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Study of Service Provisions of Anganwadi Workers (AWWs) and Views of Mothers about Integrated Child Development Services (ICDS) Scheme

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ABSTRACT

ICDS Scheme is the national flagship programme of Government of India started in 1975 to deal with the issues of malnutrition and infant mortality in the country. Children up to six years of age, the expectant, lactating mothers and adolescent girls are the beneficiaries of this programme. The present study was done to study the service provisions of Anganwadi Workers (AWWs) under ICDS scheme and the views of mothers who registered their children under six years of age at Anganwadi Center under the scheme in comparison between rural and urban areas. Since the programme is in operation from last four decades, this huge service need to be relooked about its objectives and achievements for improvement in the nutritional and health status of women and children in the country.

To attend the objectives researcher interviewed AWWs and the mothers through interview schedule, SERQUAL scale. The present study discusses different aspects of unequal distribution of services provided under the programme to different strata of society. The outcome of the study provides suggestions for making the programme effective pointing towards the findings that indicates lacuna in the programme.

Keywords: Integrated Child Development Services (ICDS) scheme, *Anganwadi workers* (AWWs), Mothers

INTRODUCTION

The provision of services provided to women and children belonging to the lower strata of society are the biggest challenge in India as these sections of population are vulnerable and mostly the victims of exploitation and abuse. They have been deprived from the facilities like health and nutrition, education etc. which are their felt needs. India is having largest number of children in the world, under 6 year age group i.e. 440 million. Every year around 1.8 million children under the age of five years die and 68000 mothers die during pregnancy (Paul, et al., 2011). A child's educational attainment depends upon health status by having protection against ill heath and thus increases the chances of employment and sufficient income (Marmot & Wilkinson, 2006). Among the vulnerable groups in the society, women and children are mostly

the victims of exploitation and abuse in India. Especially the rural population and the peoples living in slums in urban areas are most vulnerable due to their poor economic conditions, illiteracy and deteriorated livelihood resulting that they face the problem of unavailability of civic amenities and health care facilities. Government of India has taken several initiatives for development of women and children through different programmes and policies.

ICDS scheme was started on 2nd October 1975 by Government of India for improvement in maternal and child health through the frontline honorary workers called as *Anganwadi workers (AWWs)* at the focal point of delivery of services at *Anganwadi Centre (AWC)*. It is the national programme for children in India run under the Ministry of Women and Child Development. ICDS scheme has the objective of improving the nutrition and health status of children up to 6 years of age. To achieve this objective, supplementary nutrition, immunization, health checkup and referral services are provided to children below 6 years of age and expectant and nursing mothers. Non formal pre-school education is imparted to children in age group of 3-6 years. Other than this, nutrition and health education is imparted to women in the age group of 15-45 years and adolescent girls of 11-18 years of age. Out of the total population of children under six years, 48% children covered under ICDS scheme that constitute around 75.7 million children (Ministry of Women and Child Development, 2010-11). Currently the programme covers 1032.31 lakh beneficiaries which include 841.49 lakh children (up to 6 years of age) and 190.82 lakh pregnant and lactating mothers. Presently there are around 7067 projects and 14 lakh *AWCs* operational all over the country (Ministry of Women and Child Development, 2010-11). The budget allocation for the project by the ministry during the 12th five year plan is 1, 23,580 crores (Ministry of Women and Child Development, December 2011).

AWWs are service providers who are working atleast from last one year in *Anganwadi Centres (AWC)* and mothers are service seekers who have children under the age group of six years were included in the study. The focal point of delivery of services provided under ICDS scheme is *AWC* which is a courtyard play centre located within the village or urban slum. It is necessary to look at the quality of all the services provided under ICDS scheme from the perspective of service seekers and service providers. Simultaneously an understanding of women and child statistics from different socio-economic perspective and coordination of all the welfare programmes and their implementation at ground level is required. It will contribute to look at the paradox in ICDS scheme for improvement in maternal and child health related issues. The article introduces women and child development services in India especially in the matter of health in the pre and post independence period, statistics relating to child and maternal health, ICDS scheme at a glance and coordination of ICDS scheme functionaries with other programmes and government bodies.

