5.0 CONCLUSIONS AND SUGGESTIONS FOR FURTHER WORK

Every research project entails a lot of work and dedication to explore and solve the underlying complication. Thus finally each and every investigation appears with its own findings and conclusions. The present study aimed to know the existing status and services of AWCs. The focus of the study was on the activities of AWCs for women and children. The following section gives the summary of findings of the present research.

5.1 SUMMARY OF FINDINGS

Objective 5.1.1 To Study the Demographic Profile of the Sample

5.1.1.1 Information related to ICDS beneficiary and non-beneficiary women

Majority of the subject (45.30%) were in the age group of 26-35 yrs followed by 44.33% women in the age group of 15 - 25 yrs and the least (10.37%) were in the age group 36 - 45 yrs.

Out of the 300 women majority of the women (37.33%) had obtained education between 1st to 5th grade and 29.34 %women were educated between 5th to 8th grade.

Majority of the women (46.00%) were working as labor, 42.33% women were non working women and only 11.67% women were engaged in self employment activities.

Out of total respondents selected for present study, 57.35% were from families having less than 5 members. Only 1.00% respondents were from families having more than 10 members.

There were 85.66% Hindus, 10.66% Muslims and only 0.68% Christians respondent in the present study.
Majority of the respondents (46.33%) were from scheduled caste, followed by backward caste women (35.00%) and the least were from upper caste (18.67%).

Majority of the respondents (45.34%) were in the families having monthly income up to Rs.3000.

5.1.1.2 Information related to children of ICDS beneficiary and non-beneficiary women

The selected 300 women had 192 children in the age range 0 to 6 years. Out of these 192 children 44.79% were in the age range 2 to 4 years, 26.56% were between 4 to 6 years and 28.65% children were up to 2 years of age. Out of these children 53.65% were male and 46.35% were female.

Objective 5.1.2 To Study the General Profile of Anganwadis

5.1.2.1 General information regarding Anganwadi centers

Place used for running Anganwadi centre: Very few AWCs in both in rural (20.00%) and slum (5.00%) areas maintained greenery. Out of the selected AWCs 40.00% of rural AWs and 60.00% of slum AWs were being run in rented accommodations. Non rented buildings were used as AWC by 5.00% slum AWs. There were same number of AWCs (60.00%) which were being operated from open space.

Number of Working days per week: Most of the Anganwadi in rural (80.00%) and slum (60.00%) areas are working for only one day every week. However 15.00% AWs in rural and 30.00% AWs in slum areas were working for two-three days every week.

Basic Facilities available in AWCs: From the present study it is clear that there is a scarcity for the basic facilities in AWCs in both rural and slum areas. No space is available in any of the AWC in rural areas and only 5.00% AWCs in slum areas have kitchen space. Only 5 (25.00%) AWCs of rural areas were having electricity
connection as compared to 9 (45.00%) AWCs of slums that were having this facility. Only 1 (5.00%) AWC in rural area and 5 (25.00%) AWCs of slums were having storage facility. Very few AWCs in rural (10.00%) and slum 6 (30.00%) areas had toilet facility. Drinking water facility was available in only 4 (20.00%) AWCs in rural areas in comparison to 7 (35.00%) AWCs in slum areas.

**Articles of general use:** Out of the 40 AWCs studied, many of them in rural (30.00%) and in slum (55.00%) were having big durries. Regarding shelves, only 10.00% and 40.00% rural and slum AWCs respectively had them. Chairs were available in only 20.00% rural and slums AWCs. Similarly 50% AWCs of slum areas had tables in comparison to only 10.00% AWCs in rural areas.

**Kitchen articles in AWCs:** Simple kitchen articles like bowls, spoons and even cooking stove were not available in many AWCs in rural areas, as well as slum area. Even availability of a simple article like bucket was low in both rural (30.00%) and slum areas (40.00%).

**Toilet articles in AWCs:** Present study shows that among the toilet articles bucket, mug, soap, brush, towel and phenyl were seen in more number of AWs of slum areas rather than AWs of rural areas. No AW in rural (0.00%) area had the supply of phenyl, and only 5% of AWCs of slums had it. Availability of soap was also poor in both slum (15.00%) and rural (10.00%) AWs. Towel was not seen in rural AWs but it was seen in one AW of slum (5.00%) area. In rural AWs (20.00%) and slum AWs (25.00%) very few were seen having bucket. Even an item like broom was seen in only 25.00% rural and 20.00% slum AWs.

**Preschool related items in AWs:** Dholak was not available in any slum and puzzles were not available in rural AWs. Only 10.00% AWs in rural and 20.00% AWs in slum had blocks. Similarly only 20.00% and 15.00% AWs of rural and slum areas respectively had slates. The other educational articles like colored balls and charts were found in less than 16.00% AWs irrespective of their locale.
Health Equipment in AWs: Only 10.00% rural and 25.00% slum AWs were having weighing machine. Medical kit was seen in only 20.00% AWs in slum and 5.00% AWs in rural areas.

