

**FUNCTIONING OF ANGANWADIS (ICDS)
IN KAMRUP DISTRICT, ASSAM STATE**

BY

PRADIPA KALITA

A THESIS SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE
AND HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY) COIMBATORE-641 043,
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN HOME SCIENCE EXTENSION EDUCATION

APRIL 1994

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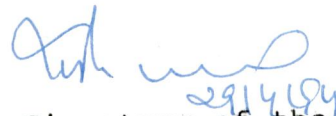
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APRIL, 1994


Certified as bonafide research work



Signature of the Head
of the Department



Signature of the
Dean of the faculty



Signature of the
Guide

Acknowledgement

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Introduction

I. INTRODUCTION

Child development is integral to overall socio economic development of a nation. Problem of child health and development present a formidable challenge. To meet this challenge every citizen of India has to make some contribution (Kumar, 1988).

The social progress and economic prosperity of a country depends on the full use of human as well as natural resources, development of and for children has come to be recognised as integral to the national Development Process. Meeting the development needs of children is not only an investment for the future but also matter of their rights as individuals (Sharada, 1988).

Early childhood is a period of flowering self awareness and building self concepts. Just as a flower opens to show to the world its nature, the child during early years shows to others what sort of person he is going to be. Because early childhood years play a vital role in moulding the personality of children, an individuals habits, attitudes, trust in people and the world, his interests etc., are all moulded by his early childhood experience (UNICEF, 1992).

Child health reflects and determines the human condition, it results from and contributes to social

development. The growth of societies depends on the quality of its people, and population quality depends on health and education (Grant Jame, 1993).

A nation's children are its supremely important asset and the nation's future lies in their proper development. The International Year of the Child (1979) provides a available opportunity to all of us to rededicate ourselves to the noble task of nation building through proper care of our children who are our human resource of the future (Ministry of Education and social Welfare, 1981).

"The children of today are the citizens of tomorrow if the citizens of tomorrow are to be equipped with freedom, intelligence and physical skills, the foundation must be laid at the pre-school in all areas (Devadas and Jaya, 1991).

No development which does not touch the health and welfare of the child is worth the name. Child is man's greatest acquisition, since it provides hope and happiness, especially if the child development is indeed an investment in human resource development on which depends national development (Kumar, 1988).

Children need to receive preparation for an active and useful life, as well as protection from various diseases,

hazards and handicaps to which they are generally more vulnerable than adults, investment in the preparation of children is increasingly coming to be recognised as highly important for national development (Madan, 1986).

The status of children in a country is directly related to socio-economic structure. Liberal investment in the growth and development of children is an important indicator of a nation's prosperity and progress.

While analysing the condition of children in India, three basic aspects stand out first, about a third of the 300 million may not have actual access to an essential minimum of nutrition health care and early opportunities. Second, the unequal access arises from the material poverty of the family depended accompanying effects of ignorance, ill health and isolation of prolonged by the rigid structure of the society. And third it has been proven, that the quality of life can be improved "here and now", through the cluster of community based services addressed specifically and on priority to the needs of children (Sharada, 1988, UNICEF, 1991).

During recent years, the government has shown an increasing concern to improve the quality of life of the children in the country. Several policy resolutions have, therefore, been made and numerous programmes which respond

to the child's development needs have launched various aspects concerning the child's status in the country, have been discussed which include demographic trends, health, education, employment in different economic activities, National policy on children, the U.N. declaration of the rights of the child, and national and international voluntary efforts aimed at promoting child development.

To give purpose and direction to the efforts, the government of India have prepared the National Plan of Action for the International Year of the Child. The plan provides for both advocacy and action.

The Nation's children are a supremely important asset. Their nurture and solicitude are our responsibility. Children's programmes should find a prominent part in our national plans for the development of human resources, so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed with the skills and motivations needed by society. Equal opportunities for development of all children during the period of growth should be our aim, for this would serve our larger purpose of reducing inequality and ensuring social justice (Indian University Association For Continuing Education, 1990).

The needs of children and the nation's duties towards them, as stated in the constitution, have been concertised by adopting a national policy for children, by the government of India in August, 1974 enjoins the state to provide adequate services to children, both before and after birth, and through the period of growth to ensure their full physical, mental and social development (Kurup, 1990).

In formulating various children's programmes in different sectors, priority shall be given to programme relating to -

Preventive and promotive aspects of child health nutrition for infants and children in the pre-school age along with nutrition for nursing and expectant mothers; maintenance, education and training of orphan and destitute children, creches and other facilities for the care of children of working or ailing mothers; care education, training and rehabilitation of handicapped children (National Policy on Children, 1989; Bajpai, 1991).

Provision of package of services to meet the biological, emotional and intellectual needs of young children can make a positive contribution to the socio-economic development of the country by preventing or minimising the wastages arising from infant mortality, physical handicaps, malnutrition, stagnation in schools and

inadequate development of mental capacities. The ICDS scheme was initially started in 1975 in 33 blocks on an experimental basis by the Ministry of social welfare (ICDS, 1990; Bose, 1986).

Anganwadi is the basic institution through which the Integrated Child Development Services (ICDS) programme is carried out. The expression "Anganwadi" is Gujarati Language from which it was taken, meaning courtyard garden (Angan. Courtyard; Wadi - garden). The concept of Anganwadi was first and officially given in the report of Mina Swaminathan Committees on preschool education in 1972. Later it was incorporated in the programme of Integrated Child Development Services (ICDS, 1975; ICDS, 1990).

At the grassroot level, Anganwadi is the focal point in the village for delivery of a package of Services to pre-school children and mothers. The package consists of supplementary nutrition, health check-up, immunisation, referral services etc. Each Anganwadi is run by an Anganwadi worker (AWW) who is the multipurpose agent of change and is supervised by the supervisor, co-ordinated by child development project Officer (CDPO). Moreover there is a helper to assist in the routine of the Anganwadi and each Anganwadi usually covers a population of 1000 in rural and

urban areas and 700 in the tribal and hilly areas (Punhani and Mahajan, 1985)

Based on this knowledge the investigator is interested to study the "functioning of Anganwadis (ICDS) in Kamrup district, Assam State" with the following objectives.

1. To study the functioning of Anganwadi
2. To study the services rendered by the Anganwadi.
3. To study the community involvement in the Anganwadi.

Review of Literature

II. REVIEW OF LITERATURE

Review of literature pertaining to the study on "Functioning of Anganwadis (ICDS) in Kamrup District, Assam State", is discussed under the following heads:

- A. Children in the societies, children, tomorrow's citizens
- B. Measures taken to improve the health of children
- C. Various programmes related to improvement of children
- D. ICDS programmes.
- E. Research Inputs.

A. CHILDREN IN THE SOCIETIES, CHILDREN, TOMMORROWS CITIZENS

We are guilty of many errors and faults but our worst crime is abandoning children, neglecting foundation of life. Many of the things we need can wait, the child cannot. Right now is the time his bones are being formed, his blood is being made, and his senses are being developed. To him we cannot say, 'tomorrow' his name is 'today' (Singh, 1986).

Children's health tomorrows wealth, children are a resource, and that any nation which neglects them would do so at its period. World Health Day (1984) this spctlights the basic truth that we must all safe guard the healthy minds and bodies of the world's children. The investment in child health is a direct entry point to improved social

development, productivity and better quality of life. Since men and women themselves are not only the object, but the most important resources and objects of socio economic development, the focus on child health is a developmental issues at all times and for all countries, thus children's health is tomorrow's wealth (Mahler, 1984).

Bajpai (1991) stated, that building for the future does not simply mean government's policies and programmes for economics development. It also means assuring a future beneficiary generation with better quality of life, social status and aspirations, this calls for investment in children.

Grant jame (1989) opined that protecting the health and the education of today's children is the most basic of all investment in the physical and mental capacity of the next generation and therefore in the social and economic development of societies.

The nation's children are supremely important asset. Their nurture and solicitude are our responsibility, children's programmes should find a prominent part in our national plans, for the development of human resources, so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed

with the skills and motivation needed by society (Dayal, 1986; Indian University Association for Continuing Education, 1990).

Sharada (1988) revealed the fact that the health and prosperity of a nation is contingent upon its human resources has been sufficiently demonstrated by the history of some of the developed countries; these countries have relied on the superior quality of their human resource for advancement.

Recognising the vital importance of children almost all countries in the world consistently emphasis the need to take a comprehensive view of the problems of young people as an essential component of development planning, and they have initiated a whole spectrum of programmes and services for children (including health, education, socialisation, recreation etc.), as inputs of critical significance for the growth and development of this section of the population.

It is maintained that in respect of human resource development, the nation has to act soon. The foundation of growth and development through the year of school age youth and adult life is laid in infancy and early childhood indeed even earlier, in the womb. Each stage of life is a preparation for the next. If the early years suffer relative neglect as they often do it will not be easy to make up

later for the lost human potential. This is to create a social order as an imperative to create a congenial environment for child growth (Rao, 1989; Subrahmanyam and Sondhi, 1990).

It is felt in most developing countries that the plight of children is as pitiable as in India or perhaps worse. It is so, partially because of constrained economic conditions and partially because of ignorance of child care practice in the modern sense (UNICEF, 1989).

The child welfare is important for the child himself for the family and for the society. The importance of child welfare service lies in the consideration that the personality of man is built up in the formative years, and the physical and mental health of the nation is determined largely by the manner in which it is shaped in the early stages. The childhood is the best period for physical, mental, and spiritual development. He is the political force for the nations. Thus the importance of child welfare hardly needs much emphasis (Chawdhry, 1983; Madan, 1985).

It is felt that to promote an appropriate environment for the growth of children there is urgent need for the re-examination of the policy priorities, with social segments pulling together, to bring together the government, the

private section, voluntary agencies, community organisation and professionals, so that a movement for the development of children may pick up across the country. Today, the needs of children can be met, and the capacities of tomorrow's adults can be protected, by empowering parents with present knowledges and supporting them in putting it into practice (Grant Jame, 1989).

B. MEASURES TAKEN TO IMPROVE THE HEALTH OF CHILDREN

Child health reflects and determines the human condition. It results from and contributes to social development. The growth of societies depends on the quality of its people and population quality depends on the health and education, child health affects growth, learning and work (William, 1987).