The present study is exploring the awareness of *AWWs* about the services provided by them under ICDS scheme and the expectation and involvement of mothers in acquiring services provided under the scheme.

CHILD DEVELOPMENT SERVICES IN INDIA

According to the report of the working group on child rights for the 12th five year plan (2012-17), India has the largest child population in the world. According to 2011 census, India has

158.7 million children in the age group of 0-6 years. Since after independence, Government of India have taken initiative for development of children. Department of women and child development was set up in 1985 as a part of Ministry of Human Resource Development. From 2006, the Department has upgraded to a Ministry of Women and Child Development. It is the nodal ministry to look after the needs of women and children. The ministry coordinates through its autonomous organizations and provides grant-in-aid to non-governmental organizations working for women and child development. In the constitution, provisions have laid down for care and protection of children. United Nations Conventions for the Right of Child (UNCRC) was adopted in 1953. Several policies have been formulated like National Policy for Children (1974), National Policy on Education (1986), National Policy on Child Labour (1987), National Nutrition Policy (1993), National Health Policy (2002), National Plan of Action for Children (2005), Early Childhood Care and Education (ECCE) Policy etc. Looking at the perspective of development of children in the early years of their life and pregnant and lactating mothers, Government of India launched Integrated Child Development Services (ICDS) scheme on 2 October, 1975. According to UN convention on the right of child, all children have certain rights including the right to health, nutrition, education, care and protection. Education of children has an inter-generational impact on poverty (Ramachandran & Patni, April 2009). Early childhood care and education is prioritized among six 'education for all' goals to be achieved by 2015.

STATISTICS RELATING TO CHILD AND MATERNAL HEALTH

In India, 1.83 million children die annually before 5 years of age. Inadequate sanitation, unsafe water supply and poor personal hygiene are responsible for 88% of children deaths occurring from diarrhea (Onis, Brown, Blossner, & Borghi, 2014). Under five Mortality Rate (U5MR) and Infant Mortality Rate (IMR) are best key indicators for monitoring child health. Report from family welfare statistics in India (2011) revealed that Infant Mortality Rate (IMR) in India is 47 per thousand live births which constitute around 12.5 lakhs infant deaths in a year. National Family Health Survey (NFHS) III revealed that 8 millions of children in India are suffering from severe under nutrition. As per 2011 census, 35.6 million children under the age group of 0-3 years are under-weight (Social Statistics Division, Ministry of Statistics and Programme Implementation, 2014).

COORDINATION WITH OTHER PROGRAMMES AND GOVERNING BODIES

In order to safeguard the interest of children and their growth and development, several intervention programmes have been started by the Government of India in the last few decades. Ministry of Women and Child Development and the Ministry of Health & Family Welfare, Department of Elementary Education, Department of Drinking Water Supply, Ministry of Panchayati Raj and other governing bodies works together to meet the requirements of health, sanitation, drinking water, pre-school education etc. and to improve the status of hunger and malnutrition in the country (Chaturvedi, September 2011). Indian government has initiate efforts to provide care and support not only for children but also for mothers and adolescent girls. These initiatives include International commitments, constitutional provisions to safeguard these sections of society, policy provisions and developmental programmes to protect their interests. National Plan of Action was started in 1974 for development of children through Early Childhood Development (ECD), nutrition and health programmes (Ministry of Women and

Child Development, 2012). In 1975, ICDS Scheme was launched to implement a model of Early Childhood Care and Education (ECCE).