5.1.2.2 Training of AWWs

Training status of AWWs in rural and slum areas: Very few AWWs of rural (0.00%) and slum (5.00%) had received training before joining. Even after joining, only 5.00% AWWs of rural and 20.00% AWWs of slum had obtained training.

Training provided to AWWs for care of pregnant and lactating women: Most AWWs of rural (20.00%) and (15.00%) slum areas were trained to provide assistance during delivery. Only 5.00% AWWs of slum and 0.00% rural were trained for post partum care.

Training provided to AWWs on health and education issues for children: Only 5.00% AWWs had been trained for taking care of health and education issues of children in AWC. In slum areas only 10.00% and 15.00% AWWs were trained for health and education issues respectively.

Training provided to AWWs on health and reproduction issues: Most (25.00%) AWWs of slums and rural areas (10.00%) reported that they had obtained training regarding preparation of supplementary food. Again very few AWWs of both rural (10.00%) and slum (15.00%) areas had obtained training regarding immunization. No AWW of rural area was trained to impart education regarding family planning and creating AIDS awareness.

Training regarding usage of health monitoring equipment: Training to use thermometer was given to only 15.00% of rural and 25.00% of slum AWWs. Similarly only 5.00% of rural and 10.00% slum AWWs were trained to use of height measuring scale. Women trained to use weight measuring scale were slightly higher for both rural (25.00%) and slum (40.00%) AWWs.
5.1.2.3 **Records Maintained by AWCs:** Six types of record registers were maintained by the AWCs. However, none of the registers were maintained by all the AWCs in rural as well as slum area. Only 25.00% rural AWCs and 20.00% slum AWCs were maintaining a staff attendance register. Many AWCs of rural (45.00%) and slum (60.00%) were maintaining the record of the child beneficiaries in the age group of 7 months to 3 years. Similarly, visit register and birth and death register were maintained by only 15.00% and 25.00% AWs in rural and slum areas respectively. Staff attendance register was maintained by only 20.00% AWs of slum areas where as this figure was 25.00% for rural AWs.

**Objective 5.1.3 To Study the Anganwadi Services for Women**

5.1.3.1 **Frequency of offered Health Services reported by AWWs**

**Distribution of supplementary nutrition:** Most of the AWWs of slum (50.00%) and rural (70.00%) areas distributed supplementary nutrition to women on a monthly basis.

**Form of Supplementary nutrition distributed to women:** Most of the rural (70.00%) and slum (50.00%) AWWs reported that they were distributing supplementary nutrition in raw form. Only 20.00% rural and 35.00% slum AWWs reported that they distributed supplementary nutrition in ready to eat form like sattu, panjiri.

**Other specific health services for women:** ANC services are provided on fortnightly basis by 15% rural AWs and 20% slum AWs, and on monthly basis of by 85% rural AWs and 80% slum AWs. Main focus of providing PNC service is on a monthly basis by all AWs of rural areas and 95% AWs of slum areas.

Frequency of distribution of IFA tablets to women in rural (100%) and slum (95.00%) areas was primarily on monthly basis. Similarly Iron tablets were also distributed on the monthly basis in all AWs of slum as well as of rural area.
Giving next immune day information to women: However present study shows the frequency of giving information regarding next immune day by Majority of AWWs in rural (85%) and in slum (70%) areas gave information of next immune day once in six months. Very few AWWs in rural (5%) and slum (10%) reported that they never informed the women about them next immune day.

Weight monitoring of pregnant women: Very few AWs (15.00%) in slum and even fewer AWs (5.00%) in rural areas monitored the weight of pregnant women on a monthly basis. Similarly, 30.00% slum and 15.00% rural AWWs monitored the weight of pregnant women once in three months.

Inspection of mouth, eyes and nails of pregnant women: Monthly mouth inspection was done in 10.00% AWs in rural and 20.00% AWs in slums. Most of the AWWs in rural (65%) and slum (70%) areas reported performing this inspection once in six months. Again, very few AWWs in rural (15%) and slum (20%) areas reported that eyes and nails inspection was done once in a month. Most of the AWWs in rural (55%) and slum (75%) were inspecting nails and eyes once in three months.

5.1.3.2 Services Obtained from AWs reported by Beneficiary

Pregnant and lactating recipients of supplementary nutrition: Out of the total pregnant women 30.00% in rural areas were availing supplementary nutrition services as compared to 23.75% women doing so in slum areas. Out of the total lactating women 22.85% in rural areas and 32.85% women in slum areas were getting supplementary nutrition. Insignificant association was observed for rural and slum status and obtaining supplementary nutrition by pregnant women ($\chi^2=0.33$) and lactating women ($\chi^2=0.03$).

Supplementary nutrition items distributed to women by AWCs: Supplementary nutrition was given in the form of sattu by 73.00% rural and
81.00% slum AWs. Khichari is also given by 33.00% AWs in rural areas and 29.00% AWs in slum areas. Other items like pohaa, dalia, matar, chana, lai and ramas are given by very few AWs in rural and slum areas.

