ATTITUDE OF MOTHERS TOWARDS ANGANWADIS (I C D S PROGRAMME)

BY

TAMILSELVI, N.

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

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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

INTRODUCTION

A Nation's children are its supremely important asset, and the nation's future lies in their proper development. An investment in children is indeed an investment in nation's future. A healthy and educated child of today is the active and intelligent citizen of tomorrow

- Tagore

Child is man's greatest acquisition, since it provides hope and happiness, especially if the child is beaming with health and vigour. An investment in child development is indeed an investment in human resource development (Kumar, 1988)

Children are the future of a nation and they constitute the most important section of the society. It is the responsibility of the country to provide conditions for the proper growth and development of children. Knowledge of child development and child training can help parents and teachers to nurture and promote the allround growth and development of children and bring about desirable social changes and social equality through children (Grover, 1987).

Children are our most precious resources. The quality of tomorrow's world and perhaps even its survival will be determined by the well-being, safety and the physical and intellectual development of children. To predict the future of a nation it has been remarked, one need not consult the stars, but it can more easily and plainly be read in the faces of its children. Children are the mirror of a nation (Goel and Jain, 1990). It is the duty of the parents to prepare children to become good citizens, developing their capacities, enriching their minds with knowledge and filling their hearts with love, truth and duty. Mankind must sweep through another vast cycle of sin and suffering before the dawn of a better era can arise upon the world (Mann, 1980).

On the welfare and satisfaction of the children depends, not only the health and welfare of the community, but the claim of the nation to civilisation itself. In most of the advanced countries, child care has been accorded the highest priority and only the best is supposed to be good enough for children. On the statute books of other countries, one comes across so many pieces of legislation for the protection of children's interest and promotion of their welfare (Chowdhry, 1963).

A child is regarded as the future hope of the family and as an individual he will determine the kind of status, the family would acquire in the future (Sheikh, 1993). The welfare of the entire community depends on the health and welfare of the child in every nation. The importance of child welfare service lies not only with the immediate health, development and security of children within a country, but also lies with conscious acknowledgement of the fact that the personality of human being is built up in the formative years of the child, and hence the physical and mental health of the nation is determined by the manner in which the life of the child is shaped in the early stages (Mahanthi, 1993).

Child development is integral to over all socio-economic development of a nation. Problems of child health and development present a formidable challenge. To meet this challenge every citizen of India has to make some contribution. It is obvious that hospitals or the medical staff alone would not be able to cope with growing needs of our children, without the active and positive involvement of the community.

It is the mother who has to assume the role of a frontline health worker and the doctor and others have only to supplement and support her efforts, whether the issue involved is diarrhoeal, dehydration or vaccine-preventable disease, low birth weight or malnutrition, infant death or childhood disability or the lack of attainment of full mental faculties (Kumar, 1988).

The equality of human resources of any country is largely determined by the equality of its Child Development Services. The children of today are the generation of tomorrow. Recent inputs into child development progremmes have not been unimpressive. The country-wide Integrated Child Development Services (ICDS), the massive Tamilnadu Noon meal Programme, the Tamilnadu Integrated Nutrition Project and more recent National Drive for Universal Immunization are heartening examples of the growing recognition on the part of our planners that promotion of child development must be a central objective of any meaning for National Development Policy (Gopalan, 1993).

Genuinely concerned with the health of the school going children, especially children of the impressionable pre-school stage, the Government of India

embarked upon a scheme of national programme for balwadis in 1970 with the basic objectives of providing supplementary food to children in the age group of 3-5 years belonging to poorer families whose monthly income does not exceed Rs.300/-.

The Central Social Welfare Board has been implementing nutrition programme right from 1971-72. The scheme includes immunisation of children and provision of environmental sanitation with the co-operation of local bodies. In 1981-82 the schematic pattern for grants-in-aid under this programme was revised as each balwadi would get an early grant of Rs.5,940 with a Balsevika and a helper working in each balwadi (Oberoi, 1983).

