditions. More than half of pregnant women at the time of survey were between 20-24 years of age. More than 4/5 of rural and tribal women were married in their teens. Study found that relatively more rural and tribal women than urban women utilised anganwadi services. The studies found that many of the people especially women are not aware of the schemes by their name though they are receiving benefits under the scheme. There is a shortfall of human resource i.e. 20% of CDPO and 40% of ACDPO, AWW, AWH are more or less in place. Still the services provided under this scheme are reaching to maximum number of desired beneficiaries. More than 60% rural and tribal mothers of children beneficiaries answered that they receive supplementary

food, around 40% urban mothers did not receive food from AWCs. Health awareness among beneficiaries is found increasing in this study. More than 80% children were found to have receives vaccines of BCG, Polio and DPT but vaccination for vitamin A has not gained its ground yet. More than 60% children between 3 to 6 years are availing preschool education at the AWCs. The study found that despite of all these ICDS faces some problems in implementation, staff inadequacy and inadequate food supplementation.

2.2.4. Centre for Budget and Governance Accountability (CBGA), New Delhi (2011)[4]: This report is a study undertaken in collaboration between the Centre for Budget and Governance Accountability (CBGA), New Delhi and UNICEF India. It analyses public spending on ICDS programme and quality of spending with regard to outputs and services delivered. This report is built on primary and secondary data gathered from one district in each of the two states Uttar Pradesh and Chhattisgarh in India. This study throws light on various constraints that arise in utilisation of funds effectively under the ICDS programme. Study found that despite an increase in the number of AWCs after 2005 the nutritional outcome of children remained poor, 946% of children in India continued to be malnourished) Though the budgetary outlays for ICDS have been increasing in recent years, they are significantly lower than the funds allotted for the programme in the eleventh five year plan. The study also focuses on poor quality of funds utilisation. The actual component of spending or precise information regarding the component was not found update with the AWCs. Financial requirements submitted to states are not accompanied by any work plan by the grass root level functionaries. Multiple reporting requirements on part of AWWs found to be time consuming affair which limited their productive activities at centre. It was also found that AWCs and other Departments involved in rendering ICDS service are not able to coordinate in effective manner which ultimately affects the services provided under the programme. This report throws light on various reasons of hurdles involved in implementation of ICDS.

2.2.5. Manhas Shashi, Dogra Annpurna and Devi Seema (2010)[5]: This study was an attempt to study the awareness of Anganwadi Workers regarding implementation of services in ICDS project Bishnah block and Purmandal block. A sample of 100 respondents i.e anganwadi workers was selected Bishnah and Purmandal blocks of Jammu district during the year 2009-2010.the results of the study revealed that

nutrition and training plays very important role in the performance of anganwadi workers. The study reflected demographic profile of the anganwadi worker of the area. Majority of the workers were in the age group of 30-40 years which is considered as most efficient age group in terms of performance of the worker. Among the respondents majority of the workers were qualified up to metric, followed by the graduates remaining workers were qualified up to middle school, intermediate and post graduation. Around 70 % workers were found trained; only 30% were found with untrained status. The study shows that mostly anganwadi workers were familiar with the various services of ICDS but the provision if these services, their importance for programme were not clear to them, also the implementation part of these services was immensely lacking in aspect of effective utilization of these services by the beneficiaries and for beneficiaries. The study also revealed that irregularities at work place were a common practice among anganwadi workers. The quality of knowledge was one of the neglected features among job profile of anganwadi workers. The study strongly felt the need of improving the quality and knowledge of anganwadi workers. Frequent interactions among anganwadi worker and supervisors should be introduced for imparting information and awareness.

2.2.6. Jena Prasanti (2013)[6]: This study was undertaken by the researcher for partial fulfilment of the degree of Masters of Arts in Rural Development, National Institute of Technology Rourkela. The study intended to access the correct knowledge among Anganwadi Worker about ICDS. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. Though government is spending lot of money on ICDS programme, impact is very ineffective. Anganwadi Workers are actually the main resource person. The sample for the study comprised of 30 Anganwadi workers belonging to three Urban Blocks of Sundargarh Districts. Twenty six knowledge indicators were considered to estimate the mean knowledge score related to six domains of ICDS services. If the response is correct then it is coded as 1 or else equal to 0. Total knowledge score is estimated by adding the individual scores of each response. Results from the analysis suggest that most of the Anganwadi workers were trained; but it was found that performance as well as awareness among Anganwadi workers regarding the importance of growth charts and growth monitoring was not satisfactory. The quality of knowledge was one of the neglected

features among job profile of Anganwadi workers. The mean knowledge score about various ICDS services is about 12.83, and the individual score ranging from minimum of 7 to maximum of 19. Therefore, the study suggests the need of improving the quality of knowledge and awareness among Anganwadi workers about various ICDS Services. So, there is a strong and intense need for improving the training quality provided to Anganwadi workers before letting them go into the field jobs. Frequent interactions among Anganwadi workers and supervisors need to be introduced for imparting information and awareness. Though Government of India puts lot of money to enhance the health status of both mother and children through AWCs, the results suggest the there is a need to relook the operational aspects of AWCs at the grass root level.

B) Articles:

2.2.7. Bhasin Sanjiv (2001)[7]: This study was conducted in Nand Nagari area of East Delhi. Out of 132 AWCs 13 AWCs were studied to assess the nutritional status of children in relation to utilization of ICDS during their early childhood. The result revealed that the 94.2% children were attending schools. The proportion of children utilizing ICDS services for more than 6 months ranged from 8.8% to 24.3%. Children who attended AWCs were nutritionally better than the children who did not attend AWC during their childhood. The study found strong relation between the gender of the child, parent's education status and degree of malnutrition of the child.

2.2.8. Bredenkamp Caryn, Akin John, Gragnolati Michael (2005)[8]: In the study researchers addressed the question of ICDS's impact on child malnutrition using a new data set of more than 11,000 children in Kerala, and estimate series of reduced from child health demand models to capture the association between access to the program and nutritional status. They examined the effect of the presence of an ICDS village level program center i.e. AWC on nutritional status. In addition to that they also studied the control for the effect of the length of time that the AWC has been established and the model the actual participation of children under the age of three. Their model shows that while the nutritional status of children living in villages with ICDS programs is not significantly better than that of children in villages without the program. There is a clear positive impact of the program on nutritional status of those

young children (under 3 years) who actually participated regularly. These results suggest that at least some of the services that ICDS provides to children are of sufficient quality to positively influence child nutrition. The paper shows that ICDS can have a measureable impact on the nutritional status of young children who attend. Children under 3 years who participate in the ICDS program are less likely to be malnourished than those who do not attend. A more concentrated efforts need to be made to recruit young children in the program. This can occur through reaching out to women while they are pregnant or at birth. These efforts would produce a shift towards preventing malnutrition instead of just treating older malnourished children.

2.2.9 Gopaldas Tara (2006)[9]: The study focuses its light on the aspect of deficiency of micronutrients among low income and middle class Indian families. These families are likely to be deficient in vitamins and minerals. The reason for this is it comes from relatively expensive items such as milk, milk products, eggs, meat fruits, vegetables. It states that along with calories and protein deficiency the rural child between 1 to 6 suffers from vitamins and minerals deficiency on large scale. This rate is alarming. The author defines two types of hunger i.e. Raw or overt hunger need to be fill belly every few hours (macro nutrients) and

Hidden hunger for micronutrients. The study depicts that several programmes were launched to address different form of hidden hunger. Still major steps should be taken to eliminate this problem. The required amount of vitamins and minerals from expensive items are unaffordable for low income as well as middle income groups. To fulfil this need government can design low cost micronutrient packages and distribute them through ICDS. It should be a part of THR system. They might be given seven sachets per week and grain/ ready flour and hopefully some oil. such sachets should be available in open market for reasonable prices. Other types of intervention suggested by this study are can be summed up as follows:

1) Fortification and multi micronutrient supplementation

2) Domiciliary counselling to make illiterate and all types of mother aware about the problem

3) Public private partnership to meet micronutrient requirements

4) Mid day meal programmes should be extended to 1 to 6 year children under ICDS

5) The use of instant vitamins and minerals fortificants should be encouraged.

6) Every major ministry at centre and state should have micronutrient and health cell. The district should be the unit of management.

Management practices and better governance are requires for effective implementation of nutrition related programme.

2.2.10. T. Sundararaman (2006)[10]: The article mainly discusses the ICDS programme in Chattisgarh where the child malnutrition rate is around 60% It narrates that the fact that ICDS is not able to address all the goals related to child rights in spite the vast area of the scheme is that ICDS largely perceived only as a measure for the management of child malnutrition. There is close relationship between poverty hunger and malnutrition but there are some non hunger factors which influence malnutrition. In Chattisgarh state ICDS projects were experiencing poor function of AWCs. There was a need felt to for fresh ways of addressing the problem of child malnutrition and mortality in a campaign mode. One of the strategies implemented was Mitanin Programme- a state wide community health volunteer programme. This initiative proved usefull in tackling the problems of malnutrition. They address this problem with two key strategies-a) wide awareness of child malnutrition b) family counselling. Mitanin programme secured community participation in its programmes. It helped to increase awareness about child malnutrition, access to health care, women participation and organisation and women empowerment. The article throws light on the aspect of role of mitanin programme in elimination of child malnutrition. More light is needed on the other aspects of ICDS programme like preschool education.

2.2.11. Nayak Nandini, Saxena Naresh (2006)[11]: The article exposes the apathy of state government of Bihar and Jharkhand towards ICDS scheme particularly in terms of coverage, financial procedures and practices adopted in the appointment of personnel, operationalisation of these projects. Author suggests some remedial methods for resolving these problems. Those remedial measures can be summarised as follows- financial allocations need to be effectively utilised. Vacancies should be filled and staffs needs to be trained. The programme should be given priority and should be supervised effectively. To correct the problem of functioning of ICDs projects procedural correction should be undertaken.

2.2.12. Rajivan Anuradha (2006)[12]: This article throws light on the Tamil Nadu state's various initiatives to address the problem of child malnutrition. It includes Noon meal programme, the Tamil Nadu Integrated Nutrition Project (TINP) and other initiatives by the state. In Tamil Nadu combating child hunger and malnutrition became political priorities and there was a pressure of expectations from below. Virtually any child between the ages 2 and 15 years are eligible for a daily hot lunch ate cost of state. Most of the feeding under this takes place out oh house mostly in ICDS centres i.e. Anganwadi centres. Nutrition occupies permanent place on the state's political agenda. Along with ICDS centres Government of Tamil Nadu successfully leveraged the massive network of centres created under different schemes like noon meal programme and TINP along with staff infrastructure and administrative capacity with focus on nutrition Security

2.2.13. Dhingra Rajni, Sharma Iesha, (2011)[13]: The health scenario in our country is rapidly changing, both in terms of the public health challenges that we face as well as our response to these challenges. As India becomes more and more developed, we have greater means at our disposal. India faces enormous challenges in the area of women's and children's health. ICDS scheme was launched to provide nutrition and education services for preschool children and pregnant and lactating mothers. The objectives of the programs are achieved through an integrated package of services including supplementary nutrition, immunization, health checkups, referrals, non formal preschool and health and nutrition education. This integrated approach is delivered through anganwadi centres located in poorer areas that are most in need of primary health care and nutrition. The program is coordinated at village, blocks, districts, states and central government levels. This paper gives review of such studies undertaken by various people and institutions.

2.2.14. Datta Vrinda, Goyal Jaya (2011)[14]: The study is focused on discussion about the steps or process of the outcome budgeting for ICDS in Maharashtra. It mainly describes methods of outcome analysis mainly the logical framework and social audits that helped to build strategies for outcome based planning and budgeting for the scheme. It describes strategies used for outcome budgeting like distinguishing between outcome budgeting like distinguishing between output and outcome

indicators, benchmarking and unit costing. The logical framework provided a systematic investigation of the causes for ongoing challenges in the policy and implementation of the scheme and its resultant implication on poor child health and nutrition outcomes. The study specifies that linking objectives and actual achievements with goals can give an idea or complete picture about the expectations and goals and state of achievement. The study reveals that identification of various output and outcome indicators can help to understand the actual functioning of ICDS. Identification of road blocks by various stakeholders can be the first step in the logical framework analysis.

2.2.15. Kent George, (2012)[15]: The paper discuses the social audit aspect of ICDS and suggests some measures to make the scheme more comprehensive. All the services provided under ICDS have contributed in achieving its goals but the result varies as the anganwadi centres differ though they are treated in same way. Author suggests target oriented function of the scheme. It is always better to have more frequent reports and they should be monitored and analyses with full use of computers and internet. The time lag between data observation and adjustment can be sharply reduced with the help of it. Moreover it emphasises that instead of taking over the function of child feeding from their parents, scheme might find some ways to make parents capable of feeding their own children. ICDS should be managed as a more business like goal seeking organisation. It suggests that there should be some incremental changes and focus should be on what works than what doesn't. Good flow of well chosen monitoring data with expert judgement and decisive action are needed to lead the expected improvements in the scheme. There is need of radical changes in management of ICDS. The article shows another side of the functioning of the scheme but it doesn't focus the actual impact of ICDS scheme on ground level.

2.2.16. Haque Shamasul and Wanee Naseer Ahmad (2013)[16]: The study was carried out in line with the qualitative research strategy. 100 ICDS centres in remote rural areas from four districts of the valley viz. Budgm, Anantnag, Ganderbal, Baramulla have been studied during the period Jan 2012 to Jan 2013. 25 centres from one district were selected for the study. The study was undertaken to analyze the functioning of anganwadi centres and also the challenges of community response towards these centres and to identify the issues, the problems in terms of infrastructure, functioning and community response towards these anganwadi centres.

2.2.17. Jemy Elizabeth (2014)[17]: The paper views the concept of child development from medical point of view and gives review of studies related to impact of ICDS on beneficiaries in general manner. This paper is a systematic review of literature which throws light on different aspects of child development like intellectual, convivial and substantial development. It also reviews various articles which can give idea about impact of ICDS on child beneficiaries. it helps the readers to understand minute components which are involved in the process of child's development. It gives us understanding about the aspects of intellectual, convivial and substantial development like ability of verbal comprehension, space visualisation, perceptual speed, reasoning, remembering, symbolising, and problem solving and even dreaming. It covers the areas of sensation, perception, memory, thought, reasoning and language. The factors which influence are heredity, stimulating environment, nursery schooling, and nutrition and socio economic status. This paper gives review of the studies conducted in the area. It also reveals that family, school, culture, hormones, nutrition, exercise, rest and sleep etc play important role in the process of growth of a child ultimately human resource of the nation. The review of literature reveals that some studies found positive impact of nutrition al input on the beneficiaries. It is found that there was a significant improvement in the average height and weight of children during the survey. The review shows that the ICDS scheme is very much crucial for the development of pre schoolers, standards of AWCs should be upgraded for effective implementation of the scheme. It further reveals that proper and sufficient nutrition supplementation provided to the beneficiaries can help the children towards a nutritionally sound and healthy life combating malnutrition. Further it should make coordinated efforts to deliver the services to its beneficiaries.

2.2.18. Thomas Nidhi, Sengupta Paramita, Benjamin Anoop, (2015)[18]: This study proposes to access the functioning of the ICDS program with regard to the services provided, an anganwadi of an urban areas of Ludhiana. It is a descriptive study in the area. AWC in the area in 2011, catering to about 20,000 populations were studied. Participants included anganwadi workers and the beneficiaries attending anganwadi. The study shows that there is big gap between the planned program and its implementation. It showed that 88.9%of AWCs under the study were housed in single rental rooms with inadequate space. 11.1%of AWC don't have toilets. Only 22.2%

had piped water supply, only 55.6% had proper lighting and ventilation. Most of the AWCs lacked towards these anganwadi centres.

2.2.19. Maity Bipasha (2016)[19]: Present study attempts to construct indices to measure the performance of the anganwadi centres across different states in India in terms of their availability, ease of accessibility for children with disabilities and skill level of the Anganwadi workers in terms of her accuracy of knowledge about nutrition requirements of pregnant women and young children. The study attempted to understand interstate disparities in the ability of the AWCs. Author found that relative to knowledge among AAWs, the variability in the availability of physical infrastructure in anganwadi centres appear to be large across states. It is also found that many states in the north east India lack essential infrastructure and knowledge among anganwadi workers which might impede the delivery of ICDS services. Author also looked at differences across states in terms of awareness about ICDS among SC/ST mothers of children who are 6 years of age or younger. It is found that awareness levels among SC/ST mothers about ICDS services is low for most states where at least 5% population belongs to each of SCs and STs. Author suggests that for strengthening of the ICDS scheme the focus should not rest only strengthening the factors that influence the supply of ICDS services but it should also address and correct the issues of the prevalence of low awareness level among its intended beneficiaries.

2.3 Conclusion:

Present chapter discusses review of literature related to the subject of the study. Since ICDS is a scheme which is very closely related to different streams like economics, sociology, medical sciences, social work, public policy, social welfare large number of literature is available on it. The literature selected for review was chosen to find out the preceding work done in this area. After reviewing the literature it can be concluded that above given literature focus on overall evaluation of ICDS scheme and its implementation. On the other hand present study is a micro level study since it is focused on the AWCs in the circles of the Mul block of ICDS project. Moreover this study has its focus on the specific area of child development. It may help us to understand the expenditure part of a particular block of ICDS as well as the views and opinion of anganwadi workers and parents of the beneficiaries about the scheme.

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CHAPTER 3

PROFILE OF CHANDRAPUR DISTRICT AND MUL TALUKA

3.1 Introduction:

Chandrapur district is famous for the great treasure of underground wealth of coal which is popularly known as black diamond. This district is also famous for its rich and thick forest and wildlife diversity.

3.2 PROFILE OF CHANDRAPUR DISTRICT:

3.2.1 Historical Perspective[1]:

Tradition and legend tells that the name of the place was 'Lokapura' which was first changed to 'Indpur' and subsequently Chandrapur. In the British colonial period the district was called as Chanda District. The name was changed to Chandrapur around 1964. Hindu and Buddhist kings are said to be ruled this area for long period. Later on Gond Kings overtook this area and ruled till 1751. After 1751 Maratha king ruled this area. Last king of Maratha dynasty Raghuji Bhosle died heirless in 1853 and the Chandrapur along with Nagpur province was annexed to British Empire. Since 1874 Chandrapur was considered as an independent district. It comprised Mul, Warora and Brahmpuri taluka. After creation of Maharashtra state as an independent state in 1960 it became one of the districts of Maharashtra state. At that time there were six taluka in the district. It was 2nd largest district in India and largest district in Maharashtra. On 16th August 1982 the district was divided in to Chandrapur and Gadchiroli district. At present Chandrapur district comprises 15 taluka.

3.2.2 Location and area:

Chandrapur district has Nagpur, Bhandara and Wardha districts on the northern boundary of it and Gadchiroli district on the east. Yavatmal district is to the west boundary of the district. On the Southern side there is Adilabad district of Telangana state. The Wainganga River, which flows uninterruptedly throughout the year, forms the eastern boundary of the district separating it from Gadchiroli district. On the southern border there are Wardha, Wainganga Rivers and Manikgad hills.

Chandrapur district is situated in the southern east parts of Maharashtra, on the north latitude of 18.4 to 20.5 and the longitude 78.5 to 80.6 east. The total area of the district is 11443 sq. km. and it is 3.5% of the area of the state. There are 15 taluka in the district. Rajura taluka covers 12% of the total geographical area of the district and is the largest taluka. Mul with 5% of total area is the smallest taluka.[2]

3.2.3 Geo composition:

Chandrapur is gifted with beautiful nature, the rich subdued land along with large rivers and nullahs, and 40 percent of the well-fired forests with rich sunlight and mineral wealth. The area of Chandrapur district can be classified into different regions. They are as follows:

1) Mul Chimur hilly area
2) Wardha Wainganga River Plain
3) Mountainous part of Chandurgad

The northern part of the district is known as Chimur, Perjagad, Mul hills. There is a mountain called Chandurgad on the south side of Rajura taluka. [3]

3.2.4 Administrative Design:

As per 2011 census, there are 1792 villages in the district, out of which 1463 are inhabited. Since 25th October 2011 Chandrapur is D class Municipal Corporation and there are total 7 Nagar Parishads in the district. Out of them, 3 are B class and 4 are C class categories. Since 17/06/2015 there are total 5 Nagar Panchayats. There is 827 Gram Panchayats in the district, with 6754 total members.[4]

3.2.5 Population: [5]

As per 2011 census, the total population of the district is 22,04,307. The highest populated taluka is Chandrapur with 21.80% of total population whereas the lowest 2.30% population resides in Pombhurna Taluka.

3.2.5.1 Female Male Ratio:

Census 2011 record shows that there are 1123834 males and 1080473 females out of the total 2204307 population. The ratio of females to per thousand males is 961 which is interestingly greater by 32 as compared to 929 in Maharashtra. In rural areas

it is 950 and in urban areas it is 968. Following table gives us information about the proportion of female per thousand male.

Table 3.1: Females behind per thousand male

Sr. no	Year	Urban area (per thousand)	Rural area (per thousand)	Total population (per thousand)
1	1961	924	931	971
2	1971	912	932	963
3	1981	917	936	959
4	1991	919	948	962
5	2001	919	948	962
6	2011	950	968	961

(Source: Economic and Social Review of Chandrapur district, 2016)

We can observe from the above given table that, there is consistent increase in the proportion of female behind per thousand male. We find that in Mul taluka the proportion of women behind per thousand male have increased gradually. In the year 1961 it was 924 per thousand male in urban area, where as 931 for rural area. In urban areas it fell in next decade whereas increased in rural area. After that it increased in both rural as well as urban area. We find consistent increase in rural area. It increased to 968 per thousand males in 2011 in rural area and 950 in urban area. Proportion of female per thousand male is consistently more in rural area than urban area. As far as total population is concerned we find the proportion decreased in initial three decades and the increased in next three decades.

3.2.5.2 Rural and urban population:

Chandrapur is predominantly rural area where more percentage of the people live in rural area. According to census 2011, total population of the district is 22, 04,307. Out of this, the proportion of rural population is 14,285,929 i.e. 64.72% and the proportion of people living in urban area is 7, 75,378 i.e. 35.18% population live in urban area. Following table give changing trend in percentage of rural and urban population in Chandrapur district.

Table 3.2: Percentage of rural and urban population

Sr. no	Year	Rural (percentage)	Urban (percentage)
1	1961	88.73	11.27
2	1971	86.14	13.86
3	1981	78.01	21.99
4	1991	71.95	28.05
5	2001	67.89	32.11
6	2011	64.84	35.16

(Source: Economic and Social Review of Chandrapur district, 2016, pg4)

Above table shows that, the percentage of the people living in rural area is decreasing and the percentage of urban population is increasing consistently. As per census 2011, the highest share that is 51.8 percent lives in Chandrapur Municipal Corporation. In Gondpipri taluka, only 1.1 percent of the urban population lives in the district. As per the 2011 census 21.8% population lives in Chandrapur taluka whereas Pombhurna taluka has only 2.3% share of the total population.

3.2.5.3 Age wise distribution of population:

We can have a comparative look at the distribution of population in 2001 census and 2011 census with help of table no 3.3

Table 3.3: Age wise distribution of population

Sr no	**Age group**	**2001 census**	**2011 census**
1	0 – 14	44.69	24.45
2	15-19	10.14	9.71
3	20-24	9.10	9.86
4	25-29	8.74	8.77
5	30-34	7.75	7.91
6	35-39	7.37	7.69
7	40-50	10.69	12.97
8	50-59	6.52	8.49
9	60 and above	8.37	9.82
10	Non specified	0.79	0.31

(Source: Census 2001 and 2011)

Above table depicts age wise distribution of population in various age groups. We can observe that more than 50 percent population is above 15 year and below 50 years age group. The percentage of children between 0 to 14 year was 44.69 percent in 2001 census whereas it has gone down to 24.45 percent in 2011 census. The district has maximum number of working age population as far as the age distribution among various age groups is concerned.

3.2.5.4 Population density:

The density of the population of Chandrapur district is 193 per sq m. The same ratio is 365 per square meter for Maharashtra State.

3.2.5.5 Scheduled Castes and Tribes:

Following table shows taluka-wise distribution of SC and ST population in Chandrapur district.

Table 3.4: Taluka-wise Population of SC and ST in Chandrapur district:

Sr. no	Tahsil	Percentage of SC	Percentage of ST
1	Warora	8.6	21.1
2	Chimur	16.5	32
3	Nagbhid	12.4	19.1
4	Brahmpuri	16	7.9
5	Sawli	12.1	15.2
6	Sindewahi	13.1	28.8
7	Bhdrawati	15.8	17.8
8	Chandrapur	19.8	9.9
9	Mul	12.8	15.2
10	Pombhurna	9.6	26.7
11	Ballarpur	24.3	12.5
12	Korapana	11	23.7
13	Rajura	16.2	19.2
14	Gondpipri	16.9	17.3
15	Jivati	20.2	29.1

(Source: Economic and Social Review of Chandrapur district, 2016, pg 5)

Above given table helps us to understand taluka wise percentage of Scheduled Caste and Scheduled Tribes in the district. The percentage of SC population is highest in Ballarpur taluka and lowest in Warora taluka. In case of ST population the percentage is highest in Chimur taluka and lowest in Brahmpuri taluka. We can observe that overall percentage of SC and ST population in Chandrapur taluka is considerable.

3.2.6 Education: [6]

Table 3.5: Number of educational institutions in Chandrapur district

Sr. no	Type of institution	No of institution	Number of students
1	Primary schools	2007	167895
2	Secondary schools	325	94597
3	Higher secondary schools	253	145940
4	Colleges	128	50162

(Source: Economic and Social Review of Chandrapur district, 2016, pg11)

The total number of students in Chandrapur district is 4585 9 4, and the percentage of students is 41.1, secondary school 23.2, higher secondary school, 35.7 and general colleges 12.3. Similarly, the percentage of scheduled caste students is 8.8, and the percentage of scheduled tribe population is 9.5.

3.2.7 Literacy: [7]

The literacy rate in the Chandrapur district can be understood with the help of the following table.

Table 3.6: Rate of literacy in Chandrapur district:

Sr. no	Year	Male	Female	Total
1	1961	39.9	8.2	24.1
2	1971	50.1	20.6	35.3
3	1981	58.3	29.5	43.9
4	1991	78.8	50.4	64.8
5	2001	89.9	75.4	82.7
6	2011	86.8	73	80

(Source: Economic and Social Review of Chandrapur district, 2016)

According to 2011 census, 80.0 percent of the population is literate, while the literacy rate in rural areas is 75.5 percent and in urban is 88.2 percent. The literacy percentage of men and women is 86.8 and 73.0 respectively. Chandrapur and Ballarpur talukas have the highest literacy rate whereas the lowest is in Jivati taluka.

3.2.8 Public Health Services: [8]

At the end of 2016, there were 16 hospitals, 24 dispensaries and 58 primary health centers in the public and government aided institutions. There are 443 doctors and 729 nurses in the total.

Table 3.7: Number of public health institutions (year 2016)

Sr. no	Type of health service	Number
1	Hospitals	16
2	Clinics	24
3	Primary health centres	58
4	Primary health sub centres	339
5	Primary health Unit	8

(Source: Economic and Social Review of Chandrapur district, 2015, pp 12)

3.2.9 Forests and forest products: [9]

Chandrapur district is surrounded by dense forest. In the year 2015-16 total forest land was 4805.92 sq km. The area is 42.0 percent of the total area of the Chandrapur district. Excellent quality of forest products are produced in large quantity in the district. Best quality of teak wood (Sagwan) is produced in large scale, besides fire wood, Tendu Patta (Bidi leafs), Bamboo, Gum, Moha etc., are also produced, in these forests.

3.2.10 Agriculture: [10]

As per 2011 Census, 20.88 percent of the total workers are engaged as cultivators and 44.79 percent as agricultural labourers in the District. Together constitute 65.67 percent of the total workers of the District. In the eastern part of the district i.e. Nagbhid, Brahmpuri, Sindewahi, Mul mainly rice is grown. In the residual parts soybean, toor, cotton is the main crops which are grown.

3.2.11 Land holdings: [11]

According to the 2010-11 agricultural census, there are 3,04,227 land holders in the district and the total land area they posses is 540914.4 hectares. The area under land holding is as follows:

Table 3.8: Land holding in Chandrapur district

Sr. no	Land holding (hectors)	Land holders (percentage)	Area (percentage)
1	0 to2	69.3	37.3
2	2 to 5	25.8	42.7
3	5 to 10	4.4	16.1
4	10 to 20	0.4	3.1
5	More than 20	0.04	0.8

(Source: Economic and Social Review of Chandrapur district, 2016)

In the Chandrapur district, maximum land holders posses 2 to 5 hectors of land where as negligible percentage of people i.e. 0.8 % have land more that 20 hectors. The percentage of the people having land less than 2 hectors is also considerable i.e. 37% of land holder have lane less than 2 hectors.

3.2.12 Crops:

The area under food grains cultivation is 276098 hectares which is 25.4% of the total cropped area, out of total 526900 hectares of total cropped area. The highest area of total cropped area is 33.3% under the production of rice followed by wheat is 3.9 % of total cropped area. The area under cultivation of pulse is 11.1% and the area under cotton is 20.0 %. Rice, Tur, Gram, Jowar, Wheat, Soyabean, Cotton are the major crops in the district.[12]

3.2.13 Irrigation:

In the district irrigation is done through wells, small irrigation projects, medium irrigation schemes and sub-irrigation schemes and also on river. The district does not have big projects for irrigation. IT has medium projects viz. Naleshwar, Chargaon, Asolamendha, Labhan sarad, Amalnala, Chandi, Ghodzari.

3.2.14 Industry

The Chandrapur district has large deposits of coal. The district also has large reservoirs of limestone. District has cement factories viz., Manikgadh Cement, L&T Cement, ACC Cement Ghugus and Hariganga Cement Company. In 1956 the Ballarpur Industries limited paper mill was founded in the district. There is Chandrapur ferroalloy plant which is a public sector unit engaged in the production of manganese based ferroalloys. Chandrapur also has super thermal power station. There are few large scale industries which manufacture glass, pottery, oil, cement, paper. Besides these industries, a steel manufacturing industry Maharashtra Elektrosmelt Ltd, Layeed industries, Swastik glass works, Dadabhoy potteries.Electrolux at Warora are located in the district.

There are many medium scale industries comprise of oil mills, saw mills, paddy processing mills, cotton ginning mills, tile manufacturing, bidi manufacturing, soap manufacturing, pottery making, tasur silk weaving etc are scattered all over the district.[13]

3.2.15 Employment:

According to 2011 Census 1058172 people are in different employment which is 48.0% of total population. Of these, 20.9% are farmers, 44.8% are farm-workers, and 2.0% are working in cottage industry and other household service providing fields.[14]

3.2.16 Industrial colonies:

With the aim of industrial development of the district, MIDC set an Industrial growth area of about 214.75 hectares at Padoli. Chanda Industrial Estate Ltd lies 3 km far from Chandrapur city. Similar industrial colony is set in Warora also. However, the important fact to notice is that all such industrial colonies are set mainly in urban areas and hence they provide employment on limited range to urban population only. Rural areas still depend on traditional ways of earning livelihood.

3.2.17 Mineral Resources:

Chandrapur district is rich in minerals. Chandrapur is included in the main area of Maharashtra's mineral wealth. There are abundant stocks of iron, limestone, solid coal etc. in the district. Copper is also found as well. Most of the stocks of

copper in the district are found in this district. Apart from this, barites and chromites etc. are found in the district. The major coal fields located in the District are Majari Telvasa coalfield, Chanda Coalfield, Ghugus Niljai Coalfield, Ballarpur Coalfield, Sasti Rajura Coalfield, Virur Chincholi Coalfield and Virur Coalfield1.[15]

From above discussion one can understand the natural, social as well as economic facet about the district. On this background we can be able to understand the basic outline of the study. Since the actual geographical area of the present study is Mul taluka of Chandrapur district, the succeeding part of the chapter enables us to know profile of Mul taluka.

3.3 PROFILE OF MUL TALUKA:

3.3.1 Historical importance:

Mul is one of the old taluka of Chandrapur district. Chandrapur was formed as independent district since 1874. Mul was one of the three taluka which Chandrapur district initially had along with Warora and Brahmpuri taluka. As per 2011 census there are 106 Villages and 49 gram Panchayats and one town in Mul taluka. Chak Kanhalgaon, Dabgaon Tukum is the smallest Village and Rajoli is the biggest Village. The Mul taluka is covered by 30% forest. There are large numbers of trees in the woods. Trees like Sisam, Behada, Moh, Tembhurni etc. are found in the forest. Wainganga is the main river in the taluka. Tadoba (Tadoba Andheri Tiger Reserve), Chandrapur, Sirpur, Bhamragarh Wildlife Sanctuary, Anandwan, Somanath, Bhandara are the nearby Important tourist destinations to see.

We can understand social, economic and demographic aspects of Mul taluka with the help of following discussion. The information given below is taken from tahsil Office Mul and panchayat Samitee Mul.