5.1.3.3 Frequency of getting important information from AWWs

Immunization day and ANM visit: Out of the total beneficiaries 42.66% in slum and 40.00% in rural areas reported that they had obtained information of immunization day only once in last 6 months. Only 20.00% rural and 25.33% slum respondents reported that information regarding immunization day was given three to four times in the last six months. Insignificant association was observed between frequency of informing women regarding immunization day and the location of AWs ($\chi^2=1.82$).

As many as 42.66% slum and 41.33% rural respondents reported that information of ANM visit was given only once in last six months by AWCs. Again 12.00% rural and 8.00% slum respondents reported that no information was given to them regarding ANM visit in last six months.

5.1.3.4 Frequency of imparting knowledge to women by AWWs

Imparting Knowledge regarding Reproductive health & balanced diet: Most of the rural (61.33%) and slum (38.66%) respondents reported that knowledge regarding reproductive health was not imparted even once during home visit in last six months. Respondents of rural (28.00%) and slum (38.66%) areas also reported that knowledge regarding reproductive health was imparted only once during home visit in last six month. Thus low frequency of imparting knowledge regarding reproductive health was seen in rural areas whereas frequency of imparting knowledge regarding reproductive health was significantly higher in slums ($\chi^2=8.373$).

Similarly trend has been observed regarding imparting knowledge of balanced diet. A large number of beneficiaries in (72.00%) rural and (62.66%) slum areas
reported that no knowledge was imparted regarding balanced diet during home visit in last six months. Followed by 22.66% rural and 30.66% slum beneficiaries who reported that knowledge was imparted regarding balanced diet only once during home visits in last six months. Insignificant association was observed between frequency of imparting knowledge regarding balanced diet and location of AWs ($\chi^2=1.49$).

**Imparting knowledge regarding ANC & PNC:** In rural (53.33%) and slum (45.33%) areas most of the respondents reported that no knowledge regarding ANC was given during home visit in last six months. Few beneficiaries in rural (33.33%) and slum (38.66%) areas reported that knowledge regarding ANC was imparted only once during home visits in last six month. Again, very few rural (13.33%) and slum (16.00%) beneficiaries reported that knowledge was imparted regarding ANC two to four times during home visits in last six month. Chi square was calculated to find the association between frequency of imparting knowledge regarding anti natal care and location of AWs which was found to be insignificant ($\chi^2=0.96$).

Similarly many beneficiaries in rural (60.00%) and slum areas (45.33%) reported that no knowledge was imparted regarding PNC during home visit in last six months. Again 29.33% rural and 38.66% slum beneficiaries reported that knowledge was imparted regarding PNC only once during home visits in last six months. The frequency of imparting knowledge regarding post natal care was insignificantly associated with the location of AW ($\chi^2=3.29$).

**Imparting knowledge regarding family planning:** Only 28.00% rural and 37.00% slum beneficiaries had not received knowledge regarding family planning during home visit in last six months. Many beneficiaries of rural (44.00%) AWs reported that knowledge was given regarding family planning only once during home visits in last six months. Again, 28.00% rural and 33.00% slum beneficiaries reported that knowledge was given regarding family planning two to four times during home visits in last six months.
Imparting knowledge regarding breastfeeding and child care: Most of beneficiaries of rural (45.33%) and slum (37.33%) areas reported that no knowledge was given regarding breastfeeding during home visits during last six months by AWWs. On the other hand 34.66% rural and 40.00% slum beneficiaries reported that knowledge regarding breastfeeding was imparted only once during home visit in the last six months. Again, 20.00% rural and 22.66% slum respondents reported that knowledge regarding breastfeeding was imparted only two to four times during home visits in last six month. There is insignificantly association between frequency of imparting knowledge regarding breast feeding and the location of AW ($\chi^2=0.99$).

Many respondents in rural (55.66%) and slum (42.66%) areas reported that during the last six months knowledge was not imparted regarding childcare even once during home visits. Only 29.33% of rural and 41.33% of slum respondents reported that knowledge regarding child care was given in home visits only once during the last six months. There is insignificant association between frequency of receiving knowledge regarding child care and location of AW ($\chi^2=2.63$).

Obtaining knowledge on child health issues in mahila mandals: Insignificant association was observed between rural and slum status of beneficiaries with frequency of imparting knowledge of immunization by mahila mandals ($\chi^2=1.48$).

Frequency of discussions on health & hygiene by AWWs in mahila mandals was significantly higher to rural area as compared to slum areas ($\chi^2=11.52$).

The frequency of imparting knowledge regarding neonate care by AWWs in mahila mandals was significantly higher in AWs situated in slums in comparison to those situated in rural ($\chi^2=34.62$) areas.

Obtaining information of child care issues in mahila mandals: The frequency of imparting knowledge regarding health education by mahila mandals was
significantly higher in AWs of slum areas in comparison to those of rural areas ($\chi^2=17.61$).

The frequency of imparting nutrition education by mahila mandals by AWWs of slum areas was significantly higher in comparison to that of rural areas ($\chi^2=16.70$).