Some of the programmes are currently in operation in India for maternal and child health. Programmes like Sarva Shiksha Abhiyaan (SSA), National Rural Health Mission (NRHM), and Millennium Development Goals (MDG) have direct relation to ICDS programme in terms of its objectives and scope (Social Statistics Division, Ministry of Statistics and Programme Implementation, 2014). Sarva Shiksha Abhiyaan (SSA) started on 2000-01 is an elementary progrmme for universalization of elementary education which works in convergence with ICDS programme. It coordinates in promoting pre-school education by providing training to *Anganwadi workers* (*AWWs*) who are the key service providers in ICDS programme along with primary school teachers and other health functionaries. National Rural Health Mission (NRHM) was launched on April 2005 and is run by the Ministry of Health. NRHM aims to provide quality health care for women with special focus on safe institutional deliveries. The scheme has an objective to provide effective health care to rural population by providing Reproductive and Child Health (RCH) services to women and children. *ASHA* (*Accredited Social Health Activists*) and *ANM (Auxiliary Nurse Midwife)* are the core functionaries in providing services under NRHM for improvement and betterment in health related issues. *AWWs* are the main health functionaries who deliver all the activities relating to health, family welfare and nutritional services at the village level. *AWW*, *ASHA* and *ANM* works together as a team by generating awareness among women, adolescents and children in gender, equity and health related issues. Millennium Development Goals (MDG) comes from Millennium declaration signed by 189 countries in September 2000. It addresses the need to protect children from conflict, violence, abuse and exploitation. It consists of eight goals planned to be achieved by 2015 out of which three goals have main focus directly on improving maternal and child health. Achieving universal primary education which is the MDG-2 and promoting gender equality and empowering women which is the MDG-3 are vital for achieving almost all the other MDG. Right of free and compulsory education act 2009 came into force on 1 April, 2010. It was needed that there should be a special focus on children's health, nutrition and education so that their optimum development can takes place.

REVIEW OF LITERATURE ABOUT PROGRESS OF ICDS SCHEME

The review of literature mentions about the progress of various services provided under ICDS scheme in different parts of India. Most of the studies were evaluation studies; some were cross-sectional studies and review studies which were focused on the causes of decline in the quality of services provided under ICDS scheme.

Based on the evaluation of scheme, it was reported that Pre-education component was very weak and needed proper attention for improvement. There was lack of coordination between ICDS staff and other health functionaries (Bashir, Bashir, Ganie, & Lone, 2014). *AWW* faced the problems of inadequate supply of medicine, irregular visit of doctor and lack of infrastructure. Community members revealed that *ANM* and doctors don't visit the center regularly and outdated medical practices are being followed to treat the diseases of the beneficiaries (Verma & Sunita, 2014). Utilization of ICDS scheme was higher among mothers and children belonging to vulnerable groups. In its implementation, the scheme emphasizes location inequality and unequal

distribution of *AWCs* within states. The quality of the health services provided under the scheme is poor (Borooah, Diwakar, & Sabharwal, 2014).

Interruption in supplementary nutrition was found due to shortage of food supply. Nearly half of *AWC* have no sanitation facility (Chaudhari, Mazumdar, Baxi, Damor, & Mehta, 2014). Chudasama et.al. (2014) revealed that immunization of all children was recorded only in 10% *AWC*. They found the gap in coverage of supplementary nutrition in children, its regular supply to the beneficiaries, in pre-school education activities, recording of immunization, regular health check-up of beneficiaries and referral of sick children.

An intervention study carried out in rural Bangalore on Positive Deviance Approach and Supplementary Nutrition revealed widespread malnutrition among pre-school children and 47.3% children in the age group of 2-6 years are underweight (Imran, Subramanium, Subrahmanyam, Seeri, Pradeep, & Jayan, 2014). ICDS should be well equipped with basic infrastructure and there must be coordination between the health and education departments to provide these services efficiently (Ranjan, 2014). Paul, et al. (2011) reviewed the situation of reproductive health, child health and nutrition in India and identified the gaps in programmes implementation. They mentioned the causes of maternal and child deaths in India. Most of the deaths of children under five years occur in neo-natal period and are due to pneumonia, diarrhea and under-nutrition. Research review was done by Joseph (2014) on the basis of intellectual development, convivial development and substantial development, aspects and factors influencing these developments and impact of ICDS scheme on child beneficiaries. The findings revealed that ICDS Scheme may be very attractive but beneficiaries don't realize its importance. Standards for *AWCs* should be formulated and implemented to upgrade them to provide Maternal and Child Health services effectively.