Every man, woman and child has the inalienable right to be free from hunger and malnutrition in order to develop fully and to maintain their physical and mental faculties. India, along with other developing countries, has a young population of 42 percent being under the age of 15 years and 19 percent under the age of six years. The problems of infection and nutrition are great in this group, particularly in children under five, who are experiencing rapid growth and are therefore more vulnerable. Both mortality and birth

rate are high. Infant mortality is around 125 per 1000 live births. Forty per cent of all deaths occur under the age of five years (Sain, 1993).

According to the 1991 census, the population of India is 846.3 million, the crude death rate is 9.8, crude birth rate is 29.5, the infant mortality rate is 80 per 1000, and life expectancy is close to 60 years (Capart Press Clippings, 1993). The earlier efforts made to provide services to the pre-school children were sectoral and lacked necessary co-ordination. It was felt that a programme may be ensured which was low in cost, economically more comprehensive and effective (Ashok, 1993).

High infant mortality rate, high levels of morbidity, high incidence of malnutrition and nutrition related diseases, temporary or irreversible disabilities and low literacy rates are some of the facts starting at the children under six years of age in India. Against such a grim background, the Government of India formulated a comprehensive child survival and development scheme drawing on the resources of the centre, state and voluntary organisations and the communities themselves.

For a decade the Government has been actively implementing, improving and expanding a most ambitious and comprehensive plan to increase the survival rate and enhance the health, nutrition and learning opportunities of pre-school children and their mothers. The Integrated Child Development Services (ICDS) Scheme is India's gift to her own future; her own child (ICDS, 1986).

The present investigation is an attempt to study the attitude of mothers towards ICDS anganwadis, attitude towards specific aspects such as supplementary nutrition, immunisation, health chek-up, referral services, nutrition and health education to women and pre-school education to children.

The specific objectives of the study are to:

1. study the profile of the families of selected mothers of anganwadi children and
2. find out the attitude of mothers towards ICDS anganwadis.

Review of Literature

II REVIEW OF LITERATURE

The review of literature pertaining to this study is discussed under the following headings:

A. Programmes for Women and Children

B. Integrated Child Development Services

C. Benefits of ICDS Programme and

D. Community Participation in ICDS Programme

A. Programmes for Women and Children :

Women constitute almost half of the world's population. But their social, economic and political status is lower than that of man in all countries. Their social status in a given society depends upon the particular role assigned to women and the social attitudes of the society was evolved towards that role (Shah, 1984).

Woman is the 'Builder and Moulder' of a nation's destiny. Though delicate and soft, she has a heart far stronger and bolder, than man. She is the supreme inspiration for man's onward march - an embodiment of peace, love, piety and compassion. The position occupied by women in a society determines the degree of development of that particular nation (Dhingra, 1988).

Welfare of women and children is inextricably linked with the welfare of the family and community and services which are directed to the strengthening and functioning of the family and the community as social institutions have always been provided along with other welfare programmes (Bhanti, 1989).

There are a number of national programmes for the development of women and children in India. Women during their reproductive period are exposed to several risk factors (including fatal) during pregnancy, child birth and lactation. Maternal morbidity and mortality are two important factors which require atmost attention. Like wise, due to rapid growth and development, infants and children are exposed to greater risks deserving special attention (Tandon, 1990).

Development of Women and Children in Rural Areas (DWCRA)

Recognising that the benefits of IRDP are imparted to only a fringe of the women in rural areas, the programme of DWCRA was brought into existence with the objective to help rural women and children through development programmes already in existence (Srivastava, 1988). Apart from the other general programmes where women are given priority, DWCRA (Development of Women and Children in Rural Areas) - a group oriented

programme – is exclusively meant for rural women and children (Singh, 1990). It is especially designed to improve the quality of life of women and children in rural areas. Although there is a specific target for coverage of women beneficiaries under IRDP, that the flow of assistance to women in rural areas has been marginal, the male members of the family usually take the decisions on the mode or utilisation of the fund provided for the women folk. There are innumerable cases where a woman member in the family is totally ignorant of the fact that a loan has been granted in her favour (Sarkar, 1993).Objectives of DWCRA includes providing an opportunity for income generating activities for individuals through a group of women by building the existing skills and occupation, utilization of locally available resources and providing suitable marketing facilities (Sankaraiah and Roamappo, 1993).