All the national health programmes have relevance to children to some extent but some of the programmes/schemes are specifically designed to promote health and well being of children. A number of nutrition programmes have also been operationalized through various departments to bring about investment in general health of children. The programmes of the Ministry of Health and Family welfare:

Programmes that have a direct bearing on child welfare are i) Universal Immunization Programme, ii) scheme for prophylaxis against blindness, iii) scheme for oral

rehydration therapy for Diarrhoeal management, iv) scheme for prevention of iron deficiency, v) scheme for establishment of sub-health centres, vi) scheme for training of dais, vii) scheme for training auxillary Nurse Midwives and Lady health visitors (Ministry of Human Resource Development, 1992).

The Integrated child development scheme has helped in improving medical and child health services (MCH) and reduction of birth rates in ICDS blocks. Accelerated expansion of the scheme will greatly help in reducing birth rate (Ministry of Health and Family welfare, 1986).

Health Services for Children

i) Curative Health Service

Availability of health services has an important role to play in deciding the trends of mortality and morbidity. Facilities for child care in India are divided into following components.

- a) Maternity hospitals, maternity wards in general hospitals, maternity homes and maternity child welfare centres.
- b) Paediatric hospital and paediatric wards in general hospitals.
- c) Primary Health Centres
- d) Family Welfare Centre

- e) Doctors in General Practice
- f) Self Employed Doctors (NIPCCD, 1979)

Preventive Health Services

The importance of preventive health services has been sufficiently recognized to prevent the communicable diseases have been taken. These prophylactic measures are as follows:

- i) Primary immunization of children.
- ii) Immunization of pregnant women against tetanus,
- iii) Prophylaxis against nutritional anaemia in mothers and children,
- iv) Prophylaxis against blindness due to vitamin A deficiency (Bhanti, 1989).

The achievement with respect to the above mention preventive measures is given below:

BCG Vaccination

BCG vaccination has been used extensively to prevent tuberculosis, first it meant vaccination campaign and more recently in vaccinating new born babies. Since BCG should be given before infection, it is indicated a priori for young children. BCG vaccination given early in life-with its lasting effect on endogenous reactivation will continue to reduce the incidence and thus hasten the eventual elimination of the diseases (Dam, 1993).

DPT immunization for children and tetanus immunization for mothers

DPT immunization is a combined vaccine against the three diseases, diphtheria, tetanus and whooping cough. Immunization of expectant mothers against tetanus may help in bringing down the neo-natal mortality in the country. Thus these two programmes aim at reducing high rates of infant mortality in the country. Besides these polio vaccine, typhoid vaccine, cholera vaccine, measles vaccine also are given for children (Arya, 1992).

Diarrhoeal Disease Control

The programme consists of a) conducting morbidity and mortality surveys in selected areas, b) health education and c) supply of ORS packets, clinician, epidemiologists, microbiologists, dietitians have been trained, who in turn from primary health centre doctors and paramedical staff. A limited supply of ORS packets is made available with health guides and sub-centres. The programme was pursued with vigour in the seventh plan period. Today's knowledge makes prevention possible on a large scale and at a low cost. The principal means are breast feeding, immunizing against measles, using a latrine, keeping food and water clean and washing hands before touching food (Grant Jame, 1993).

Maternal and Child Health Service

These services include immunization of children and mothers and prophylactic treatment against nutritional anaemia in mothers and children and blindness in children due to deficiency of vitamin A. The WHO Committee (1976) suggested that the following service should be an integral part of the MCH services:

- i. Nutrition, protection and promotion
- ii. Infection prevention and management
- iii. Family planning.

The specific objectives of MCH care is the reduction in the maternal, prenatal, neonatal, infant and child mortality and morbidity and the promotion of health of mother and child in the family. In India and many other countries the family welfare programme has been integrated with MCH activities and development of the small family norm is a major objective of the MCH activities (Mahadevan, 1990).

School Health Programme

In the third plan a school health programme was drawn consisting of minimum services for care of health of school children to be provided by states. These minimum services are: i) clean drinking water and sanitary facilities, ii) medical inspection, iii) periodic health examination, iv) measuring and weighing of the children

v) through test of teeth eye sight, hearing etc., vi) immunization and vaccination against contagious diseases, vii) detecting cases of seriously handicapped children like the blind, mentally deficient, the deaf, the dumb, the crippled, tuberculosis and cardiac cases; viii) follow-up with primary health, ix) instruction of teachers in health education (Chawdhry, 1963 and 1988).

Minimum Needs Programme

Is mainly concerned with providing necessary infrastructure for health care. Under this programme the targets are i) one primary health centre for each community development block, ii) one sub-centre for a population unit of 10,000, Under this programme, the government has committed itself to improve the quality of the primary health care, prevention and control of locally endemic diseases like leprosy, tuberculosis, malaria, blindness and goitre, provide immunization to all infants and children and improve sanitation facilities, (Park and Park, 1986; Jain, 1990; Mahadevan, 1990).

National Expanded Programme of Immunization

Is a centrally sponsored scheme being launched during the sixth plan to control the communicable diseases preventable through immunization. In this scheme all immunization will be integrated with and provided through

PHCs and subcentres in rural areas and through hospitals and dispensaries in the urban areas. The scheme also proposes the surveillance for preventable diseases and collection of baseline data relating to the pre-valence of childhood disease (John, 1985-86; Bhandari and Singh, 1986).

The health planning in India is largely based on the survey findings of the Bhole Committee (1946) and Mudaliar Committee (1961). The main objectives have been the i) control and eradication of major communicable diseases, ii) provision of curative, promotive and preventive services in rural areas throughout the network of primary health centres, iii) training of medical and paramedical personnel.

As a result of these efforts the mortality rate has declined. Life expectancy at birth has risen up, the infant mortality rate has also declined considerably. The number of hospital beds, health centres and dispensaries have also increased considerable (NIPCCD, 1979).

C. VARIOUS PROGRAMMES RELATED TO IMPROVEMENT OF CHILDREN

a) Early childhood Education (ECE)

Early childhood education (ECE) is designed to improve the children's communication (language) and cognitive (Social, emotional, intellectual and personality development) skills as a preparation for entry into primary school (Ministry of Information and Broad Casting, 1992).

b) Welfare Extension Projects

This scheme launched in 1958, provides for a programme of creches, balwadis, recreational activities for youth, maternity and child welfare service etc., (Grewal, 1984; Bose, 1986).

c) Creches/day care centres for children

Under the scheme, the services available to the children include sleeping and day care facilities, supplementary nutrition, immunization, medicines, entertainment and weekly medical check-ups (Ministry of information and Broadcasting, 1992).

d) Balwadi Nutrition Programme

BNP has been implemented since 1970-71 through the Central Social Welfare Board and four National level voluntary organisations (India, 1992). Nutritional diet is provided to the children between three to five years of age to the extent of 300 calories and 10-12 gms protein per child per day (Tandon, 1990).

e) Applied Nutrition Programme

The ANP is defined as co-ordinated educational activities among health, agricultural and educational departments and other integrated agencies with the active participation of the people to help them selves. ANP is

aimed at stimulating self help for the maximum use of locally available resources through a combination of nutrition education of the mothers (Devi, 1994).

f) Special Nutrition Programme

This programme was started in 1970-71 with the object of providing supplementary nutrition to pre-school children, pregnant women and nursing mothers from the weaker section of the community (Swaminathan, 1989; Dinesh, 1990).

g) Mid-day Meals Programme

Started in 1962-63 with the aim at providing nutritious meal to primary school children (6-11 years) and thereby improve the nutritional status by bridging the dietary gap. Its another objective has been to improve school enrollment and reduce drop outs, priority is accorded to SC/ST and Backward Classes of the community, in the feeding programme (Tandon, 1990).

h) Tamil Nadu Integrated Nutrition Project : (TNP)

This was started in 1982 and aims at improving health and nutritional status of pre-school children with emphasis on the age group 3 - 36 months, expectant and nursing women (Suria Kanthi, 1991).

i) Wheat Based Supplementary Nutrition Programme

This programme was introduced in January 1986 to cover disadvantaged pre-school children and nursing, expectant mothers. This scheme is meant to expand the existing feeding services by covering additional beneficiaries, primarily in tribal areas, urban slum and backward rural areas (Ministry of Information and Broad Casting, 1991).

j) Chief Minister's Nutrition Meal Programme

The nutrition programme of the government of Tamil Nadu was introduced by the late Chief Minister Dr. M.G.Ramachandran on 1st July, 1987. Originally it covered children in the age group 2 to 10 years living below the poverty line but from September 1984 it was expanded to include 10-14 years old. Also under the programme nutritious meal is provided to children of age group 2 to 4 years. While children upto 10 years are fed on all 365 days in a year. Children of higher ages are fed only on 200 days in a year. The meal consists of rice, dhal, oil, leafy and other vegetables, (Suria Kanthi, 1991; Rajam and Jayakumar, 1993).

k) Scheme of Welfare for children in Need of care and protection

The government of India stated this scheme for providing services for abandoned, neglected, orphaned and homeless children in 1974.

l) World Food Programme (WFP)

Between 1977-78 and 1984-85, 3 phases of WFP have been completed, the project provides supplementary nutrition for children below 6 years and pregnant/lactating mothers (Tandon, 1990).

m) Child Welfare Programmes in five year plan

In the First Five Year Plan (1951-56) the main activities promoted were the organisation of balwadies, creches, maternity and child centres, medical and midday meals, recreational and cultural programmes.

During the different five year plans importance was given for various activities for children like programmes of education, health, training and rehabilitation of physically handicapped children like the blind, deaf and dumb (NIPCCD, 1979).

n) Early Childhood Education Centres

Recognising that the holistic welfare of child development means covering such aspects as child's nutritional, health, social, mental, physical and moral and emotional development, early childhood care and education has been accorded high priority in the New National Policy on education (NIPCCD, 1989).

o) Welfare of the handicapped children

Several programmes have been taken up for the welfare of the handicapped children. Educational and rehabilitative services are provided by various organisations in the country. The focus on integration of the handicapped children with the normal children (Chandrashekhara and Lalitha, 1988).

D. INTEGRATED CHILD DEVELOPMENT SERVICE (ICDS)

As today's children are the citizens of tomorrow's world, their survival, protection and development is the prerequisite for the future development of humanity. (WHO/UNICEF 1989), so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed with the skills and motivation needed by society (UNICEF, 1991).