In a cross sectional study done in Karnataka at 40 *AWC* selected randomly through systematic sampling method, it was found that 30% of the respondents were not happy with the services provided at *AWC*. Irregular food distribution at *AWC*, food was not cooked properly, irregularity of *AWWs*, no fixed time of opening of *AWC* and far-off distance of *AWC* were found as the major problems (Nagaraja, Anil, Ravishankar, & Muninarayana, February 2014). In Himachal Pradesh, findings of the cross sectional study done at 60 *AWC* states that 53% *AWWs* reported the problem of inadequate honorarium and 73% reported the problem of excessive workload. *AWCs* need to be strengthened in structure and supplies and honorarium of *AWWs* should be increased so that they can be motivated to take interest in all activities of the programme (Thakur, Chauhan, Gupta, Thakur, & Malla, 2015). In Udaipur, a cross-sectional study was done on 1286 children under five years of age out of those 623 were boys and 663 were girls. The purpose of this study was to measure the percentage prevalence of wasting, stunting and underweight children and the analysis and interpretation was done by using WHO (World Health organization) Anthro software. The findings states that high prevalence of chronic malnutrition was found in this area (Shahnawaz & Singh, 2014). It was reported by 53% of respondents about dissatisfaction with the quality of services provided at AWC. The poor quality of food distributed at AWC (67% of respondents) and irregular preschool education was mentioned by 57% of respondents (Davey, Davey, & Dutta, 2008).

These articles identified shortcomings in the scheme and the problems in delivery of services, motivation of the key staff i.e. *AWWs*. The researchers either used purposive sampling or random sampling method for data collection and structured questionnaires were used to gather data from the respondents. In some studies, observation and informal discussions with Project Officers (POs), Child Development Project Officers (CDPOs), Supervisors, *AWWs* and *ANM* were also done.

MATERIALS AND METHODS

The purpose of the study was to find out the awareness and views of service providers and service seekers. The knowledge of *AWWs*, activities done by them for the beneficiaries and the problems faced by them were assessed. Simultaneously, the involvement of mothers in every activity and their expectation and involvement in acquiring services provided under the scheme was assessed. The present study was conducted in June - July 2013 in Meerut, a sub-urban city in the state of Uttar Pradesh, India. Urban slums and villages from Meerut were selected so that comparative study can be done in both of these areas.

However, in this study service providers are *AWWs* who are the key persons at grass root level in providing services under ICDS scheme and service seekers are those mothers who have children upto 6 years of age and their children are attending the ICDS service center called '*Anganwadi center*'*(AWC).* A sample of 15 mothers and 15 *AWWs* were chosen each from both urban slums and rural areas. Hence, total number of respondents was 60, selected from purposive sampling method. Exploratory research design was used in this study because ICDS scheme has to be looked into more precise way for giving insights into the span of 40 years journey. By using exploratory research, a problem can be studied in wider way considering different aspects (Kothari, 2012). A demographic schedule was used for *AWWs* and mothers through which general information of the respondents was collected. Interview schedule was developed by using the available tool of National Institute of Public Cooperation and Child Development (NIPCCD). It was used to assess the performance of *AWWs* regarding training, activities done at *AWC* for the beneficiaries, immunization, data recording, typology of problems etc.

Along with interview schedule, SERVQUAL scale was used for mothers who are the service seekers in the programme in which their expectations and perceptions have been measured about service quality. SERVQUAL Scale was developed by Parasuraman in 1985. The items in the scale were modified in accordance to the service delivery of *AWWs* under ICDS scheme. It includes knowledge of *AWWs*, their behavior with the beneficiaries, IEC (Information Education and Communication) materials and physical infrastructure at *AWC*. The scale analyzes the gap between perceptions and expectations of mothers, concerning with the services provided under ICDS scheme. Within the SERVQUAL model, service quality is defined as the gap between perceptions of service seekers about service delivery and their expectations about how the service delivery have been performed. The five dimensions of service quality (RATER) includes Reliability **(**Ability to perform the promised service dependably and accurately), Assurance (Ability, knowledge and politeness of employees to inspire trust and confidence), Tangibles (Physical facilities, equipment and appearance of employees), Empathy **(**Individualized, caring attention that the firm provides to its customers) and Responsiveness (Willingness to help customers and provide timely service) (Tripathi, 2013). These five SERVQUAL dimensions

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(Tangibles, Reliability, Responsiveness, Assurance and Empathy) were subdivided into 22 statements. Service quality scores were calculated through the difference between the perception and expectation scores (P-E).The range of values varies from -6 to +6 (-6 stands for very dissatisfied and +6 means very satisfied). Negative gap scores shows that the service quality perceived is poor and hence no satisfaction of respondents while positive gap scores shows that higher service quality and hence the satisfaction of respondents.