Maternal and Child Health Programme

The term Maternal and Child Health' (MCH) refers to broad and currently accepted approach of promotive, preventive, curative and rehabilitative health care for mothers and children. Maternal and child health programme forms an integral part of the Primary Health Care Delivery System from the time the Primary Health Centres were set up in 1952. The objectives of MCH

includes reducing maternal, infant and childhood mortality and morbidity and promoting reproductive health (Tandon, 1990).

National Diarrhoeal Diseases Control Programme

The National Diarrhoeal Diseases Control Programme (NDDCP) was launched in the country during the Sixth Five Year Plan (1980 - 85) with the objectives of immediate reduce of mortality from acute diarrhoeal diseases as well as associated ill - effects, particularly malnutrition in children. Considering the importance of child survival in the overall context of family welfare, Government of India has accorded high priority for the programme of the control of diarrhoeal diseases (Tandon, 1990).

Expanded Programme on Immunisation

It was launched in 1974 with the goal of reducing morbidity and mortality by providing immunisation services for all children of the world. In India this programme was however started in 1978. This programme at present is undertaken essentially for six different vaccine - preventable diseases viz., tetanus, diptheria, pertusis, tuberculosis, polimyelitis and measles (Tandon, 1990).

Feeding Programmes

The most widely prevalent type of feeding programme, is the supplementary feeding programme where food is distributed to the economically deprived with the objective of providing the deficit between the average consumption and average requirements for the major nutrients i.e., calories and proteins. Feeding of preschool children aims at preventing marginal cases of under nutrition (Patankar, 1989).

World Food Programme

World Food Programme (WFP) extends food aid for supplementary nutrition of children below six years, pregnant women and nursing mothers. During phase V from January 1990, WFP will also extend partial assistance for two innovative pilot schemes namely construction of buildings of 660 anganwadi centres and training and involvement of adolescent girls in ICDS activities (India, 1990).

Wheat - based Supplementary Nutrition Programme

A new centrally sponsored scheme of wheat-based supplementary nutrition for pre-school children and expectant mothers has been introduced from 1986. The programme follows the norms of the Special Nutrition

Programme or the nutrition content of the Integrated Child Development Services Programme (Goel and Jain, 1988).

Applied Nutrition Programme

Applied Nutrition Programme (ANP) was defined as co-ordinated educational activities among health, agricultural and educational departments and other, interested agencies, with the active participation of the people to help themselves. The aim was to raise the level of nutrition of local populations, particularly mothers and children, through improved food production and consumption. Emphasis was placed on community action and the production of low-cost protective foods including animal foods, legumes, green leafy vegetables and fruits. Their utilization for vulnerable groups in the family, especially infants and toddlers was emphasized, sometimes through community supplementary feeding programmes, with or without externally provided foods (Swaminathan, 1982).

Midday Meals Programme

Fulfilment of the health and nutritional needs of children is crucial to the well-being of the nation, since they are the biggest resource for development. On 1st july 1982, the State Government of Tamil Nadu

embarked on a new venture for feeding nearly seven million poor children in the state, in the age range of two to ten years living below the poverty line. Objectives of midday meals programme includes providing more than one third of the nutritional requirements and thus help promote health, growth, development and learning ability of the children and imparting health and nutrition education to children, parents and the community (Devadas, 1987).

Special Nutrition Programme

The Special Nutrition Programme (SNP) launched in 1970 - 71 was meant to provide supplementary nutrition to million of children below six years and expectant and nursing mothers living in urban slums, tribal areas and backward rural areas. The special Nutrition Programme aimed at bridging the existing nutritional gap by providing 300 calories and 10 - 12 grams protein for children and 500 calories and 20 - 25 grams of protein for mothers for 300 days in a year. (Kumar, 1990).