No significant association was found between rural and slum domicile status and frequency of imparting education regarding breast feeding in mahila mandals by AWWs ($\chi^2=5.23$).

**Objective 5.1.4 To Study the Anganwadi Services for Children**

**5.1.4.1 Frequency of Health Services for Children reported by Anganwadi Workers**

**Distribution of supplementary nutrition to children:** The task of distribution of supplementary nutrition to children by most AWs was performed either on fortnightly (40% in rural and 35% in slum) or monthly basis (50% in rural and 35% in slum).

**Weight and height monitoring of children:** Most of the AWs of rural (95%) and slum areas (80%) recorded the weight of children on a six monthly and three monthly bases respectively.

**Inspection of mouth, eyes and nails of children:** Very few AWs in rural (10%) and slum (5%) areas were performing monthly inspection of mouth. Most of the AWs in rural (85%) and slum (65%) areas reported doing inspection of mouth once in six months.

Similarly the frequency of eye and nail inspection by 45% rural and 45% slum AWs was done once in three months. However 25% rural and 35% slum AWs were performing this task on monthly basis. Where as 30% rural and 20% slum AWs did it only once in six months.
5.1.4.2 Frequency of Health Services received for Children reported by Beneficiaries

Distribution of supplementary nutrition to malnourished children: Out of the total number of children of selected women in rural (58) and slum (48) areas, sixteen children in rural area and nine children in slum area were identified as malnourished, according to the centre records. Very few malnourished children in rural (37.50%) and slum areas (44.44%) were obtaining supplementary nutrition.

Recipients of supplementary nutrition in AWCs: Insignificant association was obtained between the status of availing supplementary nutrition and age of the child in both rural and slum areas age group of 7 month to 3 year ($\chi^2=0.25$) as well as age group 3-6 years ($\chi^2=0.06$).

5.1.4.3 Frequency of Preschool Services for Children reported by Anganwadi Workers

Play and non formal education activities: Most of the AWs in rural (85%) and slum (70%) areas reported that play activities were organized once in a month. Similarly, for non formal education activities, it was reported that 70% AWs in rural and 60% AWs in slums organized non formal education activities once in a month.

Academic activities of AWCs: Number work activity was done by maximum number of rural (45.00%) and slum (60.00%) AWs. Similarly reading work was done by 20.00% children in rural AWs and 35.00% children in slum AWs. Knowledge of animal and their sounds was given by 15.00% AWs in rural and 35.00% AWs in slums. Other activities like writing, giving knowledge of colour, shapes, body parts and fruits were organized in very few AWCs.

Craft activities for children in AWCs: From the results it is evident that sculpturing was done by children in 80.00% rural and 50.00% slum AWCs. Craft
activities like cutting and pasting & drawing and painting was not done by most AWCs in both rural and slum areas.

Physical activities for children in AWCs: Only 20.00% AWs in rural and no AW in slum area reported having individual games for children. Physical exercises in rural AWs (5.00%) and group games in slum AWs (5.00%) got identical focus.

Other pre-school activities in AWCs: Story telling was done by 30.00% AWs of rural area where as morning prayers (10.00%) and singing (10.00%) were the activities done by least number of AWs of rural area. On the other hand 30.00% AWs of slum areas had the puzzle related activities in their program with children. Morning prayers (20.00%), singing (25.00%) dancing (20.00%) and storytelling (20.00%) were the other activities reported being done by few AWs of slum areas. Organization of dancing activity was done in fewer AWCs, in rural (5.00%) areas in comparison to AWCs in slum (20.00%) areas.

Audio visuals used for imparting education to children in AWCs: Out of the different teaching aids, the use of black board was done by maximum AWs in both rural (30.00%) and slum (55.00%) areas. The use of charts was however done by fewer AWs in both rural (10.00%) and slum (25.00%) areas.

Celebration of special days in AWCs: The study shows that children’s day was celebrated in 10.00% rural 25.00% slum AWs. Not a single AWC in rural area was celebrating Annual day. Even in the slum areas the celebration of Annual day was done by only 5.00% slum AWs.

Objective 5.1.5 To Study the Health Services availed by non beneficiary women and children

5.1.5.1 Health Services taken by non beneficiary women from alternate sources

Weight monitoring of pregnant non beneficiary women: In rural areas 55.33% women did not have their weight monitored even once during pregnancy. There
was almost same number of women who had got their weight recorded on a monthly (13.33%), three monthly (12.00%) or six monthly (19.33%) basis.

In case of slum women again, 15.33% were not weighed even once during their pregnancy. However 39.33% women had been weighed on a three monthly basis. Clearly the weight monitoring in the slum non beneficiary women was better than the counterparts.

**Mouth, eyes and nails inspection of pregnant non beneficiary women**

Mouth inspection of pregnant non beneficiary women was not done even once in case of 73.33% women of rural areas, and 57.37% of women in slum areas. In case of rural women this was done on a monthly basis in 2.66% cases, inspection on a three monthly basis was rare as most were getting it done only once in six months (17.33%), that is to say only once in the pregnancy period.