3.3.2 Location and area: [16]

Mul is a Taluka in Chandrapur District of Maharashtra State, India. The taluka Head Quarters is situated Mul town. It belongs to Nagpur division of Vidarbha region. It is one of the old taluka in Chandrapur district. It is located 45 KM towards East from District head quarters Chandrapur. It is 847 KM from State capital Mumbai towards west. Mul Taluka is has Saoli Taluka towards East, Pombhurna Taluka towards South, Sindewahi Taluka towards North, Chamorshi Taluka towards East. Mul City, Gadchiroli City, Durgapur City, Chandrapur City are the nearby Cities to

Mul. It is located at 20.07 ^{0}N and 79.67 ^{0}E. It has an average elevation of 198 metres (649 feet).

3.3.3 Population: [17]

As per 2011 census, Mul Taluka has 28,601 households. Total number of population in Mul taluka is 114611.Out of which there are 57253 females and 57,358 males. The literacy rate of Mul taluka is 64.53%, out of which female literacy rate is 57.56% and male literacy rate is 71.48 %. Out of total population, 77.8% of population lives in rural area and 22.2% lives in urban area. There are 12.75% Scheduled Caste (SC) and 15.19% Scheduled Tribe (ST) of total population in Mul Taluka. The population of children between age 0-6 is 11,591 which is 10.11% of total population. (Census 2011)

3.3.4 Important institutions in Mul Taluka:

Table 3.9: Various important institutions in Mul Taluka in Chandrapur District:

Sr .no.	Institution	Number
1	Gram Panchayat	49
2	Nagar Parishad	01
3	Panchayat Samitee	01
4	Police station	01
5	Sub police station	02
6	Anganwadi	159
7	Public hospitals	05
8	Rationing Shops	67
9	Libraries	02

(Source: Tahsil office, Statistical dept. Mul)

Above given table gives us brief idea about the various institutions in Mul taluka. It has 49 Gram Panchayats, 1 Nagar Parishad and Panchayat Samitee. There are 159 AWCs Only one Police Station and two sub police station. It has 5 public hospitals and 67 rationing shops and two Libraries.

3.3.5 Land holding:

Land holding in the Mul taluka can be studied with the help of the given table 3.10.

Table 3.10: Landholding pattern in Mul taluka

Sr. no.	Landholding in Hect	Number of land holders	Percentage	Area (Hect. R)	Percentage
1	Up to 1	11563	52.43	10167.0	33.12
2	1 to 2	4955	22.47	6745.10	21.97
3	Above 2	5538	25.10	13787.61	44.91
	Total	22056	100	30699.71	100

(Source: Tahsil office, Statistical dept. Mul)

Above table reveals that, more than 50% i.e. 52.43 percent people hold land area up to one hectare which is 33.12 percent of the total land, 22.47 percent people possess land between one to two hectors which is 21.97 percent of the total land in the taluka, whereas 25.10 percent people possess land area more than two hectors which is 44.91 percent of the total land in the taluka. It shows that more than 40 percent land is held by 25 percent of the people and around 52 percent of the population has only 33 percent land. It shows unequal distribution of the land in the taluka.

Following table 3.11 shows, distribution of land among tribes and non tribe land holders in Mul Taluka.

Table 3.11: Distribution of land among tribes and non tribe land holders in Mul Taluka

Sr. no	Details	Number	Area (hector)
1	Tribes	2894	2708.34
2	Non-Tribes	19162	27991.37
	Total	22056	30699.71

(Source: Tahsil office, Statistical dept. Mul)

Above table depicts that out of the available land maximum land is owned and cultivated by non tribes. Out of 30699.71 Hector land only 2708.34 Hector is cultivated by Tribal community.

3.3.6 Agriculture:

Out of total geographical area of Mul taluka which is 46198.40 hector. R, total cultivable land is 24855.67 hector. Paddy is the main crop grown in this area. It is one of the highest paddies producing taluka of Maharashtra. Rice, wheat, cotton, soybean are the main crops grown in the taluka. Mul taluka is also famous in the state for the great number of rice mills it has. It has 53 rice mills covering 90% of rice production in whole Chandrapur district. Rice is supplied throughout Maharashtra involving big cities like Mumbai, Pune, Nagpur, Amravati, etc.

3.3.7 Irrigation:

Irrigation facility is one of the major determinants of the productivity of agriculture sector of the country. Farmers can take more production if facility of irrigation is available to them. Following table gives us brief idea about the distribution of land between various means of irrigation.

Table 3.12: Area under irrigation in Mul taluka

Sr. no.	Means of irrigation	Area under irrigation (hector.)
1	Canals	9114.00
2	Wells	1932.00
3	Lakes	5379.75
4	Other	991.00
	Total	17416.75

(Source: Tahsil office, Statistical dept. Mul)

We can observe from table 3.12 gives brief idea about the various means of irrigation available in Mul taluka and area irrigated by them. Total 17416.75 hector land is under irrigation in Mul taluka. Out of it 9114 hector is irrigated by canals, 1932 hector land is irrigated by wells, 5379.75 hector is by lakes and 991 hector is irrigated by other sources of irrigation. We can observe that maximum portion of land under irrigation is irrigated by canals followed by land irrigated by lakes. The taluka still have wells as mean of irrigation for agricultural land.

3.3.8 Employment:

Agriculture, fisheries and rice mill (paddy processing mills), supplementary work are main source of livelihood in this taluka. Most of the people in the rural areas are farmers and agricultural laborers. The income of such families is inadequate to meet their basic needs. Mul Taluka is known as the Taluka of lakes. Fisheries production is done through it. The taluka is naturally endowed with good potential water resources and fishing activity is confined to inland water only, such as rivers, tanks and ponds.

3.3.9 Educational facilities in Mul taluka:

In this era of globalization education has become one of the basic needs of the life. Education shapes the life of a human being. Since the study is about the children i. e. young generation of the nation it is of immense importance to know about educational facilities in the taluka. Following table depicts number of educational institutions in Mul taluka.

Table 3.13: Educational institutions in Mul Taluka

Sr. no	Type of institutes	Number
1	Primary Schools	90
2	Secondary Schools	21
3	Colleges	03

(Source: Tahsil office, Statistical dept. Mul)

There are mostly Zilla Parishad schools for education in Mul taluka. Many private schools have opened now a days but they offer education in urban. There is not enough facility for vocational education in the taluka. There are no engineering, medical colleges in the taluka. For higher education people need to go nearby taluka or district place.

3.3.10 Health Services:

People need to rely on the government hospital for basic health service. However the Citizens also take advantage of private health services as per their affordability. Government is trying to provide health care to masses through the ASHA workers, nurses and health workers.

3.3.11 Transportation:

Mul is connected to district place and other taluka and villages by roads. MSRTC transportation offers bus services to all over the district. But Transportation in remote areas is not safe because the roads in the village are cramped and crude. The main mode of transport is ST bus and passenger auto. The proportion of private vehicles is very small. Mul is connected via railway also, but only taluka place and few other places have this facility. Other villages are dependent on roadways only.

3.3.12 Social life:

As far as the apparel is concerned men generally use pants shirts and women use sarees. Some young girls wear salwar kurta, and the old men wear dhoti. The food consists mainly of rice, potato, brinjal, cabbage bean, chana and other cereals. The lack of adequate nutritious food in daily diet and ignorance of parent leads to malnutrition and anemia. There are not enough employment opportunities due to lack of industrialization. Farming, road works, masonry work, hamalis etc. are sources of earnings. 60% of the families come under poverty line. The level of women education is raised significantly due to provision of free education to girls. Some of the missions of government like 'Beti Padhao, Beti Bachao' helped to promote awareness for education especially among rural population. With the changing time women started working in government, private sectors and business, but the percentage of such women is very less. The main sources of drinking water are traditional wells and bore-wells. Some villages have overhead water-tank to supply water to people through taps. However, these villages do not have water purifying plants or systems. People are left to drink impure water, especially during monsoon. This results in occurrence of many diseases in rural areas during the rainy season due to high levels of alkalis and fluoride.

3.4 Conclusion:

This chapter gives us brief idea about the profile of Chandrapur district and Mul taluka. It may help us to know about the demographic conditions of the area of study. The chapter discusses administrative setup of the district, characteristics of population residing in the area and various social and economic aspects of the district.

The second part of the chapter throws light on the demographic conditions of the Mul taluka. It discusses social economic and demographic conditions in the Mul

taluka. This chapter helps to understand the geographical and social background of the beneficiaries of ICDS scheme. It helps us to relate the functioning of ICDS scheme with the actual ground of work of the ICDS functionaries.

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CHAPTER-4
RESEARCH METHODOLOGY

4.1 Introduction:

A healthy child is the wealth of the nation. Today's children are tomorrow's human resource. The concept of child development has various aspects which are very closely related to the potential human resource of the country. It plays crucial role in the process of development of any nation. Child development involves physical, mental, emotional, cognitive as well as psychological development of a child. Health, nutrition and education provide strong support in the process of the child's development. All these have long lasting effects on children's health, ability to think, learn, work, communicate, productivity and performance in his or her further life.

This chapter tries to explain the direction of research methodology adopted for the present study. Methodology suggests the way in which researcher has to approach and analyse the problem. As mentioned earlier, this study is based on primary data collected through interaction with anganwadi workers and anganwadi beneficiaries. While analyzing the various aspects of ICDS services different researchers have followed different approaches and methods of research. In this study researcher has pursued an analytical approach in which inter-relationship between different variables is sought. This chapter discusses some significant points of methodology, such as the statement of the problem, objective of the study, hypothesis, sources of data, sampling design, collection of data and tools used for the collection of information about various issues relating to the present study, etc. The operational definitions are given for clarity of the concepts.

4.2 Statement of the problem:

ICDS scheme was launched in India in 1975, and is one of the oldest running supplementary nutrition programmes for children between 0-6 years and pregnant and lactating mothers. Basic unit of implementation of the programme is anganwadi center. Anganwadi is also responsible for preschool education, immunization, health checkups and referral services provided under ICDS scheme. It also provide nutrition and health education for women of reproductive age. In the year 2017-18 the country has 1340150 AWCs spread all over it.[1] It is essential to have anganwadi in every

community development block irrespective of the number of population. Blocks which have population more than two lakh should have at least two anganwadi centers. Though the programme has excellent objectives, strategies and financial measures, it has been criticized for being unmonitored and unsuccessful in achieving its goals. After forty years of launch of the ICDS, the country is still facing the problem of malnutrition and anemia among children and women. It is estimated that 30-40 percent of the India's children are malnourished. This includes number of children in the remote parts of Vidarbha and Chandrapur district in the central India. Many studies have been conducted to study functioning of ICDS but those are related to evaluation of functioning of ICDS, assessment of services rendered by anganwadi centers and are general in nature. Former studies conducted on ICDS were mainly related to efficacy and efficiency of AWCs in delivering child welfare services in general. Those studies do not cover evaluation about satisfaction level of beneficiaries with respect to services availed at AWC by them. Since Anganwadi centers are driving centers of the scheme a need was felt to understand the actual functioning of the AWCs.

ICDS was started in Chandrapur district in 1982. Mul is one of the taluka where ICDS project was started, when ICDS projects were launched in Chandrapur District. In the year 2017-18, there are 159 Anganwadi functioning in Mul taluka. Focus of the present study is on the impact of supplementary nutrition and preschool education services on the development of the child availing it. The period 2006 to 2016 should be reasonable to evaluate performance, effectiveness, constraints and opportunities AWCs in Mul taluka of Chandrapur district. Child development programme prior to ICDS failed due to ineffective monitoring, and some problems in the implementation of the programmes. It is felt that the timely assessment of performance of the anganwadi centers can help the effective implementation of the programme. Accordingly Mul taluka of Chandrapur district has been selected as the study area for present study entitled, "**A Socio Economic Impact of Integrated Child Development Services (ICDS) Scheme On Child Development, With Special Reference To Mul Taluka In Chandrapur District." (2006-2016)**

4.3 Objectives of the study:

1) To study effect of ICDS services on health and pre-school non formal education of 0-6 year children admitted in Anganwadi centers.

2) To ascertain the socio-economic background of the beneficiaries of services.

3) To assess the opinion of beneficiaries regarding Anganwadi facilities and Anganwadi workers.

4) To study receipt of grants and expenditure pattern of Anganwadi under ICDS (Mul taluka)

4.4 Hypothesis of the study:

Once the problem to be answered in the course of research is finally instituted, the researcher proceeds to formulate tentative solutions or answers to it. These proposed solutions or explanations are called hypothesis, which the researcher is obliged to test on the basis of facts already known or which can be made known.[1] The following hypotheses have been formed.

1) ICDS services have a positive impact on the development process of beneficiaries.

2) ICDS beneficiaries are socially and economically deprived.

4.5 Significance of Study:

In the 2016 Global Hunger Index report, India was ranked 100th among the leading countries. ICDS contributes to the development of human resources by improving the health and nutritional status of children, pregnant and nursing mothers. Human quality depends on education and skill, availability of health services. Therefore, the role of physical capital i.e. development of human resource, plays an important role in economic development. ICDS is India's primary social welfare scheme involving malnutrition and health problems and children under the age of six years and their mothers by providing health care, supplementary food and non formal pre-primary education. Supplementary nutrition, immunization and non formal pre-school education are the main basis of ICDS which focuses on the overall development of children. Considering the importance of the scheme's objective and the state of malnutrition and health status of children, the contribution of ICDS in reducing the problem is required to be measured. Therefore researcher have chosen to study '**A Socio- Economic impact of Integrated Child Development Services**

(ICDS) Scheme on Child Development with Special reference to Mul Taluka In Chandrapur District.(2006-2016),'

Mul Taluka in Chandrapur District is considered underdeveloped so that social problems have to be tackled to ensure the overall development of the taluka. This research study will be considering Socio- Economic aspects such as family, social and economic profile of the anganwadi workers and beneficiaries, issues like education, health, food intake etc. Effective assessment of the scheme may help policy makers and implementing agencies to increase the efficiency of the program and intervene in order to ensure better utilisation of resources. In rural areas of the country, a large number of families live under poverty line. In spite of noteworthy progress in the field of economics, this section of the society is not in a position to provide necessary care and security. For their children's normal growth, even today they require additional assistance and intervention from state so that the family can fulfill its basic responsibilities for the health care, education and social welfare of the children. In this case, the ICDS study can play an important role by improving its implementation. The study might prove helpful in future while designing policies and programme at block levels.

4.6 Sampling:

Sample is a subset selected from the population for detailed study. It is a smaller representation of a larger whole. For the purpose of present study, two distinct set of sample were designed and selected. First set include anganwadi workers of the selected anganwadi centers. Second set of questionnaire consisted parents of child beneficiaries of anganwadi. For the reason that anganwadi centers are sparsely spread all over the taluka, it was decided to take 32 anganwadi from selected circles and 4 beneficiaries from each selected anganwadi.

The steps followed in sampling can be elaborated as follows:

4.6.1 Selection of Chandrapur district:[2]

Chandrapur was selected purposively for the study, since it is one of the tribal and backward districts in Maharashtra. Following characteristics of the district bring out the level of backwardness of the district.

1) Rural Urban distribution of population:

As per the census 2011, total population of the district is 22, 04,307 out of which 14,285,929 (64.72%) live in rural area and 7, 75,378 (35.18%) live in urban area. It shows that Chandrapur is a predominantly rural area.

2) Density of population:

Density of the population of the Chandrapur district is 193 people per sq. km whereas the same is 365 people per sq.km for Maharashtra.

3) Proportion of SC and ST population:

As per census 2011 proportion of SC population in Chandrapur district is 15.80 percent and percentage of ST population is 17.67 percent. The total population of SC and ST population is 33.47 for the Chandrapur district.

4) Percentage of workers and non worker:

The percentage of main workers in the district is 36.49 percent and of marginal workers is 11.51 percent. Total percentage of working population is 48 percent, whereas percentage of non workers is 52 percent.

5) Category of workers:

Among the workers percentage of cultivators is 20.88 percent, agriculture labour is 44.79, people working in household industry is 2.02 and percentage other type of workers is 32.31. We can observe that total 65.67 percent people are dependent on primary sector or their livelihood.

Above discussion shows the reason of choosing Chandrapur as the area of present study. ICDS scheme was launched in 1982. Since Chandrapur is mainly one of rural districts in Maharashtra, the scheme has wide canvas to reach the unreached. It is one of the districts where ICDS is giving services for more than 35 years.

4.6.2 Selection of Mul taluka:

Mul taluka of Chandrapur district is selected for the present study on the basis of enrollment of the child beneficiaries in ICDS projects i.e. AWCs. In the year 2014-15, among the rural taluka of Chandrapur district, Mul taluka had maximum number of beneficiaries enrolled in AWC. (Refer table Taluka wise AWC and

beneficiaries in Chandrapur district,) Following table depicts enrollment of the child beneficiaries in various AWC in various taluka of Chandrapur district.

Table 4.1: Taluka wise AWC and beneficiaries in Chandrapur district

Reference year: 2014-15

Sr. No	Name of the taluka	Number of Anganwadi	Percentage	Children enrolled in anganwadi	Percentage
1	Warora	206	7.28	5391	2.47
2	Chimur	277	9.78	6166	2.82
3	Nagbhid	193	6.81	5442	2.49
4	Brahmpuri	226	7.98	8797	4.02
5	Saoli	163	5.76	3915	1.79
6	Sindewahi	163	5.76	4118	1.88
7	Bhadrawati	196	6.92	8162	3.73
8	Chandrapur	330	11.66	86313	39.47
9	Mul	159	5.62	11766	5.38
10	Pombhurna	87	3.07	2001	0.92
11	Ballarpur	200	7.06	55824	25.53
12	Korpana	172	6.08	5217	2.39
13	Rajura	180	6.37	8175	3.74
14	Gondpipri	136	4.80	3421	1.56
15	Jivti	143	5.05	3950	1.81
	Total	2831	100	218658	100

(Source: Socio economic Review, Chandrapur, 2015)

4.6.3 Selection of circles:

Table 4.4 reveals circle wise total number of anganwadi functioning in Mul taluka. With the help of given information researcher selected 4 circles out of the 6 circles i.e. Mul, Rajoli, Bhejgaon, Maroda for the purpose of study. Lottery method was used for this selection.

Table 4.2: Circle wise number of AWC in Mul taluka

Sr. no	Circle	No of anganwadi	percentage
1	Mul	28	17.62
2	Rajoli	28	17.62
3	Bhejgaon	26	16.35
4	Bembal	23	14.46
5	Chiroli	29	18.23
6	Maroda	25	15.72
	Total	159	100

(Source: CDPO office, Mul, dist Chandrapur 2016)

Among the above given circles Mul, Rajoli, Bhejgaon and Maroda circles are selected by lottery method.

4.6.4 Selection of anganwadi centers

Table 4.3: Circle wise sampling plan of anganwadi in Mul taluka

Sr. no	**Circle**	**Total no of anganwadi**	**Selected AWC**	**Selected anganwadi workers**	**Total no of beneficiaries**	**Beneficiaries**
1	Mul	28	6	6	1625	24
2	Rajoli	28	8	8	1601	32
3	Bhejgav	26	8	8	1108	32
4	Maroda	25	10	10	1151	40
	Total	107	32	32	5485	128

(Source: CDPO office, Mul, Dist Chandrapur, 2016)

One anganwadi center from the each selected village was picked up by random sampling. From Mul circle less number of anganwadi centers i. e. 6 AWCs were selected and from Maroda circle 10 number of anganwadi centers were selected for the reason that Maroda is more remote and backward circle among all the circles.

Brief look at sampling procedure:

We can take brief look at the sampling process as follows.

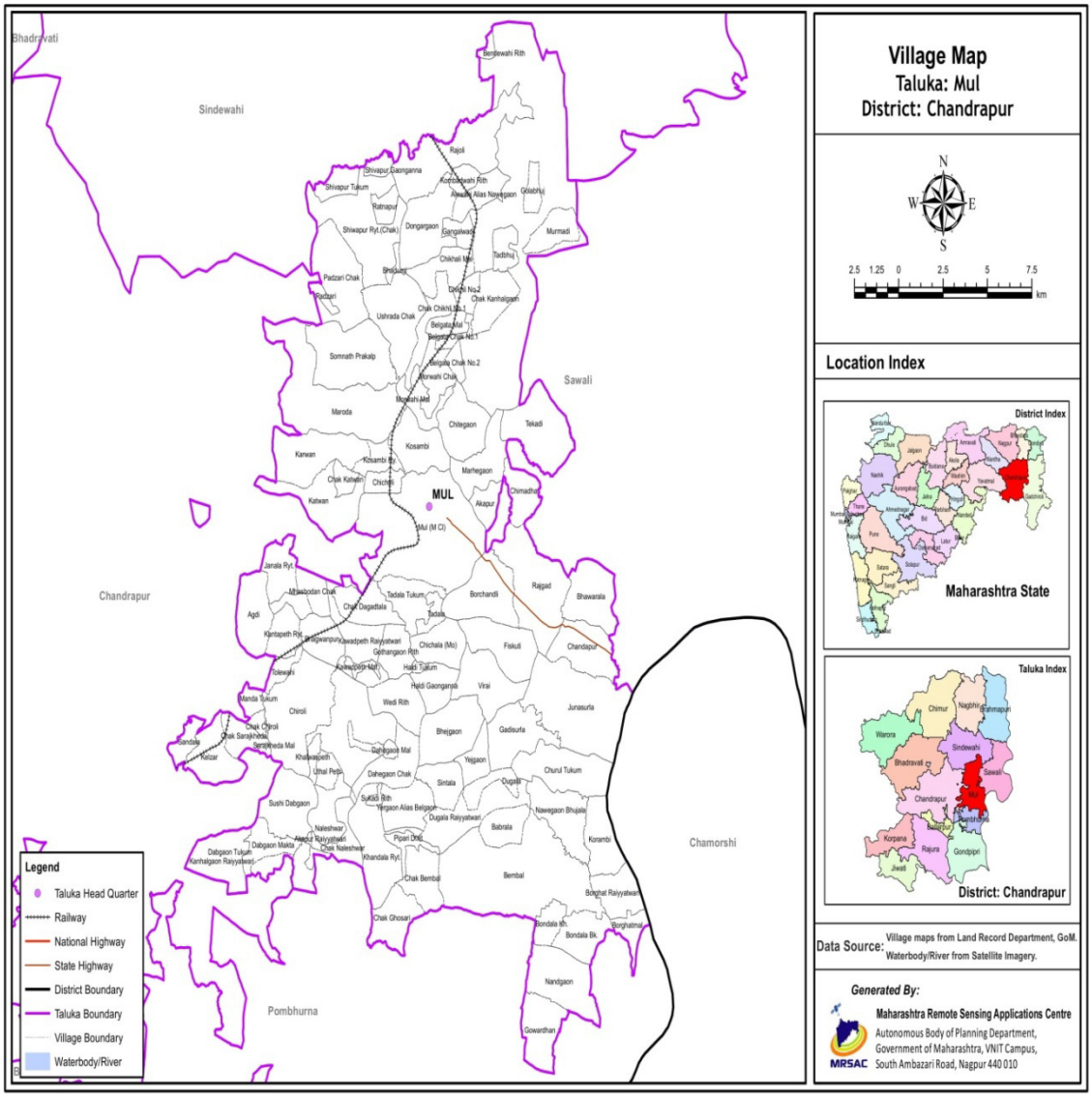
Table 4.4: Brief look at sampling procedure

Sr no	unit	Total no	No of units selected	% selected	Sampling method	Reason for selection
1	Districts in Maharashtra state	36	1 (Chandrapur)	2.77%	Purposive	Backward
2	Taluka in Chandrapur district	15	1 (Mul)	6.66%	Purposive	Remote and backward
3	Circles in Mul Block	6	4	66.66%	lottery	-----
4	AWC	107	32	29.91	Random	---------
5	AWW	107	32	29.91	Census	Each from Selected AWCs
6	Beneficiaries	5485	128	2.33	Purposive	Age 5-6 Yrs

(Source: Table 4.1 to Table 4.3)

4.6.5 Area of Study:

4.1 Map - showing Mul Taluka in Chandrapur District of Maharashtra.



(Source: Maharashtra Remote Sensing Application Centre (MRSAC), Nagpur)

4.6.6 Sampling Procedure:

The investigator visited the CDPO office at Mul and acquired the list of anganwadi centers in Mul block. There are 6 circles in Mul block. Out of these 4 circles were selected by lottery method. Anganwadi centre from the selected circles were selected by simple random sampling method. For selection of beneficiaries, investigator acquired the list of beneficiaries from the anganwadi. Thereafter the beneficiaries between 5 to 6 years were selected by purposive sampling method.

Investigator has selected beneficiaries above 5 years purposively so that the growth measures of the child can be studied.

4.6.7 Sample size:

The sample consists of two components.

1. Anganwadi workers:

32 Anganwadi are selected by random sampling. Anganwadi worker from each center were interviewed for primary data collection.

2. ICDS beneficiaries:

Out of each selected anganwadi center 4 beneficiaries of age group 5-6 were identified. 128 beneficiaries from 32 anganwadi centers are studied spread over 4 circles in Mul taluka.

4.7 Collection of Data:

Both primary and secondary methods of data collection are used by the researcher to collect the data and information for the present study. Researcher personally visited all the anganwadi centers to collect primary data. To fill the schedules of selected anganwadi worker and beneficiary, researcher approached the respective anganwadi centers. In case when guardians of beneficiaries were not available at the center a visit to their home was organized.

a) Primary Data

Primary data is collected through well structured questionnaire from the guardians of beneficiaries and anganwadi workers on separate schedules designed for them. The information collected through the schedules was supplemented by discussion and observation by the investigator.

Data collection from AWW

The first set of primary data was collected through a structured questionnaire from Anganwadi workers. The questionnaire was designed focusing on collecting their a) personal information b) family information c) information about their work. d) Their views about services provided at AWC

Data collection from anganwadi beneficiaries

The second set of primary data was collected from the guardians of anganwadi beneficiaries. This schedule focused on collecting information related to a) personal

information b) family information c) opinion about services rendered by AWCs d) opinion about child's development

Both the schedules were pretested on the same sample in pilot study and modified according to the need of the study.

b) Secondary data

Secondary data was collected from the all published data from government, CDPO office, Mul, Zilla Parishad office Chandrapur, Tahsil Office, Mul, YASHADA, Pune, various reports of Women and Child welfare department, Govt. of Maharashtra, Monthly progress reports of AWCs and other various secondary sources such as books, articles, research articles, news papers, and reports were used for collecting secondary data. Various annual reports of The Ministry of Women and Child Development, Census Repots, booklets provided to anganwadi workers for Guideline of work etc are few of the examples of the material used for secondary data.

Various Govt. institutes have their official websites on the internet. Some information regarding the secondary data has been collected from different websites of such government offices.

4.8 Analysis of data:

After collection of data has to be processed and analysed in accordance with the outline laid down for the purpose at the time of developing the research plan. This is essential for a scientific study and for ensuring that we have all relevant data for making contemplated comparisons and analysis. The term analysis refers to computation of certain measures along with searching for patterns of relationship that exist among the data group.[3] Data processing is done manually by the researcher herself in which following stages and procedure were followed-

i) Editing of data:

The data was edited to detect errors and omissions and was corrected. It helped to facilitate coding and tabulation.

ii) Coding:

Coding is done to put the answers in limited numbers of classes. It proved helpful for computer tabulation.

iii) Classification of data:

Large volume of data is classified into several homogeneous groups. Classification of such data helped to divide the data for analysis.

iv)Tabulation of data:

The assembled data was arranged and displayed in the form of tables for further analysis. Researcher used compurised table in excel for further analysis.

v) Statistical Technique:

The data was analysed with the help of various tools of analysis like percentage, growth rate. Growth rate was drawn to analyse trends in the increase in expenditure of central government on ICDS scheme, expenditure of Maharashtra government on Supplementary Nutrition as well as ICDS project of Mul Block. Percentage was used to analyse primary data collected with the help of questionnaire.

4.9 Scope of the study:

The researcher has selected Chandrapur district for the purpose of study. The geographical scope of the present study is confined to the boundaries of Mul taluka in Chandrapur district of Maharashtra State. The period covered in this study is 2006 - 2016. There are 159 anganwadi centers in Mul taluka. These are divided in 6 blocks for administrative purpose. The 32 Anganwadi centers from the 4 blocks (out of 6 blocks) are selected for the purpose of the study. The research outcome is expected to throw light on the actual functioning of the ICDS services in the Mul Taluka.

4.10 Limitation of the study:

The study is for the specific age group of the ICDS beneficiaries who have received the services of ICDS through anganwadi centers. The research study is focused on analyzing the impact of the services delivered by ICDS on child development. The concept of child development encompasses various aspects like physical, mental, emotional, social, cognitive, intellectual development of the child. Therefore the study area is vast. Researcher has taken the physical development of the child for the purpose of study.

Actual beneficiaries could not provide required data hence information is collected from parents of the beneficiaries.

The analysis is limited to analyzing the primary data from respondents in Mul taluka of Chandrapur district (Maharashtra). The findings are based on the

information provided by anganwadi workers and parents of beneficiaries. The possibility of hiding certain content cannot be denied. The researcher tried her best to establish good rapport with the respondents. Still due to their workload and time constraint few of them were not eager to communicate. In such a case researcher had to explain the purpose of the study first, convinced them and then carried on filling up the schedules.

Analysis of secondary data related to expenditure of central and state governments on ICDS services is for the period of 10 years. Secondary analysis is confined to the expenditure of government for Mul taluka only. It does not include expenditure incurred on ICDS services other than Mul taluka. The secondary data used is for the period 2006-2016 only.

4.11 Chapter scheme:

The dissertation is divided in to six chapters as given below:

Chapter 1

This chapter gives introduction about the present study .it is mainly divided in two distinct parts. First part illustrates the concept of child development and tries to cover the possible aspects of the concept. Second part consists of introduction of ICDS scheme and builds a periphery of the key concepts of the present study like administration of ICDS, funding pattern of the scheme, services provided under the scheme and functioning of anganwadi etc.

Chapter 2

This chapter contains review of literature for the present study.

Chapter 3

Chapter 3 is divided in two parts. Part I contains information about historical background of Chandrapur district, geographical location, administrative structure, population, health services, status of education, employment and industry etc

Part 2 of the chapter gives us an overall understanding about the geographical location, administrative structure, population, employment, education, health facilities, and social life of the Mul Taluka.

Chapter 4

This chapter includes information about research methodology. Following points are mentioned in this chapter-research problem, objectives of research, hypothesis of

research work, methods and techniques of research, method of data collection and chapter scheme.

Chapter 5

This chapter is divided in to four parts. First part analyses secondary data which elaborates expenditure of government on IDS scheme at central, state and block level. Second part of the chapter contains tabulation and data analysis of the data collected from anganwadi workers. Third part contains tabulation and data analysis of the data collected from anganwadi beneficiaries. Fourth part contains hypothesis testing.

Chapter 6

This chapter gives findings and suggestions based on the study.

4.12 Conclusion:

The chapter Research Methodology gives us methodological framework of the present study. It elaborates various aspects of the research which determine the area and scope of the study. It introduces us to the objectives, hypothesis and significance of the study as well as throws light on the sampling, data collection and the methods of analysis. It also gives us brief idea of limitations of the study. We can have a brief introduction of chapters and scheme of chapters. In this way present chapter helps us to understand outline of the present research.

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2) Directorate of Census operations, Maharashtra (2011): “District Census Handbook”, Chandrapur, Census of India 2011, pp 35-36

3) Kothari C. R. (2004): “Research Methodology”, New Age International Publishers, New Delhi, pp 30

CHAPTER-5

DATA ANALYSIS AND INTERPRETATION

5.1 Introduction:

This chapter incorporates data analysis and interpretation of the research work. Part I of this chapter consist analysis of the secondary data. Part II consist of analysis of questionnaire of anganwadi workers and part III consists of analysis and interpretation of questionnaire for parents of beneficiaries.

5.2 PART-I

ANALYSIS OF EXPENDITURE OF ICDS

Under Integrated Child Development Services (ICDS) Scheme, funds are allotted under two heads i.e. ICDS (General) and supplementary Nutrition. Prior to 2005 the Central Government used to give 100 percent assistance for the administrative cost and the cost of providing supplementary nutrition was borne by the state. But it was found that due to constraint of resources the states were not able to provide supplementary nutrition in satisfactory way. The sharing pattern was changed time to time for better execution of the scheme. It was changed again from 2016-17. For supplementary nutrition it is made 50:50 between centre and state, 90:10 for North East States and 3 Himalayan states. For ICDS (General) it is 60:40 between centre and states, 90:10 for North east States and 3 Himalayan states. This part of analysis discusses expenditure of central Government, State Government and ICDS project of Mul Block under ICDS scheme.

5.2.1 Central government budget allocation and expenditure under ICDS Scheme

The Central Government provides funds for ICDS projects. It shares cost of ICDS projects with the state government. Following table 5.1 and figure 5.1 provides information about the budget allocation and expenditure under ICDS for the period of 2006 to 2016.