ICDS is the first country wide programme involving coordinated efforts for providing an integrated package of services for the young child and the mother, The Ministry of Human Resource Development undertakes the overall monitoring of the programme through a central cell and the state level coordinating cells have a management information system (Manual on Monitoring Social Components of ICDS, 1987; Chetanon, 1991).

ICDS is best understood as a programme for child protection as well as child development (Sharma, 1989). It takes a holistic approach to the child by providing a package of services namely, supplementary nutrition, immunization, Health Check-up, referral services, treatment of minor illness, nutrition and health education to women, pre school education to children in the age group of 3-6 years, convergence of other supportive services like water supply, sanitation etc for the different beneficiary groups are shown in Fig. 1 (Manual on ICDS, 1984; ICDS, 1985-86; ICDS, 1989; Kumar, 1993).

Supplementary Nutrition

Supplementary nutrition is to bridge the dietary gap between the home diet and the actual nutritional need, and is provided to pregnant women, lactating mothers and children below 6 years in the ICDS, belonging to poorer socio-economic groups to reduce the morbidity and mortality rates in these groups (ICMR, 1986; Sawhney, 1990; Kurup, 1990).

Immunization

ICDS has played a significant role in improving the immunization status of children, pregnant women and nursing mothers, through the introduction of immunization programme against tetanus, diphtheria, Whooping cough etc., (Mahajan, 1989; NIPCCD, 1990).

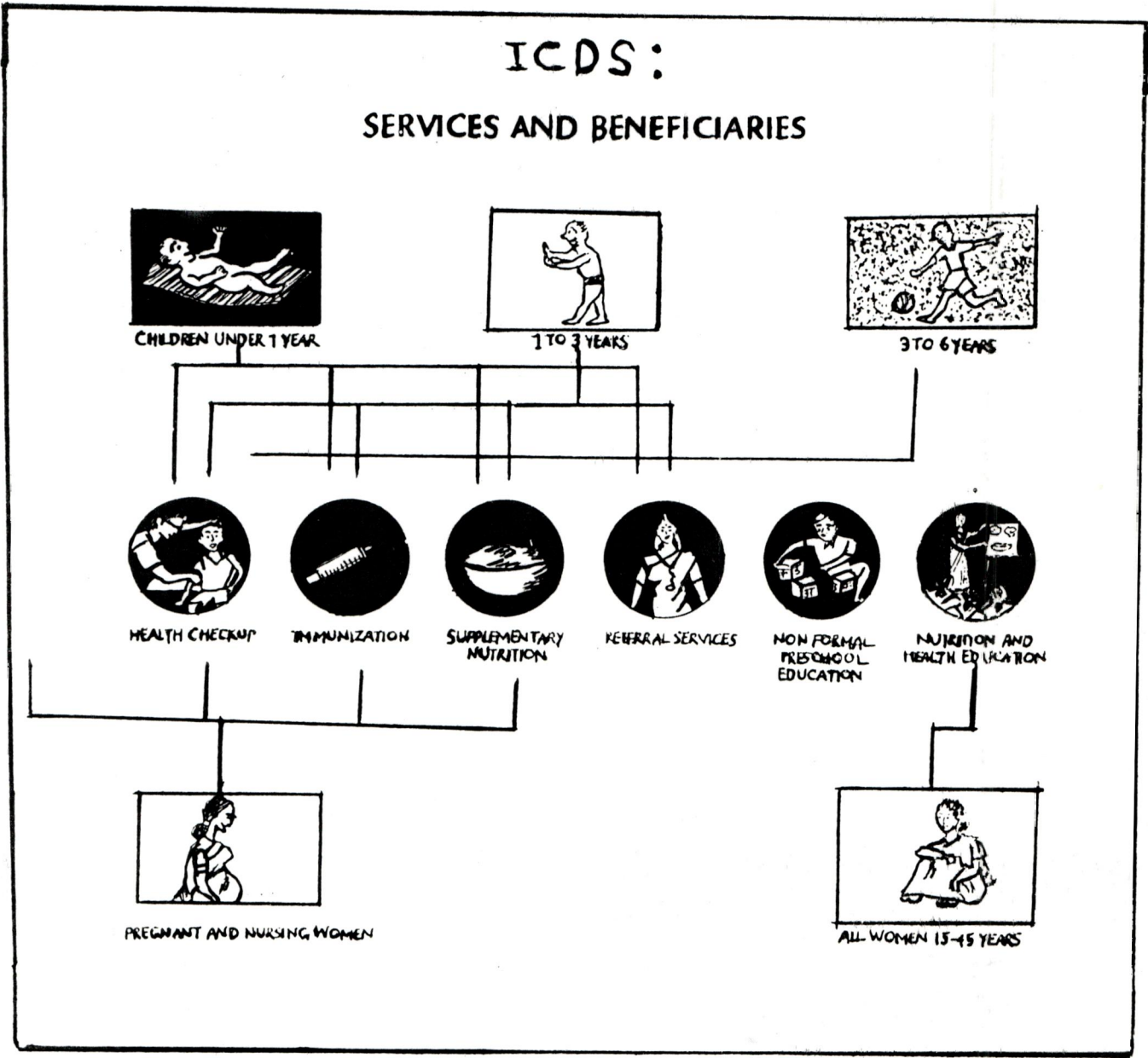


Figure-1

Health Check up

The services include antinatal and postnatal check-up of mothers, new-borns and children upto 6 years of age. This is done every 3 to 6 months to detect any incidence of diseases or under nutrition and to treat it (Ministry of Welfare, 1991).

Referral Services

Referral services are provided to both mothers and children and high risk cases are sent to referral hospital also for special care (Kapil, 1990).

Nutrition and Health Education

Nutrition and health education is an important component the ICDS which aims to create awareness regarding nutrition and health among the community with a special emphasis on women (Sawhney, 1990). It aims at effective communication of certain basic health and nutrition message with a view to enhancing the mother's awareness of the child's needs and her capacity (NIPCCD, 1988).

Non-formal Pre-school education

Pre school education is a non-formal setting, which forms the backbone of the ICDS programme as well services coverage on the preschool centre. Children between the ages of 3 and 5 attend the anganwadi for three hours a day

(UNICEF, 1984). There is no formally structured curriculum and flexibility is encouraged (Ministry of Human Resource Development, 1990).

The ICDS TEAM

ICDS serves through a network of anganwadis. The anganwadi worker is at the front line of the ICDS programme, selected from the community, who are appointed on an honorary basis to provide an integrated package of services to children below 6 years, pregnant women and nursing mothers. The Anganwadi is run by an Anganwadi worker and helper (Subramaniam 1985; Chandra, 1989; Integrate Child Development Services, 1990).

Anganwadi worker should receive a three months basic training. The three months training of AWWs includes courses in child development, community work, identification of disabilities, record keeping, survey techniques, family planning and training in imparting non-formal, nutrition and Health education (Bhalla, 1989).

The supervisor (Mukhya Sevika) is responsible for 14-25 Anganwadis, she also acts as friend, philosopher and guide to Anganwadi workers and assist in record keeping, home visits, organising community meetings and visit of health personnel. She provides on the job orientation courses to Anganwadi

workers (NIPCCD, 1987; Hand Book of Instruction Regarding ICDS Programme, 1990).

The child development Project Officer provides the link between ICDS functionaries and government administration. The officer is also responsible for securing Anganwadi premises, identifying beneficiaries, ensuring supply of food to centres and flow of health services and monitoring programmes and reporting to the state government (NIPCCD, 1984; Nutrition and Child Bureau of Women and Child Development, 1990).

The medical officers, the lady health visitors and female health workers from nearby primary health centres and sub-centres form a team with social welfare functionaries to implement ICDS. Organisational set-up of ICDS shown in Fig. 2 (Sharma, 1987; Gupta, 1989).

Monitoring ICDS

Right since the inception of ICDS there has been emphasis on proper monitoring and evaluation for getting feed back on proper implementation and coordination of the programme (NIPCCD, 1987; Profile of India, 1990).

New Innovation in Integrated Child Development Services

In the implementation of the Integrated Child Development Services (ICDS) programme, some deficiencies

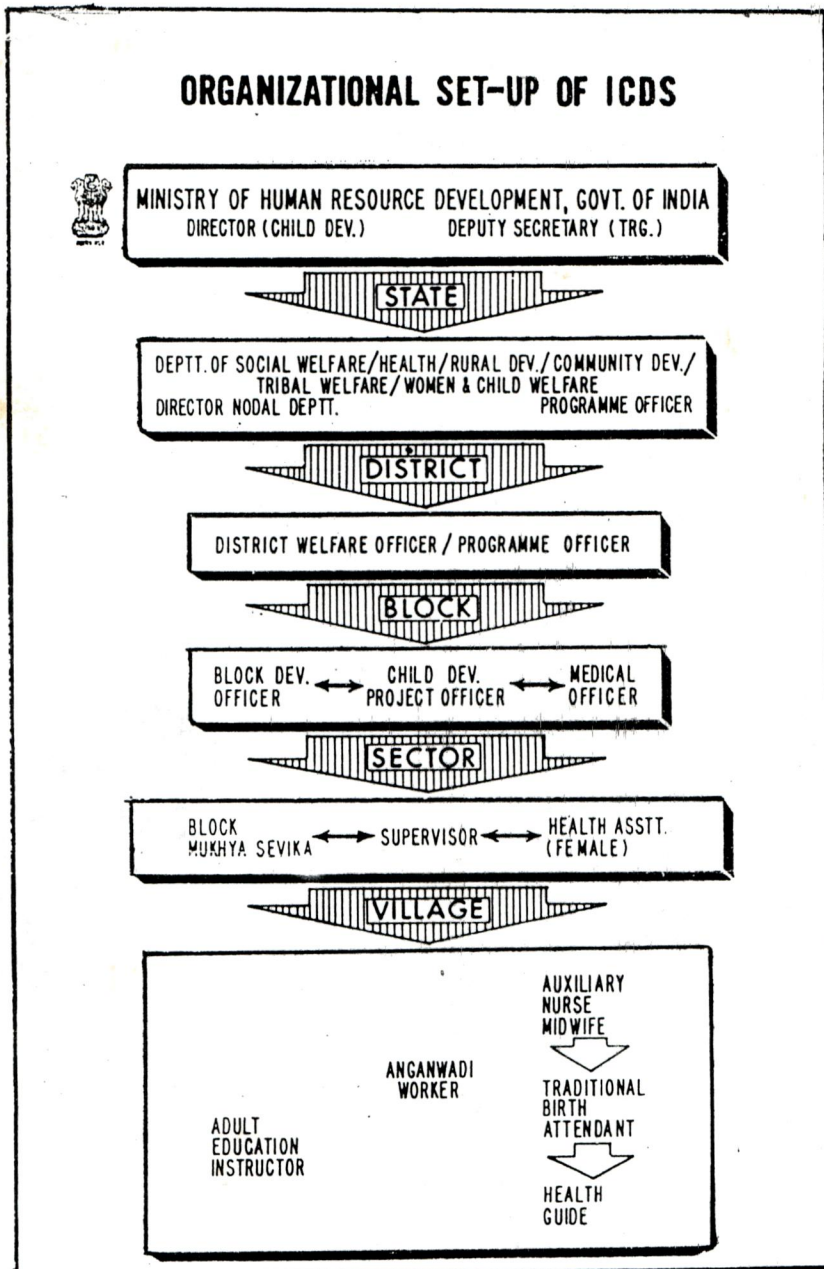


FIGURE - 2

have been recorded. To remedy these, additions-interventions are proposed to be made in this programme.