Similarly the inspection of eyes and nails of pregnant women was reported to not having been done even once by 85.33% women of rural area and 65.33% women of slum area. The picture in this case is also quite similar as the case of oral inspection. The frequency of eyes and nail inspection was once in three months in case of 20.00% slum women and 2.66% rural women.

**5.1.5.2 Health Service Taken by Non Beneficiary Children**

**Weight and height monitoring of children:** Most subjects of rural areas did not get the body weight of their child monitored even once. A large number of children from rural areas were getting their children weighed on a six monthly basis (16.07%). Most women of slum got their child’s weight recorded on a six monthly basis (13.33%). There were only 16.67% women who did not get their child’s weight recorded even once in 6 months. Other women reported that it was recorded on a monthly basis (10.00) or three monthly (60.00%) basis.
As regards the frequency of height monitoring, the height of 39.28% children of rural was not recorded even once in six months. Most children (37.50%) in rural area had been monitored for gain in height on a six monthly basis.

Again, 36.66% children of slums were those whose height was not recorded even once in 6 months. There were only 23.34% children whose height was recorded on a monthly basis.

**Mouth, eyes and nails of children:** Most of the women (66.07%) of rural areas did not get the mouth inspection of their child even once in 6 months. Majority of the children from rural areas were getting their mouth inspection on a six monthly frequency (19.64%).

In slum area also only 30.00% women did not get the oral inspection of their child done even once in 6 months. Many women reported that it was recorded on a three monthly basis (20.00%) or six monthly (46.67%) basis.

As regards the inspection of eyes and nails, most of the women (57.14%) of rural areas did not get the eyes and nails inspection of their child even once. Only 3.57% women of rural areas reported that they were getting the eyes and nails inspection of their child done once in a month. Other women reported that it was done on a three monthly basis (16.07%) or six monthly (23.21%) basis.

In slum areas again, most of the women (46.67%) of slum areas did not get the eyes and nails inspection of their child done even once. Other women reported that it was recorded on a monthly basis (16.67%) or six monthly (16.17%) or three monthly (20.49%) basis.

**Objective 5.1.6 To Study the Maternal Services availed by Beneficiary and Non-beneficiary Women**

**5.1.6.1 Maternal Services availed by women**
Place of delivery of beneficiary and non-beneficiary women: The beneficiary women who were having their delivery done in hospital (46.00%) are less than those having their deliveries done at home (54.00%). However, distribution of non-beneficiaries according to their place and delivery, which may be either in hospital (50.67%) or at home (49.33%) is almost equal.

Persons conducting birth delivery: Most beneficiary women had their delivery done by trained person, that is by a doctor (21.66%) or dai (21.00%). Similarly in case of non beneficiary women most deliveries were conducted by a trained person, that is either by a doctor (27.00%) or by a trained dai (17.00%). Taking the service of trained or untrained personal for delivery for child was insignificantly associated with the beneficiary and non beneficiary status of respondents ($\chi^2=3.42$).

ANC services availed by ICDS beneficiary and non-beneficiary women: The obtained $\chi^2$ value of 20.14 indicates that higher frequency of ANC was associated with non beneficiary status of women.

Reasons for not availing antenatal care: Permission of family is an important barrier for not receiving ANC mentioned by 69.49% beneficiary women and 72.91% non beneficiary women. Few beneficiary women (22.03%) as compared to 41.66% non beneficiary women do not feel the need of ANC. Transportation difficulty was declared as an obstacle by 47.45% beneficiary women and 37.50% non beneficiary women. many beneficiary (23.73%) and non beneficiary (87.50%) women rationalize their non acceptance of ANC by saying that it is expensive. Non availability of female health worker was also one of the reasons suggested by 74.57% beneficiary women and 60.41% non beneficiary women. Other reasons which included laziness, carelessness were given by 20.33% beneficiary women and 39.58% non beneficiary women.

PNC services availed by ICDS beneficiary and non-beneficiary women: The study shows that 26.00% beneficiaries and 27.33% non beneficiaries had not
availed any kind of PNC service in their previous pregnancy. Beneficiary and non-beneficiary status of women and frequency of availed PNC services are insignificantly associated ($\chi^2=0.82$).

**Regular attendance in health camps:** Beneficiary women (38.66%) were more regular in attending health camps in comparison to their counterparts (8.00%). Thus beneficiary and non beneficiary status of women was significantly associated with attendance in health camp ($\chi^2=113.36$).

**Women getting regular supply of poshahar during pregnancy:** The slum domicile status was significantly associated with receiving regular poshahar as evident from $\chi^2$ value 4.52 which is significant at .05 level.

**Reasons for non-receipt of regular poshahar by beneficiary women:** Most of the rural (24.13%) and slum (34.78%) beneficiaries found that food items were not tasty and therefore, did not take it. Lack of variety was also stated by rural (20.68%) and slum (23.91%) women for not taking the poshahar regularly. Another reason for not taking poshahar was its poor quality as stated by 20.68% rural and 26.08% slum beneficiaries.