Although the SERVQUAL scale have been used in several studies including the banking sector, retail sector, Delhi metro, health care sector in hospital setting to analyze the gap between service transactions and the expectations of customer in those transactions. The scale has not been used frequently in provision of services relating to health in the community setting. In this research, an initiative is taken to analyze the service quality provided to mothers and their children by using the SERVQUAL scale and to assess supply of services provided by *AWWs* to their target group under ICDS programme through *AWC*. The findings of the study have shown in the form of tables mentioned below:

RESULT AND DISCUSSION:

Comparison of demographic background between *AWWs* and mothers

Table 1: Personal information of AWWs and mothers

		Anganwadi Workers(n=30)				**Mothers (n=30)**			
		Rural (n=15)		**Urban (n=15)**		**Rural (n=15)**		**Urban (n=15)**	
		No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Age	15-35	12	80%	7	46.7%	0	0%	4	26.7%
	36-55	3	20%	8	53.3%	15	100%	11	73.3%
Marital Status	Married	12	80%	12	80%	14	93.3%	15	100%
	Unmarried/widow	3	20%	3	20%	1	6.7%	0	0%
Religion	Hindu	8	53.3%	12	80%	1	6.7%	14	93.3%
	Muslim	7	46.7%	3	20%	14	93.3%	1	6.7%
Caste	General	7	46.7%	6	40%	5	33.3%	0	0%
	O.B.C/ S.C	8	53.3%	9	60%	10	66.7%	15	100%
Education	Illiterate	0	0%	0	0%	4	26.7%	5	33.3%
	Primary/ Secondary	10	66.7%	3	20%	11	53.3%	8	53.3%
	Graduate/ PG	5	33.3%	12	80%	0	0%	2	13.3%

Results from table (1) show that most of the *AWWs* in rural and urban area are Hindu. The number in urban area was still larger than that of rural area. Among the mothers, there was a drastic variation in the population of respondents in urban and rural area on the basis of religion. In rural area, most of the mothers were Muslim while in urban area, most of them were from the Hindu religion. The condition was still reverse in urban area. Most of the mothers and *AWWs* in

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both rural and urban area belong to Scheduled Caste (SC) population. In rural area, educational status among *AWWs* (26.7%) was lower than that of urban area (33.3%). *AWWs* in rural area were either having primary or secondary education and in urban area most of them were either graduate or having post graduation. Most of the mothers in both rural and urban area were illiterate. Some of them were either having primary or secondary education. Educational status of mothers in urban and rural area was lesser as compared to that of *AWWs.*

Table 2: Family information of AWWs and mothers

		Anganwadi Workers (n=30)				Mothers (n=30)			
		Rural (n=15)		Urban (n=15)		Rural (n=15)		Urban (n=15)	
		N	%	N	%	N	%	N	%
Family Structure	Joint Family	7	46.7%	4	26.7%	7	46.7%	4	26.7%
	Nuclear Family	8	53.3%	11	73.3%	8	53.3%	11	73.3%
Family Income (Monthly)	2000-6000	5	33.3%	9	60%	2	13.3%	12	80%
	6000-8000 & above	10	66.7%	6	40%	13	86.7%	3	20%

The findings of table (2) shows that most of the *AWWs* and mothers in rural area live in joint family and in urban area, they live in nuclear family. In slum areas both *AWWs* (60%) and mothers (80%) have low monthly income whereas in rural areas, 33.3% *AWWs* and 13.3% mothers have low monthly income. Family income of *AWWs* and mothers in urban area was lower than that of rural area.