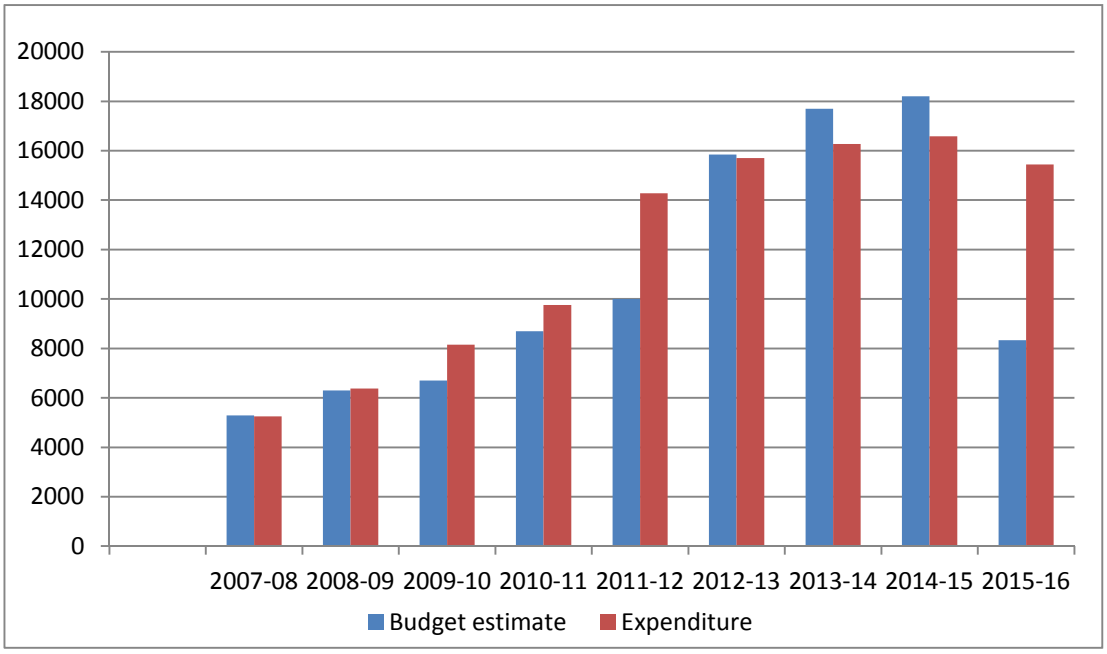
Table 5.1: Central government's budget allocation and expenditure under ICDS Scheme

Sr. no	Year	Budget Estimate (Crores)	Revised Estimate (Crores)	Expenditure (Crores)	% Growth in Expenditure	% of Expenditure to BE
2	2007-08	5293.00	5396.30	5257.09	-	99.32
3	2008-09	6300.00	6300.00	6379.36	21.35	101.26
4	2009-10	6705.00	8162.00	8157.76	27.88	121.67
5	2010-11	8700.00	9280.00	9763.11	19.68	112.22
6	2011-12	10000.00	14048.40	14272.20	46.19	142.72
7	2012-13	15850.00	15850.00	15701.50	10.01	99.06
8	2013-14	17700.00	16312.00	16267.50	3.60	91.91
9	2014-15	18195.00	16561.60	16581.80	1.93	91.13
10	2015-16	8335.77	15483.77	15438.90	-6.89	185.21

(Source: Annual Report 2016-17, WCD Ministry, Government of India)

The above given table 5.1 depicts central Government's budget allocation and expenditure under ICDS scheme. The same is represented in the figure 5.1 and figure 5.2.

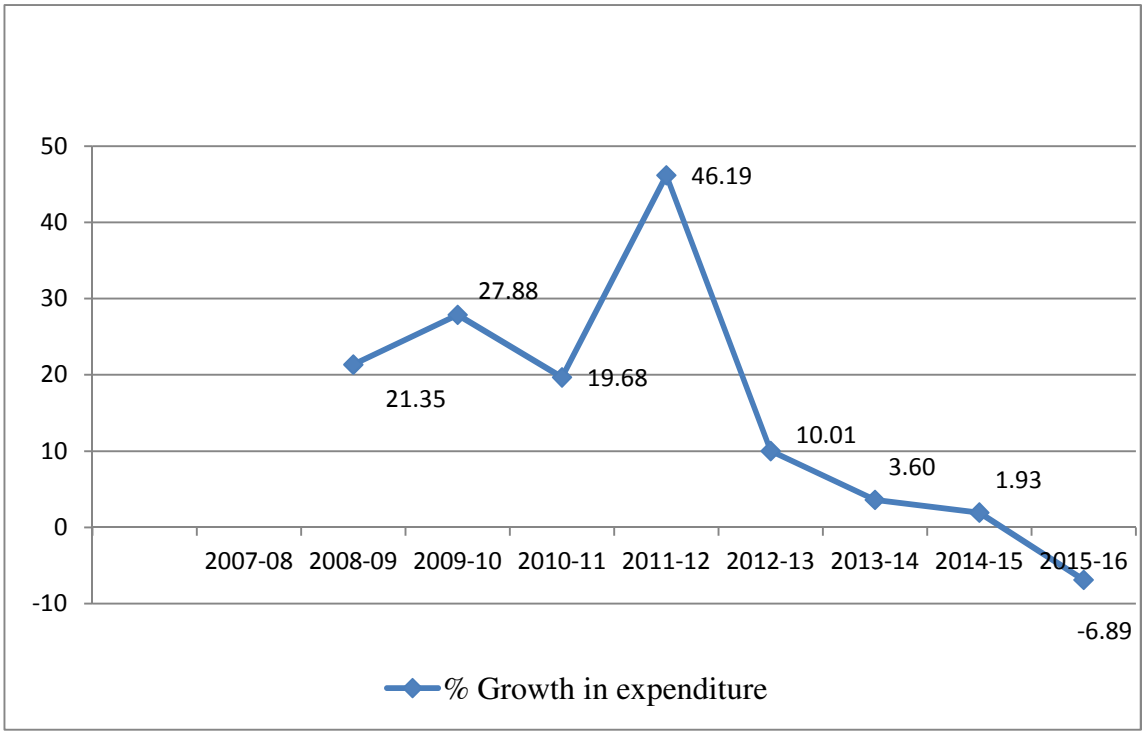
Figure 5.1: Central Government's budget allocation and expenditure under ICDS Scheme



(Source: Table 5.1)

Above given table gives us information about the allocation and expenditure in the budget of Central Government for various years. In the year 2007-08 the expenditure of central government on ICDS scheme was Rs.5257.09 crores. The budget estimate was RS. 5293 crores . We can observe that the estimated budget has increased gradually in further years till 2014-15. It can also be noticed that, the actual expenditure on the ICDS scheme is more than the budget estimates for respective years. The difference in the budget estimates and actual expenditure have increased gradually. We find consistent increase in the budget estimate and actual expenditure till the year 2014-15. After this in the year 2015-16 there is cut in the budget estimate i.e. it has gone down to RS.8335.77 crores but the actual expenditure is Rs.15438.90 crores and the revised estimate is RS.15483.77 crores. We find that in the year 2015-16 there is fall in the budget estimate and expenditure by the Central Government on ICDS scheme.

Figure 5.2: Percentage Growth in the expenditure of Central Government on ICDS



(Source: Table 5.1)

Figure 5.2 gives us percentage growth in the expenditure of central Government of India on ICDS scheme. We can observe considerable fluctuation in year wise growth in percentage of expenditure by the Central Government. In the year

2008-09 it was 21.35 percent, it increased to 27.88 percent in the year 2009-10. For the year 2011-12 the rate was declined by 19.68 percent and increased sharply to 46.19 percent in the year 2011-12. After year 2011-12, rate we can observe consistent decrease in the rate of growth in expenditure by the Central Government. For the year 2014-15 the growth rate has decreased to its lowest rate i.e.1.93. in the year 2015-16 growth rate of the expenditure by the Central Government has gone to -6.89. It shows that though the expenditure by the Central Government for the ICDS scheme is increasing; it is increasing at a decreasing rate. Due to the changes in government policies, we find decline in the expenditure on ICDS.

5.2.2 Expenditure on supplementary nutrition programme in Maharashtra

Following table gives us the growth of beneficiaries of SNP and breakup of expenditure in rural and urban blocks of ICDS on SNP by Government of Maharashtra. It may help us to understand the growth in the beneficiaries and expenditure on providing SNP to them.

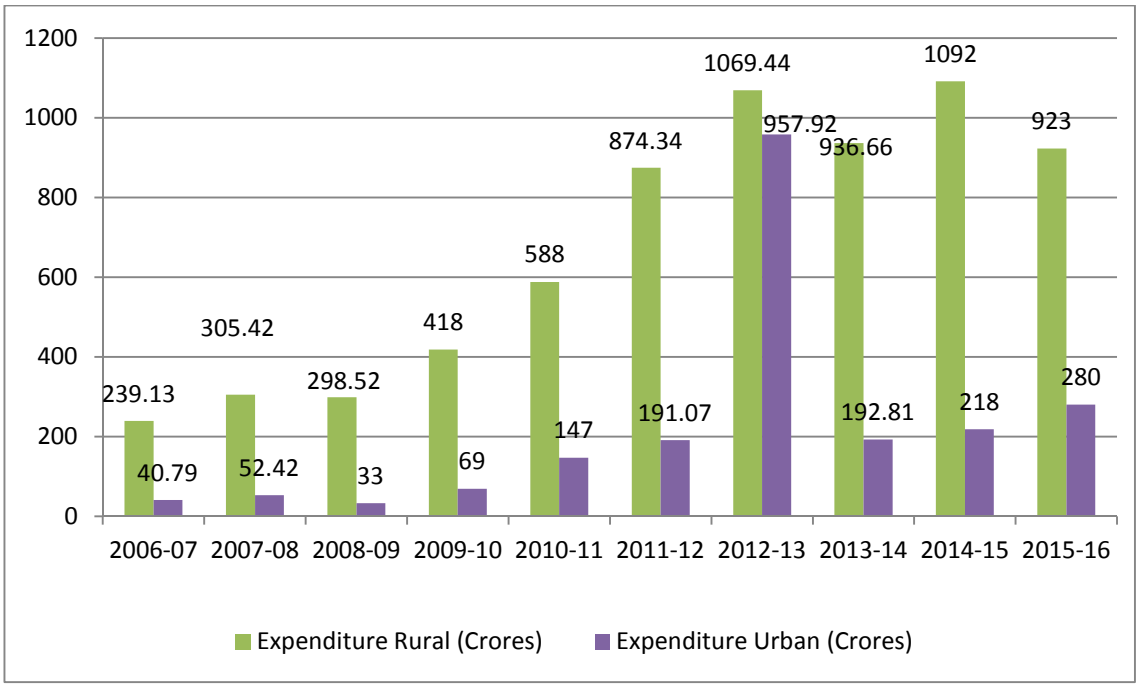
Table 5.2: Expenditure on supplementary nutrition programme in Maharashtra

Sr. No.	Year	Beneficiaries Rural and Tribal (lakh)	Beneficiaries Urban (lakh)	Expenditure Rural (Crores)	Expenditure Urban (Crores)
1	2006-07	51.81	8.38	239.13	40.79
2	2007-08	52.61	9.53	305.42	52.42
3	2008-09	54.37	10.43	298.52	33.00
4	2009-10	59.71	12.84	418.00	69.00
5	2010-11	62.39	13.18	588.00	147.00
6	2011-12	61.82	12.78	874.34	191.07
7	2012-13	62.10	12.22	1069.44	957.92
8	2013-14	60.64	12.07	936.66	192.81
9	2014-15	59.94	11.98	1092.00	218.00
10	2015-16	57.15	11.59	923.00	280.00

(Source: Economic Survey of Maharashtra, from 2006-07 to 2015-16)

Above table 5.2 is represented in the figure 5.3 given below.

Figure 5.3: Expenditure on supplementary nutrition programme in Rural and Urban Maharashtra



(Source: Table 5.2)

It can be observed from the given table 5.2 and figure 5.3 that there is drastic difference in the expenditure incurred on Supplementary Nutrition Programme in rural and urban areas of Maharashtra. The expenditure in rural blocks (including tribal) is considerably greater than the expenditure in urban blocks in Maharashtra. The reason behind this can be understood again from table 5.2. We find that the number of beneficiaries in rural (including tribal) blocks is far more than the beneficiaries in urban projects. Hence it is quite likely that the expenditure on these projects in rural areas is more than the expenditure on the projects in urban areas. We find proportional relationship between the number of beneficiaries and expenditure on them in the respective projects. There is gradual increase in the expenditure on rural projects till the year 2012-13. In the year 2013-14 there is decline in the expenditure on the SNP by the state. This is due to the decrease in the number of beneficiaries in rural area. The trend of sending child to the private school can be one of the reasons behind the drop in the rate of children going to AWC. It can be stated that due to the decrease in the number of beneficiary in both, rural as well as urban projects, the expenditure on SNP by the State is decreasing,

5.2 Analysis of expenditure of ICDS project of Mul Block

Table 5.3: Expenditure of ICDS project of Mul Block for the period 2006- 2016

Sr. no.	Year	ICDS (General)	SNP	Total
1	2006-07	38,36,455	-	38,36,455
5	2010-11	64,49,795	75,35,815	1,39,85,610
6	2011-12	1,14,97,867	47,03,892	1,62,01,759
7	2012-13	1,31,15,087	44,27,794	1,75,42,881
8	2013-14	1,13,27,294	41,84,353	1,55,11,647
9	2014-15	1,25,25,527	50,59,651	1,75,85,178
10	2015-16	1,46,17,439	1,12,10,843	2,58,28,282

(Source: CDPO office, Mul)

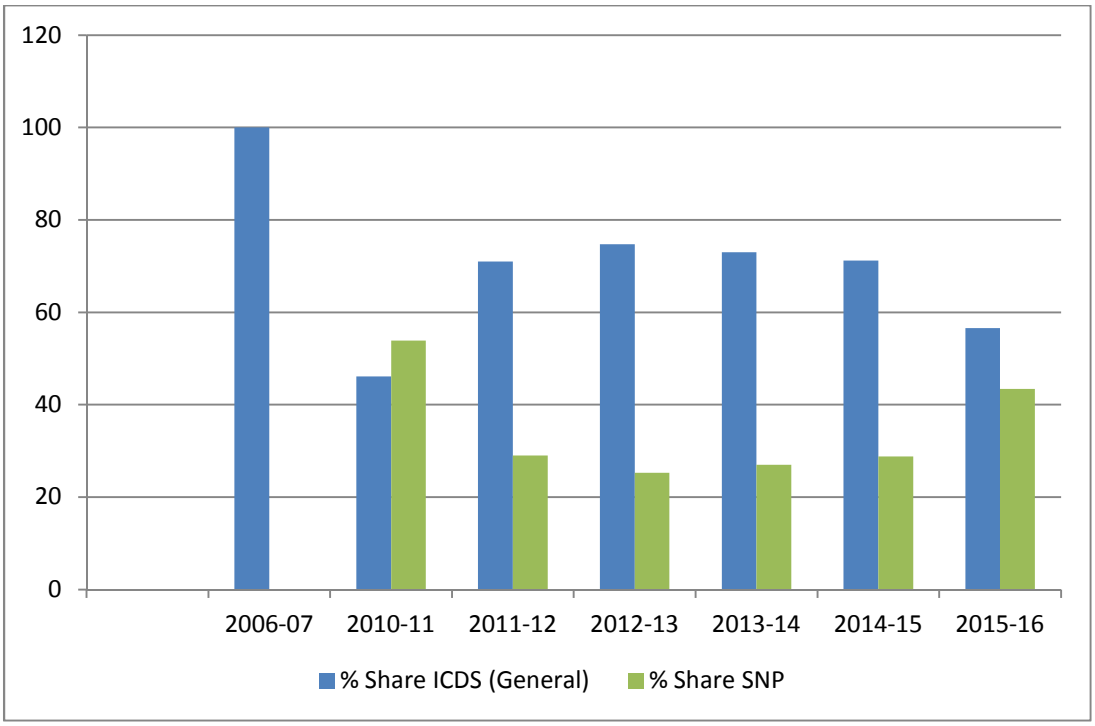
Above table reveals expenditure of ICDS project of Mul Block for the period 2006- 2016. It gives us information on the expenditure on ICDS (General) and SNP for respective years. Based on this table, we have analysed further the share of expenditure on ICDS (General) and SNP in total expenditure and trend in growth in the expenditure in the table 5.4 and table 5.5 which are given below followed by the respective figures for the table.

Table 5.4: Share of ICDS general and SNP in total expenditure in Mul Block

Sr. no	Year	ICDS (General) Total Expenditure	Share %	SNP Total Expenditure	Share %	Total
1	2006-07	38,36,455	100	NA	0	38,36,455
2	2010-11	64,49,795	46.12	75,35,815	53.88	1,39,85,610
3	2011-12	1,14,97,867	70.97	47,03,892	29.03	1,62,01,759
4	2012-13	1,31,15,087	74.76	44,27,794	25.24	1,75,42,881
5	2013-14	1,13,27,294	73.02	41,84,353	26.98	1,55,11,647
6	2014-15	1,25,25,527	71.23	50,59,651	28.77	1,75,85,178
7	2015-16	1,46,17,439	56.59	1,12,10,843	43.41	2,58,28,282

(Source: Table 5.3)

Figure 5.4: Percentage Share of ICDS (General) and SNP in total expenditure in Mul Block



(Source: Table 5.4)

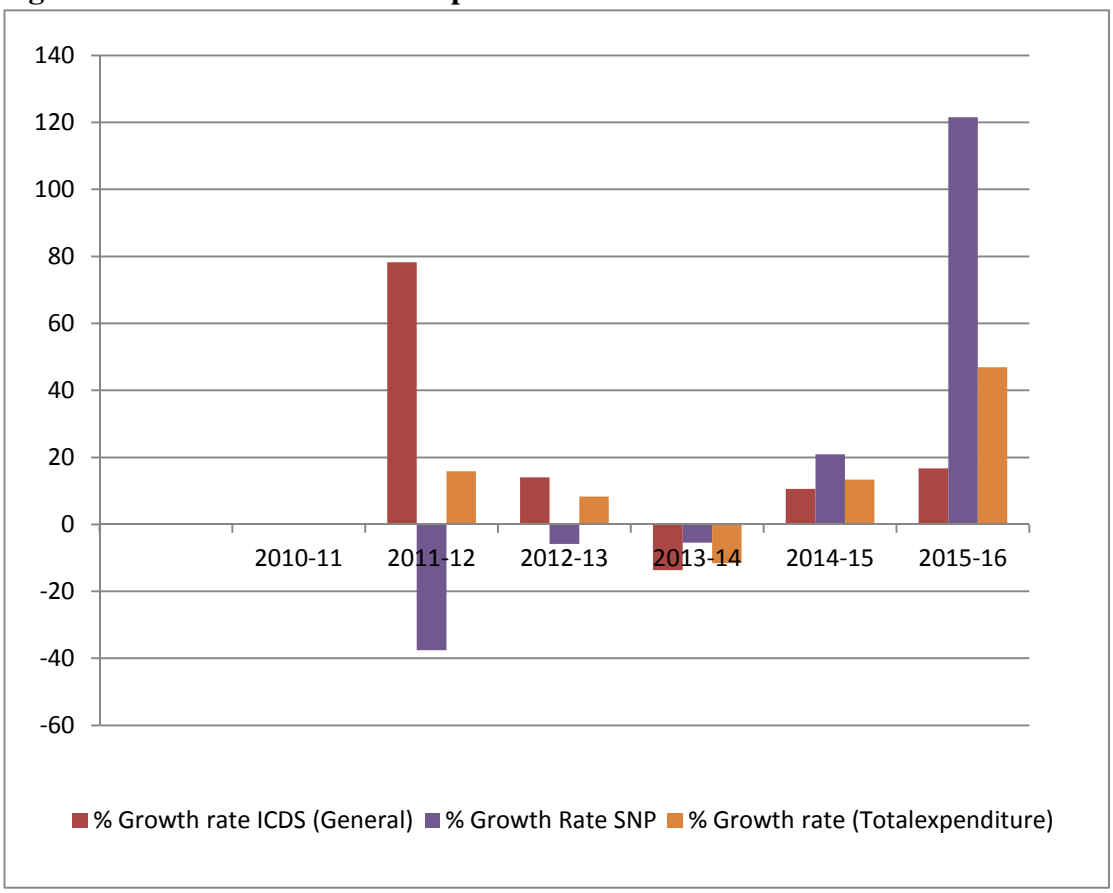
Figure 5.4 depicts percentage share of ICDS (General) and SNP in total expenditure in Mul Block. It can be observed that the percentage share of ICDS general is more than the percentage share of supplementary nutrition Programme and this is because SNP includes expenditure only on the supplementary nutrition but ICDS (General) encompasses several other items like PSE, Wages of AWW and helper and other expenses of the project. It can also be observed that initially the expenditure on ICDS (General) is increasing till 2012-13 and decreasing afterwards. On the other hand expenditure on SNP had downward trend and after 2014-15 it started increasing. The reason behind this can be the changing policies of the government in budget allotment or the changes in the number of eligible beneficiaries in the area. In the year 2006-07, we find 100 percent share of ICDS (General) in the total expenditure and zero shares of SNP because AWCs use to get grains and eatables in kind. Therefore the data about the fund allotment was not available.

Table 5.5: Growth rate in the expenditure of Mul Block of ICDS

Sr. no	Year	ICDS general Total Expd.	Growth rate	SNP Total expd	Growth Rate	Total expd	Growth rate
2	2010-11	64,49,795		75,35,815		1,39,85,610	
3	2011-12	1,14,97,867	78.27	47,03,892	-37.58	1,62,01,759	15.85
4	2012-13	1,31,15,087	14.07	44,27,794	-5.87	1,75,42,881	8.28
5	2013-14	1,13,27,294	-13.63	41,84,353	-5.50	1,55,11,647	-11.58
6	2014-15	1,25,25,527	10.58	50,59,651	20.92	1,75,85,178	13.37
7	2015-16	1,46,17,439	16.70	1,12,10,843	121.57	2,58,28,282	46.88

(Source: Table 5.3)

Figure 5.5: Growth rate in the expenditure of Mul Block of ICDS



(Source: Table 5.5)

Above table and figure depicts the rate of growth in the expenditure of ICDS scheme in Mul Block for the period 2010-11 to 2015-16. The data prior to this period was not available hence present table and analysis does not include it. In the year 2011-12, the rate of growth for ICDS (General) has increased by 78.27 percent, but it decreased by 37.58 percent for SNP. The overall rate of growth of expenditure for Mul Block is 15.85 percent. The rate has gone down for ICDS (General) to 14.07 percent and we find further decrease i.e. -13.63 in expenditure in the year 2013-14. In the next year it rose to 10.58 and for 2015-16 it was 16.70 percent. In case of SNP we find consistent decreased in the expenditure on supplementary nutrition till 2013-14. In the year 2014-15, the expenditure increased by 20.92 percent. In the year 2015-16 it grew by 121.57 percent.

5.3 PART-II

ANALYSIS OF QUESTIONNAIRE OF ANGANWADI WORKERS

Anganwadi workers are ambassadors of the services provided by ICDS scheme. Study of these may help one to understand the family, social and economic profile of the same. They are selected from local community. Their economic, social, financial and educational status influences the quality of the services they impart. In this way they play an important role in the process of child development. They are the linkage between the implementing authority and actual beneficiaries. The successful delivery of the ICDS services depends upon skills and knowledge of this key functionary. Hence it is important to understand their background which affects their performance on the ground level.

(A) PERSONAL AND FAMILY INFORMATION OF AWW:

5.3.1 Classification on the basis of age of anganwadi workers

Anganwadi workers are chosen from local community who are well acquainted with the people, language, culture and area of the anganwadi center. Following table depicts age of anganwadi workers selected for the present study.

Table 5.6: Age wise classification of AWW

Sr. no	Age group	Frequency	Percentage
1	20 to30	1	3.13
2	31 to 40	11	34.37
3	41 to 50	5	15.62
4	51 to 60	14	43.75
5	Above 61	1	3.13
	Total	32	100

(Source: Field Survey)

From above table it can be observed that the anganwadi workers who were interviewed are of different age groups. Age of 3.13 percent AWW is between 20 to 30 years. 34.37 AWW are between 31 to 40 years.15.62 AWW are between 41 to 50 years.43.75 percent AWW are between 51 to 60 years age group and 3.13 per cent are above 61 years. It can be seen that among the AWW interviewed the large number of AWW belong to 51 to 60 years age group. More than 50 percent AWW are above 30 years. Very few of them 3.30 percent are below 30 years. Age group 31 to 40 also has prominent no of 34.37 percent workers. It shows that all age groups are prevalent in anganwadi service. Women are willing to work as anganwadi worker.

5.3.2 Classification on the basis of marital status of anganwadi workers

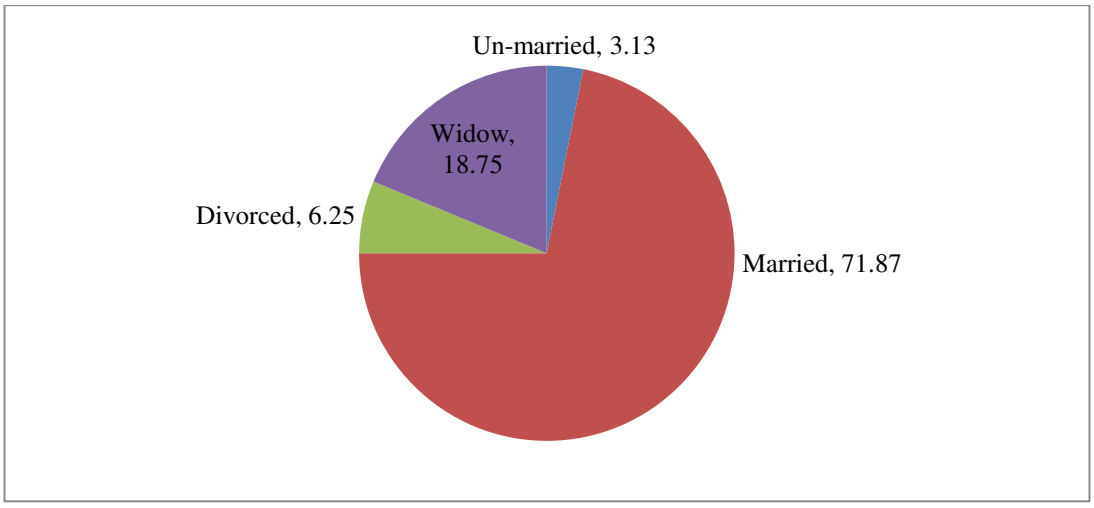
Marital status of the anganwadi workers is represented in the following table and figure.

Table 5.7: Marital status of anganwadi workers

Sr. no	Marital Status	Frequency	Percentage
1	Un-married	1	3.13
2	Married	23	71.87
3	Divorced	2	6.25
4	Widow	6	18.75
	Total	32	100

(Source: Field Survey)

Figure 5.6: Marital status of anganwadi workers



(Source: Table 5.7)

From the above table 5.7, it can be seen that the number of married AWW is large but the percentage of un-married divorced and widows is also considerable. The job as anganwadi worker gives such women financial support for their further life. In the study it was found that 71.87 percent AWW are married. 3.13 percent are unmarried, 6.25 percent are divorcee and 18.75 percent are widow.

5.3.3 Classification on the basis of education of anganwadi workers

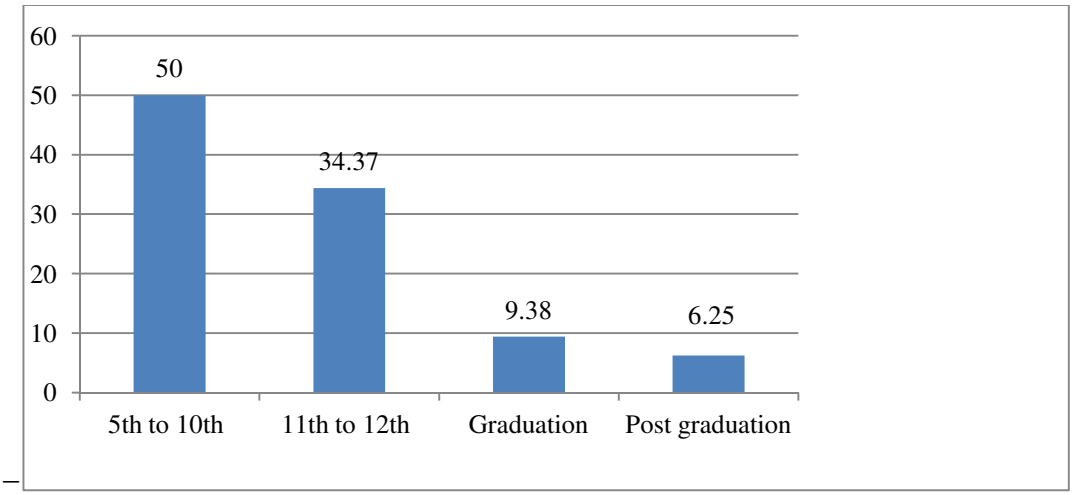
Education level of the anganwadi worker is very important because they are prime functionaries of the ICDS services. Their education can help them for better performance of the services provided at AWC. Education level of anganwadi worker is given in the following table 5.8 and represented in figure 5.7.

Table 5.8: Education level of Anganwadi worker

Sr. no	Education	Frequency	Percentage
1	5^{th} to 10^{th}	16	50
2	11^{th} to 12^{th}	11	34.37
3	Graduation	3	9.38
4	Post graduation	2	6.25
	Total	32	100

(Source: Field Survey)

Figure 5.7: Education level of Anganwadi worker



(Source: Table 5.8)

Among the AWWs interviewed all AWW are educated but the level of education varies. Education level of 50 percent AWW is 5th standard to 10th standard. Most of them have completed their education till SSC. 34.37 percent AWW have completed their education till 12th standard followed by 9.38 percent who are graduate and 6.25 percent are post graduate. It can be stated that though the level of education in rural areas is enhancing, most of the girls do not complete their education. Several factors like social, economical, geographical are responsible for this. Since these AWW are drivers of ICDS services their level of education influences their productivity and results.

5.3.4 Classification on the basis of caste of AWW

Though we are living in the era of globalization and boundaries of class system are disappearing, we see caste system is still prevalent in rural areas. Caste and religion influence lives in rural areas. Religion, tradition and customs are integral part of rural culture. Classification of the AWW selected for the present study is given table no 5.9 which shows social structure of these AWW.

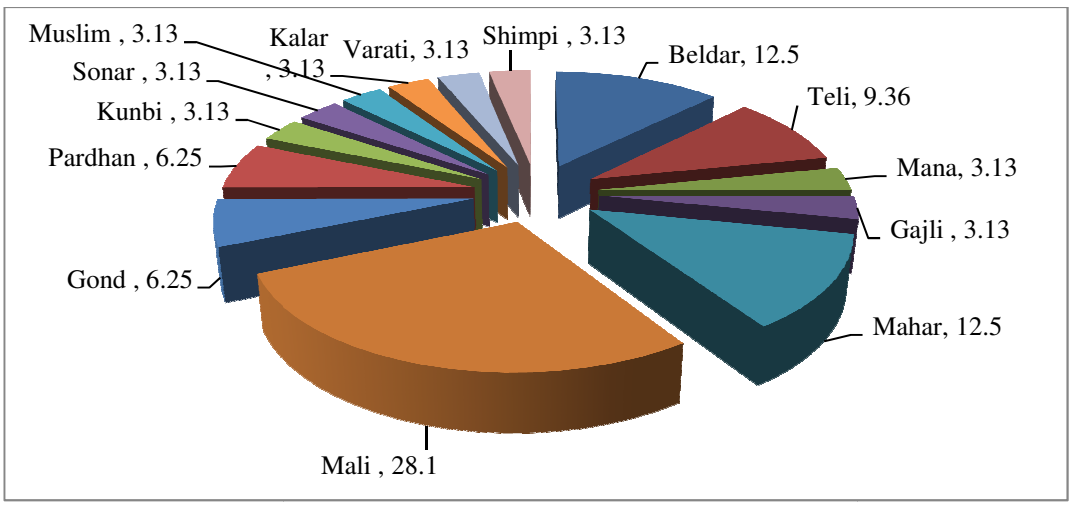
Table 5.9: Classification on the basis of caste of AWW

Sr. no	Caste	Frequency	Percentage
1	Beldar	4	12.5
2	Teli	3	9.36
3	Mana	1	3.13
4	Gajli	1	3.13
5	Mahar	4	12.5
6	Mali	9	28.1
7	Gond	2	6.25
8	Pardhan	2	6.25
9	Kunbi	1	3.13
10	Sonar	1	3.13
11	Muslim	1	3.13
12	Kalar	1	3.13
13	Varati	1	3.13
14	Shimpi	1	3.13
	Total	32	100

(Source: Field Survey)

The table 5.9 shows the information regarding classification of anganwadi workers on the basis of their caste and represented in figure 5.8 given below.

Figure 5.8: Classification on the basis of caste



(Source: Table 5.9)

Figure 5.8 shows that maximum number of AWW belongs to Mali caste, 12.5 percent anganwadi workers belong to Beldar and 12.5 percent Mahar community following 9.36 percent from Teli, 6.25 percent AWW are from Pardhan and 6.25 percent belong to Gond caste. Percentage of the AWW which belong to Kunbi, Sonar, Muslim, Kalar, Varati, Shimpi, Mana and Gajli is 3.13 percent each. We can observe that the AWW belongs to varied castes. It includes ST, SC, and OBC categories. From the above table and figure we come to know that anganwadi workers in Mul, Maroda, Rajoli Bhejgaon Circles of Mul Block are from varied social background. More than 50 percent of them belong to Scheduled Caste or Scheduled Tribes, Participation of Mali community is maximum followed by Beldar and Mahar community each. We can say that with the changing world participation of the women from OBC, SC, ST and NT is in anganwadi service is also increasing.