**Number of beneficiary and non-beneficiary women vaccinated for tetanus during pregnancy:** Number of non beneficiaries receiving TT vaccination during pregnancy was significantly higher in comparison to beneficiaries ($\chi^2=32.26$).

**Reasons for not taking TT shots:** Safe delivery of baby without taking TT vaccine was stated as a reason for not taking TT shot by 24.53% beneficiary women and 54.38% non beneficiary women. Family restriction faced by 21.70% beneficiary women and 28.07% non beneficiary women was also another reason for this. Other reasons like lack of time, extra work load, carelessness were given by 11.32% beneficiary women and 22.80% non beneficiary women.

**Consumption of iron folic acid tablets during pregnancy:** The study shows that 36.00% beneficiary women had taken iron folic acid tablets in their last pregnancy.
in comparison to only 26.66% non beneficiary who did so. Consumption of iron folic acid tablet during pregnancy was done by significantly more beneficiary women as compared to non beneficiary women ($\chi^2=11.17$).

**Reasons for not taking IFA:** Earlier delivery of healthy babies without taking IFA tablets was the reason of not taking IFA by 38.09% beneficiary women and 25.71% non beneficiary women. Lack of knowledge of its purpose was found as a reason in 80.95% beneficiary women and 40.00% non beneficiary women. Other family members of 76.19% beneficiary women and 38.57% non beneficiary women also discourage them to take IFA during pregnancy.

**5.1.6.2 Post Maternal Services for Mothers**

**Pre-lacteal feed given by ICDS beneficiary and non-beneficiary women:** The beneficiary and non-beneficiary status of women was significantly associated with pre lacteal feed given ($\chi^2=10.54$).

**Duration of breast feeding practiced by ICDS beneficiary and non-beneficiary women:** Insignificant association was observed between beneficiary and non beneficiary status of women and duration of breastfeeding ($\chi^2=2.56$).

**Number of beneficiary and non-beneficiary women who got the birth weight of their child recorded:** There was no association between recording of birth weight and beneficiary and non beneficiary status of women ($\chi^2=1.58$).

**Reasons for not getting birth weight recorded:** Most of the (41.66%) beneficiary women and (81.81%) non beneficiary women expressed that superstitions / belief stigma was reason for not getting the birth weight of their baby recorded. Again 52.78% beneficiary and 95.46% non beneficiary women reported that non availability of weighing machine was the reason for not getting the birth weight of their child recorded.
ICDS beneficiary and non-beneficiary women according to status of feeding colostrums: The obtained $\chi^2$ value indicates that beneficiary status was significantly associated with feeding of colostrum to infants ($\chi^2=15.47$).

Reason for not giving colostrum to infant: Most of the beneficiary women (42.50%) and non beneficiary women (54.39%) reported that their family members did not allow them feed colostrums to their child. Again, 30.00% beneficiary women and 40.35% non beneficiary women expressed that superstitions/belief stigma is the reason for not giving colostrum to their babies. Few women (22.50% beneficiaries and 31.52% non beneficiaries) reported that the reason for not giving colostrum to the baby was that it could be hard to digest for infants and could cause digestive problem.

5.1.6.3 Utilization of Immunization Services by Children among Beneficiary and Non beneficiary Respondents

In the children of age group, birth to one and half months, most children had received polio vaccination and the dropout rate was 6.60% only in the beneficiary group. However this dropout rate was higher in non beneficiary group (20.93). In this age group vaccination for Hepatitis –B1 was very low. Consequently dropout rates were also highest for this vaccine which was 81.13%, for beneficiary group and 88.37% for non beneficiary group.

Similarly, pattern of vaccination was seen for children between one and half –two and half months. Whereby the dropout rate was lowest for polio vaccine and highest for Hepatitis –B2 for both beneficiary and non beneficiary respondents.

Again in the children of age group, two and half - three and half months, most of the children had received polio vaccine and the dropout rate was 14.86% in the beneficiary group as compared to 16.90% drop out rate of non beneficiary group. Dropout rate was highest for Hepatitis –B3 which was 83.78% for beneficiary group and 91.54% for non beneficiary group.
Conclusions And Suggestions for Future Work

The dropout rate of children for immunization for measles was 84.28% in beneficiary women and 90.32% in non beneficiary group.

Regarding polio booster and syrup of vitamin A in the age group of 24 months – 36 months the dropout rate of beneficiary group was lower than that of non beneficiary children.

**Objective 5.1.7 To Study the Nutritional Knowledge of Women**

**Nutritional Knowledge of Beneficiary and Non-Beneficiary Women:** Nutrition knowledge of women was significantly more among the beneficiary women in comparison to non beneficiaries women (z= 3.92).

**Differential nutritional knowledge of women according to age, educational level and maternal status:** From the study it is evident that the nutritional knowledge of beneficiary women below 30 years of the age was almost similar to that of the non beneficiary group t = 0.65. However in the women above 30 years of age, the beneficiary women (15.25) have scored higher than their counterpart (12.90) on nutrition knowledge. This difference is significant as the obtained t value 2.80 is significant at 0.01 level.