- a) Some of the Anganwadis would be converted into Anganwadi cum crech centres to solve the problem of low attendance of younger group of children (0-3 years).
- b) It is also proposed to provide services to adolescent girls.
- c) Non-formal education will be provided to women.
- d) It is proposed to construct about a lakh integrated women and child development centres.
- e) It is also proposed to establish Ready to Eat Food Plants (Ministry of information and broad casting, 1991).

Community Participation

The ICDS scheme focuses on the community as a unit for fostering child development. It envisages that beneficiaries as well as local organisations would come forward to render support on running the Anganwadi and Smooth implementation of the scheme (Sharma, 1987).

Anganwadi Provides the following activities as

1. Anganwadi is a place where in a safe, secure and congenial environment rich with varied toys and equipment.

2. Anganwadi helps the child to grow physically, mentally and socially.
3. Malnourished children are given supplementary nutrition, pregnant and nursing mothers are also given supplementary nutrition.
4. Immunization against various disease is given to the children and expectant mothers.
5. Regular health check up is given to children, nursing mothers and expectant mothers.
6. Health and nutrition education is given to all mothers especially pregnant and nursing mothers (Hand Book of Supervisor, 1989).

Job Responsibilities of Anganwadi Workers

Anganwadi workers is responsible for :

- 1) Organising non-formal pre-school education and supplementary nutrition feeding for children under six years, pregnant women and nursing mothers.
- 2) Giving health and nutrition education to mothers .
- 3) Making home visits for education of parents, particular mothers;
- 4) Eliciting community support and participation in running the programme
- 5) Assisting the primary health centre staff in the implementation of health component of ICDS, viz.,

immunization, health check up, referral services and health education.

- 6) Maintaining liason with other institutions in village and other village functionaries.
- 7) Bringing to the notice of the CDPO any development in the village which require further attention.
- 8) Weighing each child every month, use referral card for referring cases.
- 9) Maintaining records relating to delivery of services to children and mothers etc., (Bose, 1986; Hand Book of Instruction Regarding ICDS Programme, 1991; Kamble, 1990).

Job Responsibilities of the Anganwadi Helper

Each Anganwadi is to have a helper to assist the Anganwadi worker a local elderly women, who will generally assist the Anganwadi worker in running various Anganwadi activities. She is responsible for maintaining cleanliness both in the Anganwadi centre and the Anganwadi children; bringing children to Anganwadi centre; looking after physical needs of the children; preparing supplementary foods according to the instruction given by the Anganwadi worker; helping the Anganwadi worker in weighing of children and administration of first aid (A Guide Book of Anganwadi Worker, 1986).

E. RESEARCH INPUTS

Gandhi (1986) conducted a study on "Community participation in the urban ICDS project" vizag, Andhra Pradesh. His study revealed that the most of the Anganwadis were being supported by way of rent free accommodation by the youth club and Mahila Mandals and were closely connected with the ICDS Programme and helped the Anganwadi worker regularly.

Sharma conducted a survey on "Eliciting community participation in strengthening pre schools education component in ICDS (1987)" reported that, the community should be involved from the initial stage of implementation of ICDS for its operation.

Goswami (1986) conducted a study in preschool education in ICDS.

The major finding of the study are as follows:

- 1) The coverage of children under the scheme was found to be limited and some anganwadi centres were being run in the local primary school ghar, youth club etc.,
- 2) It was observed that most of the Anganwadi centre teaching aids and equipment were not adequate and anganwadi centres were supposed to run for 3 hours daily,

- 3) In most of the centres it was found that the worker and helpers often came late and sent the children back just after the distribution of food without conducting the pre school education session.

Adhish et al. (1990) conducted a study on "Impact of ICDS on pre school education and development of children in Aligarh district. The study revealed that the intellectual status of the children in ICDS villages was definitely better than that of the children in the non ICDS village and higher intellectual status in ICDS area was due to the impact of pre-school education and better nutritional status of children.

Tandon et al. (1981) conducted a study on "Nutrition and health delivery system of ICDS" reported that, nutrition and health delivery system of ICDS, functioning through the health delivery system of ICDS, functioning through the health infrastructure of the PHC has been found to be successful on delivery the essential services to the pre-school children, pregnant and lactating women of remote rural and tribal areas and urban slums. It was found to have improved the nutritional status of younger and pre-school children.

A study was conducted by Kanthinath and Saradha Suresh "Impact of Health Education on Immunization Strategy" 1000 mothers having children under 10 years were selected from and ICDS block in Madurai, Tamil Nadu.

The major finding of the study was as follows:

About 90 per cent mothers were aware of the primary doses of immunization, but only 50 per cent knew about the booster doses. Only 52 per cent mothers adhered to the immunization schedule. Health education was being imparted by doctors and health workers.

A study was undertaken by the Godavari Kamalanathan and Baradha (1989) on "Assessment of health status of children in Anganwadis". The anganwadis of an urban ICDS block sample comprised 200 children in the age group 3-4 years with an equal sex representation.

Sex-wise prevalence of malnutrition revealed that female children suffered slightly more (53%) than male (38%). All the children were fully immunized. The various diseases leading to morbidity in children were respiratory tract infections (51%), skin diseases (24%) gastro-intestinal disorders (12%) musculo skeletal (13%) helminthiasis (8%), iron deficiency (19%) vitamin A deficiency (11%) and pale conjunctiva (10%).

Sharma and Chand (1984-86) conducted a study "perception and participation of the community in ICDS" in urban, rural and tribal project in Rajasthan, Jaipur and Chaksu blocks which had 100 anganwadis each and Chhoti Sadri had 50.

Major finding of the study are as follows :

The level of awareness and participation of women respondents and community leaders was low in all the three blocks. The awareness of women respondents community leaders and project functionaries was the highest for supplementary nutrition followed by preschool children education and immunization. Among medical and paramedical functionaries, awareness was the highest for immunization followed by supplementary nutrition and vitamin A prophylaxis.

In the urban block participation of the community was negligible. In the rural and tribal blocks the involvement of local organisations was evident in their providing accomodation for the Anganwadis.

The study was undertaken by Subramaniam (1989) to assess "The impact of ICDS on immunization, supplementary nutrition, non-formal education and family size in an ICDS area" in the urban ICDS project Madras VII, Tamil Nadu, 100 families were selected for this study.

It was found that ICDS scheme had a positive impact on the immunization status and supplementary feeding. Non formal education raised the level of knowledge regarding breast feeding (92%), supplementary feeding (79%), growth chart (80%) environmental hygiene (92%) family planning (81%) and immunization (50%). About 26% families had four children each and 25 families had three children each. Only three families had nine children, and nine families had one child.

Deb (1982) and Subramaniam (1987) conducted a study on "Impact of ICDS programme" who found that the mothers of ICDS areas were better informed of the care during prenatal period, importance of supplementary feeding, growth monitoring of immunization and diseases of children than those in non-ICDS areas. It may be recalled here that the information on these aspects is disseminated in ICDS areas through Health and Nutrition Education.

Mehendale et al. (1982) conducted study on a "Nutritional status in ICDS and Non ICDS area" found that protein energy malnutrition is comparatively lower in the ICDS blocks and the nutritional status of children is better than those of the non-ICDS areas.

Khosla (1985) conducted a comparative study of "Impact of pre school education component of ICDS" was undertaken by NIPCCD in 300 Aws. The result is showed that children attending Aws performed significantly better task of

listening, comprehension object vocabulary, sequential thinking and time perception.

Begum and Malathi (1986) conducted a study on "Impact of Health and Nutrition education, component" in urban ICDS block, Anekal in Karnataka, found significant improvement in their knowledge, attitude and practices regarding infant feeding, deficiency diseases, hygiene and sanitation as compared to mothers who had not received Health and Nutrition Education.

Sharma et al. (1987) conducted a study on "Community participation in ICDS scheme" found that the legal coordination committees which are supposed to involve the community in the programme are non-existent in most cases. It has been reported in the study that both participation and involvement of the community in the ICDS programme and activities was minimal; it was confined to utilization of services only.

A study on "Health and Nutritional status of ICDS and Non-ICDS children" was conducted by Phagat et al. (1990) in Haryana. The findings revealed that there were as many normal as malnourished cases in the ICDS as in the non-ICDS children. There were more cases of moderate and severe malnutrition in the ICDS children as compared to the non ICDS children.