5.3.5 Classification on the basis of years of Anganwadi service

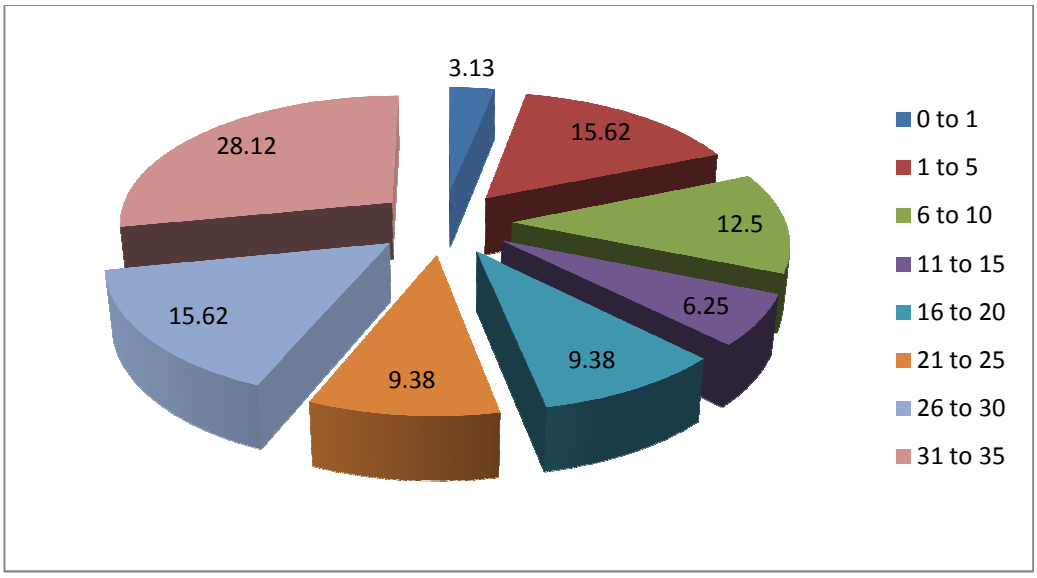
Any individual becomes expert with increasing years of experience. The same is true for AWW. Their experience helps them to undertake their responsibilities more efficiently.

Table 5.10: Years of Anganwadi service

Sr. no	Years of anganwadi service	Frequency	Percentage
1	0 to 1	1	3.13
2	1 to 5	5	15.62
3	6 to 10	4	12.5
4	11 to 15	2	6.25
5	16 to 20	3	9.38
6	21 to 25	3	9.38
7	26 to 30	5	15.62
8	31 to 35	9	28.12
	Total	32	100

(Source: field survey)

Figure 5.9: Years of Anganwadi service



(Source: Table 5.10)

Above given table reveals that among the AWWs interviewed only 3.13 percent AWW have completed their one year of anganwadi service. 15.62 percent workers have completed their one to five years of service. It is observed that, these anganwadi workers belong to young generation. More than 50% of AWW are working as AWW for more than 15 years. More year of service enable them to impart ICDS services more efficiently.

5.3.6 Classification on the basis of number of members in the family

Family size is an important factor which influences standard of living of a person, since it increases number of people sharing available resources for the family. Comparatively smaller families can have better life than the families having more number of members. Classification of anganwadi workers on the basis of number of family members they have in their family is depicted in the following table. It helps us to understand the family size of the AWW and we could understand their responsibilities at personal front.

Table 5.11: Number of members in the family

Sr. no	No. of family members	Frequency	Percentage
1	1 to 5	28	87.5
2	6 to 10	4	12.5
	Total	32	100

(Source: Field Survey)

The above table reveals that 87.5 percent AWW have 1 to 5 members in their family and 12.5 percent AWW have 6 to 10 members in their family. As these workers have big size of family they need to contribute in monetary terms to the family. These members include old age members as well as children. AWW need to take care of them along with their job responsibilities.

5.3.7 Classification on the basis of number of children in the family enrolled in the school.

Following table elaborates the number of children of AWW families enrolled in the schools.

Table 5.12: Number of children in the family enrolled in the school.

Sr. no	No of children enrolled in the school	Frequency	Percentage
1	0	14	43.75
2	1	5	15.62
3	2	13	40.63
4	3 and above	0	0
	Total	32	100

(Source: Field Survey)

Study shows that 43.75 AWW families have no children enrolled in schools. Since we have more numbers of AWW who are above 40 years, these workers have children who have completed their schooling. 15.62 percent AWW have one child in their family who is enrolled in school. 40.63 percent AWW have two children who are pursuing their school education. It shows that more than 50% AWW have children who are taking their school education. The family has to bear the expenses

for the education of the child. Education cost is one of the major expenses of the families though they reside in rural areas.

5.3.8 Classification on the basis of occupation of father/husband

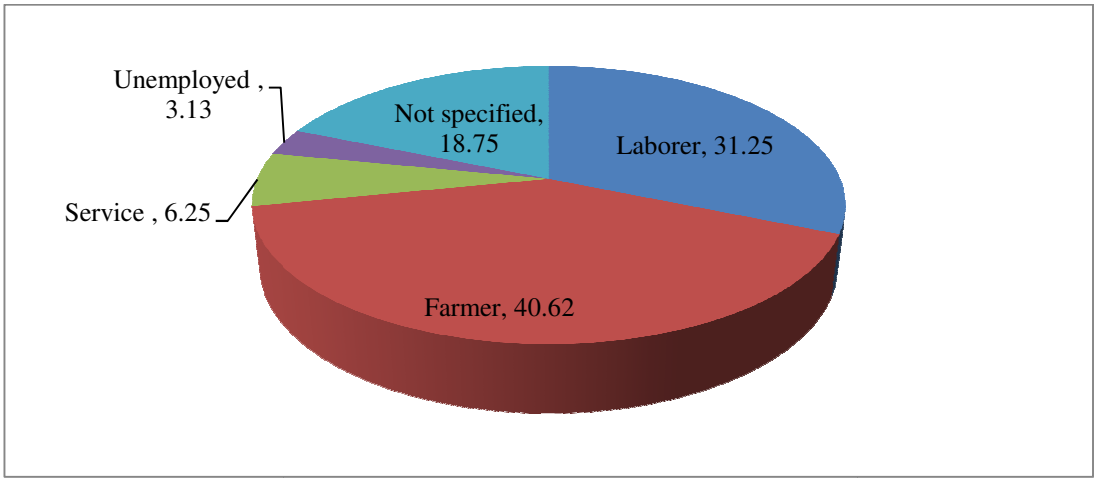
Occupation of the other family members is of crucial importance when we want to know the economic and social health of any person. AWW workers receive honorarium for their work. The amount they receive is not sufficient to meet their basic needs. In such a case income of husband or father can be a support for them.

Table 5.13: Occupation of father/husband of AWW

Sr. no	Occupation of husband/father	Frequency	Percentage
1	Labourer	10	31.25
2	Farmer	13	40.62
3	Service	2	6.25
4	Unemployed	1	3.13
5	Not specified	6	18.75
	Total	32	100

(Source: Field Survey)

Figure 5.10: Occupation of father/husband of AWW



(Source: Table 5.13)

Given table 5.13 discusses such occupations of the husband or father of AWW which were interviewed. It is evident from the table that the AWW interviewed belong to different family background. The occupation of their spouse or parent is

mostly of unorganized in nature. 31.25 percent people are working as labourers which are either agriculture labour or forest labourer. 40.62 percent people are farmers. 6.25 percent are earning their livelihood from service. 3.13 percent people are unemployed and 18.75 percent have not specified the occupation of their spouse or parent. We can conclude that since considerable numbers of people have no permanent source of income here the AWW bears the responsibility of their family and work for their family needs. These AWW are supporting pillars for their family in social as well as economic sense.

5.3.9 Classification on the basis of Monthly income of the family of AWW

Income of the family determines standard of living of the family. Basic needs of the family like food, shelter, clothing, education, health and hygiene, sanitation etc can be fulfilled if the family earns satisfactory level of income. Hence we can say that it directly influences quality of lives of the people. Given table and pie diagram depicts income level of the family. It helps us to understand financial status of the anganwadi workers.

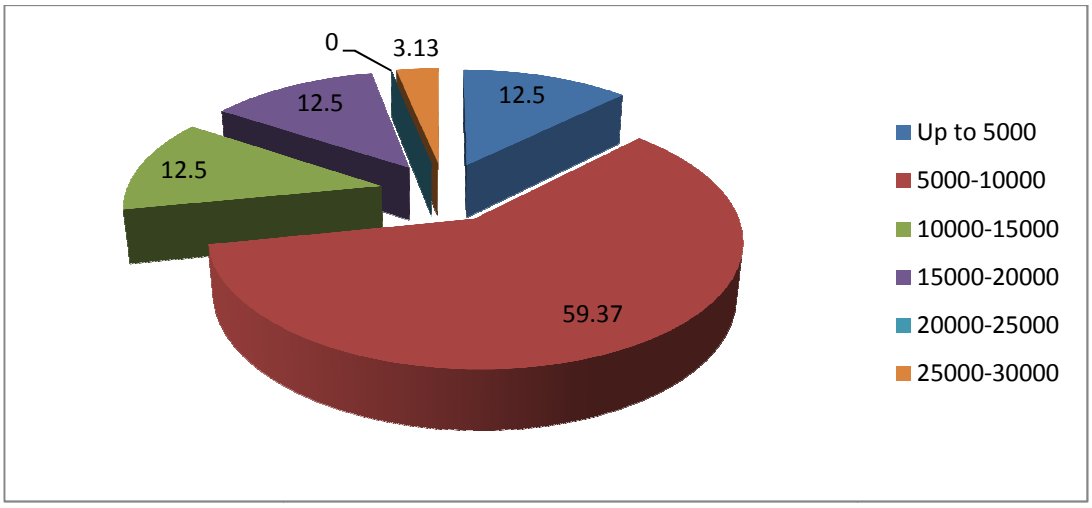
Table 5.14: Monthly income of the family of AWW

Sr. no	Monthly income of the family	Frequency	Percentage
1	Up to 5000	4	12.5
2	5000-10000	19	59.37
3	10000-15000	04	12.5
4	15000-20000	04	12.5
5	20000-25000	0	0
6	25000-30000	01	3.13
	Total	32	100

(Source: Field Survey)

Table 5.14 depicts monthly income of the family of the anganwadi workers. The same is represented in the figure 5.11 given below.

Figure 5.11: Monthly income of the family of AWW



(Source: Table 5.14)

The given table and graph shows that monthly family income of 12.5 percent anganwadi workers is Rs. 5000 per month. It is found that these AWW are the only earning member in the family or the only member in the family i.e. they are either divorcee or widow. Monthly income of 59.37 percent AWW is between Rs. 5000 to 10000, 15.5 have monthly family income between Rs.15000 to 20000 where as 3.13 percent AWW have their monthly family income between Rs. 25000 to 30000 which is considerably high as compared to other AWW. It was also found that the AWW whose monthly family income is above Rs.15000 live in joint family. So they have more number of people who are employed and earning. Maximum number of AWW i.e. 59.37 percent has their income between Rs. 5000 to 10000, in such families spouse/ father of AWW is the only member who compliments income of AWW.

5.3.10 Classification on the basis of distance of anganwadi from home

Distance from home to workplace is very important for any person. Proximity of workplace helps an individual to reach workplace in time. It saves their travelling cost and time. Following table elaborates the classification of the AWW on the basis of distance of anganwadi from their residence.

Table 5.15: Distance of anganwadi from home

Sr. no	Distance of AWC from Home	Frequency	Percentage
1	0 to 1km	29	90.62
2	1 to 3 km	2	6.25
4	More than 3	1	3.13
	Total	32	100

(Source: Field Survey)

90.62 percent AWW answered that the distance of AWC from home is up to one km. 6.25 said that it is 1 to 3 km and 3.13 answered that the distance is more than 3 km. Since AWW are local resident of the village, mostly they live in the same village of anganwadi centre. It saves their cost of travelling and helps for regular attendance at the workplace.

5.3.11 Classification on the basis of mode of reaching to AWC

In present era travelling from home to workplace and vice versa is a part of lives of the people. People spend a lot of time for reaching to their workplace in urban areas. In rural areas also people travel for their work. The mode of transport depends on the distance and the transportation system prevalent in that particular area. The distance between home and workplace in rural areas are shorter as compare to urban areas. The study area of the present study is rural area of the Chandrapur district of Maharashtra. Following data explains the mode of travelling adopted by the AWW to reach their work place.

Table 5.16: Mode of reaching to AWC

Sr. no	Mode of travelling to AWC	Frequency	Percentage
1	Walking	29	90.62
2	Cycle	1	3.13.
3	Motor cycle	1	3.13
4	Bus	1	3.12
	Total	32	100

(Source: Field Survey)

The mode of reaching to anganwadi can be one of the important factors which affect regular attendance of the child as well as anganwadi worker. 90.62 percent AWW answered that they reach to AWC by walking the distance. 3.13 percent answered that they use bicycle, 3.13 percent use motor cycle and 3.12 percent said that they travel by bus to reach the AWC.

B) INFORMATION ABOUT ANGANWADI

5.3.12 Classification on the basis of the construction type of AWC building

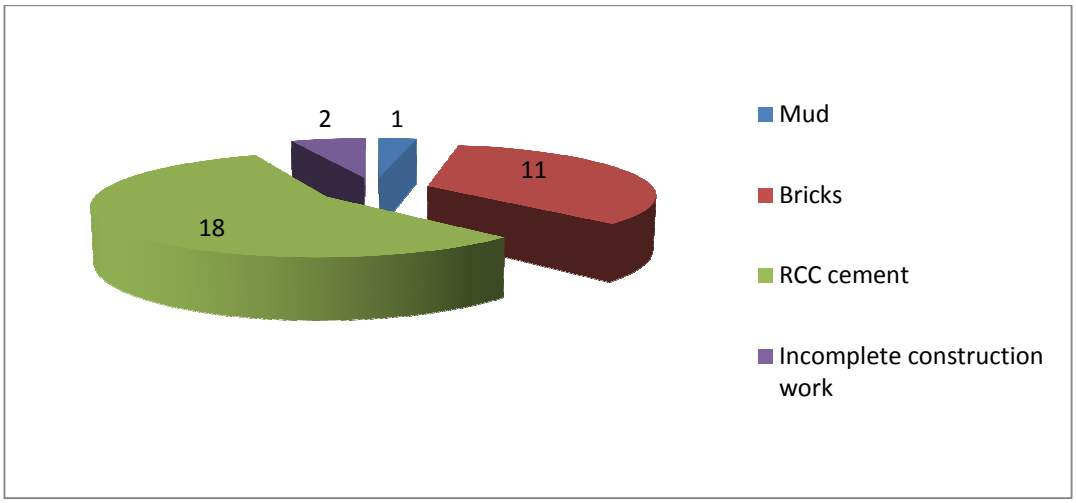
Anganwadi center in the community is the first point of contact with the beneficiaries for providing health, nutrition, education and other services to them. Building of anganwadi centre is very important component of infrastructure required for ICDS for effective delivery of ICDS services. The place of anganwadi centre can be a rented place or owned by the centre or provided by the local self government. The given table 5.12 briefs about the type of construction of the building of anganwadi center and the same is represented in figure 5.7.

Table 5.17: Type of construction of anganwadi building

Sr. no	Construction of AWC	Frequency	Percentage
1	Mud	1	3.13
2	Bricks	11	34.36
3	RCC cement	18	56.25
4	Incomplete construction work	2	6.25
	Total	32	100

(Source: Field Survey)

Figure 5.12: Type of construction of anganwadi building



(Source: Table 5.17)

The table 5.17 and the figure 5.12 discloses that only 1 (3.13%) AWC building is made of mud i.e. Kaccha building. 11(34.36%) are made of bricks and 18 (56.25%) have complete plaster of cement. Construction of 2 (6.25%) AWC is incomplete. When any AWC has its own and permanent place they can have many activities for the children and it helps them to provide better facilities.

5.3.13 Classification on the basis of things taught at anganwadi centre

Preschool non formal education is one of the services provided under ICDS scheme. The intention behind this service is to provide non -formal education to the children between 3 to 6 years by play way method. There are various components of non formal preschool education which are taught at anganwadi center.

All Anganwadi workers answered that they teach the concepts of animals, birds, fruits, flowers, colours, types of vehicles, numbers and alphabets at the center while conducting PSE. Preschool non-formal education is one of the services delivered by ICDS centers. All the AWW i.e. 100 percent AWW answered that they take help of educational materials while teaching at the centre. It includes charts, blackboard, educational toys poem and stories, jingles. It helps the children to understand the concept properly. It prepares the base of children for formal education.

5.3.14 Classification on the basis of availability of educational material at AWC

Non formal preschool education is a part of EEC of ICDS scheme. State government provides educational kit to the AWCs which will help them to impart PSE in more effective way. Play ay method of imparting education is adopted at AWC which needs educational material like toys, flannel boards with cutouts, dolls, puppets, building blocks, charts, dafali etc. following table gives information about availability of such material at AWC.

Table 5.18: Availability of educational material at AWC

Sr. no	Availability of educational material	Frequency	Percentage
1	Yes	29	90.62
2	No	2	6.25
3	Not answered	1	3.13
	Total	32	100

(Source: Field Survey)

90.62 percent AWW answered that they have educational material required for imparting pre-school education. 6.25 percent AWW said that they do not have such material and 3.13 percent not answered this question. Lack of teaching aid material is major hurdle of the preschool education service delivered by AWCs. Educational toys and play material motivates children to attend anganwadi regularly. It is one of the major factors which can enhance child's interest in

5.3.15 Classification on the basis of regularity and adequacy of Supplementary nutrition served at AWC

AWC are expected to serve hot and freshly cooked food to its beneficiaries daily. It includes snacks or meal. Such food can be prepared by mahila mandal or Self Help Groups or at AWC. 100 percent anganwadi workers answered that supplementary food is served regularly and in adequate quantity at anganwadi centers. Cooking and serving supplementary food is one of the prime responsibilities of the anganwadi centers. It was found that all AWCs undertake this responsibility as per the guidelines if ICDS.

5.3.16 Classification on the basis of opinion of AWW about lags in payment of honorarium

AWW receive honorarium for their work. It helps them to earn for themselves and their families. In Maharashtra it is Rs.5000 per month.

Table 5.19: Delay in payment of honorarium

Sr. no	Details	Frequency	Percentage
1	Always	18	56.25
2	Sometimes	13	40.62
3	Never	01	3.13
	Total	32	100

(Source: Field Survey)

Honorarium is paid to the AWW for their services rendered under ICDS. When asked the 56.25 percent AWW answered that the payment of honorarium is always delayed. 40.62 percent mentioned that payment of honorarium is delayed sometimes and 3.13 percent mentioned that it is never delayed.

5.3.17 Classification on the basis of liking of nature of work

Liking and interest in the work which we perform gives best results at the end. Working with children itself is a challenging job. One need patience and enthusiasms to deal with children.

Table 5.20: Liking of nature of work

Sr. no	Details	Frequency	Percentage
1	Yes	29	90.62
2	No	03	9.38
	Total	32	100

(Source: Field Survey)

In spite of 90.62 percent AWW answering that they are not satisfied with their honorarium, 90.62 mentioned that they like their work and the nature of their work. They mentioned that they perform their job wholeheartedly. Whereas 9.38 percent mentioned that they do not like the nature of their work but since they need job they are in this field.

5.3.18 Classification on the basis of training acquired for anganwadi job

Anganwadi workers are frontline functionaries of the ICDS scheme. They are chosen from local community and are paid honorarium for their contribution towards these services. Once they are selected for the job of AWW they need to undergo training for this job. NIPCCID conducts trainings through Panchayti raj Training centres. Training helps them in effective delivery of ICDS services. 100 percent AWW answered that they have acquired training from panchayat raj training centers. The AWW have joined this training after their selection for the job as anganwadi worker.

5.3.19 Classification on the basis of opinion of AWW about the training

They are provided refresher training which upgrades their knowledge and efficiency while performing their duties. They are given both, theoretical and practical training. Following table depicts Opinion of AWW about the training they are received for their job.

Table 5.21: Opinion about training

Sr. no	Details	Frequency	Percentage
1	Very useful	28	87.5
2	Useful	4	15.5
3	Good	0	0
4	Not useful	0	0
	Total	32	100

(Source: Field Survey)

From the table 5.22 we can see that 28 AWW opined that the training they received for their job proved very useful form them. 4 AWW expressed that it was useful. We can see that all the anganwadi workers answered that the training proved useful from them. It helped them to understand the objectives of their responsibility and requirements of the beneficiaries both.

5.3.20 Classification on the basis of membership of union of AWW

All anganwadi workers are members of union of anganwadi workers. They take part in strikes, or marches of the union. But in case of small problems they seek

solution from supervisors and CDPO. In case of major grievances only they approach to higher authorities or union. Most of the times the problems are solved at block levels satisfactorily.

5.3.21 Classification on the basis of need of services provided by ICDS

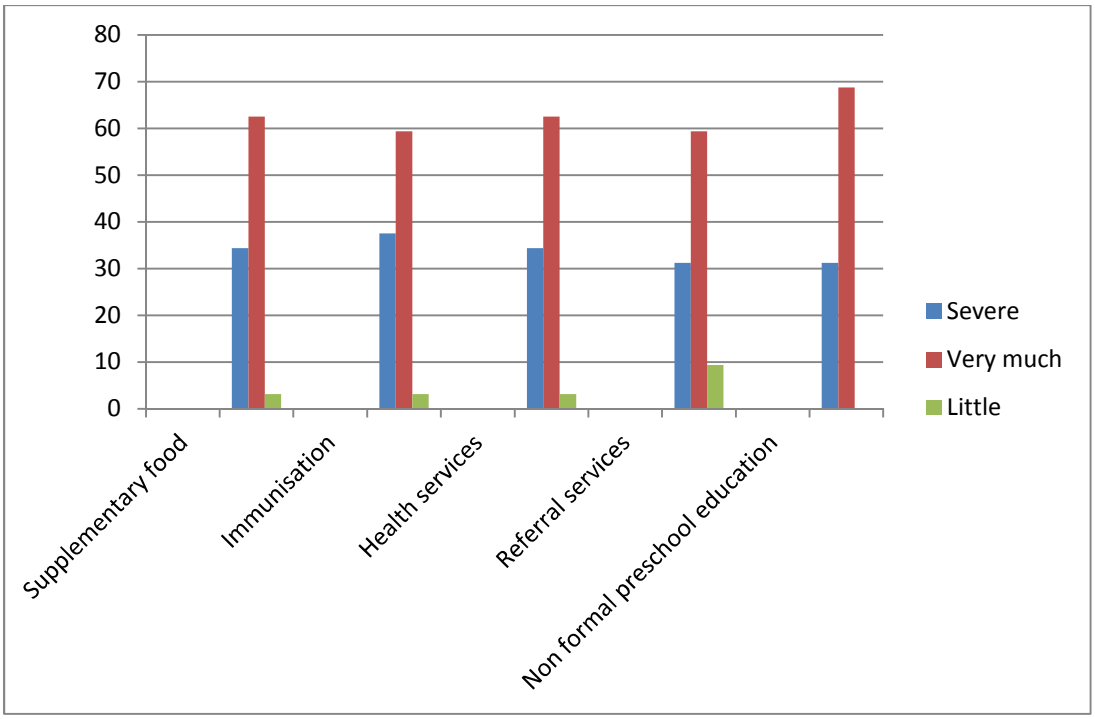
ICDS provides an integrated package of services for children between 0 to 6 years, expectant and lactating mothers and adolescent girls. It includes supplementary nutrition, immunisation, pre- school education, health referral services and health education. Since AWW are frontline functionaries of these services their opinion about the need of the services imparted through ICDS is very important for the present study. Table 5.22 provides information about it.

Table 5.22: Need of services provided by ICDS

Sr. no	Name of the Service	Severe	Very much	Little	Total
1	Supplementary food	11 (34.37)	20 (62.5)	01 (3.13)	32 (100)
2	Immunisation	12 (37.5)	19 (59.37)	01 (3.13)	32 (100)
3	Health services	11 (34.37)	20 (62.5)	01 (3.13)	32 (100)
4	Referral services	10 (31.25)	19 (59.37)	03 (9.38)	32 (100)
5	Non formal preschool education	10 (31.25)	22 (68.75)	0 (0)	32 (100)

(Source: Field Survey)
Note: Figures in brackets indicate percentage.

Figure 5.13: Need of services provided by ICDS



(Source: Table: 5.22)

Above table explains opinion of AWW about the need of ICDS services rendered by AWC. 34.37 percent AWW answered that need of SNP is severe, 62.5 percent very much, 3.13 percent answered that the need of SNP is little. 37.5 percent mentioned that need of immunization service is severe whereas 59.37 percent mentioned that is very much and 3.13 percent mentioned that it is little. About health services34.37 opined the need is severe, 62.5 percent said it is very much and 3.13 said the need of health service little. In case of referral services 31.25 answered that requirement of the service is severe, 59.37 said very much and 9.38 answered little. We can observe that most of the AWW have recorded that need of ICDS services is either severe or very much. Very few have said that the need is little. It underlines the need of ICDS services for community from frontline worker's point of view.

5.3.22 Classification on the basis of arranging immunisation camps

Immunisation is very crucial for the children in the early years of their life. It protects them from diseases and keeps them healthy, which ultimately supports their overall development. Health services are provided by ASHA and ANM to the beneficiaries. Anganwadi worker co ordinates with these functionaries and facilitates

arrangement of immunisation camps. All 100 percent AWW answered that they arrange immunisation camps on regular basis. Vaccinations are given as per the prescribed vaccination schedule for the child.

5.3.23 Classification on the basis of regularity in health heck up of children at AWC

Health check up is one of the foremost responsibilities of anganwadi worker. This activity is held at anganwadi center itself. Regularity in health checkup helps the AWW to monitor the health and growth status of the child. In case of underweight or malnourished children they can take extra efforts to bring them in the category of normal children. Table 5.27 depicts regularity in health checkup of the children at AWC.

Table 5.23: Regularity in health heck up of children in AWC

Sr. no	Regularity in health check ups	Frequency	Percentage
1	Yes	30	93.75
2	No	02	6.25
	Total	32	100

(Source: Field Survey)

Above table reveals that 93.75 percent respondents answered that health checkup is conducted regularly once in a month. 6.25 percent answered that there are no regularity in health check up.

5.3.24 Classification on the basis of factors monitored in monthly health check up at AWC

In the regular health check up schedules AWW is expected to take weight, height, arm measurement and circumference of head of the child to monitor growth of the child. Following table reveals information about the actual practice about these factors.

Table 5.24: Factors monitored in monthly health check up at AWC

Sr. no	Details	Frequency			Percentage		
		Yes	No	Total	Yes	No	Total
1	Weight	32	0	32	100	00	100.00
2	Height	32	0	32	100	00	100.00
3	Arm measurement	32	0	32	100	00	100.00
4	Circumference of head	27	5	32	84.37	15.63	100.00
5	Teeth	23	9	32	71.87	28.13	100.00

(Source: Field Survey)

Above multi response table reveals information about the factors monitored in monthly checkup at AWC. All 32 anganwadi workers answered that they take weight, height and arm measurement monthly and record it in the record books. 27 AWW (84.37) mentioned that they take perimeter of head of the child monthly, whereas 5 (15.63) mentioned that they do not take it regularly. 23 (71.87) AWW answered that they check teeth of the children but sine oral check up needs specialist they just observe teeth of the children and refer them to doctors if any problem is found.

5.3.25 Classification on the basis of information given to parents

Anganwadi works are supposed to give information to the local people about health, nutrition, sanitation, cleanliness, health care measures to create awareness among the local people. All AWW answered that they give information about immunization, nutritional intake of the child and development of the child to the parents. They also provide them information which will help the mothers about feeding practices at home and easy ways to enhance nutritional quality of the diet. They suggest some simple receipes which can be included in the daily diet. Anganwadi workers also mentioned that, the negligence on the part of the parents is a big hurdle in the implementation of such programmes.

5.3.26 Classification on the basis of regularity of updating of records at AWC

Updating of records about all the activities being conducted at AWW under various services of ICDS is one of the important responsibilities of anganwadi

worker. Such data is collected at ground level functionary viz. AWW for ICDS scheme, which helps government while formulating its policies and objectives. When a child is registered at AWC, the AWW starts keeping all the records of the growth of child like separate registers for girls and boys, separate growth monitoring charts for girls and boys, MPR, family survey registers, records of stocks of supplementary Nutrition, records of daily activities under preschool education. Along with this they need to keep records of all the other activities performed at AWC and report it to their supervisors. Following table 5.27 reveals information about regularity of updating of records at anganwadi centre.

100 percent AWW answered that they keep all the records updated for ICDS. They update records of stocks of Supplementary Nutrition, daily distribution of Supplementary nutrition and records of preschool education activities and attendance of beneficiaries on daily basis. They need to update records of other activities held at the centre time to time. Monthly progress Report is also updated by AWW on regular basis.

5.3.27 Timeliness in receiving funds from government

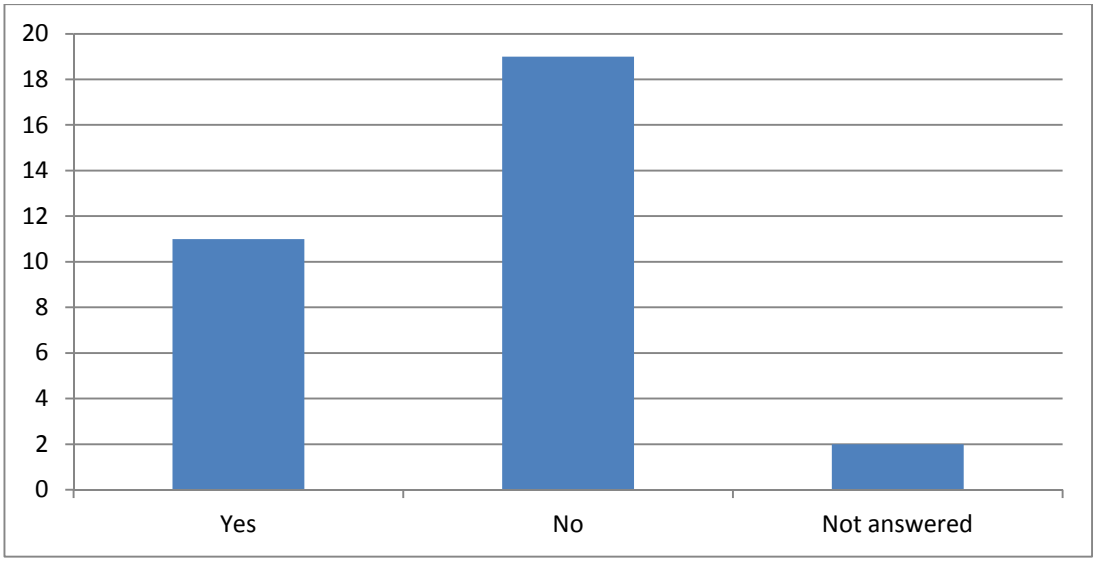
Funds for ICDS scheme are allocated by central as well as state government. Funds are given under two heads i.e. ICDS general and supplementary Nutrition programme. Funds are transferred through chain of the authorities like central to state, from state to district and from district to block.

Table 5.25: Timeliness in receiving funds from government

Sr. no	Timeliness in receiving funds	Frequency	Percentage
1	Yes	11	34.37
2	No	19	59.38
3	Not answered	2	6.25
	Total	32	100

(Source: Field Survey)

Figure 5.14: Timeliness in receiving funds from government



(Source: Table 5.25)

The above given table reveals that 34.37 percent AWW said that fund are received in due time, but 59.38 percent answered that fund are not received time to time. 6.25 percent AWW did not answer the question. It was observed that many of them are not aware/ well informed of the actual funding pattern under ICDS. They work at grass root level but are not aware of the economic aspect of the services they deliver.

5.3.28 Form in which funds receive

Following table gives classification on the basis of knowledge of AWW about the forms or heads in which funds are received for AWW

Table 5.26: Form in which funds receive

Sr. no	Details	Frequency	Percentage
1	Supplementary food	10	31.25
2	Toys	5	15.62
3	Educational material	1	3.13
4	Other	3	9.38
5	Toys and educational material	4	12.5
6	Educational material and other	2	6.25
7	Not answered	7	21.87
	Total	32	100

(Source: Field Survey)

Above table shows that 31.25 percent AWW answered that funds are allotted for supplementary food, 15.62 answered for toys, 3.13 said funds are given in the form of educational material, 9.38 mentioned other, 12.5 percent answered that fund are received for toys and educational material whereas 6.25 said it is for educational material and other and 21.87 did not answered the question.

Above discussion shows that AWW are not aware about the actual pattern or heads under the particular project receives fund from government and the various heads under which the funds are to be spent. It shows their inability to give information about financial aspect of the ICDS. We can say that AWW provides the services at ground level but not well informed about the financial provision for the projects in which they are working.