The study shows that the nutritional knowledge of pregnant beneficiaries (17.09) was similar to pregnant non beneficiaries (16.27) as the obtained t value is insignificant (0.90). Similarly, nutrition knowledge of lactating beneficiaries (13.08) and lactating non beneficiaries was similar as is evident from the insignificant t value (0.34).

The beneficiary (13.09) and non beneficiary (12.28) illiterate women have no significant difference in the nutritional knowledge. This is further indicated by the insignificant t value (.76).

Again, a comparison of nutrition knowledge scores of literate beneficiaries (17.31) and non beneficiaries (16.89) also shows no difference on this aspect, as the obtained t value 0.88 is insignificant.
Differential knowledge regarding breast feeding in women according to occupation, family income and family pattern: The beneficiary (16.67) and non beneficiary (17.03) working women have almost similar nutritional knowledge as the obtained t value .62 is insignificant.

In contrast, the beneficiary non working mothers (15.11) have recorded higher score on nutritional knowledge in comparison to non beneficiary non working women (13.60). The obtained t value 2.18 is significant.

The obtained t value 3.18 shows that the nutritional knowledge of beneficiary women (14.51) from families with monthly income below Rs.6000 was higher than that of non beneficiary women (13.17) of the same income group.

However in case of women from families where monthly income was above Rs. 6000, there was no difference in nutrition knowledge of beneficiary (17.25) and non beneficiary group (18.00), as the obtained t value of 0.54 is insignificant.

Among the women of joint family it was found that the nutrition knowledge of women of beneficiary group (16.08) was higher than that of non beneficiary group (14.36) which is also evident from the t value (2.12), which is significant. However among women of nuclear families the beneficiary women (18.05) were having similar nutritional knowledge as non beneficiary women (17.84) as is also evident by the insignificant t value 0.41.

Objective 5.1.8 To Study the Breast Feeding Knowledge of Women

Knowledge Regarding Breast Feeding Among Beneficiaries and Non-Beneficiaries Women According to Area: In the rural area, knowledge regarding breast feeding was found to be significantly higher among the beneficiaries as compared to non beneficiaries (Z=4.05). In the slum area knowledge regarding breast feeding was found to be significantly higher among the beneficiaries as compared to non beneficiaries (z=5.74).
Difference in the mean score of knowledge regarding breast feeding shows significantly more knowledge among the beneficiary women \((z=6.87)\) as compared to their counterpart.

**Differential knowledge regarding breast feeding in women according to age, maternal status and educational level:** In the women below 30 year of the age, the knowledge regarding breastfeeding of the beneficiary group (13.11) was higher than that of non beneficiary group (11.97). This is also evident by the \(t\) value which is significant (2.35).

Similarly, among the women above 30 years of age, the beneficiary women (12.93) have scored higher on knowledge regarding breastfeeding in comparison to non beneficiary women (11.27). Again, this difference is also significant as the obtained \(t\) value 3.16 is significant at 0.01 level.

When knowledge of mother regarding breastfeeding was compared on the basis of their maternal status it was found that the difference in the knowledge of breastfeeding of pregnant women of beneficiary group (12.68) and non beneficiary group (12.02) was similar which is evident by the obtained \(t\) value 0.96.

However in case of lactating women, the women of beneficiary group (13.19) had significantly higher knowledge regarding breastfeeding than their counterparts (11.99) as the obtained \(t\) value (2.70) is significant.

The beneficiary (11.68) and non beneficiary (10.84) illiterate women have no significant difference in the knowledge, regarding breast feeding as indicated by the insignificant \(t\) value 1.27.

Again, literate beneficiaries (13.03) and non beneficiaries (12.46) also show no difference on this aspect as the obtained \(t\) value 1.56 is insignificant.

**Differential knowledge regarding breast feeding in women according to occupation, family income and family pattern:** Among working women, the
beneficiary women (12.39) had scored higher than the non beneficiary women (11.10). The obtained t values 2.38 is also significant which shows that women of working status having significantly higher knowledge regarding breastfeeding than their counterparts. However, this was not so among non working women. In this group the women of beneficiary status (13.11) show no difference in their knowledge regarding breastfeeding from their counterparts as the obtained t value (1.80) is insignificant.

In case of women from families where monthly income was below Rs 6000, there was no difference in knowledge regarding breastfeeding of beneficiaries (11.34) and non beneficiaries group (10.90), as the obtained t value of 1.20 is insignificant.

Again among the women from families where monthly income was above Rs 6000, there was no difference in breastfeeding knowledge of beneficiary (12.25) and non beneficiary group (11.65), as the obtained t value of 0.47 is insignificant.

Among the women of joint family there was no difference in the breastfeeding knowledge of beneficiaries (10.90) and non beneficiaries (10.23) which is also evident from the t value (1.23) which is insignificant.