Table 3: Location of AWC in the community

		Anganwadi Workers (n=30)				Mothers (n=30)			
		Rural (n=15)		Urban (n=15)		Rural (n=15)		Urban (n=15)	
		N	%	N	%	N	%	N	%
Distance of AWC from residence	200-500m	10	66.7%	8	53.3%	13	86.7%	15	100%
	600-900m & above	5	33.3%	7	46.7%	2	13.3%	0	0%
AWC building belongs to	Government	11	73.3%	4	26.7%	-	-	-	-
	Private/Rent	4	26.7%	11	73.3%	-	-	-	-

Results from table (3) show that the distance of *AWC* was near to that of the residence of both *AWWs* and mothers. *AWC* was approachable for both mothers and *AWWs.* For *AWWs,* it was quite distant as compared to that of location of *AWC* for mothers. In rural area, most of the *AWC* buildings were government owned while most of the buildings in urban area were either

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privately owned or on rent. The space occupied to run the centre was highly insufficient to provide the services.

Table 4: Weekly activities conducted at AWC and problems faced by AWWs

		Anganwadi Workers (n=30)			
		Rural (n=15)		Urban (n=15)	
		N	%	N	%
Mode to communicate with community	Interpersonal communication charts/posters	12	80%	1	6.7%
	Community meeting	3	20%	14	93.3%
Weekly activity- PT/games conducted	Yes	2	13.3%	14	93.3%
	No	13	86.7%	1	6.7%
Weekly activity- Pre-School Education conducted	Yes	6	40%	6	40%
	No	9	60%	9	60%
Weekly activity- Food provided	Yes	9	60%	3	20%
	No	6	40%	12	80%
Weekly activity- Mother's Meeting conducted	Yes	11	73.3%	3	20%
	No	4	26.7%	12	80%
Weekly activity- Immunization conducted	Yes	2	13.3%	5	33.3%
	No	13	86.7%	10	66.7%
Problems in collecting information	Yes	1	6.7%	2	13.3%
	No	14	93.3%	13	86.7%
If yes, typology of problems	Work overload	1	6.7%	1	6.7%
	Communication gap	0	0%	1	6.7%
Problems in running AWC	Yes	4	26.7%	4	26.7%
	No	11	73.3%	11	73.3%
If yes, typology of problems	Unavailability of food	3	20%	1	6.7%
	No helper	1	6.7%	3	20%
	Not applicable	11	73.3%	11	73.3%
Satisfaction with the job	Yes	4	26.7%	14	93.3%
	No	11	73.3%	1	6.7%
If yes, give reasoning	It gives satisfaction	3	20%	12	80%
	No other source of livelihood	1	6.7%	2	13.3%
	Not applicable	11	73.3%	1	6.7%
If no, give reasoning	Honorarium is not satisfactory	11	73.3%	1	6.7%
	Not Applicable	4	26.7%	14	93.3%

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Table (4) shows that in rural area the mode of communication of *AWWs* with the mothers was through interpersonal communication or through charts and posters. While in urban areas community meetings were organized by *AWWs* to interact with the mothers. Since, in rural areas most of the *AWC* were government owned, they have enough space for using charts and posters to display there. In urban areas, most of the *AWC* were either private or on rent. They don't have sufficient space to display IEC (information, education and communication) materials like charts and posters due to which they are unable to create interest among the community members for utilizing the services provided under the programme. Table shows that there was variation in weekly activities done at *AWC* in both rural and urban area. Food distribution and mothers meeting were mostly the activities in *AWC* located in rural areas. While in urban areas games and routine immunization were mostly the activities done at *AWC.* In rural areas, most of the mothers were Muslim and immunization programme was lesser done as an activity during a week. In urban areas, *AWC* don't have cooking utensils and at most of the times, food was not provided by the government. If it is available, it is not in appropriate quantity. Sometimes food was not properly distributed by *AWWs* depending upon the beneficiaries registered at *AWC.* Pre-school education was the weaker component in both the localities. Since the mothers were either illiterate or primary educated in both the areas due to which they avoid to send their children at *AWC*. The lack of skills and expertise of AWWs results in the incapability of *AWWs* to motivate mothers so that they send their children to the *AWC*. Communication gap between *AWWs* and mothers resulted into problems faced by *AWWs* in collecting information that resulted into the lack of interest and concern of community members about the activities and components included in ICDS programme. In rural area, 73.3% *AWWs* revealed about the dissatisfaction with the honorarium and hence no satisfaction with the job. In the study done by Department of Community Medicine (Patil & Doibale, June 2013), 87.7% *AWWs* mentioned the problem of inadequate honorarium. Some of the *AWWs* revealed that for them it was the only source of their livelihood. Since the honorarium was not satisfactory, it results into their effectiveness and efficiency in performing the duties.