5.3.29 Classification on the basis of opinion about funds allotted is sufficient or not.

ICDS provides integrated package of services with the convergence of different department of the government. ICDS is a programme in which center as well as state government provides its share. Over the period of 36 years ICDS has received good amount of funds for its implementation. The funds are distributed among the states and UT by center. State also contributes its share and the money is handed over to WCD for disbursement. Following table expresses opinion of anganwadi workers about the funds allotted to ICDS projects.

Table 5.27: Whether the funds allotted are Sufficient or not

Sr. no	Sufficiency of funds	Frequency	Percentage
1	Yes	1	3.13
2	No	29	90.62
3	Not answered	2	6.25
	Total	32	100

(Source: Field Survey)

Funds provided by government plays important role in the delivery of ICDS services. When the question asked to the anganwadi workers 3.13 percent AWW answered that the funds are sufficient but 90.62 percent AWW said that funds provided by government are not sufficient for the delivery of ICDS services. 6.25 percent preferred to not answer the question.

5.3.30 Classification on the basis of other sources of funds available to AWC

Community participation is one of the important features of ICDs scheme. Involvement of society is expected from the establishment of AWC. Anganwadi worker can make fund available for AWC with the help of local community.

Table 5.28: Other sources of aid/ funds

Sr. no	Details	Frequency	Percentage
1	Yes	4	12.5
2	No	26	81.25
3	Not answered	2	6.25
	Total	32	100

(Source: Field Survey)

When the question asked 12 .5 percent answered that they do receive help from other sources. 81.25 percent said that they do not receive any help from other sources. 6.25 percent not answered this question. The AWW who answered that they receive fund from sources specified that they get such aid from Grampanchayats, NRHM or contribution from villagers for any specific purpose.

5.3.31 Classification on the basis of efforts taken for malnourished children at AWC

Special efforts are taken at anganwadi center for malnourished children. They are first categorized according to the grades of malnutrition and treated according to the guidelines of ICDS and WHO norms for severely malnourished children.

All 32 AWW answered that they take special efforts for malnourished children. They refer the child to PHC. They increase frequency of the intake of the child at AWC more than regular schedule. They advice and educate the parents about feeding at home. If the mother is not following feeding practices for such children, they go to the house of the beneficiaries and cook THR for the child and make them eat. At anganwadi centers they keep healthy snacks in one corner of the AWC easily accessible to the child which is known as 'Balkopra' in Marathi. Such efforts are taken under special programme by state known as Village Child Development Centre (VCDC) which is conducted through AWCs.

5.3.32 Classification on the basis of availability of medicine kit at AWC

Medicine kits are provided by state to each anganwadi center under ICDS scheme. These are meant for treating common ailments and for providing first aid in case of injuries and accidents. AWW have basic knowledge about the general symptoms and treatment for it.

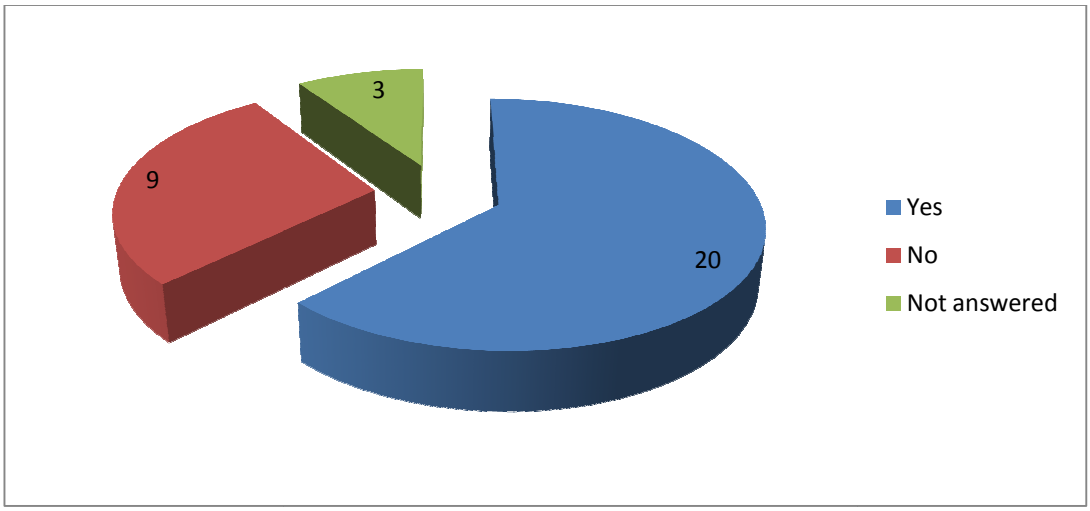
Table 5.29: Availability of first aid kit at AWC

Sr. no	Details	Frequency	Percentage
1	Yes	20	62.5
2	No	9	28.12
3	Not answered	3	9.38
	Total	32	100

(Source: Field Survey)

Table 5.29 depicts information about the availability of first aid kit at anganwadi centers and is represented in figure 5.15 given below.

Figure 5.15: Availability of first aid kit at AWC



(Source: Table 5.29)

When the study was conducted it was found that 20 (62.5) AWCs have first aid kits available at the centers for the children in case of emergency. On the contrary 9 (28.12) AWW answered that first aid kit is not available at the AWC. Out of 32 AWC 3 (9.38) did not answer the question.

5.3.33 Referral services

Referral service is an important feature of ICDS scheme.

Table 5.30: Referral services

Whether severely ill children referred to PHC / doctors

Sr. no	Details	Frequency	Percentage
1	Yes	30	93.75
2	Not answered	2	6.25
	Total	32	100

(Source: Field Survey)

Referral services are one of the important services rendered by AWC under ICDS. When asked 93.75 percent AWW answered that the ill child is sent to PHC for further treatment. 6.25 percent AWW preferred to not answer the question.

5.3.34 Classification on the basis of attention provided whether the child is given full treatment till recovers

A child should get full treatment for any kind of ailment or injuries. Following table illustrates that, whether attention is provided by AWC towards complete treatment is given to the child till recovery; when a child is referred to the PHC or medical officer

Table 5.31: Attention provided whether the child is given full treatment till recovers

Sr. no	Details	Frequency	Percentage
1	Yes	30	93.75
2	No	0	0
3	Not answered	2	6.25
	Total	32	100

(Source: Field Survey)

93.75 percent AWW answered that they take follow up of the ill child referred to PHC for treatment. This is important since the many of the parents are not well educated and aware about the health of the child. Negligence on their part may lead to health hazards. At the same time 6.25 percent AWW did not answered the question. They were not able to answer the question

C) INFORMATION ABOUT GROWTH OF THE BENEFICIARY

5.3.35 Classification on the basis of weight of the child according to their age (Boys)

Weight of the children admitted to AWC is monitored on regular basis. AWW check and records the weight every month. The growth chart book contains full record of the ideal path of increase in the weight of the child in graphical form. The child is categorised based on that. Under Village and Child Development Centre (VCDC) special efforts are taken to increase weight of the child as per its age

While maintaining records of weight of the child the records of boys and girls are recorded in the separate graph books. The ideal weight at different ages are different for boys and girls. We have also taken the weight of the boys and girls separately and analysed them in two different tables. The chart of ideal measurement is given in annexure.

Table 5.32: Weight of the children according to their age (Boys)

Category	0 years		1 years		2 years		3 years		4 years		5 years		6 years	
	Weight (kg)	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**
1	Below 2.5 kg	04 (6.45)	Below 7kg	05 (8.06)	Below 10 kg	02 (3.22)	Below 12 kg	04 (6.45)	Below 14 kg	03 (4.84)	Below 16 kg	02 (3.22)	Below 18 kg	02 (3.22)
2	2.5 to 3 kg	44 (70.97)	7 to 9 kg	38 (61.29)	10 to 12 kg	37 (59.68)	12 to 14 kg	40 (64.52)	14 to 16 kg	42 (67.74)	16 to 18 kg	39 (62.91)	18 to 20 kg	40 (64.52)
3	3 to 3.500	10 (16.13)	9 to 10 kg	16 (25.81)	12 to 13 kg	20 (32.26)	14 to 15 kg	16 (25.81)	16 to 17 kg	14 (22.58)	18 to 19 kg	18 (29.03)	20 to 21 kg	18 (29.03)
4	Above 3.500	04 (6.45)	Above 10 kg	03 (4.84)	Above 13 kg	03 (4.84)	Above 15 kg	02 (3.22)	Above 17 kg	03 (4.84)	Above 19 kg	03 (4.84)	Above 21 kg	02 (3.22)
	Total	62	Total	62	Total	62	Total	62	Total	62	Total	62	Total	62

(Source: Field survey)
Note: Figures in brackets indicate percentage.

Above given table 5.32 depict classification of children (boys) according to their age and weight. We can observe weight of 62 boys at various stages of their age. The table gives weight of the same 62 boys from at the time of birth to age of 6 years.

At the time of birth 4.45 percent children were below 2.5 kg. Most of the boys i.e. 70.97 percent were between 2.5 to 3 kg. Ideal weight of the child (boy) at birth is 3.300 kg. Weight of 16.13 percent boys was in the group 3 to 3.5 which is considered as ideal weight of a child at the time of birth and is sign of a healthy child. 6.45 percent children were above 3.5 kg At the age of 1 year, weight of 8.06 percent children was below 7 kg, which is considerably low and can be considered as underweight.61.29 percent boys are between 7 and 9 kg, weight of .81 percent boys is between 9 to 10 kg and 8.84 percent boys are above 10 kg. At the age of 2 years, 59.68 percent were between 10 to 12 kg where as 32.26 percent are between 12 to 13 kg. In this age group 3.22 percent are below 10 kg and 4.84 percent are above 13 kg At the age of 3 years, 64.52 percent boys are between 12 and 14 kg which is a normal range of weight for the boys at this age. 25.81 percent are between 14 and 15 kg which is very close to the ideal weight, whereas 3.22 percent are above 15 kg and 6.45bis below 12 kg which is underweight. At the age of 4 years, 67.74 percent boys are in the normal range of weight i.e. 14 to 16 kg, whereas 22.58 percent are between 16 to 17 kg. The children in this group are very close to or in the ideal weight. Likewise we can observe the weights of the same children for the 5 and 6 years. We can observe that maximum numbers of children are in the normal range of the weight where they are neither at risk nor have achieved ideal range of weight.

5.3.36 Classification on the basis of weight of the child according to their age (Girls)

Following table depicts classification of children (girls) according to their age and weight. This table gives us weight of 66 girls at different ages i.e. from zero years to six years. It helps us to understand the change in the weight of the all 66 girls studied as ICDS beneficiary

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Table 5.33: Weight of the child according to their age (Girls)

Category	0 years		1 years		2 years		3 years		4 years		5 years		6 years	
	Weight (kg)	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**	**Weight (kg)**	**Frequency**
1	Below 2.5 kg	03 (4.54)	Below 6.500 kg	03 (4.54)	Below 9 kg	04 (6.06)	Below 11.500 kg	07 (10.61)	Below 13.500 kg	04 (6.06)	Below 15.500 kg	04 (6.06)	Below 18	04 (6.06)
2	2.5 to 3 kg	53 (80.31)	6.500 to 8.500 kg	41 (62.12))	9 to 11 kg	41 (62.12)	11.500 to 13.500 kg	35 (53.03)	13.500 to 15.500	38 (57.57)	15.500 to 17.500	41 (62.12)	18 to 20 kg	41 (62.12)
3	3 to 3.5	07 (10.61)	8.500 to 9.500 kg	19 (28.79)	11 to 12 kg	19 (28.79)	13.500 to 14.500 kg	22 (33.33)	15.500 to 16.500 kg	21 (31.83)	17.500 to 18.500 kg	19 (28.79)	20 to 21 kg	19 (28.79)
4	Above 3.500	03 (4.54)	Above 9.500 kg	03 (4.54)	Above 12 kg	02 (3.03)	Above 14.500 kg	02 (3.03)	Above 16.500 kg	03 (4.54)	Above 18.500 kg	02 (3.03)	Above 21	02 (3.03)
	Total	66	Total	66	Total	66	Total	66	Total	66	Total	66	Total	66

(Source: Field survey)

Note: Figures in brackets indicate percentage.

Above given table 5.33 depict classification of children (girls) according to their age and weight. We can observe weight of 66 girls at various stages of their age. The table gives weight of the same 66 girls from at the time of birth to age of 6 years.

At the time of birth 4.54 percent children were below 2.5 kg. Most of the girls i.e. 80.31 percent were between 2.5 to 3 kg. Ideal weight of the child (girls) at birth is 3.200 kg. Weight of 10.61 percent girls was in the group 3 to 3.5 which is considered as ideal weight of a child at the time of birth and is sign of a healthy child. 4.54 percent children were above 3.5 kg At the age of 1 year, weight of 4.54 percent children was below 6.500 kg, which is considerably low and can be considered as underweight.62.12 percent girls are between 6.500 and 8.500 kg, weight of 28.79 percent girls is between 8.500 to 19.500 kg and 4.54 percent girls are above 9.500 kg. At the age of 2 years, 62.12 percent were between 9 to 10 kg where as 28.79 percent are between 11 to 12 kg. In this age group 6.06 percent are below 9 kg and 3.03 percent are above 12 kg. At the age of 3 years, 53.03 percent girls are between 11.500 and 13.500 kg which is a normal range of weight for the girls at this age. 33.33 percent girls are between 13.500 and 14.500 kg which is very close to the ideal weight, whereas 3.03 percent are above 14.500 kg and 10.61 is below 11.500 kg which is underweight. At the age of 4 years, 57.57 percent girls are in the normal range of weight i.e. 13.500 to 15.500 kg, whereas 31.83 percent are between 15.500 to 16.500 kg. The children in this group are very close to or in the ideal weight. Likewise we can observe the weights of the same children for the 5 and 6 years. We can observe that maximum numbers of children are in the normal range of the weight where they are neither at risk nor have achieved ideal range of weight.

5.3.37 Classification on the basis of height of the child according to their age (Boys)

Table 5.34: Height of the children according to their age (Boys)

Sr. no.	0 years		1 years		2 years		3 years		4 years		5 years		6 years	
	Height (cm)50	Frequency	Height (cm)76	Frequency	Height (cm)88	Frequency	Height (cm)96	Frequency	Height (cm)103	Frequency	Height (cm)110	Frequency	Height (cm) 116	Frequency
1	Below 47	2 (3.23)	Below 73	2 (3.23)	Below 85	3 (4.84)	Below 93	3 (4.84)	Below 100	2 (3.22)	Below 107	2 (3.22)	Below 113	2 (3.22)
2	47 to 52	58 (93.55)	73 to 78	56 (90.32)	85 to 90	54 (87.10)	93 to 98	54 (87.10)	100 To 105	53 (85.48)	107 to 112	53 (85.48)	113 to 118	53 (85.48)
3	Above 52	2 (3.23)	Above 78	4 (6.45)	Above 90	5 (8.06)	Above 98	5 (8.06)	Above 105	7 (11.29)	Above 112	7 (11.19)	Above 118	7 (11.19)
	Total	62	Total	62	Total	62	Total	62	Total	62	Total	62	Total	62

Source: Field Survey

Note: Figures in brackets indicate percentage.

Above given table 5.34 depicts classification of beneficiaries according to their age and height. We can observe that the height of 3.23 percent boys was below 47 cm, height of 93.55 percent boys was between 47 to 52 cm and only 3.23 percent boys were more than 52 cm tall. For baby boys ideal height at the time of birth is 50 cm. At the age of one year, the height of 3.23 percent boys is below 73 cm, 90.32 percent between 73 cm to 78 cm and height of 6.45 percent were above 748 cm. The ideal height for one year child referred by ICDS is 76 cm. At the age of two years 4.84 percent children were below 85 cm, 87.10 percent were between 85 to 90 cm, 9.06 percent were above 90 cm. Among 3 year old boys, height of 4.84 percent children was below 93 cm, 87.10 percent were between 93 to 98 cm, 8.06 percent were above 98 cm. When the same group of children was 4 year old, height of 3.22 percent were below 100 cm, 85.48 percent children were between 100 to 105 cm tall and height of 11.29 percent boys was above 105 cm When they were 5 year old, height of 3.22 percent were below 107 cm, 85.48 percent were between 107 to 112 cm and 11.19 percent were above 112 cm. At the age of 6 we find the same data which was for age of 5 years. We can conclude that the growth in the height of the children in ICDS project is satisfactory. Maximum children are found in the normal range of height as per their age. The percentage of the children who are short is small as compared to the percentage of children who are in normal range of height.

5.3.38 Classification on the basis of height of the child according to their age (Girls)

The ideal height for girls according to their age is different for girls.
Following table depicts information about the height of the 66 girl beneficiaries at their age from zero years to six year.

Table 5.35: Height of the child according to their age (Girls)

Sr. no.	0 years		1 years		2 years		3 years		4 years		5 years		6 years	
	Height (cm)	Frequency	Height (cm)	Frequency	Height (cm)	Frequency	Height (cm)	Frequency	Height (cm)	Frequency	Height (cm)	Frequency	Height (cm)	Frequency
1	Below 46	03 (4.54)	Below 71	07 (10.61)	Below 83	07 (10.61)	Below 92	06 (9.09)	Below 100	06 (9.09)	Below 106	05 (7.57)	Below 113	05 (7.57)
2	46 to 51	59 (89.40)	71 to 76	55 (83.33)	83 to 88	54 (81.82)	92 to 97	55 (83.33)	100 To 105	54 (81.82)	106 to 111	54 (81.82)	113 to 118	54 (81.82)
3	Above 51	04 (6.06)	Above 76	04 (6.06)	Above 88	05 (7.57)	Above 97	05 (7.57)	Above 105	06 (9.09)	Above 111	07 (10.61)	above 118	07 (10.61)
	Total	66	Total	66	Total	66	Total	66	Total	66	Total	66	Total	66

(Source: Field survey)

Note: Figures in brackets indicate percentage.

Above given table 5.35 depicts classification of beneficiaries (girls) according to their age and height. We can observe that the height of 4.54 percent girls was below 46 cm, height of 89.40 percent girls was between 46 to 51 cm and 6.06 percent girls were above 51 cm. For baby girls ideal height at the time of birth is 49 cm. At the age of 1 year, the height of 10.61 percent girls was below 71 cm, 83.33 percent girls were between 71 cm to 76cm and of 6.036 percent were above 76 cm. The ideal height for one year girl child referred by ICDS is 74 cm. At the age of two years 10.61 percent children were below 83 cm, 81.82 percent were between 83 to 88 cm, height of 7.57 percent girls was above 88 cm. When this group of girls was 3 year old, height of 9.09 percent girls was below 92 cm, 83.33 percent were between 92 to 97 cm, 7.57 percent girls was above 97 cm. likewise we can observe height of the girls at the age 4 years, 5 years and 6 years. The table reveals that the percentage of the girls in the medium range of height is maximum i.e. 81.82 for rest of the ages. The percentage of the girls who are short and the percentage of the girls who are taller than average range is less than the percentage of the girls in the normal range.

5.3.39 Classification on the basis of arm measure measurement of the child (Boys)

Table 5.36: Arm measure measurement of the child (Boys)

Sr. No.	Arm measurement (cm) / age	Frequency					
		1 year	2 years	3 years	4 years	5 years	6 years
1	Below 11.5 cm	1 (1.61)	2 (3.23)	2 (3.23)	1 (1.61)	1 (1.61)	1 (1.61)
2	11.5 cm to 12.5 cm	2 (3.23)	2 (3.23)	1 (1.61)	2 (3.23)	1 (1.61)	1 (1.61)
3	Above 12.5 cm	59 (95.16)	58 (93.54)	59 (95.16)	59 (95.16)	60 (96.78)	60 (96.78)
	Total	62	62	62	62	62	62

(Source: field survey)
Note: Figures in brackets indicate percentage

A special tape for taking arm measurement is devised and distributed to all AWC under ICDS. The tape is divided in to three parts. i.e. below 11.5 cm which is shown in red colour indicates severe, second part which ranges between 11.5 to 12.5cm shown in yellow colour shows children near severe and third part starts from 12.5cm which is shown in green colour indicates normal growth of the child. Above table shows that maximum 95.16 percent boys have arm measurement above 12.5 cm, 3.23 percent have arm measurement between 11.5 to12.5 cm and 1.61 percent are below 11.5 cm at their age of one year. At the age of two year children having arm measurement above 12.5 cm are 93.54 percent, whereas number of children having arm measurement between 11.5 to 12.5 cm are 3.23 percent and again 3.23 percent were below 11.5 cm. At the age of 3 years arm measurement of 95.16 percent were above 12.5 cm, 3.23 were between 11.5 to 12.5 cm and 3.23 percent below 11.5cm. When the children were 4 years, among these children 95.16 percent had arm measurement above 12.5 cm, 1.61 percent were between 11.5 to 12.5 cm, and 1.61 percent were below 11.5 cm arm measurement. At the age of 5 years, 96.78 percent had arm measurement above 12.5 cm, 1.61 percent were between 11.5 to 12.5 cm and 1.61 percent were below 11.5 cm. It was found that at the age of 6 also, arm measurement of 96.78 percent children was above 12.5 cm, 1.61 percent was between 11.5 to 12.5 cm and 1.61 percent were below 11.5cm.

5.3.40 Classification on the basis of arm measurement of the child (Girls)

Table 5.37: Arm measurement of the child (Girls)

Sr. No.	Arm measurement (cm) / age	Frequency					
		1 year	2 years	3 years	4 years	5 years	6 years
1	Below 11.5 cm	2 (3.03)	1 (1.53)	1 (1.53)	0	0	0
2	11.5 cm to 12.5 cm	3 (4.54)	3 (4.54)	3 (4.54)	3 (4.54)	2 (3.03)	1 (1.52)
3	Above 12.5 cm	61 (92.43)	62 (93.93)	62 (93.93)	63 (95.46)	64 (96.97)	65 (98.48)
	Total	66	66	66	66	66	66

(Source: field survey)
Note: Figures in brackets indicate percentage.

The given table shows that maximum 92.43 percent girls have arm measurement above 12.5 cm, 4.54 percent have arm measurement between 11.5 to12.5 cm and 3.03 are below 11.5 cm at their age of one year. At the age of two year children having arm measurement above 12.5 cm were 93.93 percent, whereas number of children having arm measurement between 11.5 to 12.5 cm were 4.54 percent and again 1.53 percent were below 11.5 cm. At the age of 3 years arm measurement of 93.93 percent were above 12.5 cm, 4.54 were between 11.5 to 12.5 cm and 1.53 percent below 11.5 cm. When the children were 4 years, among these children 95.46 percent had arm measurement above 12.5 cm, 4.54 percent were between 11.5 to 12.5cm and no girls found below 11.5 cm arm measurement. At the age of 5 years, 96.97 percent had arm measurement above 12.5 cm, 3.03 percent were between 11.5 to 12.5 cm and no child found below 11.5cm arm measurement . It was found that at the age of 6 also, arm measurement of 98.48 percent was above 12.5 cm, 1.52 percent was between 11.5 to 12.5 cm and 0 percent were below 11.5 cm.

5.3.41 Head circumference (Boys)

Table 5.38 Head circumference (Boys)

Sr. no.	0 years		1 years		2 years		3 years		4 years		5 years	
	Head circumference (cm)	frequency	Head circumference (cm)	frequency	Head circumference (cm)	frequency	(Head circumference (cm)	frequency	Head circumference (cm)	frequency	Head circumference (cm)	frequency
1	Below 34.3	NA	Below 45.9	02 (3.22)	Below 48.1	02 (3.22)	Below 49.3	01 (1.61)	Below 50	01 (1.61)	Below 50.5	01 (1.61)
2	34.3 to 34.7	NA	45.9 to 46.3	30 (48.39)	48.1 to 48.5	30 (48.39)	49.3 to 49.7	31 (50.00)	50 to 50.4	31 (50.00)	50.5 to 50.9	31 (50.00)
3	Above 34.7	NA	Above 46.3	0	Above 48.5	0	Above 49.7	0	Above 50.4	0	Above 50.9	0
4	Not available	62	Not available	30 (48.39)	Not available	30 (48.39)	Not available	30 (48.39)	Not available	30 (48.39)	Not available	30 (48.39)
	Total	62	Total	62	Total	62	Total	62	Total	62	Total	62

(Source: field survey)
Note: Figures in brackets indicate percentage.

Head circumference shows growth of the brain of the child. Hence it is expected that the growth of head circumference should be according to the age of the child beneficiary. But it was found that the AWW do not take measurement of head circumference regularly. It was also found that they are not aware of the importance of taking head measurement thoroughly. Since the ideal measurement of head circumference for boys and girls is different we have presented in two different tables. The above table 5.38 depicts information about head circumference of the 62 boys. It can be seen that, the information about head circumference of these children at the time of their birth is not available with the AWW. At the age of one year, head circumference of 2 boys was below 45.9 cm which is below normal range whereas 30 children are in normal range. At the age of 2 years also we find the same picture i.e. two beneficiaries are below normal range but in the next stage of their growth i. e. at 3 year only one child is below normal range and 31 boys are in normal range of head circumference. We find the same trend for the period till they complete their age of 5 years. We can also find that the data for 30 boys was not available.

5.3.42 Head circumference (Girls)

Table 5.39 Head circumference (Girls)

Sr. no.	0 years		1 years		2 years		3 years		4 years		5 years	
	Head cirumference (cm)	Frequency	Head cirumference (cm)	Frequency	Head cirumference	Frequency	Head cirumference	Frequency	Head cirumference	Frequency	Head cirumference	Frequency
1	Below 33.6	0	Below 44.6	0	Below 46.9	0	Below 48.2	0	Below 49	0	Below 49.6	0
2	33.6 to 34.1	0	44.6 to 45.1	22 (33.33)	46.9 to 47.4	22 (33.33)	48.2 to 48.7	22 (33.33)	49 to 49.5	22 (33.33)	49.6 to 50.1	22 (33.33)
3	Above 34.1	0	Above 45.1	0	Above 47.4	0	Above 48.7	0	Above 49.5	0	Above 50.1	0
4	Not available	66	Not available	38 (57.57)	Not available	38 (57.57)	Not available	38 (57.57)	Not available	38 (57.57)	Not available	38 (57.57)
	Total	66	Total	66	Total	66	Total	66	Total	66	Total	66

(Source: Field Survey)
Note: Figures in brackets indicate percentage.

Above given table reveals information about the measurement of head circumference of the girl beneficiaries. The data about the head circumference of the girls at the age of zero is not available. In the group of one year old girls, head circumference of only 22 girls is available. All 22 girl child are in normal range of measurement of head circumference. We can observe that, for next four years also all 22 girls are in normal range of head circumference. The data for head circumference of rest of the38 girls was not available. Anganwadi workers specified that they do not take head circumference regularly. The measurement is taken by ANM at the time of quarterly health check up and kept in their records.

5.4 PART-III

ANALYSIS OF ANGANWADI BENEFICIARIES

Part III of this chapter is discussion about the analysis and interpretation of questionnaire for beneficiaries. This part helps us to understand reviews and opinion of parents of child beneficiaries of AWC.

A) INFORMATION OF BENEFICIARY

5.4.1 Classification of the beneficiaries on the basis of gender

One of the major goals of ICDS is eliminate gender inequality in the society and to protect the girl child. Hence it is important to observe the participation of the girl child in the sample. Following table gives us information about the participation of boys and girls in the survey.

Table 5.40: Classification on the basis of gender of beneficiaries

Sr. no	Gender	Frequency	Percentage
1	Male	62	48.43
2	Female	66	51.57
	Total	128	100

(Source: Field Survey)

Above table reveals that among the beneficiaries selected for the study, 48.43 percent were male and 51.57 percent were females. It shows that participation of female beneficiaries is considerable/ more than fifty percent.

5.4.2 Classification of beneficiaries according to their weight at birth

Weight at birth is of crucial importance in the further life of the child. Weight of the child at the time of birth is one of the parameter to understand about the growth in the further life of the child.

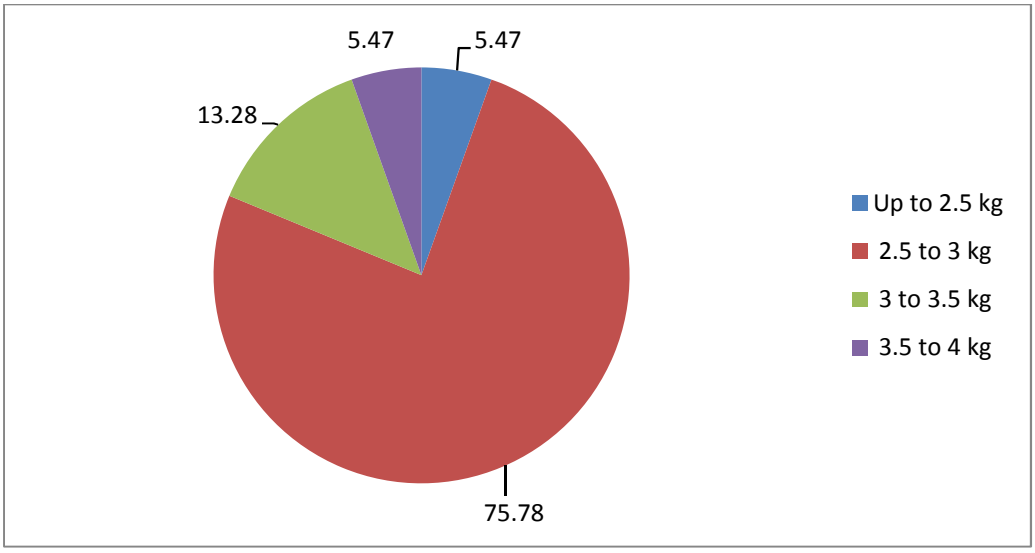
Table 5.41: Classification of beneficiaries according to their weight at birth

Sr. no	Weight at birth	Frequency	Percentage
1	Up to 2.5 kg	07	5.47
2	2.5 to 3 kg	97	75.78
3	3 to 3.5 kg	17	13.28
4	Above 3.5 kg	07	5.47
	Total	128	100

(Source: Field Survey)

Above table 5.41 shows the weight of the children at the time of their birth and is represented in the figure 5.16.

Figure 5.16: Weight at birth



(Source: Table 5.41)

Among the children studied it was found that weight of 5.47 percent children was below 2.5. It was found mostly near 2.5 kg. Weight of 75.78 percent children was between 2.5 to 3 kg at the time of birth, 13.28 percent were between 3 to 3.5 kg and 5.47 percent were above 3.25 kg. It shows that around 75 percent children are below 3 kg. It means underweight at the time of birth which can be the result of poor maternal care during pregnancy. The women in rural areas do not get proper medical care, rest, nutritious diet and personal care during the period of pregnancy. Since around 90 percent families of the beneficiaries are dependent on primary sector for their livelihood and belong to low income group it is obvious that the women in such families do not get proper care during pregnancy and ultimately results in the birth of underweight children.

B) INFORMATION ABOUT FAMILY OF THE BENEFICIARY

5.4.3 Classification on the basis of age of parents of beneficiaries

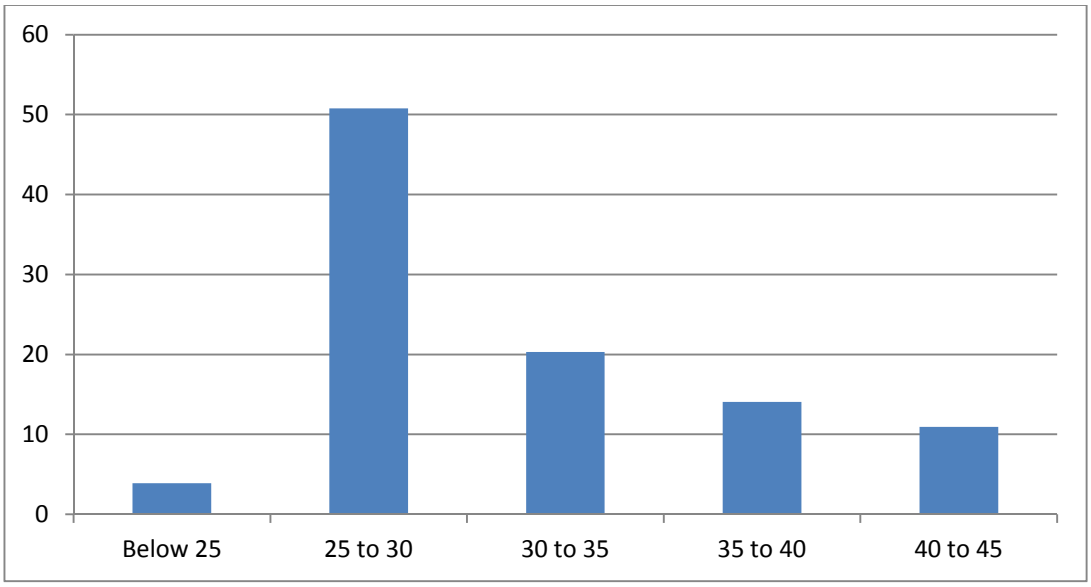
Age of parents plays important role in the upbringing of the child. Father or mother of the child should be mature and ready to bear responsibility of the child. If the parents are educated and financially sound they can give the child a better future. Following table and graph depicts education level of the parents of children selected for the present study.