However, when women of nuclear families were compared it was found that the beneficiary women (12.90) were having significantly more knowledge regarding breastfeeding than non beneficiary women (11.34), which is also evident by the significant t value 3.15.

5.2 LIMITATIONS OF THE STUDY

In any research work it is not possible to attain perfection, more so in social research because human being is a complex organism. A number of factors affect his behavior and it is not possible to study all of them. The present research work is no exception and has the following limitations:-

✓ The study has been carried out in Agra city hence only locale based generalizations can be drawn.
The study is conducted only on pregnant & lactating women and their children.

Although the researcher has studied the service availed by beneficiaries yet no attempt has been made to draw the effect of these services on beneficiaries.

The study has not assessed the differences in PSE obtained by non beneficiary children. The primary reason for not doing so was that the children were studying in schools of diverse nature (Government schools, Private Schools, Nagar Palika Schools, Taking private tuition and not going to school) hence a common ground for deriving comparisons was difficult to establish.

5.3 IMPLICATIONS OF THE STUDY

Certain implications can also be derived from the finding of the present investigation which are:-

AWWs have undergone training during this study. They have been trained for preparation of weaning food, making educative tools using indigenous material and ANC services that must be given. This workshop can prove to be useful to AWWs to perform their duties in a better way.

The study gives the information about the services the children and women are availing and also the reason for not availing the services. This information can prove beneficial for improving strategies to ensure better implementation of ICDS services.

The present study assessed the knowledge of women regarding nutrition and breastfeeding. The results give an idea of the gaps in knowledge which can be helpful to identify areas of knowledge that are needed to be strengthened to improve implementation strategies.
Adequate infrastructural facilities are a pre-requisite for successful implementation of any program. An effort has been made to assess the availability of infrastructure in AWCs through this study. This finding of the present study has been able to identify specific infrastructure needs of the AWCs for successful implementation of ICDS program.

5.4 SUGGESTIONS AND IMPLICATION BASED ON THE RESEARCH FEEDINGS:-

1- Anganwadi workers require extrinsic motivation to perform. Some type of recognition at state level /district level may be able to boost their morale and improve conscientiousness towards their work. Perhaps some increase in perks is also required although the researcher is in no capacity to say so.

2- Home visits were done by AWWs but it seems that the focus often drifted to casual conversations whereby they failed to inform the beneficiaries about health camps or to impart, nutritional education. The need to keep in mind the focus on the objective of home visit needs to be emphasized.

3- Low cost material that is locally available can be used for development of play and education material. This needs to be emphasized to reduce the cost and enhance the quality of preschool education.

4- A lack of variety in AW activities was clearly seen. It would be a good idea to identify willful creative workers, mother or volunteers who could be ready to participate in the conduct of program. There are many women who enjoy the position of authority to boost their ego the only difficulty is to identify them. Since AWWs have a good rapport with local public this is not an unachievable task.

5- Of course lack of space was very clear in the AWs visited. Well organized placement of articles having specific place for each type of activity can make the AWs more organized and functional.

6- The AWWs seldom displayed the work of children. This can be motivating for the children as well as AWWs. Involvement of the women folk in
preparation of supplementary nutrition could make it easy for AWWs in addition to making the supply regular.

7- It is a good idea to keep the area within the AW clean, but the cleanliness of the surroundings should also be attended to, there is the need to emphasize it.

8- Proper seating arrangement in AWs for children, workers and mothers needs to be emphasized and ascertained.

9- There was a shortage of resources, the AWWs should focus on building up the resources over the period of time. There may be many local agencies willing to do so. Lions club and Rotary club have done so in the past. The AWWs should able to generate resources through such agencies.

10- Dropout rate for immunizations was very high. The AWWs need to educate women regarding its importance which can be done during home visits or doctor’s visit. If AWWs draw out a plan of the themes of education on a weekly basis or monthly basis, no area would be neglected.

11- Before proceeding for home visits the AWWs must remind herself about the primary objective of the day so that she is that she able to deliver the services and not indulge in informal conversations.

12- Regular monitoring and evaluation can improve the performance.

13- The AWWs may be asked to fill the self assessment forms. This will make them aware about their performance quality.

14- One day in a month may be earmarked when the AWWs may take the suggestions of beneficiaries for improvement of services.

15- The training program should strengthen the focus on systematic organization of AW space. This will help make AWs more organized and functional.

16- The motivation of AWWs needs to be enhanced and ICDS needs to think very seriously on this.

**5.5 SUGGESTIONS FOR FURTHER RESEARCH**
Research is an ongoing process. Therefore, the investigator does not claim that findings in the present study are final. Suggestions for further research in this area are as below

- This study is restricted to Agra district only. Since it is a national program the service delivery nature in other parts country can be studied and comparisons can be made. This will help to optimize the service delivery system of the scheme.

- A further study on adolescents, married women (not only pregnant and lactating women) can give useful information.

- Intervention study to raise the awareness of the beneficiaries regarding the services they should expect from ICDS will be a useful study as it will empower them to demand for their rights.