Table 5: SERVQUAL: Summary of means of *AWWs* expectations and gap scores

Statement	Dimension	Perception score	Expectation Score	Gap Score
Modern looking equipments at AWC	Tangibles TA1	2.733	4.5	-1.767
Physical facilities at AWC-visually appealing	TA2	2.567	4.4	-1.833
AWWs-neat appearing	TA3	4.167	5	-0.833
Materials in AWC-visually appealing	TA4	3.1	4.967	-1.867
Facilities provided by AWWs in time as promised	Reliability RL1	3.1	4.933	-1.833
AWWs shows interest in solving problems of beneficiaries	RL2	3.267	4.933	-1.666

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AWWS performs services right the first time	RL3	2.933	4.9	-1.967
Services provided by AWWs at time as promised	RL4	3.133	4.9	-1.767
Error free records by AWWs	RL5	3.4	4.133	-0.733
AWWs tell the mothers time for service delivery	Responsiveness RS 1	3.2	4.833	-1.633
Prompt service by AWWs to beneficiaries	RS2	3.233	4.933	-1.7
AWWs always willing to help the beneficiaries	RS3	3.567	4.933	-1.366
AWWs never busy to respond the beneficiaries	RS4	3.633	4.133	-0.5
Behaviour of AWWs makes comfortable to beneficiaries	Assurance AS1	3.333	4.833	-1.5
Mothers feel safe in taking services of AWWs	AS2	3.8	4.9	-1.1
AWWs respond consistently courteous	AS3	4.067	4.933	-0.866
Proper knowledge to AWWs for responding the questions of mothers	AS4	3.567	4.9	-1.333
Individual attention given by AWWs to every beneficiary	Empathy EM1	3.2	5	-1.8
Working hours of AWWs in convenience of beneficiaries	EM2	4.1	4.933	-0.833
Personal concern by AWWs to each beneficiary	EM3	3.4	4.867	-1.467
AWWs committed in providing best services to beneficiary	EM4	2.9	4.967	-2.067
AWWs understand the specific needs of beneficiaries	EM5	3.4	4.967	-1.567

TA- Average gap score for tangible items = (TA1+TA2+TA3+TA4)/4 = -1.575
RL- Average gap score for reliability items = (RL1+RL2+RL3+RL4+RL5)/5 = -1.5932
RN- Average gap score for responsiveness items = (RS1+RS2+RS3+RS4)/4 = -1.29975
AS- Average gap score for assurance items = (AS1+AS2+AS3+AS4)/4 = -1.19975
EM- Average gap score for empathy items = (EM1+EM2+EM3+EM4+EM5)/5 = -1.5468
OSQ- Overall service quality = (TA+RL+RN+AS+EM)/5 = -1.4429

In table (5), perception and expectation scores of mothers were calculated along all five dimensions. A tangible dimension includes the appearance of physical facilities, equipments and

materials at *AWC*. It was found that IEC materials and physical infrastructure available at *AWC* are not visually appearing. Reliability includes the ability of *AWWs* to provide the services accurately available under ICDS scheme. Responsiveness comprises of the willingness of *AWWs* to help the mothers in providing prompt services to them. It was found that *AWWs* are busy and are overworked due to their involvement at various places. Assurance includes the ability of *AWWs* in performing the duties and their behavior with the beneficiary mothers and children while providing services. Empathy includes the provision of personal concern by *AWWs* for the convenience of beneficiaries. It was calculated through the difference between the perception and expectation scores (P-E). Average gap score of the entire dimension and overall service quality was calculated by taking average of all the dimensions of the scale. Along the entire dimension gap score comes out to be negative which shows that the service quality perceived by mothers is poor and hence no satisfaction of respondents with the delivery of services provided under the programme.