Table 5.42: Age of parents of beneficiaries

Sr. no	Details	Frequency	Percentage
1	Below 25	5	3.90
2	25 to 30	65	50.79
3	30 to 35	26	20.31
4	35 to 40	18	14.07
5	40 to 45	14	10.93
	Total	128	100

(Source: Field Survey)

Figure 5.17: Age of parent of beneficiaries



(Source: Table 5.42)

Table 5.42 shows that maximum of the parents of the beneficiaries i.e. 65 (50.79%) are between the age group 25 years to 30 years following age group 25 to 30 years which have 26 parents (20.31%). There are 18 (14.07%) parents between the age group 35 to 40 and 14 (10.93%) parents between 40 to 45 years age group. Age of 5 (3.90%) parents is below 25 years. It was found that the age group between 25 to 30 years and 30 to 35 years, which consists more than 50 percent parents includes more number of mothers. The reason behind this can be the early marriages in rural areas. It imposes early motherhood on them. 3.90 percent parents were below 25 years which were also women. The early marriages in rural areas are the main reasons behind malnourishment and anemia among the mothers and their young ones.

5.4.4 Classification on the basis of family status of the parent

Family plays vital role in the life of any human being. Marital status of the parents can be considered as one of the influencing factor in the stability of the family. A stable family gives sense of protection and belongingness to the child. It plays important role in physical, mental, emotional and social development of the child. Table 5.39 shows marital status of the parents of the children selected for the study.

Table 5.43: Classification on the basis of family status of parents of the beneficiaries

Sr. no	Details	Frequency	Percentage
1	Married	122	95.31
2	Divorced	2	1.56
3	Widow/ widower	4	3.13
	Total	128	100.00

(Source: Field Survey)

It was found that 95.31 percents parents are married and living with the family. 1.56 percent parents are divorced and 3.13 percent were widow/ widower. Being a single parent poses several problems in front of them especially if they are women.

5.4.5 Classification on the basis of education of parent of the beneficiaries

Education is considered as a tool in the hands of human being which can change their destiny. Educated parents can give better care, nourishment and can complement the process of overall development of the child.

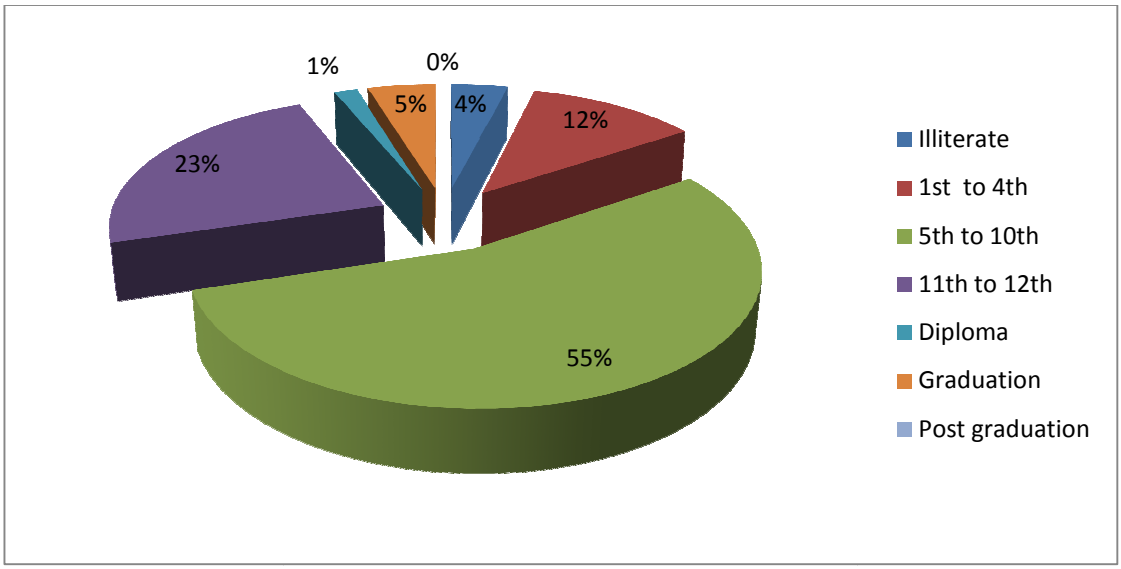
Table 5.44: Classification on the basis of education of parent

Sr. no	Details	Frequency	Percentage
1	Illiterate	05	3.90
2	1^{st} to 4^{th}	15	11.72
3	5^{th} to 10^{th}	70	54.69
4	Up to 12^{th}	30	23.44
5	Diploma	02	1.56
6	Graduation	06	4.69
7	Post graduation	00	00
	Total	128	100

(Source: Field Survey)

Table 5.44 shows information about educational qualification of the parents of the beneficiaries and represented in figure

Figure 5.18: Education of parents of the beneficiaries



(Source: Table 5.44)

From the above table and figure it can be seen that 3.90 percent parents are illiterate, 11.72 percent have acquired education till 4th standard, 54.69 percent are educated till SSC, and 23.44 have completed their education till 12th standard. 1.56 parents are diploma holders, 4.69 are graduate.

The table reveals that maximum number of parents of the beneficiaries (54.69) is educated between 5th std to 10th std. the number of women in this segment is considerable. 23.44percent parents are educated till 12th standard. It was found that no parent among these have completed their post graduation. Only 1.56 percent is diploma holder, 4.69 percent are graduate.

5.4.6 Classification on the basis of caste

Classification of the beneficiaries on the basis of their caste is explained as follows.

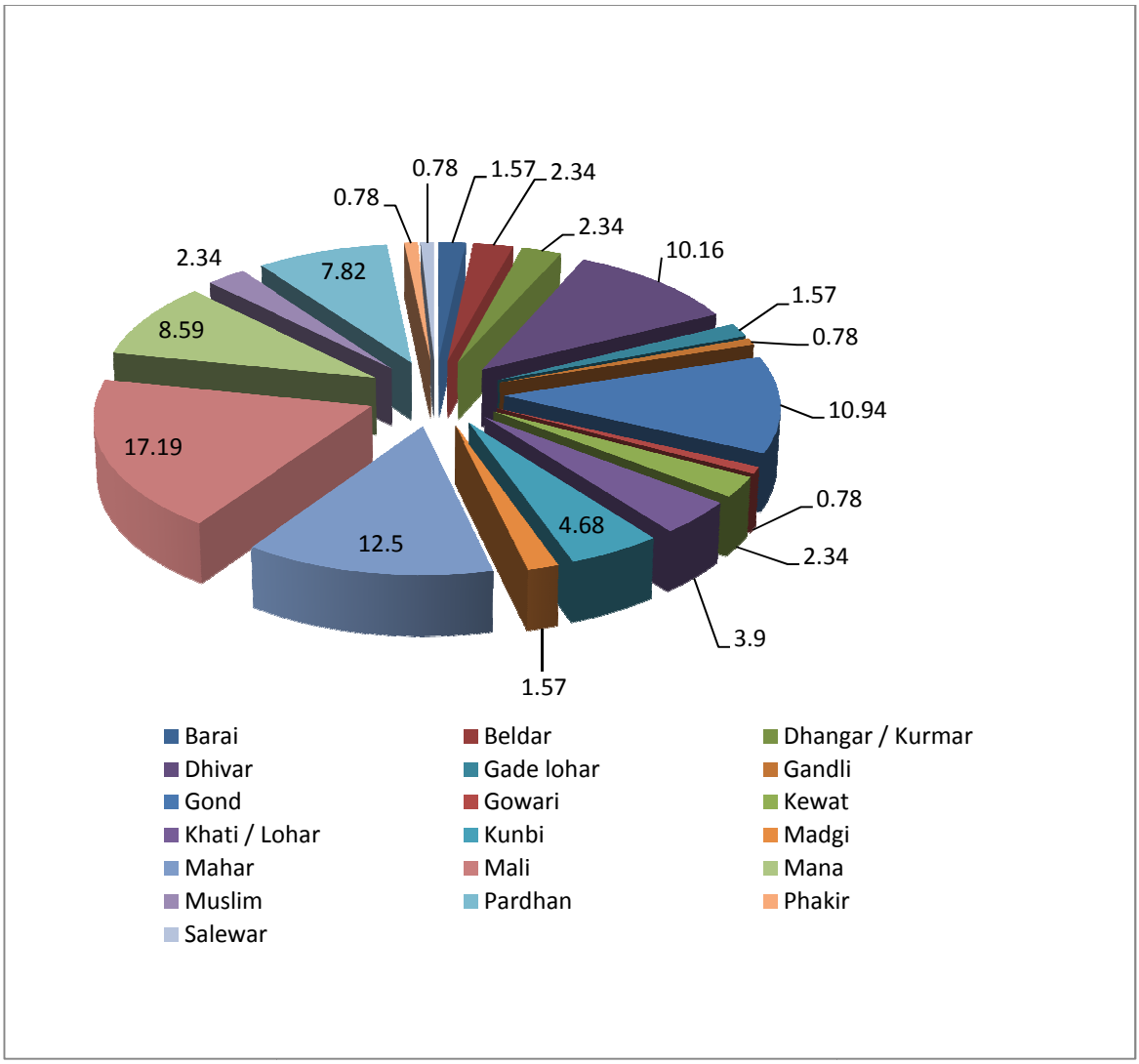
Table 5.45: Classification on the basis of caste

Sr. no	Caste	Frequency	Percentage
1	Barai	02	1.57
2	Beldar	03	2.34
3	Dhangar / Kurmar	03	2.34
4	Dhivar	13	10.16
5	Gade lohar	02	1.57
6	Gandli	01	0.78
7	Gond	14	10.94
8	Gowari	01	0.78
9	Kewat	03	2.34
10	Khati / Lohar	05	3.9
11	Kunbi	06	4.68
12	Madgi	02	1.57
13	Mahar	16	12.5
14	Mali	22	17.19
15	Mana	11	8.59
16	Muslim	03	2.34
17	Pardhan	10	7.82
18	Phakir	01	0.78
19	Salewar	01	0.78
20	Sonar	02	1.57
21	Teli	07	5.46
	Total	128	100

(Source: Field Survey)

Above table 5.45 depicts classification of the beneficiaries on the basis of their caste and represented in figure 5.19.

Figure 5.19: Classification on the basis of caste



(Source: Table 5.45)

Given table depicts classification of the beneficiaries on the basis of their castes. Among the beneficiaries 17.19 percent are from Mali caste followed by Mahar caste 12.5 percent. After that 10.94 percent are Gond and 10.16 percent are Dhivar, 8.59 percent are Mana and 7.82 are Pardhan, 5.46 percent are Teli, 4.68 percent are Kunbi, 5.47 percent are Lohar, 2.34 percent are Muslim, Beldar, dhangar and Kewat each. 1.57 percent respondents belong to Barai, 1.57 from Madagi and again 1.57 from Sonar caste. 0.78 percent is Gandli, 0.78 are Gowari, 0.78 are Phakir and 0.78 are Salewar caste. We find various types of caste which are from ST, SC, NT, SBC and OBC category. We can observe that these castes are dominant in the area. It can be said that ICDS is successfully reaching to the people who are left

behind in the rapidly moving world. ICDS gives priority to the location where SC, ST, NT population is dominant. We can find the same factor in the given table and figure.

5.4.7 Classification on the basis of occupation of parent

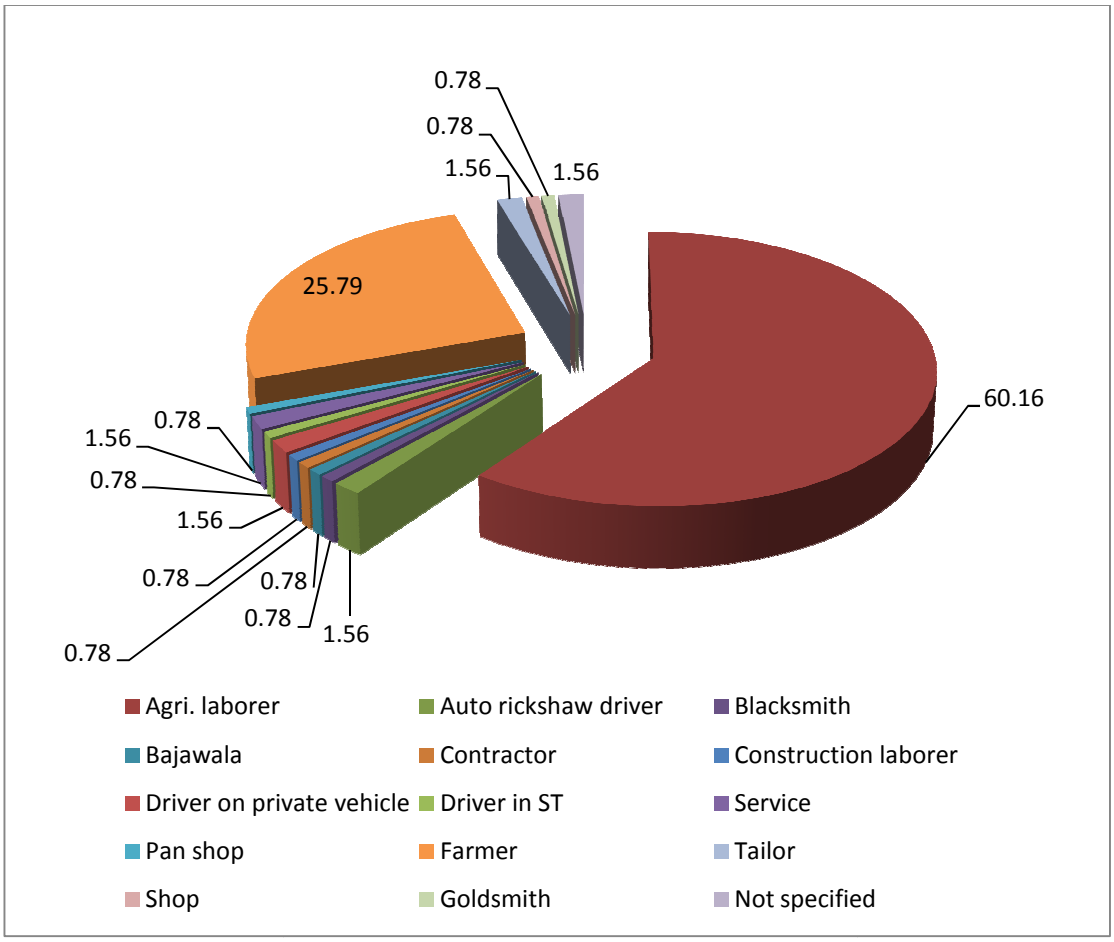
Occupation of the person is his/ her source of livelihood. It determines purchasing power of the person. It influences the consumption pattern as well as savings of the family. The occupational pattern of the parents of the beneficiaries is shown by the given table 5.42 and represented in figure 5.16.

Table 5.46 Classification on the basis of occupation of parent

Sr. no	Occupation of parent	Frequency	Percentage
1	Agri. labourer	77	60.16
2	Auto rickshaw driver	02	1.56
3	Blacksmith	01	0.78
4	Bajawala	01	0.78
5	Contractor	01	0.78
6	Construction labourer	01	0.78
7	Driver on private vehicle	02	1.56
8	Driver in ST	01	0.78
9	Service	02	1.56
10	Pan shop	01	0.78
11	Farmer	33	25.79
12	Tailor	02	1.56
13	Shop	01	0.78
14	Goldsmith	01	0.78
15	Not specified	02	1.56
	Total	128	100

(Source: Field Survey)

Figure 5.20: Occupation of parents of the beneficiaries



(Source: Table 5.46)

It can be seen that maximum number i.e. 6.16 percent parents of the beneficiaries are agricultural labourers. These people earn their bread and butter by working on daily wages. 25.79 percent people are farmers who cultivate their own land. Around 2.34 percent parents are working in Government Jobs like teacher and ST driver. Many of them work as black smith, bajawala, own pan shop, tailor etc. 0.78 percent are contractor of construction work and again 0.78 percent are in the business of gold i.e are goldsmith. It shows that the people in the area are either in agriculture sector or working in the areas where there is least assurance of fix and regular income. Very few of them have secured jobs.

More than 50 percent are involved in the employment which cannot provide security and assurance of regularity of income. Such circumstances pose more

difficulties in front of them. It affects the childhood of younger generation adversely and may disrupt the smooth process development of the child.

5.4.8 Classification on the basis of monthly income of the family

Monthly income of the family of the beneficiary is the major factor which influences their life and standard of living. The chance to get better life increases with higher income level and vice versa. For better understanding of the social and economic profile of the beneficiary it is important to know about the income level of the family from which they belong to. Following table depicts classification of the beneficiaries on the basis of the monthly income of their family.

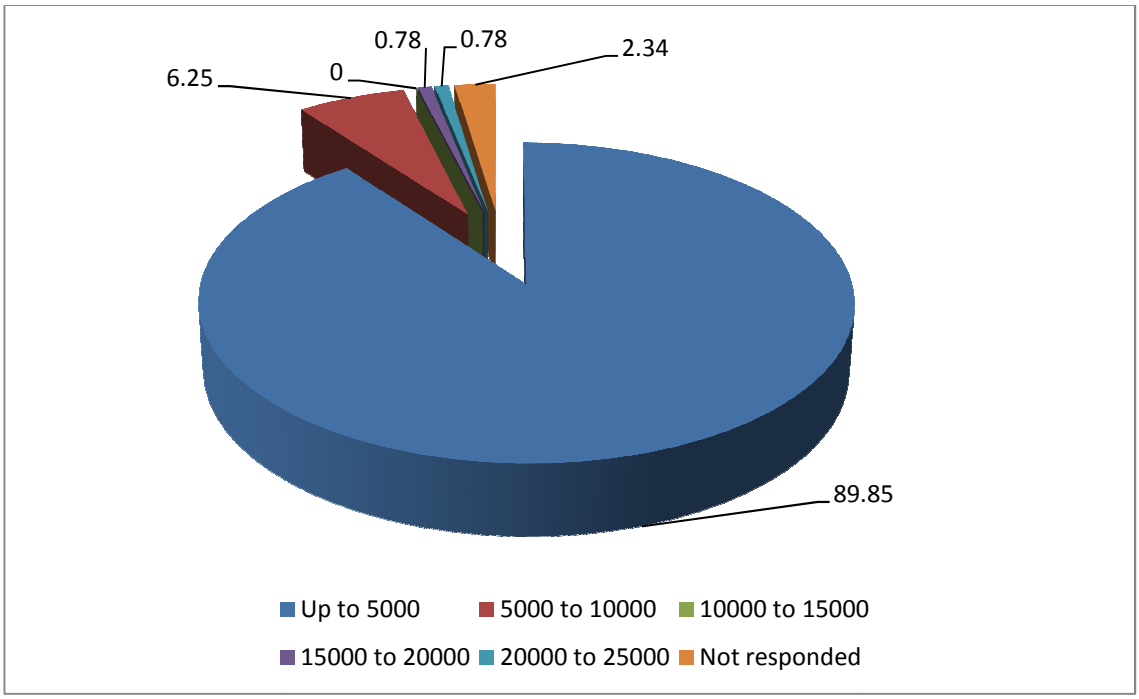
Various studies have pointed that wealth of the family has tremendous impact on the standard of living of the people of the nation. Monthly income of the family is an integral part of the wealth possessed by the family. Persistent poverty has more detrimental effects on IQ of the child as well as school achievement and socio emotional functioning of the child. It also influences dietary intake of the people which ultimately is closely bound with health of the people. Given table shows classification of the beneficiaries on the basis of monthly income of their parents.

Table 5.47: Classification on the basis of monthly income of the family

Sr. no	Monthly Income (Rs)	Frequency	Percentage
1	Up to 5000	115	89.85
2	5000 to 10000	08	6.25
3	10000 to 15000	00	00
4	15000 to 20000	01	0.78
5	20000 to 25000	01	0.78
6	Not responded	03	2.34
	Total	128	100.00

(Source: Field Survey)

Figure 5.21: Monthly income of the family



(Source: Table 5.47)

Above table and figure reveals that 89.85 percent of the families have their monthly income up to Rs. 5,000. 6.25 percent families earn Rs.5,000 to Rs.10,000 monthly. It shows that monthly income of around 95% families is below Rs. 10,000 per month. Out of residual 5% families 0.78 percent families fall under monthly income of Rs.15, 000 to Rs.20,000 and Rs. 20,000 to Rs.25,000 each. 2.34 percent have not specified their monthly income. There was not found a single family which belongs to monthly income Rs. 10,000 to Rs.15,000. Given information shows that there are large numbers of people in the area who live below poverty line and does not possess sufficient purchasing power to maintain their basic standard of living. The children belonging to such families are at higher risk because such families cannot provide them nutritious food, health, hygiene, sanitation and due care required by them.

5.4.9 Classification on the basis of number of members in the family

In rural areas joint family system is still prevalent. Such families may have more number of dependent member viz. children and old age people. Number of family members in the family determines cost of living of the family. More number in

family results in more expenses on living. Given table 5.48 shows numbers of members in the family of the respondents.

Table 5.48: Number of members in the family

Sr. no	Details	Frequency	Percentage
1	1 to 3	17	13.28
2	3 to 5	79	61.72
3	5 to 7	25	19.53
4	7 to 9	04	3.13
5	More than 9	03	2.34
	Total	128	100

(Source: Field Survey)

It can be seen that 79 (61.72) respondents have 3 to 5 members in their family followed by 25 (19.53) respondents have 5 to 7 members in their family. 17 (13.28) respondents have 1 to 3members and 4 (3.13) have 7 to 9 members in their family. 3 (2.34) have more than 9 members in their family. It shows that maximum people live in joint family system.

5.4.10 Number of earning members in the family

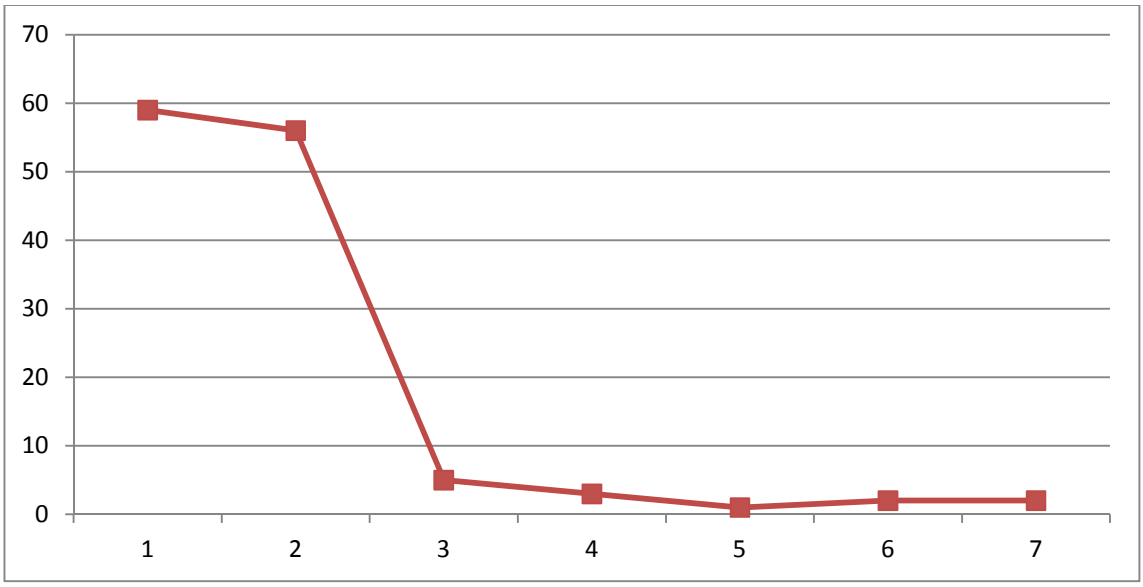
Number of working members contributes toward greater family income which may result in better standard of living of the family members. Following table depicts number of earning members in the families of the beneficiaries.

Table 5.49: Number of earning members in the family

Sr. no	Earning members in the family	Frequency	Percentage
1	1	59	46.09
2	2	56	43.76
3	3	05	3.91
4	4	03	2.34
5	5	01	0.78
6	6	02	1.56
7	7	02	1.56
	Total	128	100

(Source: Field Survey)

Figure 5.22: Number of earning members in the family



(Source: Table 5.49)

We can observe that 46.09 percent families have only one working member. In 43.7 percent families there were two members, 3.91 percent families have 3 members who works and earn money for the family. We can observe that lesser number of families have more number of earning members. These are mainly the families where more number of young people are engaged in working class. Families living in joint family system also show higher level of income. 2.34 percent have 4 working members, 0.78 have 5 members in the family working. 1.56 percent families have 6 members and again 1.56 have 7 members earning for the family. Such families enjoy better standard of living as compared the families who have only one earning member.

5.4.11 Classification on the basis of the type of house

Houses in India vary from palaces of maharajas to small huts. In urban areas people live in buildings and in rural areas have also changed their typical pattern of housing. Following table depicts the various types of houses of the respondents.

Table 5.50: Classification on the basis of the type of house

Sr. no	Details	Frequency	Percentage
1	Hut	18	14.06
2	With tin Shed Roof	03	2.34
3	Bricks and with slab (no plaster)	52	40.63
4	Cement pucca house	55	42.97
	Total	128	100

(Source: Field Survey)

Above table 5.50 shows that 18 (14.06%) live in huts which are of old type of residence. 3 (2.34%) live in the house with tiled roof. 52 (40.63% live in a house having brick walls and slab but no plaster to the wall, whereas 55 (42.97%) live in a pucca house. It shows that with the changing world housing pattern in rural areas is also changing. People under poverty line are benefitted from gharkul yojana / pradhan mantri Awas yojana, formerly Indiara Awas Yojana. Huts are made up of mainly Mud which old type of construction in rural areas.

5.4.12 Classification on the basis of number of rooms in the house

Following table tells about the number of rooms available in the house of the beneficiaries studied. The houses in this area typically have one vharanda or space before entering the house, one room, and one kitchen.

Table 5.51: Number of rooms in the house

Sr. no	Details	Frequency	Percentage
1	1	12	9.37
2	2	69	53.90
3	3	24	18.75
4	4	23	17.98
	Total	128	100

(Source: Field Survey)

Above table depicts number of rooms in the houses of beneficiaries. It was found that maximum number of respondents 53.90 percent have two room followed by 18.75 percent have 3 rooms and 17.98 percent have four rooms in their home. It

also shows that 9.37 percent people have only one room at their home. It shows per person space available for the people living there.

5.4.13 Classification on the basis of things/ commodities at home

Facilities at home increase comfort of the person. In the changing world of globalization we find that consumers benefit from new products which reduce stress in the life of a person. Information about availability of such commodities or facilities may help us to understand the lifestyle of the people which may in turn help us to access quality of the life of the respondents. Following table give information about this.

Table 5.52: Possessions or commodities at the home of beneficiary

Sr. no	Details	Frequency	Percentage
1	Television	119	92.97
2	Refrigerator	10	7.81
3	Two wheeler	14	10.93
4	Car	01	0.78
5	Gas	99	77.34
6	Mobile	121	94.53

(Source: Field Survey)

Above multi respondent table depicts information about the possessions which beneficiaries have. It is found that 92.97 percent people have television at their home, followed by 94.53 percent people who have mobile phones. 77.34 percent people have gas connection at their home and 10.93 percent possess two wheeler. It is found that negligible number of people 0.78 percent own car and 7.81 percent people have refrigerator at their home. It reveals that the people in rural areas possess more number of consumer goods like television and mobiles than commodities like gas which are indeed essential for better standard of one's standard of living.

5.4.35 Classification on the basis of component of daily intake of the family of the beneficiary

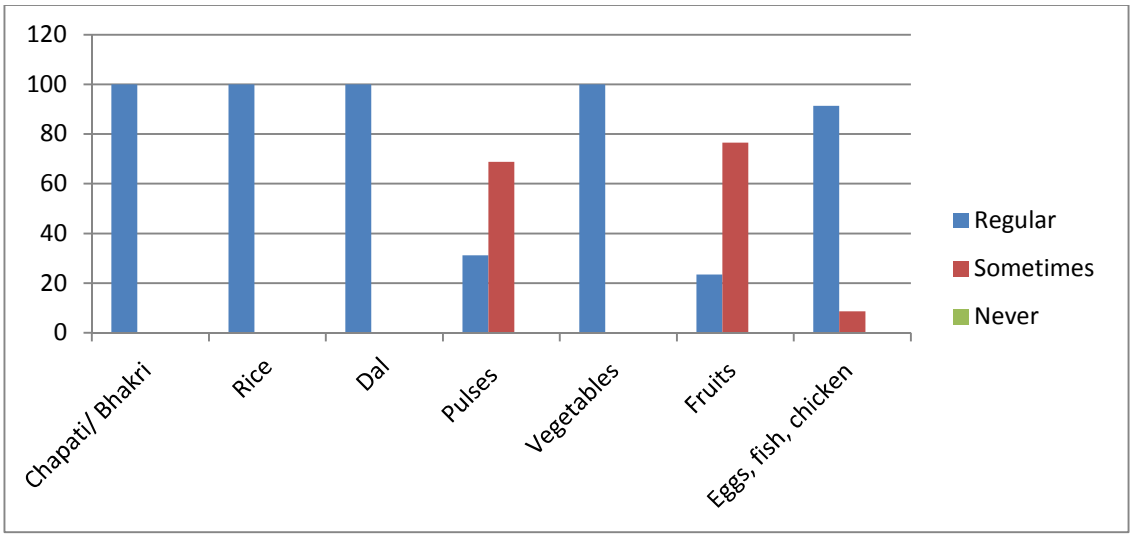
Component of the intake is an integral factor which affects physical growth of the child which ultimately influences overall performance of the child. Following table illustrates components of the daily diet of the family of the beneficiaries.

Table 5.53: Component of daily intake of food in the family

Sr. no	Items	Regular	%	Sometimes	%	Never	%	Total percentage
1	Chapati/ Bhakri	128	100	0	0	0	0	100
2	Rice	128	100	0	0	0	0	100
3	Dal (grams)	128	100	0	0	0	0	100
4	Pulses	40	31.25	88	68.75	0	0	100
5	Vegetables	128	100	0	0	0	0	100
6	Fruits	30	23.43	98	76.57	0	0	100
7	Eggs, fish, chicken	117	91.40	11	8.60	0	0	100

(Source: Field Survey)

Figure 5.23: Component of daily intake of food in the family



(Source: Table 5.53)

Above given table and figure reveals that almost all people studied, consume chapatti, rice dal (grams) and vegetables on regular basis. Eggs, chicken and fish are also part of their regular diet. 31.25 percent answered that pulses are included in their regular meals whereas 68.75 percent answered that they consume pulses sometimes. Fruit is found to be consumed not regularly but sometimes. 23.43 percent answered that they consume fruits regularly and 76.57 percent answered that they eat fruits sometimes. 91.40 percent people said that they consume egg/ chicken/ fish regularly whereas 8.60 percent people said that they consume it sometimes.

It is interesting to know that, though 100 percent people answered that they eat wheat, rice (cereals), dal (gram) and vegetable regularly, it was found that they consume it either for one meal. The quantity consumed is not found as per the calorie needs of per person. Most of them consume chapatti in the evening and not for lunch since they don't get time to cook in the morning. Rice and dal are consumed daily. It can be understood from the above discussion that though these people consume all types of food items, the diet they follow does not fulfill ideal calories intake for a person and child.

C) INFORMATION ABOUT ANGANWADI

5.4.14 Classification on the basis of distance of AWC from home of the beneficiary

Proximity to the AWC is of immense importance for the beneficiaries for their regular attendance at AWC. While selecting the location for establishing ICDS project, priority is given to the areas which have more number of scheduled castes and scheduled Tribes especially backward tribes. The intention behind this is that such people are mostly from deprived class and poor in reach of social services. If anganwadi are established near to such areas it helps government to provide basic services through the network of AWCs.

Table 5.54: Distance of anganwadi from home

Sr. no	Details	Frequency	Percentage
1	0 to 1km	118	92.19
2	1 to 3 km	08	6.25
3	More than 3 km	02	1.56
	Total	128	100

(Source: Field Survey)

Above table reveals that the distance between home and AWC for 92.19 percent beneficiaries is less than 1 km. 6.25 percent need to travel 1 to 3 km to reach the AWC. The distance is more than 3 km for 1.56 percent beneficiaries. Proximity to residence of beneficiaries enhances the chances of regular attendance through which the beneficiaries can be served and monitored in better way. It enhances the chances of more coverage of ICDS scheme.

5.4.15 Classification of the beneficiaries on the basis of mode of reaching to AWC

Parents need to take out time to drop the child at AWC and to pick them up after finishing the sessions at AWC. If AWC is close to their residence it saves their time as well as cost of travelling. Following table depicts the mode of travelling availed by the beneficiaries to reach the anganwadi center.

Table 5.55: Mode to reach AWC

Sr. no	Details	Frequency	Percentage
1	Walking	119	92.97
2	Cycle	5	3.91
3	Bus	0	0
4	Not specified	4	3.12
	Total	128	100

(Source: Field Survey)

5.4.16 Classification on the basis of regularity in attendance of the beneficiary

Regular attendance of the child helps anganwadi worker to monitor and provide services in better way. They get supplementary feeding on regular timing, they benefit from regular preschool education sessions and get chance to socialize. When parents go for work they can spend quality time at AWC. For effective functioning of ICDS regular attendance of 3 to 6 years children is of utmost importance. Given table elaborates regularity of attendance of beneficiaries.