Methodology

III. METHODOLOGY

The methodology pertaining to the present study entitled functioning of Anganwadis (ICDS) in Kamrup District, Assam State involves the following steps :

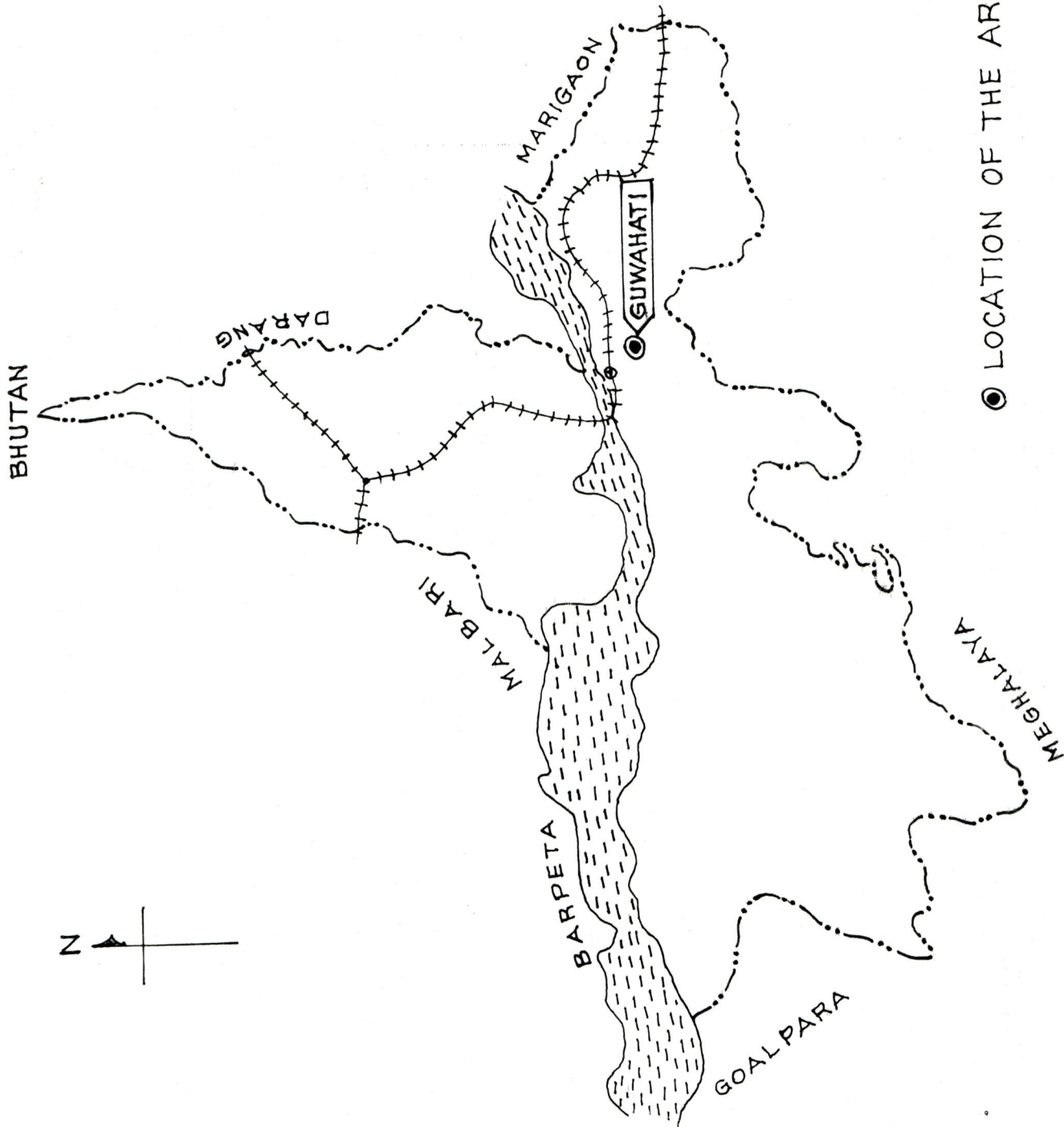
- A. Selection of the Area
- B. Selection of the sample
- C. Selection of the method and tool
- D. Collection of the data
- E. Analysis and Interpretation of data

A. SELECTION OF THE AREA

The area selected for the present study was Guwahati City which was situated in Kamrup District of Assam. This area was selected due to the good rapport created by the investigator and the co-operation extended by the people and easy accessibility and all the more the city is the investigators native place.

Assam which is situated in the north-east corner of India is surrounded by Bhutan, Tibet and Arunachal Pradesh in north, Nagaland and Manipur on east, Meghalaya and Mizoram on south and Bangladesh, Tripura and West Bengal on west. Geographical area covered by Assam is 78,523 Sq.km. comprising 23 Districts with a population of 223 lakh in 1991 (Provincial Census Record of 1991). *Figure 3 shows the location of Guwahati in Kamrup District of Assam.

MAP OF KAMRUJ VISITHICI



37a

● LOCATION OF THE AREA

Figure -3

B. SELECTION OF SAMPLE

Selection is that part of the universe which we select for the purpose and investigation (Gupta, 1990).

There are 100 Anganwadis presently functioning in Guwahati city under the urban ICDS project. Out of these 25 were chosen randomly for the study from north, east, west and south corner of Guwahati due to easy accessibility.

A sample is any group of measurement selected from a population for analysis (Gupta, 1993).

Random sampling is that in which every item in the universe has an equal chance of being selected (Palamiswamy and Manoharan, 1991).

From every selected Anganwadis 125 mothers of Anganwadi children in age group of 16-45 years were randomly selected with the help of respective Anganwadi workers and 25 AWWs were also selected for the study.

C. SELECTION OF THE METHOD AND TOOL

The interview method was adopted for this study. According to (Shidhu, 89), interview is a two way method which permits in that it involves the collection of data through direct verbal interaction between the interviewer and interviewee.

An interview schedule refers to a set of statements and questions to be answered by the respondents in a face to face interview and filled by the interviewer himself (Chawdhari, 1991).

According to Good and Hatt, schedule is the name usually applied to a set of questions which are asked and filled by an interviewer, in fact to face situation with another.

Accordingly, for this study, two different interview schedules were prepared and administered both for the Anganwadi worker and the mothers of Anganwadi children. A pilot study was carried out in this area having a sample of 20 mother respondents and 5 AWWs. Based on the gained experiences of the pilot study the schedule was restructured and utilised for the purpose of collecting data from the sample. Two different interview schedules are evolved and presented in Appendix I and II.

An interview schedule 'A' was evolved to collect information about the details regarding training and experience of the Anganwadi worker, teaching, feeding programme, and Anganwadi activities, and the use of instructional materials method of teaching, information about the staffing pattern, problems of the Anganwadi

worker, physical facilities of Anganwadi centre etc. Plate.1 shows the interviewing the Anganwadi worker.

An interview schedule 'B' consisted of details regarding socio-economic background of the family, opinion of mothers on the general details, classes conducted for them on nutrition education, health and hygiene and family welfare etc., views of mothers on sending their children to the Anganwadi, their participation on Anganwadi programmes and the parent teachers association were called for.

D. COLLECTION OF THE DATA

The investigator, was very particular on households with mothers of the Anganwadi children and Anganwadi worker in Anganwadi centre. After establishing a rapport the investigator met the respondents and collected the required information.

E. ANALYSIS AND INTERPRETATION OF THE DATA

The data obtained through the interview were more informative. The collected data were consolidated, tabulated and analysed.



INTERVIEWING THE ANGANWADI WORKER
PLATE - I

Results and Discussion

IV. RESULTS AND DISCUSSION

The results of the study are discussed under the following heads:

- A. Background information about the mothers of the Anganwadi children
- B. Mothers' views on sending their children to the Anganwadi
- C. Opinion of the mothers regarding the Anganwadi programmes
- D. Suggestion given by the mothers for the betterment of the Anganwadi
- E. Background information about the Anganwadi worker
- F. Information about the Anganwadi and its functions.

A. BACKGROUND INFORMATION ABOUT THE MOTHERS OF THE ANGANWADI CHILDREN

The background information about the mothers of the Anganwadi children includes the following:

- 1. Age - wise distribution
- 2. Educational status
- 3. Occupational pattern
- 4. Income distribution of the family
- 5. Type of family
- 6. Size of family

1. Age-wise distribution

The age-wise distribution of the mothers of the Anganwadi children is presented in Table I.

TABLE I
AGE - WISE DISTRIBUTION OF THE MOTHERS

S.No.	Age in Years	n:125	Percentage
1.	16 - 25	54	43
2.	26 - 35	65	52
3.	36 - 45	6	5
4.	46 and above	Nil	Nil

It is clear from the above table that majority of the mothers 52 per cent belonged to the age group of 26-35 years and 43 per cent belonged to the age group of 16-25 years, only a meagre number of selected mother belonged to the age group of 36-45 years.

2. Educational status

The educational status of the mother is given in Table II.

TABLE II
EDUCATIONAL STATUS OF THE MOTHERS

S.No.	Educational status	n:125	Percentage
1.	Literate	95	76
2.	Illiterate	30	24

It is interesting to note that 76 per cent of mothers were literate, and 24 per cent were illiterate.

3. Occupational pattern

It is surprising to note that out of 125 respondents, majority of them (70 per cent) were house wives and the remaining 30 per cent were working as Anganwadi workers, teachers, clerks, Ayahs and also engaged in business.

4. Income distribution of the family

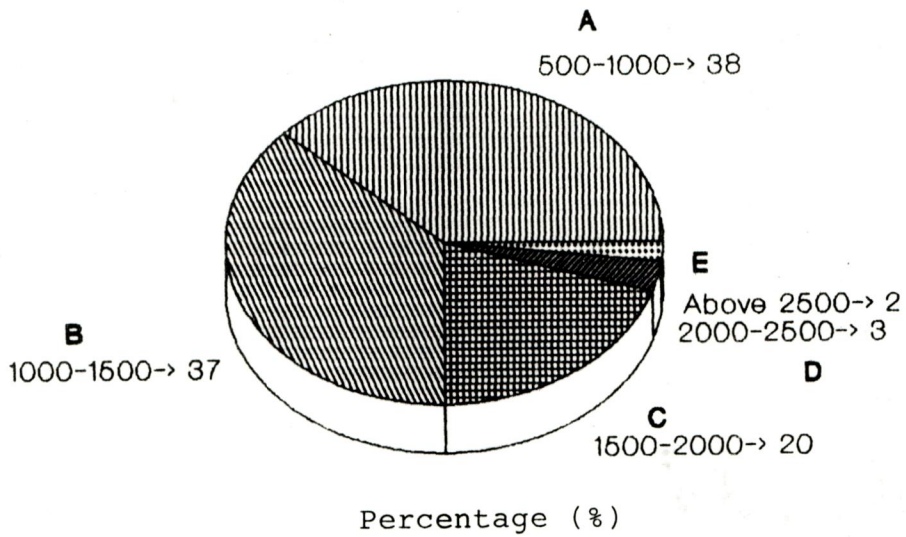
Table III shows the income distribution of the family.