DISCUSSION:

The data from various sources were analyzed against the research question to draw conclusions about paradox in justice in relation to ICDS scheme. Both mothers and children who are the beneficiary of this programme leads to marginalization in several forms in context of Indian society. Children from weaker sections of society have lower nutritional status. Socio-economic factors affecting nutritional status other than income are large family size, literacy rate of parents and their occupation (Viswanathan, February 2003). Marginalization of children is effected through the families rather than directly through the children. They are dependent upon their parents for their nurture and nourishment and their development is directly affected by the socio-economic status of their parents. It has come out in the findings of researches done in this area that parental education and appropriate parenting in early years of a life of a child have a long term effect on the development of a child. It is very important determinant other than socio-economic status (Allen, January 2011). Therefore, in addition to poverty alleviation, other determinants should also be taken into consideration for child development (Field, 2010). Although all the determinants are inter related to each other and affects each other in one or the other way. Poverty and socio-economic status of the parents are the root cause of other factors that hindered their child growth and nurture. The problem of poverty leads to parental incapacity to provide care and support to children against the risks of life especially in the matters of health and nutrition and it impact on ability to work of person and to access health care services and quality resources (Marmot & Wilkinson, 2006). The health of child and his socio-economic needs are affected by family environment and health of mother. This includes maternal health, illness of mother, family violence and stress of the parents. Poverty in turn affects children as they have less access to nutritious food, adequate housing and healthcare that indicates towards health inequality (Irwin, Siddiqui, & Hertzman, 2007). Early childhood development and access to early childhood education have determining effects due to poverty, isolation and gender inequality. The children from rural areas whose parents are poor and they either have little or no education have detrimental effects on their physical and educational development (Woodhead & Moss, 2007). Making ICDS and crèches work in urban slums by Working Group on Urban Poverty revealed that in slum areas; peoples belonging to SC and ST are abundant in number. The population comprising poor people has the worst educational level and bad housing

conditions (Singh, July 2011). In rural area of India, the factors that are responsible for poverty that leads to inequality are low levels of getting primary education, poor access to avail healthcare services, lack of family planning, malnutrition, lack of immunization, lack of water and sanitation and poor quality housing (WHO Statistical Information System, 2010). Some of the peoples residing in villages migrate to urban areas in search of better employment, education and health facilities. Due to the rapid growth of urbanization children have harmful effects on health and nutrition which deteriorate their physical and cognitive growth (Ghosh & Shah, 2014).

An evaluation report on the scheme presented in its report the causes for the failure of this programme as this scheme has not reached to the extent as expected. The causes mentioned in the report are inadequate supervision, lack of medical resources, lack of coordination with health department and other implementation issues (Population Research Centre, 2009). As per the findings of the study, *AWWs* in both urban and rural area mentioned the problem of work overload. *AWWs* are overworked and not able to justify their routine work (Desai, Pandit, & Sharma, January-June 2012). All these factors contribute for the marginalization of the programme.

CONCLUSION:

The findings explore that most of *AWWs* and mothers are from low income group, have low educational status and belongs to SCs population due to which the programme is perceived as a low status programme that indicates towards its systematic marginalization. Other than this, insufficiency of proper place, material and equipments are the factors that lead to structural deprivation. There should be advancement in the programme to bring new technology in it to deal with the problems of health, infant mortality, school dropout, child protection etc. Lack of interest and knowledge of mothers about the real purpose of the programme are the main barriers in the effectiveness of the programme. Support system of ICDS is not changed in the past few years. Systematic inclusion for the betterment of the programme has to be done by community engagement and encouraging partnership of stakeholders. *AWWs* in both the areas are not satisfied with the job. Since the honorarium is not satisfactory, it results into their inactiveness and efficiency in performing the duties. It is needed to have operational changes in the programme.

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