Table 5.56: Regularity in attendance of the beneficiary

Sr. no	Details	Frequency	Percentage
1	Yes	122	95.31
2	No	01	0.78
3	Not specified	05	3.91
	Total	128	100

(Source: Field Survey)

122 (95.31 percent) respondents answered that their child goes to anganwadi center regularly. Only 1 (0.78) percent said that their child doesn't go to anganwadi regularly and 05 (3.91 percent) parent did not specify their answer about the question. The reason behind not going 1 (0.78 percent) child was found that the distance of anganwadi is more.

5.4.17 Classification on the basis of interest of child about AWC

Preschool education imparted to the children between 3 to 6 years at anganwadi. Following table depicts interest of the children for attending anganwadi.

Table 5.57: Does child like to go to AWC

Sr. no	Details	Frequency	Percentage
1	Yes	124	96.88
2	No	02	1.56
3	Not specified	02	1.56
	Total	128	100

(Source: Field Survey)

96.88 percent respondents answered that their child likes to go to anganwadi. 1.56 percent recorded that their child does not like to go to anganwadi whereas 1.56 percent did not record their response.

5.4.18 Classification on the basis of whether AWC is airy

The building of AWC is the most important infrastructure for establishing anganwadi centre. The building of AWC, basic facilities at AWC plays crucial role while imparting ICDS services through AWC. Well constructed building with clean and airy interior is very important for the children going to anganwadi centre. Table 5.56 depicts the status of anganwadi building according to it ventilation.

Table 5.58: Classification on the basis of whether AWC is airy

Sr. no	Details	Frequency	Percentage
1	Yes	115	89.85
2	No	11	8.59
3	Not specified	02	1.56
	Total	128	100

(Source: Field Survey)

From the above table we can observe that 89.85 percent respondents answered that anganwadi building is airy and have good ventilation. 8.59 percent answered that they

do not have airy class room at the centre. 1.56 percent respondents did not answer the question.

5.4.19 Classification on the basis of availability of washroom at AWC

Availability of washroom is very important for maintaining cleanliness and health of the child.

Table 5.59: Washroom availability at AWC

Sr. no	Details	Frequency	Percentage
1	Yes	103	80.47
2	No	18	14.06
3	Not specified	07	5.47
	Total	128	100

(Source: Field Survey)

75 percent AWW answered that their centers have washrooms for the children who attend anganwadi for availing ICDS services. 25 percent AWW answered that their centers do not have washroom. These centers were mainly found to be attached to the zilla parishad schools and they use the washrooms meant for schools.

5.4.20 Classification on the basis of cleanliness of washroom of AWC

Following table illustrates the classification of AWCs on the basis of cleanliness maintained in washrooms.

Table 5.60: Classification on the basis of cleanliness of washroom of AWC

Sr. no	Cleanliness of washroom of AWC	Frequency	Percentage
1	Yes	108	84.37
2	No	15	11.72
3	Not specified	05	3.91
	Total	128	100

(Source: Field Survey)

It was found that 84.37 percent respondents mentioned that the AWC where their child is enrolled have clean washroom. 11.72 percent respondents mentioned that

their AWC did not have clean washrooms whereas 3.91 percent respondent did not mention their answer.

5.4.21 Classification on the basis of availability of water in washroom

Non availability of ample water is common phenomenon in most of the rural areas. Availability of sufficient water for daily use helps the anganwadi worker and anganwadi helper to maintain cleanliness at AWC. Making water available is one of the principal responsibilities of the AWW and AWH. Following table gives a picture of availability of water in the washroom for sanitation purpose.

Table 5.61: Classification on the basis of availability of water in washroom

Sr. no	Availability of water in washrooms	Frequency	Percentage
1	Yes	103	80.47
2	No	19	14.84
3	Not specified	06	4.69
	Total	128	100.00

(Source: Field Survey)

Availability of water is of immense importance for clean and healthy life. Many villages in our country face the problem of water shortage which affects their day today life severely. Availability of water at AWC for washrooms is crucial because it is related to the children attending the AWC. 80.47 percent AWC have water available for washroom and 14.84 percent AWC have no water available for washrooms. 4.69 percent did not record any response. Such non availability of water at washrooms to be used commonly leads to infections and diseases among children.

5.4.22 Classification on the basis of availability of clean and sufficient potable water in AWC

Potable drinking water is the right for everyone. It is important for a healthy life. Provision of clean and sufficient water for beneficiaries is primary responsibility of AWC. Following table gives classification of AWC studied regarding availability of clean and sufficient water at AWC.

Table 5.62: Availability of clean and sufficient potable water in AWC

Sr. no	Availability of clean and sufficient potable water	Frequency	Percentage
1	Yes	116	90.62
2	No	08	6.25
3	Need to fetch from long distance	04	3.13
	Total	128	100

(Source: Field Survey)

In the field survey it was found that 87.5 percent AWC have facility for clean and safe water for drinking. At the same time 12.5 percent AWC does not have this facility. It reveals that in the post globalization era we still are not able to provide drinking water facilities for our future human resource. They are deprived of the basic needs. It affects their health and ability to undergo different activities.

5.4.23 Supplementary nutrition

Supplementary feeding is an initiative by ICDS to eliminate malnutrition among the children at very young age. Following table gives information about distribution of supplementary nutrition at AWC.

Table 5.63: Whether supplementary nutrition is given daily and sufficient

Sr. no	Details	Frequency	Percentage
1	Yes	124	96.88
2	No	01	0.78
3	Not specified	03	2.34
	Total	128	100

(Source: Field Survey)

Above table reveals that 96.88 AWC among the AWC studied provide supplementary nutrition daily. They specified that they have specific schedule for the week and as per the schedule they distribute supplementary nutrition. The items served in supplementary nutrition include nutritious Khichdi, sprouts usal, sweet Lapashi (wheat Kheer), Halwa made from wheat flour, laddo etc. They are provided

small book late of various nutritious recipes which help them as guideline for supplementary feeding.

5.4.24 Classification on the basis of taste of supplementary food

Taste of the food is very important criteria for the child for consumption of the food. Eating habit of the child can be changed by providing them food of the taste which they like. Supplementary food is cooked at AWC and served to the beneficiaries.

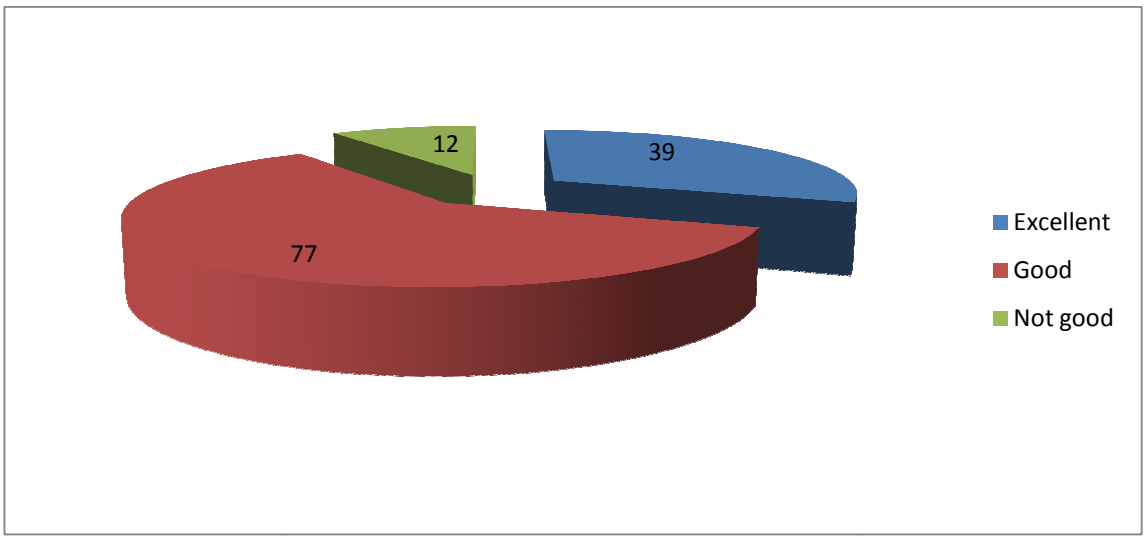
Table 5.64: Classification on the basis of taste of supplementary food

Sr. no	Details	Frequency	Percentage
1	Excellent	39	30.47
2	Good	77	60.15
3	Not good	12	9.38
	Total	128	100

(Source: Field Survey)

Classification of the beneficiaries on the basis of their response about taste of supplementary food served at anganwadi center is depicted in the table 5.64. the same data is represented in the figure

Figure 5.24: Taste of supplementary food



(Source: Table 5.64)

We can observe from above figure that heir response as taste of food is good, followed by 39 respondents who recorded their response that the taste of food served at anganwadi is excellent. 12 answered that the taste of supplementary nutrition is not good.

5.4.25 Classification on the basis of whether the THR given in AWC is taken or not

Table 5.65: Classification on the basis of whether the THR given in AWC is taken or not

Sr. no	Details	Frequency	Percentage
1	Regular	122	95.31
2	Sometimes	04	3.13
3	Not responded	02	1.56
	Total	128	100

(Source: Field Survey)

Above table reveals that 95.31 percent beneficiaries consume the food served at anganwadi center regularly. 3.13 percent consume it sometimes whereas 1.56 percent did not record their answer.

5.4.26 Classification on the basis of Attention given that food served is consumed wholly by the child in AWC

Supplementary feeding to children is one of the daily activities at AWC. Children are provided fresh and hot food on daily basis. Mere serving the food is not sufficient but it is important that the child should consume the food completely. Following table depicts the opinion of respondents about the same.

Table 5.66: Attention given that food served is consumed wholly by the child

Sr. no	Details	Frequency	Percentage
1	Yes	126	98.44
2	No	02	1.56
	Total	128	100

(Source: Field Survey)

Above table shows that 98.44 percent parents of the beneficiaries answered that, it is ensured that all the food served at the centre is consumed by the child. They make them to seat and eat the fresh food completely. In the rural areas when the mother goes to the farm or work early morning she cannot cook and serve nutritious food to her children for their breakfast or lunch. When the child goes to AWC it can avail this facility which contributes towards their growth.

5.4.27 Classification on the basis of cleanliness of utensils used at AWC for serving supplementary food

When we talk about health and hygiene, cleanliness of utensils used for serving food is of immense importance. It helps to prevent diseases and infections among children. All 100 percent respondents mentioned that the utensils used for serving food to children are cleaned on regular basis. Anganwadi helper takes care of this responsibility.

5.4.28 Classification on the basis of regularity in immunisation

Immunisation service is provided at AWC in convergence with health department. In the monthly visit of ANM and ASHA worker child is vaccinated as per their vaccination schedule. 100 percent children are immunized. It shows increasing awareness among the parents about the health of their child.

5.4.29 Classification on the basis of frequent sickness among the children

Frequent Illness among the children can be taken as the symptom of weaker health of the child. Immunity of the child is the base of his healthy life ahead. Following table depicts the tendency of sickness among the children studied.

Table 5.67: Frequent sickness

Sr. no	Details	Frequency	Percentage
1	Yes	14	10.94
2	No	114	89.06
	Total	128	100

(Source: Field Survey)

89.06 percent respondents answered that their child does not fall sick frequently. 10.94 percent mentioned that there is problem of frequent sickness. It shows that immunity of these children who are benefitting from AWC services protects them from frequent sickness. Immunisation, eating habits, hygiene habits taught at AWC and practiced at home helps them to stay healthy.

5.4.30 Place of treatment taken

Following table elaborates where families of beneficiaries go for treatment.

Table 5.68: Place of treatment taken

Sr. no	Details	Frequency	Percentage
1	At home	01	0.78
2	Primary health centre	68	53.13
3	Private hospital	17	13.28
4	PHC and Private hospital	39	30.47
5	Home, PHC, Private hospital	03	2.34
	Total	128	100

(Source: Field Survey)

Above tables shows maximum number i.e. 53.13 percent respondents go to primary health centre for treatment followed by 30 percent who answered that they prefer to go to either PHC or Private hospital for medical treatment, 13.28 said that they go to private hospitals only and 2.34 percent answered that they take treatment at home or PHC or private hospitals. Only 0.78 percent people specified that they try home remedies for illness and in case of severity refer to doctor. That might be because the Mul taluka is a rural area so it has villages which do not have good quality of health institutions. Since some villages are in interiors of the area does not have good connectivity to taluka or villages which have PHC or clinics.

5.4.31 Classification on the basis of completion of treatment taken during sickness of child

People in rural areas are mostly not aware of the complete care about health issues of the children. They may treat illness as regular part of the childhood. Several times people do not take

Table 5.69: Completion of treatment taken during sickness of child

Sr. no	Details	Frequency	Percentage
1	Yes	124	96.87
2	No	01	0.79
3	Not specified	03	2.34
	Total	128	100

(Source: Field Survey)

96.87 percent respondents answered that they take complete treatment for sickness of the child. 0.79 answered that they do not take complete treatment and 2.34 did not answer the question. It was also found that according to them complete treatment means feeling better than before. When asked about the course of medication prescribed by doctor, they could not provide explanation.

5.4.32 Classification on the basis of opinion about growth in weight, height of the child

Following table gives information about opinion of parents about growth in weight, height of the child

Table 5.70: Growth in weight, height of the child is satisfactory

Sr. no	Details	Frequency	Percentage
1	Yes	113	88.28
2	No	07	5.47
3	Not specified	08	6.25
	Total	128	100

(Source: Field Survey)

Table 5.70 tells about parent's feedback about the increase of weight of the child is satisfactory or not. 88.28 percent people are satisfied with the growth in weight of the child whereas 5.47 percent are not satisfied with the growth of the weight of the child. 6.25 percent did not answer the question. Feedback of the parent was based on the information and counseling provided by AWW. It was also found that parents who recorded their feedback were aware about age wise ideal weight of the child and 6.25 percent were not aware about ideal weight of the child.

5.4.33 Classification on the basis of opinion about Supplementary Feeding at AWC

Following table depicts opinion of the respondents regarding whether supplementary nutrition provided at AWC is helpful in the growth of the child.

Table 5.71: whether SN is helpful in the growth of the child

Sr. no	Details	Frequency	Percentage
1	Yes	121	94.53
2	Not responded	07	5.47
	Total	128	100

(Source: Field Survey)

We can observe that 94.53 percent respondents answered that supplementary nutrition provided at anganwadi centers is helpful for the growth of the child, whereas 5.47 percent did not answer the question.

5.4.34 Classification on the basis of opinion about health and nutrition education service

Health and Nutrition education is an important service given at AWC. Parents specifically mothers are given information about health factors and guidance about intake of the beneficiaries which creates awareness among the parents. They also educate parents to reduce expenses on bakery products, chocolates, or junk food like chips and kurkure and purchase fruits, green vegetables, milk and milk products, eggs and healthy food with saved money. Along with they are given information about the frequency of food a child should be given and a tentative schedule about the intake of the child.

Table 5.72: Opinion about health and nutrition education

Sr. no	Details	Frequency	Percentage
1	Yes	123	96.10
2	Not specified	05	3.90
	Total	128	100

(Source: Field Survey)

Table 5.72 shows that maximum (96.10) parents answered that they get guidance about the diet of the child. It helps them to include required amount of various food items in the diet of their children. They try to provide meal with whatever grains they have at their disposal. 3.90 percent mentioned that though the guidance is available they cannot go regularly since they work on daily wages so need to rush for work and someone at home drops the child to AWC

5.4.36 Classification on the basis of location of PHC

Health care services availed during pregnancy and after birth of the child are very crucial for survival and well being of the child as well as the mother. Primary health centers are the key centers for health services in rural areas. Accessibility of PHC is very important for availing health services in rural areas.

Table 5.73: Location of nearest Primary Health Center

Sr. no	Details	Frequency	Percentage
1	In the village	65	50.78
2	Neighboring village	34	26.56
3	Taluka place	29	22.66
	Total	128	100

(Source: Field Survey)

50.78 percent respondents answered that primary health center is available at their village. 26.56 percent answered that they have to go to neighboring village for availing Health service and 22.66 percent mentioned that they have to go to taluka place for the same.

5.4.37 Classification on the basis of availability of doctors at PHC

Children are referred to PHC in case of major ailment, malnourishment or special cases. Involvement of medical officer in the service is one of the crucial factors in the scheme. Following table elaborates availability of doctors at PHC

Table 5.74: Availability of doctors at PHC

Sr. no	Details	Frequency	Percentage
1	Yes	114	89.06
2	No	08	6.25
3	Not specified	06	4.69
	Total	128	100

(Source: Field Survey)

89.06 percent mentioned that doctors are available at PHC when they go there for treatment. 6.25 percent mentioned that doctors are not available at PHC and 4.69 percent did not record any response for the question.

5.4.38 Classification on the basis of registration of mother of beneficiary in anganwadi centre during pregnancy

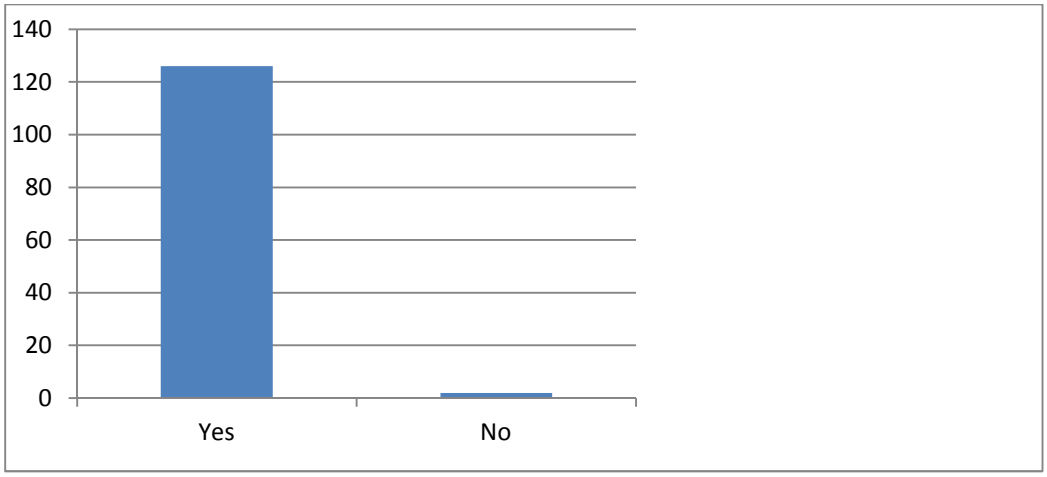
Expectant mothers are one of the target groups of the services imparted under ICDS scheme. The intention behind this is child should receive pre birth care and nourishment for further life. Expectant mother can avail supplementary nutrition service, immunisation facility health education for better health of her child. Following table shows registration of mothers of beneficiaries at AWC during their pregnancy.

Table 5.75: Registration of mother of beneficiary in anganwadi centre during pregnancy

Sr. no	Details	Frequency	Percentage
1	Yes	126	98.43
2	No	02	1.59
	Total	128	100

(Source: Field Survey)

Figure 5.25: Registration of mother of beneficiary in anganwadi centre during pregnancy



(Source: Table 5.75)

The table 5.75 and figure 5.25 tells about registration of the mother of the beneficiaries in anganwadi center during their pregnancy. 98.43 percent respondents mentioned that mother of the beneficiary was registered at AWC at the place where they reside. They also mentioned that they availed the services for the whole duration of their pregnancy and after birth of their child they use to receive all these services given under ICDS scheme. It helped them to take care of their child and themselves. They received health education and guidance about intake and feeding practices at home. They also mentioned that the support of AWW was appreciable. 1.59 percent answered that they were not registered at AWC.

5.4.38 Classification on the basis of Services availed at AWC during pregnancy.

Stages of child development include the prenatal stage which is from conception to child's birth. Pregnant mother is also one of the beneficiaries of ICDS scheme. They can take advantage of the services provided at AWC. Following table provides information about the services availed by the mothers of the beneficiaries during pregnancy.

Table 5.76: Services availed at AWC during pregnancy.

Sr. no	Details	Frequency	Percentage
1	Immunisation	113	88.28
2	Supplementary nutrition	125	97.65
3	Counseling	128	100
4	Health check ups	113	88.28
5	Health and nutrition education	120	93.75

(Source: Field Survey)

Above multi respondent table illustrates that 88.28 percent mothers of the beneficiaries availed the immunisation service from AWC, 97.65 percent have received supplementary nutrition i.e. THR, all have received counseling service through either at AWC or through home visit by AWW. 88.28 percent have acquired health check up facility and 93.75 percent have taken advantage of health and nutrition education provided by AWW.

5.4.39 Classification on the basis of Immunisation of beneficiary at the time of birth

Vaccination is of immense importance for the child to lead a healthy life ahead. In this modern era people have become aware about the health of their child. People in rural areas prefer giving birth to child in the hospital. In addition in the home visits and counseling AWW also provide them information regarding prenatal and neo natal care of the child. She ensures that the pregnant lady or her family enrolls her name in the hospital for the delivery.It is shown in table that all the beneficiaries were immunized at the time of their birth. The very first vaccination given to the child is of BCG is. This is given free of cost in government hospital where as private hospital charge fees for it. In both of the options it is given to the new born baby.

5.4.40 Classification on the basis of health check up held in AWC

Table 5.77: Health checkups frequency at AWC

Sr. no	Details	Frequency	Percentage
1	Every month	77	60.16
2	Quarterly	51	39.84
3	Half yearly	0	0
4	Random	0	0
	Total	128	100

Source: Field Survey

Above table shows that 60.16 percent answered that health check up is done every month and 39.84 percent answered that it is conducted quarterly.

5.4.41 Classification on the basis of regularity of pre -school education at AWC

All respondents answered that pre -school activity is conducted at AWC on regular basis. It enables children at AWC to understand basic concepts related to the formal education like alphabets, numbers, colour, vehicles, shapes, name of the fruits, vegetables, days of the week, months. While teaching AWW narrates different stories, jingle and different kind of ways by which the child can understand the basic ideas. This activity is conducted daily. But it was also found that since the AWW has to bear varied responsibilities she gets comparatively less time for qualitative preschool education.

5.4.42 Classification on the basis of help of educational material while teaching

Educational material proves to be of great help while teaching to the children at pre primary level. It helps them to understand the concept and remember. For PSE state provides the basic material like charts, flannel board with cutouts, building blocks, beads and string etc. following table explains the same.

Table 5.78: Help of Educational aid while teaching

Sr. no	Details	Frequency	Percentage
1	Yes	120	93.76
2	No	03	2.34
3	Not specified	05	3.90
	Total	128	100

(Source: Field Survey)

We come to know from above table that 93.76 percent respondents mentioned that help of educational material like charts, puppets, toys is taken while imparting the services under non formal pre- school education. 2.34 percent mentioned that help of such material is not taken while teaching whereas 3.90 percent did not mention their answer.

5.4.43 Classification about availability of toys and play material at AWC

Toys play vital role in the emotional world of the child. May be rich or poor they are possessive about their toys. ICDS adopts play way method for preschool non formal education for imparting preschool education at AWC. For the purpose ICDS provides educational material and toys to each anganwadi center. The play material can be for indoor games or outdoor games. The AWC can make more play material available by developing them with locally available resources and community participation. It attracts children and motivates them to attend anganwadi regularly.

Table 5.79: Availability of toys at AWC

Sr. no	Details	Frequency	Percentage
1	Yes	109	85.15
2	No	17	13.29
3	Not specified	02	1.56
	Total	128	100

(Source: Field Survey)

While answering the question about availability of toys at AWC 85.15 percent respondents mentioned that toys are available at AWC for the children. 13.29 percent

mentioned that toys are not available rather available toys are not in good condition and hence not available. Since children handle them in their own way so it was found that at many centers toys were worn out and were not in good condition. 1.56 percent did not answer the question.

Review about Social development of child

Social development of the child is one of the important objectives of the ICDS scheme. Along with the physical and motor development ICDS targets at social, psychological and emotional development of the child. Following table reveals opinion of the parents of the beneficiaries about their participation in socializing.

5.4.44 Classification on the basis of ability of the child to mix

Meeting new people have massive impact in the emotional world of the child. It provides practical life education to the children. It infuses the feeling of being a part of the society and develops the sense of belongingness, which ultimately contributes to the social development of the child. Following table depicts ability of the child to mix with the people and socialize.

Table 5.80: Does the child like to Mix with new people?

Sr. no	Details	Frequency	Percentage
1	Yes	121	94.53
2	No	01	0.79
3	Not specified	06	4.68
	Total	128	100

(Source: Field Survey)

Above table shows that 94.53 percent answered that their child can mix with new people. 0.79 answered that their child does not mix. 4.68 did not answer the question. It shows that going to anganwadi helps the child to learn to get mix with peer group and helps them to become social being.

5.4.45 Classification on the basis of ability of the child to Participate in conversation

Following table explains opinion of the parents about ability of the child to participate in conversation.

Table 5.81: Participation in conversation

Sr. no	Details	Frequency	Percentage
1	Yes	120	93.75
2	No	02	1.56
3	Not specified	06	4.69
	Total	128	100

(Source: Field Survey)

We can observe from table 5.81 that 93.75 percent answered that their child can participate in conversation in fluent way. They can express their feelings and convey message through right choice of words and without hesitation. It helps them to mix with their peer group and communicate comfortably when they come across new people.

5.4.46 Classification on the basis of the opinion of parents about change in behavior of the child

Along with the education alphabets, numbers, colour, vehicle etc which is important for formal education, values based taught are given at AWC. They are educated about importance of cleanliness, good habits, respecting elderly people, team activities etc. which will generate good spirit among them. Following table gives Classification on the basis of the opinion of parents about change in behavior of the child.

Table 5.82: Change in behavior of child

Sr. no	Details	Frequency	Percentage
1	Yes	120	93.75
2	No	02	1.56
3	Not specified	06	4.69
	Total	128	100

(Source: Field Survey)

93.75 percent respondents answered that they can observe change in the behavior of the child like eating habits have changed, children are aware about personal hygiene, likes to mix with peer group, eager to know new things, etc. which indicate social and emotional development. 1.56 percent mentioned that they do not experience any kind of change in the child and 4.69 percent did not specify their answer. It was also found that the children who not experiencing any noticeable change in overall behavior are from the group of the children who are irregular in attendance. We can say that regular attendance of the child can only give better result of ICDS scheme.

5.4.47 Classification on the basis of punctuality of AWC

The timing of anganwadi center can be decided according to the convenience and schedule of that particular village. It is directed by the ICDS that the AWC should be open for 4 ½ hours every day. The time for each activity is allotted in the specified schedule of all AWC. It is also directed that AWC should open daily at scheduled time. Following table illustrates whether the AWC are opened on scheduled time or not.

Table 5.83: Opens on time

Sr. no	Details	Frequency	Percentage
1	Yes	120	93.76
2	No	04	3.12
3	Not specified	04	3.12
	Total	128	100

(Source: Field Survey)

5.4.48 Classification on the basis of frequency of parent meeting

Interaction between AWW and parents can improve the results of the efforts initiated by ICDS scheme. Through the meetings this can be facilitate. Following table depicts details of parent meeting held at AWC.

Table 5.84: Parent meeting

Sr. no	Details	Frequency	Percentage
1	Regularly	1	0.79
2	Sometimes	121	94.53
3	Not specified	04	3.12
	Total	128	100

(Source: Field Survey)

Table 5.84 reveals opinion of respondents about frequency of holding parents meetings at anganwadi centers. 0.79% respondents expressed that such meetings are held regularly at AWC, whereas 94.53% answered that AWC conduct parent meeting sometimes and 3.12%did not respond to this question. The reason behind not arranging formal parents meetings was found that majority of people in the area work in unorganized sector. They need to leave home early morning. Hence all parents cannot come on specified dates for the meeting. But while doing home visits and other activities AWW communicates with the parents personally. They provide information related to growth and development of the child. Interaction with parents helps them to understand the pattern of development of the child.

5.4.49 Classification on the basis of treatment given by AWW to child at AWC

Behavior of AWW is very important for beneficiaries. It is quiet natural that behavior can change person to person. Treating beneficiaries in satisfactory manner is very important to generate reliance among the beneficiaries. It is very essential for universalisation of ICDS. Table 5.93 displays classification on the basis of opinion of respondents regarding the treatment given by AWW to the beneficiaries.

Table 5.85: Treatment given by AWW to child

Sr. no	Details	Frequency	Percentage
1	Excellent	52	40.62
2	Good	74	57.81
3	Satisfactory	02	1.57
4	Not good	00	00
	Total	128	100

(Source: Field Survey)

The table 5.85 depicts that 52 (40.62%) expressed that the treatment given them is excellent followed by 74 (57.81%) expressed that the treatment they receive from anganwadi worker is good. 2 (1.57%) expressed that they get satisfactory treatment. We can say that all beneficiaries are satisfied with the treatment they receive at AWC and feel that they are being treated well.

5.4.50 Classification on the basis of satisfaction of the beneficiaries about services provided by AWC

ICDS is India's most comprehensive and multidimensional programme which addresses the issues of early childhood care and development. It is a child centered programme. It undertakes various activities which help in proper foundation of psychological, physical and social development of the child. Following table reveals whether the respondents are satisfied with the services provided by AWC.

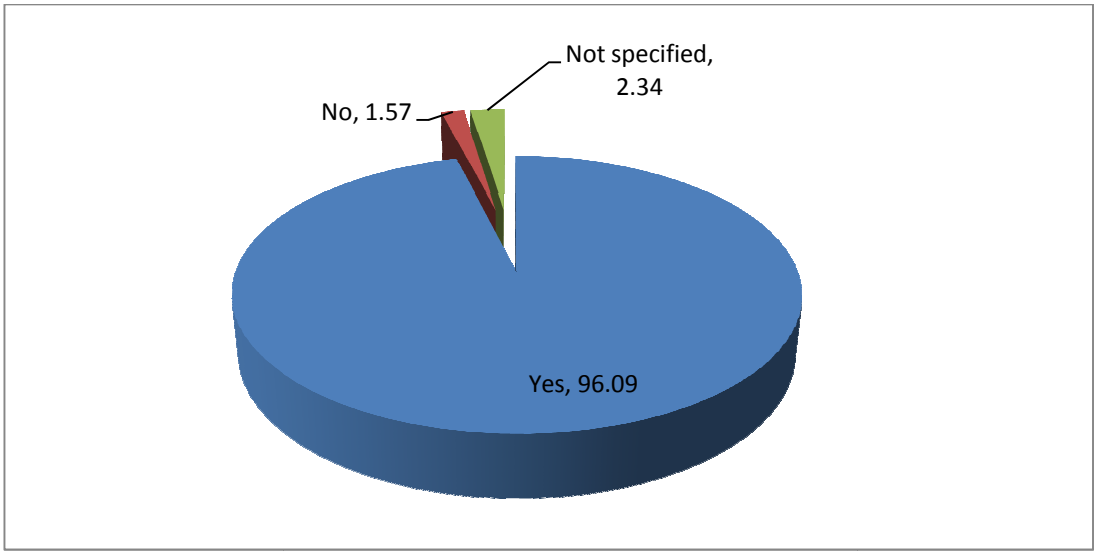
Table 5.86: Whether Satisfied with the services provided by AWC

Sr. no	Details	Frequency	Percentage
1	Yes	123	96.09
2	No	02	1.57
3	Not specified	03	2.34
	Total	128	100

(Source: Field Survey)

Above table 5.86 depicts the satisfaction level of beneficiaries about the services availed from anganwadi centers by them and represented in figure 5.26 given below.

Figure 5.26: Satisfaction about anganwadi services



(Source: Table 5.86)

From above table and figure it can be seen that maximum number i.e. 96.09 percent respondents specified that they are satisfied with the services rendered by anganwadi centers. 1.57 percent mentioned that they are not satisfied with the services provided by anganwadi centers, whereas 3.34 percent respondents did not answer this question.

5.5 Hypothesis Testing:

For present research the data collected is qualitative in nature and hence hypothesis testing is done in following way.

Hypothesis 1:

ICDS services have a positive impact on the development process of beneficiaries.

The hypothesis is accepted. Present study proved this hypothesis. The hypothesis says that ICDS scheme has a positive impact on the development of the beneficiaries. From the various tables which show analysis of weight, height, arm measurement and head circumference of the selected children, we can reach to the conclusion that physical growth of the children availing anganwadi services is satisfactory. From the tables showing growth in the weight of the beneficiaries, we can observe that the percentage of both, boys and girls is maximum in the group which is close to ideal range of weight for respective ages. Percentage of underweight children for that same group of children is decreasing with their growing age. In case of height also we find that the growth of height for both groups, i.e. boys and girls is satisfactory. At the age of 6 years around 85% boys and 81% girls have ideal or close to ideal height. At the same age we have 3.03 % boys and 11.09 % girls who are taller than the ideal height for their age. We found that arm measurement of 96% boys and 98% girls is above 12.5 cm which is an indicator of normal growth of the child. Along with physical growth parents of beneficiaries answered that they experience change in the behavior of child like eating habits have changed, children are aware about personal hygiene, likes to mix with peer group, eager to know new things, etc. which indicate social and emotional development. 94.53 percent answered that their child can mix with new people. Only 0.79 answered that their child does not mix. 4.68 did not answer the question. It shows that going to anganwadi helps the child to learn to get mix with peer group and helps them to become a social being. 93.75 percent answered that their child can participate in conversation in fluent way. They can express their feelings and convey message through right choice of words and without any hesitation. It helps them to mix with their peer group and communicate comfortably when they come across new people. All the above factors shows that

ICDS scheme have a positive impact on the development process of the children admitted to AWC.