TABLE III
INCOME DISTRIBUTION OF THE FAMILY

S.No.	Income Rs/month	n:125	Percentage
1.	500 - 1000	47	38
2.	1000 - 1500	46	37
3.	1500 - 2000	25	20
4.	2000 - 2500	4	3
5.	Above 2500	3	2

From the above table it is very clear that majority of the families of the selected mothers belonged to the low income group. This is diagram matically represented in the form of pie diagram (Fig.4).

INCOME DISTRIBUTION OF THE FAMILY



- A. 500 - 1000
- B. 1000 - 1500
- C. 1500 - 2000
- D. 2000 - 2500
- E. Above 2500.

Fig - 4

5. Types of Family

Table IV gives the type of family of the selected mothers.

TABLE IV
TYPES OF FAMILY

S.No.	Types of family	n:125	Percentage
1.	Nuclear	88	70
2.	Joint	37	30

It is very interesting to note that 70 per cent respondents belonged to the nuclear family and 30 per cent belonged to the joint family.

6. Size of family

The size of family of the selected mothers is presented in Table V.

TABLE V
SIZE OF FAMILY

S.No.	Family size	n:125	Percentage
1.	1 - 3	30	24
2.	3 - 6	85	68
3.	6 and above	10	8

It is observed from the above table that out of 125 respondents 68 per cent had a family size of 3-6 members 24 per cent of the respondents had a family size of 1-3 members and the remaining eight percent had six and above family members.

B. MOTHERS VIEWS ON SENDING THEIR CHILDREN TO THE ANGANWADI:

Mothers views on sending their children to the Anganwadi include the following:

1. Reasons for sending the children to the Anganwadi
 2. Problem faced by mothers in sending their children to the Anganwadi
 3. Opinion of mothers towards the child improvement
1. Reasons for sending the children to the Anganwadi

Table IV explains the reasons given by the mothers for sending their children to the Anganwadi.

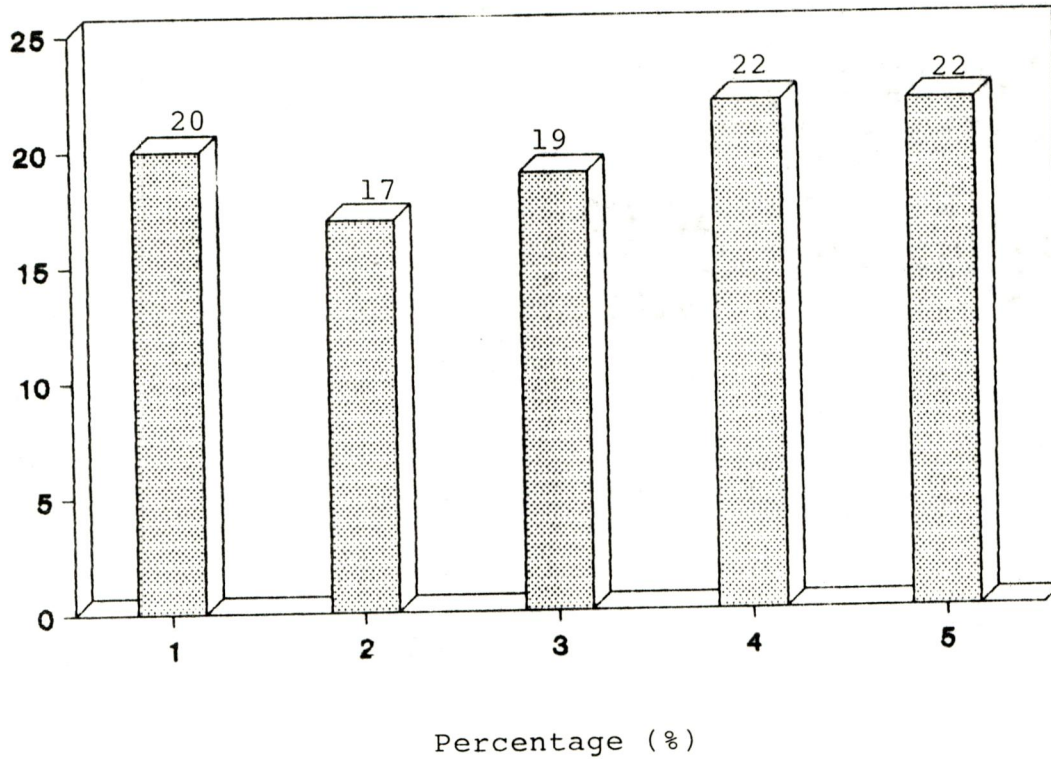
TABLE VI
REASONS FOR SENDING THE CHILDREN TO THE ANGANWADI

S.No.	Reasons	n:125	Percentage*
1.	To get free education and free meals	71	20
2.	To get free health service	60	17
3.	To develop good habits	70	19
4.	To engage the children	80	22
5.	To prepare the children for pre-school education	80	22

* Multiple response

The presented data reveals that majority of the mothers sent their children to the Anganwadi, for the following reasons: to get free education and free meals, free health service, develop good habits, engage the children in activities and prepare the children for pre-school education. This is diagrammatically represented in the form of bar diagram (Fig.5).

REASONS FOR SENDING THE CHILDREN TO THE ANGANWADI



1. To get free education and free meals
2. To get free health services
3. To develop good habits
4. To engage the children
5. To prepare the children for pre school education.

Fig - 5

2. Problems faced by the mothers in sending their children to the Anganwadi

TABLE VII
PROBLEMS FACED BY THE MOTHERS IN SENDING THEIR CHILDREN TO THE ANGANWADI

S.No.	Problems	n:125	Percentage
1.	Anganwadi is far from their houses	10	8
2.	Child denies to go	50	40
3.	More household duty	60	48
4.	Due to lack of time	5	4

Out of 125 mothers 48 per cent of the mothers revealed that, the household duties prevented them from sending their children to the Anganwadi in time. 40 per cent of mothers said that child is not willing to go, to make them go to the Anganwadi takes time (8 per cent) said that the Anganwadi is far from their houses and (4 per cent) said that due to lack of time they were unable to send their children to the Anganwadi in time.

3. **Opinion of mothers towards the child improvements**

Majority of the respondents felt that Anganwadi helps the child to grow physically, mentally and socially,

Noteworthy changes are found out in the behaviour of the children after attending the Anganwadi, the children developed good habits, maintain discipline and also learnt more about group life like adjustment etc. Due to this the mothers try to be regular in sending their children to the Anganwadi.

C. OPINION OF MOTHERS REGARDING THE ANGANWADI PROGRAMMES

Opinion of mothers regarding the Anganwadi programmes include the following :

1. Opinion of mothers regarding the services rendered by the Anganwadi for the children.
2. Opinion of mothers regarding the services provided by Anganwadi for mothers.
1. Opinion of mothers regarding the services rendered by the Anganwadi for the children.

Majority of the mothers are satisfied with the services rendered by the Anganwadi. The Anganwadi workers are very responsible and are running the Anganwadi smoothly and look after the physical, mental and social needs of the children. They are also responsible for preparation of nutritious foods and distributed equally to the children, Anganwadi worker and helper are regular in their duties. Anganwadi worker taught various aspects to children like rhymes, songs, story telling, drawing, physical exercise, science

experience, habit formation, general knowledge for the developed knowledge and skill of children. Anganwadi centres has necessary equipment needed for the children.

2. Opinion of mothers regarding the services provided by Anganwadi for the mothers

The mothers are better informed of the care during prenatal and postnatal period, importance of breast feeding and supplementary feeding, growth monitoring of immunization and diseases of children and family planning by the Anganwadi worker. Apart from these the mothers were well informed of the cooking techniques, food processing and preservation, kitchen gardening etc.

D. SUGGESTION GIVEN BY THE MOTHERS FOR THE BETTERMENT OF THE ANGANWADI

Table VIII shows the suggestion given by the mothers for the betterment of the Anganwadi.

TABLE VIII
SUGGESTION GIVEN BY THE MOTHERS FOR THE BETTERMENT OF THE
ANGANWADI

S.No.	Suggestions	n:125	Percentage*
1.	Organise cultural programme	68	20
2.	Provide free books, uniform	98	29
3.	Arrange field trips for children	79	24
4.	Appoint a doctor who can look after the children at least monthly	89	27
* Multiple response			

The presented data reveal the suggestion given by the mothers for the betterment of the Anganwadi. They are as follows: Anganwadi should organise cultural programmes, through this we can inculcate the values of culture to the young minds. It should provide free books and uniforms thus they can increase the attendance and encourage the poor children to attend Anganwadis. Anganwadi should arrange field trips, so that children can enrich knowledge about the environment. The appointment of doctor, will help the nation to get healthy children for the future India.

E. BACKGROUND INFORMATION ABOUT THE ANGANWADI WORKERS

The background information about the Anganwadi workers regarding age, educational level, experience and marital status is presented in the Table IX.

TABLE IX
BACKGROUND INFORMATION ABOUT THE AWWs

S.No.	Details	n:25
1.	Age in years: 21 - 30	25
2.	Educational level : Matriculates	20
	Graduates	5
3.	Experience in years: Upto 10 years	15
	10 and above	10
4.	Marital status : Married	12
	Unmarried	13

It is clear from the above table that all the selected Anganwadi workers belonged to the age group of 21-30 years. Majority (20) of the AWWs are literate upto matriculation. very few (5) AWWs completed their degree. Majority (15) of the AWWs have working experience upto 10 years, and 10 of them had working experience 10 years and above. Out of 25 AWWs, 12 got married. All the AWWs had undergone training and attended refresher course, only a meagre number of AWWs had not attended the refresher course. The training and refresher course helped the AWWs became more responsible persons so they were duty conscious and they run the anganwadi successfully.

F. INFORMATION ABOUT THE ANGANWADI AND ITS FUNCTION

Information about the Anganwadi and its function includes the following:

1. Views of the Anganwadi worker about the physical structure of Anganwadi.
2. Functioning of the Anganwadi.
3. Community participation in functioning of Anganwadi
4. Problem faced by the Anganwadi workers
5. Suggestions given by the Anganwadi workers for the smooth functioning of the Anganwadi.