Hypothesis 2:

ICDS beneficiaries are socially and economically deprived.

This hypothesis is accepted. Present research proved the above statement. Among the beneficiaries studied around 15 percent belong to SC category, 27 percent belong to ST and around 35 percent belong to OBC. About 85.95 percent parents of the beneficiaries earn their livelihood from agriculture sector. Around 6.24 percent work in unorganised sector; only 2.34 percent work in government sector, around 6 percent work in other sector. Monthly income of the 89.85 families of the beneficiaries is below 5000 per month. Only 6.25 percent families earn between 5000 -10000 per month, only 1.56 percent families earn above 15000 per month. It shows that the families of beneficiaries live their life with very less money.

5.6 Conclusion:

Present chapter discusses analysis and interpretation of Primary as well as secondary data in the study. The data is collected with the help of well designed questionnaire for anganwadi worker and anganwadi beneficiaries. Present discussion throws light on the various aspects of the analysis in this Chapter. The first part of the chapter elaborates expenditure of ICDS Scheme by Central Government, state government and at the block level. Part II of the chapter contains analysis of the questionnaire of anganwadi workers. 32 anganwadi workers from each of the selected AWC were interviewed and primary data was collected through it which helped to understand the background of the AWW who are the actual facilitators of ICDS scheme. It contains information regarding functioning of AWC and opinion of AWW about anganwadi services. It also contains the information of weight, height, arm measurement and head circumference of all 128 beneficiaries which helps to understand the trend of growth of the children. The third part of the chapter is analysis of questionnaire for the parents of the beneficiaries. It helps us to understand opinion of parents of the beneficiaries about the services availed at AWC which are provided under integrated Child Development Scheme as well as their experience and observation about the behavior of their child. It helps us to understand the impact of

these services on the children. Forth part contains testing of hypothesis. All these four parts of the chapter 5 helps us to analyse and understand the data collected for the purpose of present study. Findings and conclusions drawn based on the analysis done in this chapter are presented in the next chapter

CHAPTER 6

CONCLUSION AND SUGGESTIONS

6.1 Introduction:

Present chapter discusses conclusions and suggestions based on the analysis and interpretation of the data collected for the study entitles, "Socio economic impact Integrated Child Development Services (ICDS) scheme on child development, with special reference to Mul taluka in Chandrapur district." (2006-2016) Following conclusions have been drawn on the basis of the observations of the study.

6.2 Findings:

Part I

1. During the period of study, actual expenditure of Central Government on ICDS is found to be more than the budgeted allocations. The budget estimates are revised every year and the provisions were made to meet the actual expenses. The growth in the expenditure on ICDS is found to be increasing, but at decreasing rate.

2. Number of beneficiaries of Supplementary Nutrition Programme is higher in rural and tribal projects than the urban projects. Hence the expenditure on SNP in rural and tribal ICDS projects in Maharashtra is found to be higher than the urban projects.

3. Expenditure of the ICDS programme in of Mul block consists of general expenditure (such as wages) and expenditure on SNP. During the study period the general expenditure increased but the expenditure on SNP fell for much of this period. Taken together however, the total expenditure shows an increasing trend.

Part II

4. Mul Block of ICDS scheme has experienced staff of anganwadi workers. Maximum anganwadi workers belong to the age group above 41 years and on an average they have completed at least 15 years of their anganwadi service. More than 25 percent AWW are working as AWW for 35 years. Such a senior and experienced staff can impart services in efficient manner. Seniority generates bonding with the work and with growing age they can understand the implementation of services in better way. It enhances quality of the activities conducted at AWC. We can say that

ICDS has more experienced frontline functionaries at the very first contact point with beneficiaries.

5. About 25% AWW were either divorcee or widow. Working as anganwadi worker gives them opportunity to stand on their own and helps them to be independent as well as it gives them opportunity to get involved in society and provide sense of stability.

6. Education level of anganwadi workers was not satisfactory. Maximum AWW have acquired education till or less than 12^{th} standard. Negligible numbers of AWW have completed their graduation or post graduation. These anganwadi workers belong to varied segment of the society. Maximum of AWW were from SC, ST, or OBC category. Participation of the women from backward segment of the society is increasing in ICDS services.

7. Most of the families of AWW belong to economically vulnerable group. Less than 10% have assurance of fix income. Remaining families have no fixed monthly income. Maximum family members work as agriculture labourer, farmers and have monthly income less than Rs. 10,000 per month. Maximum of them do not have any other source of income than their regular work. Average income level of these families is found low.

8. Maximum number of AWW reside in the same villages where AWC is located. Such proximity of the work place enhances regular attendance of anganwadi worker at anganwadi centre which ultimately helps to render ICDS services to the beneficiaries.

9. Maximum AWC buildings were made up of bricks, cement. The construction of few AWC observed was in incomplete status. In spite of the building constructed as pucca building, some of these centres had some problems like cracks in the wall, broken tiles etc.

10. All the AWW have acquired training from Panchayat Raj Training centers. It proved very useful for them when they actually started working at the community level. It is also found that there is a recurrent lag in the receipt of honoraria of anganwadi workers. The workload on AWW is tremendous. They have to work hard for fulfilling the objectives of ICDS. They coordinate and conduct various activities

for betterment of the society but compared to their input the rewards they receive is less In spite of such circumstances AWWs are keenly interested in their work and maximum of them mentioned that, they like the nature of their work. It provides them sense of satisfaction.

11. Opinion of AWW about intensity of requirement of ICDS services found positive for services rendered by ICDS. All AWW mentioned that ICDS services are of immense importance. All of them ranked supplementary nutrition, immunization and health services as either severely needed or very much needed.

12. Growth monitoring of beneficiaries is done minutely. For this the AWW conducts monthly health checkup at anganwadi. They take weight, height, arm measurement and circumference of the head of the child and record it. It helps them in growth monitoring of the child. It was also found that AWW takes weight, height and arm measurement regularly but measurement of circumference of the head was not found taken on regular basis which is recently introduced in the growth monitoring schedule. It was also found that they are not properly aware about the reason of taking circumference of head which is an important indicator of growth of the brain of the child.

13. Anganwadi workers play important role in informing and educating parents, specifically the mothers about childcare like immunization schedule of the child, diet requirement of the child, health and nutrition education, and other several aspects of growth and development of the child.

14. All records at AWC are updated regularly. It includes MPR, family survey Registers, growth charts, records of beneficiaries etc. such accurate and timely data collected from grass root level helps policymakers and government to get actual picture of ICDS services and further strategies. It was also observed that updating the records consumes considerable time of the activities to be performed at AWC.

15. Most of the AWW were not acquainted with the actual funding pattern of ICDS and the various heads under which ICDS projects receive funds from government. They were also not aware of the actual cost sharing pattern between state and central government. It seems that they just perform the responsibilities assigned to them but

not aware of the actual implementation or stages of implementation and funding at block, district, state and central level.

16. Malnourished children are given special attention and care. Such children are referred to the medical officer for further treatment. Frequency of feeding is increased to 8 times a day in case of malnourished children. AWW provide support and guidance to the parents about feeding practices at home. It shows remarkable contribution of AWW in eradication of malnutrition. AWCs also provide referral services for major ailment and malnourished children. They also take follow up of such beneficiaries referred to PHC or community health centers.

17. AWCs are not properly equipped for medical emergencies. They are provided with first aid box for treating minor injuries and accidents, but since many of the AWCs are located in rural and remote parts of the taluka they should be well equipped for medical emergencies.

18. The growth of children availing ICDS services found to be satisfactory. Among the children studied, maximum children both girls and boys were found in the normal range of weight. Percentage of the children in ideal weight was lower than the percentage of the children in the normal range. The percentage of the underweight children was also found in the area. The height of the children both boys and girls found to be average as compared to their ideal height laid down by ICDS scheme. Girls were found taller than boys if compared with their average height. Arm measurement of maximum children was also found in normal range. Though in lesser number, but still we find short and underweight children in the block, number of which should be brought to zero for eliminating malnutrition from the state and from the country also. Height and weight of the children improved during the six year they spent at the AWC. More number of children came closer to the ideal height and weight at the age 6.

Part III

19. Number of girls availing benefits under ICDS scheme is found satisfactory. It marks considerable participation of girl child in the ICDS scheme.

20. In case of maximum beneficiaries weight at the time of their birth was found low. Though the mothers in the area are registered at AWC during their pregnancy, and avail services under ICDS scheme, most of them are not given proper care at home. Inadequate prenatal care, improper diet and rest results in low birth weight of the children in the rural areas.

21. Education level of the parents of the beneficiaries studied was found poor. Around 4 percent of them were illiterate. Maximum number of were educated below or up to 12^{th} standard. Very few have taken education of diploma and degree. It depicts the status of education in rural areas of the state where dropout rate is high among the children specifically girls. They do not get opportunity to pursue higher education. Uneducated and under educated parents are most of the time ignorant about the health, education, growth and development of the child.

22. Maximum beneficiaries belong to castes like Mahar, Madgi, Pardhan, Gond, Mali, Teli, Kunbi, Mana etc. The percentage of beneficiaries from the castes like Gowari, Dhangar, Gandli, Gosawi, Kewat and Salewar was also considerable. Most of these castes belong to backward classes. It shows that ICDS scheme is reaching to the people who are socially deprived and really need the services and participation of backward classes in the scheme is increasing considerably.

23 Maximum parents work in agriculture sector, either as agriculture labour or farmers. Remaining parents found to be working in unorganised sectors like auto rickshaw driver, Bajawala, construction labourer, tailor, Pan shop etc. we find that the percentage of the people earning subsistence level of income in the area is considerable and their work does not provide any kind of guarantee of regularity in the income. Most of the people have no fixed income. It was found that maximum families of the beneficiaries have their monthly income less than Rs. 10,000 per month. Maximum people in this category work as agriculture labourer or in the unorganized sector. It shows that the people in rural areas live in vulnerable situation. They do not possess sufficient purchasing power to cater their basic needs like food, health, hygiene and sanitation which is of immense importance for overall development of a child.

24. The family size of most of the beneficiaries was big. Maximum families had 3 to 5 or more number of members in their family. It shows that most of the people live in

joint family system. Such a large size of family has to bear considerable expenses for fulfilling basic needs of all family members. Women in such families need to work more for household work. They need to take care of old age members of the family along with the children. Most of them work on daily wages to support their families. In such a condition they don't get enough quality time for their children. Income of such families gets divided for fulfilling various family responsibilities and such families cannot spend sufficient money on the nutrition, health and education of the children. It was also found that maximum numbers of families have only one person or two persons who work and earn for the family.

25. The type construction of houses in rural areas is changing with the changing time. Maximum families of the beneficiaries live in the house built with bricks. With the changing type of house the structure of house is also changing. Very few people live in one room, Average number of people live in the houses having 2 rooms. Most of the people belonging to this group are found to be beneficiaries of housing schemes of Government. Such well built home gives children a clean and healthy surrounding and lead a better life. Maximum families of the respondents have commodities like television and mobiles than the necessities like gas connection. Maximum people do not own comforts or luxurious goods like car and refrigerator. It shows subsistence level of standard of living of the respondents in the Mul Taluka.

26. The dietary intake of the families of the beneficiary was found not sufficient to fulfill the calorie requirement of a person or a child. It affects the growth of the child. Since most of these people belong to lower income group they are not in a position to spend adequate portion of their income on their food budget.

27. Maximum beneficiaries live in proximity to anganwadi which helps them to attend anganwadi regularly. This enables ICDS scheme to serve more number of eligible beneficiaries. Maximum beneficiaries walk the distance; very few use bicycles to reach AWC. Maximum beneficiaries attend the anganwadi regularly. Still around 1 percent respondent mentioned that their child do not go AWC regularly since they live near their farm and hence are isolated from the village. Regular attendance facilitates anganwadi centre to render maximum services to the beneficiaries. They can monitor growth and development of the children more efficiently and regularly. Supplementary feeding given at AWC, play material and

activities conducted at the AWC generates interest among them and they come to AWC willingly.

28. Most of the anganwadi in Mul taluka have good ventilation system, but still there are some AWC which not have proper ventilation system. Average number of AWCs has facility of toilet but around 15 percent AWC do not have toilets. Some of them were located near primary school or Gram Panchayats and it was found that they utilise the washrooms of these institutions. Cleanliness in washrooms is maintained at maximum number of AWC, which is very important for the health of children, but considerable percent of respondents mentioned that washrooms are not always clean. Rural parts of the Maharashtra have problem of water availability. Hence shortage of water can be the reason of this. Around 90 percent AWCs have sufficient and clean water available for drinking for the children but it was also found that some of AWC which do not have facility of tap at the centre take water from tap of primary schools, hand pump or nearby house in the ward where AWC is located. It shows that though the coverage under ICDS is increasing AWCs in rural areas but the centres lack in basic facilities.

29. Preparation and distribution of supplementary food is done on daily basis. AWC have a fixed schedule for supplementary food to be served throughout the week. They serve variety of food to fulfill calorie requirement of the children. Children are given two serving in a day which include snacks in the morning and one hot meal. But the families which live in exteriors of the villages do not attend AWC regularly and hence do not get supplementary feeding regularly. Maximum respondents answered that the taste of supplementary food served at AWC is excellent or good. The reason can be that the food is prepared and served fresh and hot. Food is prepared by self help group or anganwadi centre by AWW or AWH. Around 10 percent respondent mentioned that the taste is not good. This factor depends upon the process of cooking. AWW or AWH provide attention to the child that it completely consumes the food served in their plates. The utensils used for cooking and serving the food at AWC are clean. They are cleaned by anganwadi helper before and after use. Take home ration (THR) is distributed to the children below 3 years.

30. Non formal preschool education is imparted on regular basis. Though there is no prescribed syllabus for PSE, they teach different concepts and things which prepare

the base of children between 3 to 6 years for formal education. Children are taught the concepts like alphabets, numbers, vehicles, colour, shapes, name of the fruits, vegetables, days of the week, months, importance of cleanliness and values etc. it is taught with the help of different stories, jingle and with the help of group activities. Help of educational material is taken while teaching. They use charts, toys, blocks, cards, indoor and outdoor games, puzzles to impart preschool education in play way method. Maximum number of AWC had educational material and toys for conducting PSE activities. Educational material is made available from states as well as Anganwadi workers can develop educational material with locally available resources with the help of community members. Some of the AWC had no sufficient material for imparting PSE or available material was not in good condition.

Since AWW are required to conduct various activities in given schedule they do not get ample time to teach the children in innovative way and conduct outdoor activities. Anganwadi worker should be freed from other responsibilities for conducting this activity.

31. At most of the AWCs, toys are available for the children. Most of them have indoor toys and play material available for children. Provision of outdoor play material like swings, slides was not found in most of the AWC. Most of them share such facilities of primary schools since they are located in the premises of such schools. Around 13.29 percent AWC did not have sufficient toys rather available toys were not in a good condition and hence not available for playing. All AWCs should have ample material for children because children can learn many things through playing and it contributes to the process of their all-round growth.

32. Immunisation of the beneficiaries is done regularly. This facility is arranged every month at AWC. Beneficiaries are given vaccinations according to the immunization schedule of the child. ANM and ASHA worker provide this service at anganwadi center. It protects the child from frequent sickness.

33. Maximum respondents mentioned that they take treatment either at Primary Health Centre or private hospitals.It was also found that though the people seek treatment at PHC or private hospitals, most of them take treatment till the child feels better. Most of the time, they do not complete the duration for which the medicines are given. Small villages in Mul Taluka do not have specialised health services

available at the local level. Average number of villages have primary health center, rests of the villagers have to go to neighboring village or taluka place for availing health services. Almost all people need to go to either private or government hospitals at taluka or district place in case of emergency. Mul town, as a taluka place also does not have any multi specialty hospital. In case of such situation people need to go to either Chandrapur or Gadchiroli which is a neighboring district place.

34. Awareness among the women about prenatal childcare is increasing. The percentage of the women taking advantage of ICDS services during pregnancy is found to be about 98 percent. These mothers of the beneficiaries were registered at anganwadi where they reside. They also availed the services like counseling about childcare, breast feeding, and supplementary nutrition during their pregnancy and post delivery. Still about 1.5 percent mothers could not avail the service since they live in exterior of the village. Though the percentage of such mothers looks like very small, it is necessary that each and every mother and child should be reached for universalisation of ICDS. The percentage of the mothers who availed services at AWC during pregnancy is found to be satisfactory. They have acquired immunisation service, supplementary nutrition i.e. facility of Take Home Ration, counseling service, health check up facility and health and nutrition education provided by AWW.

35. Parents are satisfied about the growth in weight, height and overall development of their children. Health and nutrition education imparted by AWW found to be useful in home feeding practice and child care for the mothers. Immunisation, eating habits, hygiene habits taught at AWC and practiced at home helps them to stay healthy

36. The objective of social and emotional development of the children in AWC is noticeable. Parents of the beneficiaries find change in the behavior of the children. The children have become social and can mix with the people. Children can participate in conversation without hesitation and can express their feelings. They can communicate with their playmates and elderly people.93.75 percent parents mentioned they the behavior of the child is changed.

37. Parents meetings are not held regularly. Since most of the people work in agriculture sector, they need to start work early morning so they are not able to attend meeting arranged at AWC, instead at the time informal visit to AWC

38. Respondents are satisfied with the treatment they receive from AWW. Anganwadi beneficiaries are satisfied with the services which they receive at anganwadi centre.

6.3 Suggestions:

Following suggestion can be drawn on the basis of the present study.

1. AWW should be offered refresher training at regular intervals.
2. Separate counseling sessions should be arranged for AWW on weekly basis. In the same manner separate sessions should be arranged for parents both fathers and mothers of beneficiaries on weekly basis to give more exposure to the services.
3. Frequency of meetings of AWW and other programs consumes time of education and health related activities of the children, so it should be reduced, so that they will be able to give more time for developmental activities for the children.
4. The AWC where supplementary food is prepared and served at AWC consumes maximum time in preparing the food and serving and making the children to sit and eat. It consumes a lot of time of AWW. Parents should be educated through rigorous campaigning about feeding practices and giving due attention to the child's intake.
5. All anganwadi should be provided with washrooms and water should be available in ample quantity.
6. All the AWC are not uniformly good in providing all services effectively. It is very important that weaknesses have to be identified and bridge the gap in order to make the services to reach the beneficiaries in all aspects without any hindrance.
7. Two distinct cadres of functionally trained workers for 0 to3 years and 3 to 6 years can efficiently take up specialised responsibilities.
8. Greater participation of women self help groups and mothers committee can enhance functions of AWCs.
9. Emphasis should be laid on changing feeding behavior –frequency, quantity, quality.
10. Parents should be educated about the regular attendance of their children at AWC.
11. Importance of household level food security should be persuaded to the parents and families of beneficiaries.
12. Enough attention should be given on educating families of beneficiaries on how to improve nutrition within the family food budget and improve child care behavior.

13. More emphasis should be given on creating general awareness about prenatal care. For that purpose emphasis should be given on the care of pregnant mothers. so along with pregnant mothers their families also should be invited for visits.

14. Though many beneficiaries disclosed satisfaction regarding supplementary nutrition, efforts should be taken to supply food with better quality and variety.

15. THR should be provided in the form of grains instead of powder.

16. Home contacts of pregnant women should be increased.

17. Introduction of professional, voluntary actions and partnership with community based organizations and voluntary agencies can improve performance and efficiency of AWC.

18. At grass root level ICDS is linked with employment issues. The people who do not have good income are not in the position to feed and take care of their children. Providing better work opportunities in rural area may result in increased child care. This problem should be addressed at policy level.

19. Rigorous monitoring and evaluation of the performance of scheme at all level can help in reducing the problems at implementation level.

20. Role of local community committee in planning and execution at village level may enhance reach of services of ICDS to needy people.

6.4 Conclusion:

From above discussion we can say that ICDS scheme plays very important role in the rural areas of Mul Taluka. Though we find few hurdles in the effective implementation of the scheme, the role it plays in the development of the beneficiaries cannot be denied. In the area like Mul taluka where people are not highly educated, belong to lower income group, have lesser opportunities for regular and fixed income, and do not have basic facilities are supported by ICDS scheme for the health, nutrition, vaccination, pre -school education in an integrated manner. In spite of such positive points the scheme should be restructured and redefined for more effective execution and universalisation of it.

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ANNEXURE-I

M.Phil Research work to be submitted to
Tilak Maharashtra Vidyapeeth, Pune

SOCIO ECONOMIC IMPACT OF INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS) ON CHILD DEVELOPMENT: WITH SPECIAL REFERENCE TO MUL TALUKA IN CHNDRAPUR DISTRICT

Questionnaire for Anganwadi Workers

A) Personal and Family Information of AWW

1) Name:

2) Age: 3) Marital status:

4) Education: 5) Caste:

6) Years of anganwadi service:

7) No of members in the family:

Sr. No.	Name	Age	Occupation	Income

8) No of children in the family enrolled in the school: _____

9) Occupation of father/husband:

1) Farmer 2) Labour

3) Service 4) Other. (Pl. specify)_____

10) Monthly income of the family:

1) Below 5000 2) 5,000 to 10,000

3) 10,000 to 15,000 4) 15,000 to 20,000

5) 20,000 to 25,000 5) above 25,000

11) Distance of anganwadi from home

1) 0 to 1km 2) 1 to 2 km 3) 2 to 3 km

4) 3 to 6 km 5) above 6 km

12) Mode of reaching to AWC

1) Walking 2) Bicycle

3) Motor cycle 4) Bus

B) Information about Anganwadi

13) Construction type of AWC:

1) Mud 2) Stone

3) Bricks 4) Cement

14) Things taught at anganwadi center:

Sr. no	Details	Yes/No	Sr. no	Details	Yes/No
1	Alphabets Marathi		6	Fruits	
2	Alphabets- Marathi		7	Flowers	
3	Number counting		8	Vehicles	
4	Animals		9	Colours	
5	Birds		10	Other	

15) Availability of educational material:

1) Yes 2) No

16) Is Supplementary nutrition served daily and in adequate quantity?

1) Yes 2) No

17) Are there any lags in payment of honorarium?

1) Always 2) Sometimes 3) Never

18) Do you like the nature of your work?

1) Yes 2) No

19) Have you acquired training for anganwadi job?

1) Yes 2) No

20) Opinion of AWW about training

1) Very useful 2) Useful

3) Good 4) Not useful

21) Are you member of union of AWW?

1) Yes 2) No

22) Opinion about need of services provided by ICDS

A) Supplementary Nutrition

1) Severe 2) Very Much 3) Little 4) Not required

B) Immunisation

1) Severe 2) Very Much 3) Little 4) Not required

C) Health check up

1) Severe 2) Very Much 3) Little 4) Not required

D) Referral Services

1) Severe 2) Very Much 3) Little 4) Not required

E) Non formal Preschool Education

1) Severe 2) Very Much 3) Little 4) Not required

F) Health and Nutrition Education

1) Severe 2) Very Much 3) Little 4) Not required

23) Do you arrange immunisation camps at AWC?

1) Yes 2) No

24) Is health check up of children done regularly in AWC?

1) Yes 2) No

24.1) Pl. Specify. _____

25) Which factors are monitored in monthly health check up at AWC?

1) Weight 2) height 3) arm measurement

4) Circumference of head 5) Teeth

26) On which of the following thing information given to parents?

1) Immunization 2) Intake of the child 3) Health of the child

4) Other. (Pl. specify) _____

27) Do you update records regularly?

1) Yes 2) No

28) Do the AWC receive timely funds from government?

1) Yes 2) No

29) In which forms the AWC receive funds?

1) Cash 2) Educational material 3) Toys

5) Other. (pl specify) _____

30) Are the funds allotted sufficient for running AWC activities efficiently?

1) Yes 2) No

31) Are any other sources of funds available to AWC?

1) Yes 2) No

31.1) if yes pl. specify._____

32) Are special efforts taken for malnourished children at AWC?

1) Yes 2) No

32.1) if yes pl. specify._____

33) Is medicine kit available at AWC?

1) Yes 2) No

34) Is Referral service provided to the beneficiary?

1) Yes 2) No

35) Is attention provided whether the child is given full treatment till it recovers?

1) Yes 2) No

36) If you have any suggestions please mention below.

_____

_____

_____

_____

_____

_____

_____

_____

C) Information about growth of the beneficiary:

1) Name of the beneficiary: _____

Sr. no.	Details/ Age	At birth	1year	2 years	3 years	4 years	5 years	6 years
1	Weight							
2	Height							
3	Arm measurement							
4	Circumference of Head							

2) Name of the beneficiary: _____

Sr. no.	Details/ age	At birth	1year	2 years	3 years	4 years	5 years	6 years
1	Weight							
2	Height							
3	Arm measurement							
4	Circumference of Head							

3) Name of the beneficiary: _____

Sr. no.	Details/ age	At birth	1year	2 years	3 years	4 years	5 years	6 years
1	Weight							
2	Height							
3	Arm measurement							
4	Circumference of Head							

4) Name of the beneficiary: _____

Sr. no.	Details/ age	At birth	1year	2 years	3 years	4 years	5 years	6 years
1	Weight							
2	Height							
3	Arm measurement							
4	Circumference of Head							

ANNEXURE-II

M. Phil Research work to be submitted to
Tilak Maharashtra Vidyapeeth, Pune

SOCIO ECONOMIC IMPACT OF INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS) ON CHILD DEVELOPMENT: WITH SPECIAL REFERENCE TO MUL TALUKA IN CHNDRAPUR DISTRICT

Questionnaire for Parent of Anganwadi Beneficiary

A) Information of Beneficiary

1) Name of the beneficiary:

2) Age: 3) Gender:

4) Weight at Birth: 5) AWC place & No:

B) Information of parent of the beneficiary:

1) Name:

2) Age: 3) Gender:

4) Marital status: 5) Education:

6) Caste: 7) Occupation:

8) Monthly Income:

C) Family Information:

9) No. of members in the family:

Sr. no	Name	Age	Relation with beneficiary	Occupation	Income

10) Number of earning members in the family:

11) Type of house:

1) Hut 2) Tin roof

3) Kaccha house 4) cement

12) Number of rooms in the house:

1) One 2) Two

3) Three 4) Four

13) Which commodities do you have at your home?

1) Television 2) Refrigerator 3) Two wheeler

4) Car 5) Gas 6) Mobile

14) Which of the following are component of daily intake of the family?

Sr. no.	Components	Regular	Sometimes	Never
1	Chapatti-bhaji			
2	Rice			
3	Dal /grams			
4	Cereals			
5	Green vegetables			
6	Fruits			
7	Eggs, meat, chicken			

D) Information about Anganwadi:

15) How far is the AWC from your home?

1) 0 to 1 km 2) 1 to 3 km 3) 3 to 6 km 4) more than 6 km

16) How do you go to AWC?

1) Walking 2) bicycle 3) motor cycle 4) Bus

17) Does the child attend anganwadi regularly?

1) Yes 2) No

18) Does the child like to go to anganwadi?

1) Yes 2) No

19) How is the ventilation system of anganwadi building? (Whether AWC is airy)

1) Yes 2) No

20) Does AWC have washroom facility?

1) Yes 2) No

21) If yes, is washroom clean?

1) Yes 2) No

22) Is sufficient water available in the washroom?

1) Yes 2) No

23) Does the AWC have availability of clean and sufficient potable water for children?

1) Yes 2) No

24) Whether supplementary nutrition is given daily and sufficient?

1) Yes 2) No

25) How is the taste of supplementary food?

1) Excellent 2) Good 3) Not Good

26) Does the child consume THR given in AWC?

1) Yes 2) No

27) Is attention given at AWC that food served is consumed wholly by the child?

1) Yes 2) No

28) Are the utensils used at AWC for serving supplementary food are clean?

1) Yes 2) No

29) Are vaccinations given regularly to the child?

1) Yes 2) No

30) Is there any tendency of frequent sickness in case of your child?

1) Yes 2) No

31) if the child is sick, where do you take treatment?

1) Home 2) PHC 3) private hospital

32) If the child is sick, do you complete the course of medicine?

1) Yes 2) No

33) Are you satisfied about growth in weight, height of the child?

1) Yes 2) No

34) Opinion about Supplementary Feeding at AWC

1) Excellent 2) Good 3) Satisfactory 4) Not satisfactory

35) Opinion about health and nutrition education service

36) Location of PHC

1) Village 2) nearby village 3) taluka place

37) Are doctors available at PHC

1) Yes 2) No

38) Did the mother of beneficiary was register in anganwadi centre during pregnancy?

1) Yes 2) No

38.1) if yes pl. mention the centre.

38.2) Services availed at AWC during pregnancy

1) Immunization 2) Supplementary nutrition 3) Counseling

4) Health checkup 5) Health and nutrition education

39) Is the beneficiary immunized at the time of birth?

1) Yes 2) No

40) Is health check up done regularly at AWC?

1) Yes 2) No

40.1) If no, pl. mention the reason.

_____

41) Is pre -school education activity conducted daily at AWC?

1) Yes 2) No

43) Is help of educational material taken while teaching?

1) Yes 2) No

44) Are toys and play material available at AWC?

1) Yes 2) No

45) Is the child able to mix with others?

1) Yes 2) No

45.1) please explore briefly about ability of the child to Participate in conversation?

_____

_____

47) Do you find change in the behavior of the child because of attending anganwadi?

1) Yes 2) No

47.1)If yes, pl. explain. _____

_____

48) Is anganwadi center punctual about its timing?

1) Yes 2) No

49) How frequently the meetings of the parents are conducted at AWC?

1) Regularly 2) Sometimes 3) Never

49.1) If Never, pl mention the reason. _____

50) How do you feel about the treatment given by AWW to child?

1) Excellent 2) Good 3) Satisfactory 4) not good

51) Are you satisfied about overall services provided by AWC to the beneficiaries?

1) Yes 2) No

52) If you have any suggestions kindly mention below.

_____

_____

_____

_____

_____

_____

_____

_____

Thank You!

ANNEXURE-III

ICDS PROJECTS IN INDIA

Sr. no	States	No of Aanganwadi	Beneficiaries SNP (6 months-6 years)	Beneficiaries PSE (3-6years)
1	Andhra Pradesh	55602	24,85,090	887707
2	Telangana	35634	1471617	518374
3	Arunachal Pradesh	6028	226323	113933
4	Assam	62153	3310885	1801441
5	Bihar	91677	9892618	2331123
6	Chhattisgarh	49963	2018755	1076149
7	Goa	1254	54192	16815
8	Gujarat	52092	3269470	1505347
9	Haryana	25962	931711	304609
10	Himachal Pradesh	18925	436807	128374
11	Jammu &Kashmir	29599	295039	300126
12	Jharkhand	38432	3337759	1234533
13	Karnataka	64558	3997286	1760253
14	Kerala	33115	699638	342843
15	Madhya Pradesh	92210	6225342	2895419
16	Maharashtra	109779	5625176	2791321
17	Manipur	9883	355176	179522
18	Meghalaya	5870	470489	213650
19	Mizoram	2244	80360	872588
20	Nagaland	3455	288747	144525
21	Odisha	71288	3823385	1549474
22	Punjab	26656	893492	330705
23	Rajasthan	60801	2781462	968244
24	Sikkim	1290	25316	11487
25	Tamil Nadu	54439	2428094	1099654
26	Tripura	9911	299116	152204

27	Uttar Pradesh	187997	18379231	7353599
28	Uttarakhand	20067	675452	198621
29	West Bengal	114781	6471698	3151562
30	Andman & Nikobar Island	720	11325	2688
31	Chandigarh	500	52265	27994
32	Delhi	10897	697158	262732
33	Dadra & Nagar haveli	302	18111	9356
34	Daman & Diu	107	6308	2643
35	Lakshadweep	107	4652	2292
36	Pondicherry	855	25162	2285
	Total	1349153	82064707	34544192

(Source: Annual Report 2016-17, WCD, page 212)

ANNEXURE- IV

Chart showing ideal Weight, Height and Head circumference as per the age of the child

Boys			Age	Girls		
Head circumference	**Height**	**Weight**		**Weight**	**Height**	**Head circumference**
cm	**cm**	**Kg**		**kg**	**cm**	**cm**
34.5	50	3.3	0	3.2	49	33.9
43.3	68	7.9	6 months	7.3	66	42.2
46.1	76	9.6	1 year	8.9	74	44.9
48.3	88	12.2	2 year	11.5	86	47.2
49.5	96	14.3	3 year	13.9	95	48.5
50.2	103	16.3	4 year	16.1	103	49.3
50.7	110	18.3	5 year	18.2	109	49.9

(Source: Village Child Development Centre guide, Rajmata Jijau Mata bal Aarogya v Poshan Mission, Aurangabad, Government of Maharashtra, pp 17)