1. Views of the Anganwadi worker about the physical structure of Anganwadi:

Table X shows the physical structure of the Anganwadi

TABLE X
PHYSICAL STRUCTURE OF THE ANGANWADI

S.No.	Items	Facilities available	Facilities Not available
1.	Rented building	17	8
2.	Proper ventilation	17	8
3.	Proper lighting	17	8
4.	Enough space in the room	18	7
5.	Smooth flooring	17	8
6.	Adequate water supply	19	6
7.	Enough furniture	20	5
8.	Proper kitchen and equipped with essential vessels for cooking and serving	25	-
9.	Proper store - room	18	7
10.	Play ground	15	10
11.	Toilet facilities	16	9
12.	Enough shelves to keep the materials	25	10

It is clear from the above table that the majority of the Anganwadi is run in the rented building, properly

ventilated. The class room is big and spacious with smooth flooring, well lighted and had adequate furniture for class room, adequate water supply. And also it has proper kitchen equipped with essential vessels and utensils for cooking and serving, proper store - room to store the food materials and enough shelves to keep the play materials, records and other things. Above these majority of anganwadi is provided with play ground and toilet facilities. Plate 2 shows the physical structure of the Anganwadi building.

2. Functioning of the Anganwadi

All the Anganwadi workers are maintaining the required records and registers. With the help of observation it is found that the hygiene in the Anganwadis are satisfactory. The Anganwadi workers are proving their sincerity and honesty in their work and showing motherly affection to the children. They are adopting various teaching methods and aids by which they are inculcating the values of education, cleanliness, discipline, hygiene, good habits, good behaviour to the children. They are very particular about the cleanliness of the Anganwadi. Above all they are conducting meetings for the mothers regularly in different aspects and make them use the services rendered by the Anganwadi. It was interesting to observe that all the selected Anganwadi workers rendered the following activities in their respective Anganwadis.

- * Organise prayer before starting the pre - school class
- * Conduct classes in non formal pre - school children
- * Take weight of the Anganwadi children
- * Conduct outdoor play activity.

(Plate.3 to 6)

3. **Community participation in functioning of the Anganwadi**
Community participation in functioning of the Anganwadi is presented in the Table XI.

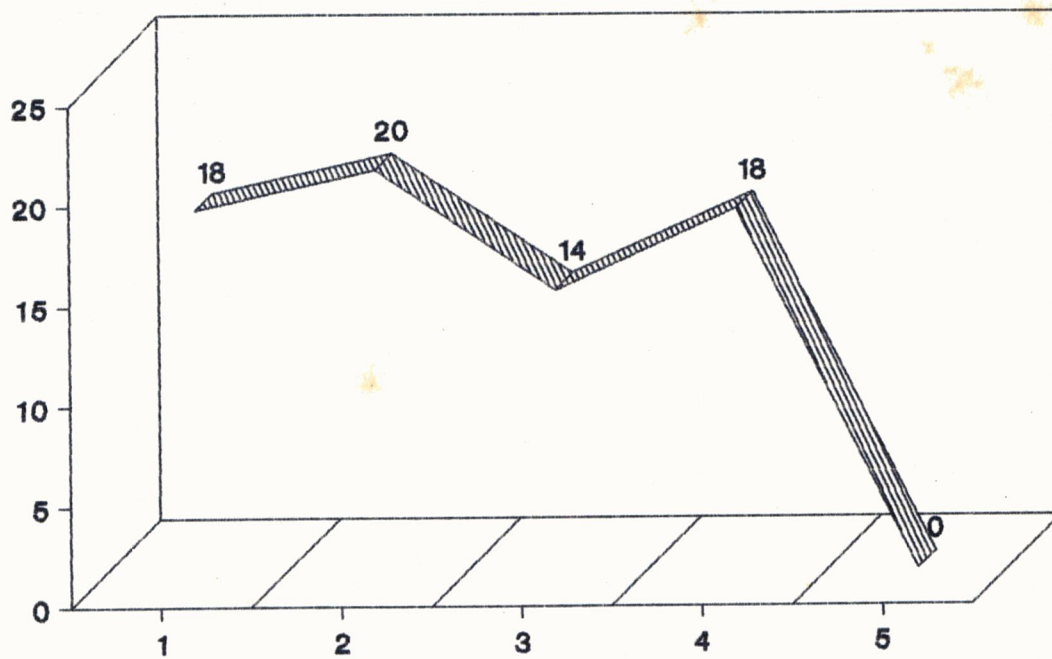
TABLE XI
COMMUNITY PARTICIPATION

S.No.	Organisation	n:25*
1.	Mahila Mandal	18
2.	Youth Club	20
3.	Local Committee	14
4.	School	18
5.	Co-operative Society	Nil

* Multiple response

Community participation is an essential component in improving the knowledge and perception of the beneficiaries. Out of 25 selected Anganwadi, 20 Anganwadi received the help from local organisation like Youth club, 18 were received

COMMUNITY PARTICIPATION



1. Mahila Mandal
2. Youth club
3. Local committee
4. School
5. Co-operative society

Fig - 6

the help from Mahila Mandal and school, and remaining 14 were received help from local committee. The community participation help the Anganwadi to run smoothly and efficiently. This is diagrammatically represented in the form of bar diagram (Fig. 6).

4. Problems faced by the Anganwadi workers (AWWs)

Table XII show the problems faced by the Anganwadi workers.

TABLE XII
PROBLEMS FACED BY THE ANGANWADI WORKERS

S.No.	Problems	n:25*
1.	Lack of co-operation from the parents	15
2.	Difficulties from children	13
3.	Play facility	8
4.	Lack of adequate furniture	5
5.	Lack of adequate teaching aids	9
* Multiple responses		

Out of 25 AWWs, 15 AWWs reveal that they are unable to get co-operation from the parents, and this poses a hurdle to run the Anganwadi smoothly. Lack of adequate furniture and play materials creates the problem between the children, they quarrelled with each other for place and play

materials. The AWWs is in trouble to control the children. The teaching aid is not adequate according to need, so government should provide enough teaching aids, to the Anganwadi.

5. Suggestions given by the Anganwadi workers for the smooth functioning of Anganwadi:

All the AWWs suggested that AWWs and helper should prove their sincerity and honesty in their work. The people and government should provide them helping hand to run smooth functioning of the Anganwadi.



ANGANWADI BUILDING
PLATE - 2



ANGANWADI CLASS START WITH PRAYER
PLATE - 3



TEACHING IN ANGANWADI
PLATE - 4



WEIGHT MEASUREMENT OF
ANGANWADI CHILDREN
PLATE - 5



OUTDOOR PLAY ACTIVITY BY
ANGANWADI CHILDREN
PLATE - 6

Summary and Conclusion

V. SUMMARY AND CONCLUSION

A study on 'Functioning of Anganwadis (ICDS) in Kamrup District, Assam state' was carried out with 25 Anganwadi workers and 125 mothers of the Anganwadi children in 25 selected Anganwadis from east, west, north, south corner of Guwahati city to elicit information on functioning of Anganwadi, services rendered by the Anganwadi, and community involvement in the Anganwadi programme. The major findings of the study are summarised below:

1. Out of 125 selected mothers majority (52 per cent) of them belonged to the age group of 26-35 years. 76 per cent of the mothers were literates.
2. Out of 125 selected mothers, majority of them (70 per cent) were housewives and remaining 30 per cent working as Anganwadi workers, teacher, clerks, ayah, labourers and also were engaged in business. Majority of them belonged to the lower income group.
3. Majority (70 per cent) of the respondents belonged to the nuclear family, 68 per cent had a family size of 3-6 members and remaining 24 per cent had a family size of 1-3 members and (8 per cent) had families with six and above members.

4. Majority of the mothers sent their children to the Anganwadi, to get free education and free meals, free health services, to develop good habits, to engage the children in various activities, to prepare the children for pre-school education.
5. 48 per cent stated that, household duty prevented them in sending their children to the Anganwadi in time, 40 per cent said that child is not willing to go to the Anganwadi, remaining 4 per cent were unable to send their children in time due to lack of time and Anganwadi is far from their houses.
6. Highest number of respondents felt that the Anganwadi helps the child to grow physically, mentally and socially and children are able to develop good habits, maintain discipline and also learnt more about group life like adjustment etc., after attending the Anganwadi.
7. Majority of the mothers are satisfied with the services rendered by the Anganwadi. The AWWs and helpers are very responsible in their duties. They look after the physical, mental and social needs of the children. The AWWs are very responsible in teaching various aspects to children like rhymes, songs, story telling habit formation, science experience, general knowledge, drawing etc.,

through which they can gain their knowledge and skill.

8. The mothers are better informed on various aspects of family welfare like family planning, care during prenatal and postnatal period, importance of breast feeding and supplementary feeding, diseases of children, cooking techniques etc.
9. The mothers suggested that Anganwadi should organise cultural programmes, through this we can inculcate the values of culture to the young minds. It should provide free books and uniforms thus they can increase the attendance and encourage the poor children, should arrange field trips for children to improve their knowledge. The appointment of doctor will help to get healthy children for the future India.
10. All the selected AWWs belonged to the age group of 21-30 years. Out of 25, 20 were literate upto matriculation. 15 of them were had working experience upto 10 years and 12 of them were married. Except meagre number of AWWs all the AWWs, had undergone training and attended refresher courses.
11. Majority of the Anganwadi were functioning in rented accomodation, properly ventilated. The class

rooms are big and spacious with smooth flooring, well lighted and had adequate furniture, proper kitchen equipped with essential vessels and utensils for cooking and serving, proper store room to store the food materials and enough shelves to keep the play materials, records etc.

12. All the AWWs maintained required records and registers and discipline of the Anganwadi. The AWWs showing motherly affection to the children and adopted various teaching methods by which they inculcated the values of education, cleanliness, hygiene, good habits, develop good behaviour to the children and conducting mothers meetings in various aspects through which the mothers can run their family smoothly and happily.
13. Out of 25 AWWs majority of them received help from local organisation like youth club, mahila mandal, school etc.
14. Only few AWWs have stated their problems, it is impossible for them to get co-operation from the parents, inadequate play materials creates the problem between the children, they are unable to use necessary teaching materials in conducting classes for children and mothers due to the inadequate teaching aids.

15. All the AWWs suggested that the AWWs and helper should prove their sincerity and honesty in their duties. The people and Government should provide their helping hands to run the Anganwadi smoothly.

Based on the experience gained in the study the investigator wants to recommend the following for future consideration.

1. The Anganwadi should be provided with adequate play materials and teaching aids.
2. Parents should give their co-operation so that it will help the AWWs to carry out their activities smoothly.
3. CDPO and supervisors, need to visit the centre frequently for better guidance, and supervision of the Anganwadi.
4. Regular health check-up should be provided in Anganwadi for the children.
5. Refresher courses to be arranged periodically for Anganwadi workers in innovative methods of teaching and new approaches of dealing with children.
6. The Anganwadi worker can be encouraged to form Parent Teacher Association for the betterment of the Anganwadi and the children.
7. Anganwadi workers have to approach officials of ICDS and related departments for the requisite inputs.

CONCLUSION

Children are blooming flowers of the garden of the society and to spread their fragrance around they need care at an early stage. Politically, socially and economically child is the seed of the future national growth, children are the most valuable possessions, assets, and wealth of a nation. They are citizens, leaders of the future. Therefore care must be given in early stages itself to promote the overall development.

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Appendix

APPENDIX I

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND
HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY)

COIMBATORE - 641 043.

AN INTERVIEW SCHEDULE TO ELICIT INFORMATION FROM
ANGANWADI WORKERS OF ICDS IN KAMRUP DISTRICT ASSAM

Date :

1. Name of the Anganwadi worker :
2. Year of the joining in the job :
3. Educational Qualification :
4. Have you received any training in ICDS : Yes No

If yes, mention the name of the training institutions :

5. Where do you reside ? :

Local/other place

6. Name and Address of the Anganwadi centre :
 - a. Centre No :
 - b. Place :
 - c. Area :

7. Where is centre located :
- a. Owned building :
 - b. Rented building :
 - c. School :
 - d. Youth club :
 - e. Local library :
8. Is the building properly ventilated : Yes No
9. Is the Anganwadi well lighted ? : Yes No
10. Is the space sufficient ? : Yes No
11. Is it closed one ? : Yes No
12. Condition of the flooring :
Good/damaged/mud floor/with
patcha
13. Is there any drinking water facilities ? : Yes No
- If no, where from do they
get water :
- a) Well :
 - b) Tube well :
 - c) Pond :
 - d) Any other :
 - e) Municipality pipe :
14. How many children are enrolled
in Anganwadi ? :

15. What is the average attendance :

16. Mention the age group of children in Anganwadi :

Age group (Years)	:	Number of children
2 - 2 Years	:	
2-1/2 - 3-1/2 Years	:	
3 - 3-1/2 Years	:	
3-1/2 - 4 Years	:	
4 - 4-1/2 Years	:	
Above 5 Years	:	
Total Number	:	

17. How many children are taking mid-day meal ? :

18. What are the items provided in mid-day meal ? :

19. Total number of feeding days per week :

20. How many helpers are there at anganwadi ?

Nature of work

- a. Preparation of foods :
- b. Cleaning the utensils :
- c. Care of the children :
- d. Any other, specify :

21. What are the aspects thought in Angawadi ? :
- | | | | |
|-----------------------|---|-----|----|
| a. Rhymes | : | Yes | No |
| b. Songs | : | Yes | No |
| c. Story telling | : | Yes | No |
| d. Drawing | : | Yes | No |
| e. Physical exercise | : | Yes | No |
| f. Demostration | : | Yes | No |
| g. Health and Hygiene | : | Yes | No |
| h. Toilet training | : | Yes | No |
| i. Science experience | : | Yes | No |
| j. Habit formation | : | Yes | No |
| k. General knowledge | : | Yes | No |

22. What is the method of teaching ?

- | | |
|------------------|---|
| a. Through play | : |
| b. Songs | : |
| c. Story telling | : |
| d. Activities | : |
| e. Training | : |

23. Are you using teaching aid for teaching ? : Yes No

If yes, mention

a. Chart :

b. Poster :

c. Flash card :

d. Flannel graph :

e. Flip book :

f. Black board :

g. Puppet :

h. Slide :

i. Video cassettes :

j. Roller charts :

k. Bulletin Boards :

l. Photographs :

m. Models :

24. Who provides you these teaching aids ? :

a. Supplied :

b. Purchased :

c. Prepared :

25. Do you have the following facilities in the Anganwadi ? :
- a. Class room :
 - b. Furniture :
 - c. Teaching aid :
 - d. Kitchen and relevant utensils:
 - e. Proper drainage :
 - f. Play ground :
 - g. Proper store room :
 - h. Toilet :
 - i. Primers,pencils,note books :
 - j. Box/Almirah and lantern :

26. What are the service provided by your anganwadis ?

 Services

Yes / No

- 1. Supplementary nutrition
 - 2. Immunization of children and mothers
 - 3. Health check-up of children,pregnant and nursing mothers
 - 4. Referral services for children and mothers to P.H.C. and district hospital
 - 5. Nutrition and population education
 - 6. Non-formal education to preschool children
-

27. Supplementary Nutrition Coverage :

Particulars	Pregnant mothers	Nursing mothers	Children (0-6 years)	Total
-------------	------------------	-----------------	----------------------	-------

28. What are the types of food given by ICDS in your Anganwadi Centre ? Mention the name of the items.

29. How many children are immunized :

30. Do you provide health check-up for the mothers ? :

31. Do you take height, weight measurement for the children every month : Yes No

If yes, do you record them : Yes No

32. Did you refer any serious cases to the P.H.C. : Yes No

If yes, then mention whom you referred ?

a. Children :

b. Pregnant mothers :

c. Nursing mothers :

d. Others :

33. Do you know the mothers of the Anganwadi children personally ? : Yes No

40. Do you get any help from the following organisations ? : Yes No

If yes, specify the name

a. Mahila mandal :

b. Youth club :

c. Local committee :

d. School :

e. Co-operative society :

f. Any other, specify :

41. Does the community help you to run the Anganwadi smoothly ? : Yes No

42. How is the community involving itself in the following programmes :

Programmes : Nature of involvement

a. Supplementary nutrition :

b. Immunization, health check-up and referral services :

c. Pre-school non formal education :

d. Nutrition, health and population education programme :

e. Functional literacy classes :

f. Others :

43. Are you maintaining records and registers properly : Yes No

44. Does the supervisor or health officer visit the Anganwadi regularly ? : Yes No

If yes, mention the frequency of visit,

- a. Once in a week :
- b. Once in fortnight :
- c. Once in a month :
- d. Once in three month :
- e. Once in six month :
- f. Once in a year :
- g. No fixed time :

45. Do you notice any improvement in the children in terms of

- a. Cleanliness :
- b. Punctuality :
- c. Personality :
- d. Habits :
- e. Good bahaviour :
- f. Sense of responsibility :
- g. Group feeling :
- h. Tolerance :
- i. Patience :
- j. Learnt many things :
- k. Socialibility :

46. What problems you face in the Anganwadi ? :
- a. Play facility :
 - b. Seating facility :
 - c. Lack of cooperation from parents :
 - d. Problem from the children :
 - e. Lack of adequate food items :
 - f. Lack of food :
 - g. Others :
47. Have you solved them : Yes No
48. Give suggestion for the smooth functioning of Anganwadi :

9. Where is the Anganwadi located in your area ?

10. Why are you sending your children to the Anganwadi centre?

11. Do you send your children to the Angan wadi regularly ?

Yes

No

if no, give reason

12. Who takes the child to Anganwadi ?

13. What are the steps taken by you, to maintain the regularity of your child to go to the Anganwadi ?

14. Have you faced any problems in sending your children to the Anganwadi ?

Yes

No

If yes, what type of problem faced by you ?

15. Do you find any change in your children after attending the Anganwadi ?

Yes No

If yes, changes are :

a. Physically healthy :

b. Social in nature :

c. Cleaniness :

d. Educational in nature :

e. others :

16. Does your child take the meal at Anganwadi ?

Yes No

17. Does the child like to eat all types of foods given in Anganwadi ?

Yes No

If no what type they do not like ?

18. Do you feel that the preparation of food at the Anganwadi is hygienic ?

Yes No

19. Do you feel that there should be change in the menu ?

Yes No

20. Do you think that meal provide by Anganwadi is nutritious ?

Yes No

21. Do you discuss your child's performance with the Anganwadi worker ?

Yes No

22. Are you aware of the people working in Anganwadi ?

Yes No

23. If yes, mention

24. Do you visit the Anganwadi ?

Yes No

25. Do you attend the mothers meetings regularly ?

Yes No

Give your opinion about these meetings.

26. Did you get any service from Anganwadi when you were pregnant/nursing mothers ?

Yes No

If yes, specify.

a. Nutrition

b. Immunization

c. Any medicine (like vitamin tablet)

d. Medical Services/Referral Services

27. Do you attend the class conducted for mother regularly ?

Yes No

if No, give reason

a. Lack of interest

b. Lack of time

c. Teaching is bad

d. Topics are not useful

e. Others, specify

28. How often the classes are organised ?

Weekly

Fortnightly

Monthly

29. What classes are they conducting ?

30. Do you like the classes ?

Yes No

if yes, give reason

if no, give reason

31. What are the items discussed in the class ?

32. What methods do they employ while mothers meetings conducting ?

a. Lecture/discussion

b. Demonstration

c. Film show

d. others specify

Which method do you find interesting ?

33. Are the classes arranged according to your convenience ?

Yes

No

if no, have you talked about it to the Anganwadi worker?

34. Have you suggested any topic of your interest ?

Yes

No

35. From where do you get immunized during pregnancy ?

36. Have you immunized the child against various diseases ?

Yes

No

37. Do you take the child to the P.H.C. when he falls sick ?

Yes

No

38. Do you think that Anganwadi is adequately well equipped?

Yes

No

39. If it is inadequate, have you taken any steps to procure them ?

Yes No

40. Do you think, the Anganwadi is useful ?

Yes No

41. Are you satisfied with the Anganwadi programme ?

Yes No

42. Give your suggestions for the betterment of the Anganwadi ?