Tamil Nadu Integrated Nutrition Project (TINP)

The main objective of the project is to improve the nutrition and health provisions of pre - school children with emphasis on the age group 6 - 36 moths, expectant and nursing women. It aims to increase health coverage

for all under weight pre - school children and also improve immunisation programme. Specifically the programme aims at reduction in the incidence of protein energy malnutrition among children under three years of age, reduction in the infant mortality rate through immunisation, reduction in the incidence of vitamin A deficiency in children under five years of age and reduction of incidence of nutritional anaemia in pregnant and nursing women (Suriyakanthi, 1991).

B. Integrated Child Development Services

Government of India, launched a number of programmes to provide services to children so that the Infant Mortality Rate could be reduced and also to help children in their overall development. Most of these programmes are clubbed with women welfare programmes as both are mutually inclusive. National Policy for Children (NPC) laid down : It shall be the policy of 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. The state shall progressively increase the scope of such services, so that within a reasonable time all the children in the country enjoy optimum conditions for the balanced growth (Shekhara and Lalitha, 1988).

The government was attempting the daunting task of ensuring good health and nutrition for all pre - school children in the country with the help of the Integrated Child Development Services, a comprehensive scheme of child survival and development launched in 1975 (Dhar, 1989). The scheme is implemented with an aim to provide facilities like supplementary nutrition, immunisation, nutrition and health education to pregnant women, pre - school education to children in the age group of 3 - 6 years and other supportive services like water supply and sanition (Joshi, 1992). The scheme has become the world's largest nutrition programme for children. According to the annual report of the Department of women and Child Development for 1992 - 93 the beneficiaries under the scheme include 1.83 crore children and mothers (Indian Journal of Home Science, 1993).

Types of Beneficiaries under ICDS as referred by Miglani (1986).

Beneficiaries	Services
Expectant and nursing mothers	Health check - up Immunisation of expectant mothers against tetanus Referral services supplementary nutrition Nutrition and health education.

Other women 15 to 45 years	Nutrition and health education
Children below 1 year of age	Supplementary nutrition Immunisation Health check-up Referral services
Children between 1 and 3 years of age	Supplementary nutrition Immunisation Health check up Referral services
Children between 3 and 6 years of age	Supplementary nutrition Immunisation Health check up Referral services Non formal preschool education.

The essence of the programme is " Integration ". The services complementary to one another are integrated into a package to overall effect. The organisation is also integrated through co - ordination at various levels in the management of services by different department agencies running the programme which is inter sectoral. The blue print is well done interms of target groups, services, management, training and funding, the role of different functionaries, monitoring and evaluation (Ashok, 1993).

C. Benefits of ICDS Programme

The benefits of ICDS are explained with the results of few research studies conducted in different parts of the country. Dhar (1989) organised a study on " ICDS -

A participatory Approach " in Udaipur district revealed that the ICDS ensured the very survival of the child before continuing the care which will make the child healthy, provide mental stimulation and introduced the child to a process of learning in preparation for school.

Chandha and Sen (1993) through a study on " Mental ability and Social Maturity of the children of Integrated Child Development Services and the children of non - ICDS, revealed that the children who were attending anganwadi' componsate for some of the ill - effects of socio cultural and economic deprivation conditions prevailing at their homes, thereby contributing relatively to better congnitive abilities such as intelligence and social maturity among themselves (beneficiaries) than the children who were not attending anganwadi' (non - beneficiaries).

NIPCCD (1992) study designed to ascertain the efficiency of the ICDS has indicated that the scheme has helped in the better utilisation of health services and pre - school education facilities. Better school enrolement in ICDS areas is illustrated by the finding that of the primary school children in the age group of

6 to 14 years, 85 per cent in ICDS and 15 per cent in non - ICDS areas have pre - school experience. The study has also revealed that the nutritional status of children in ICDS areas was better than of these in non - ICDS areas.

Bhandari and Mandovara as quoted by Shekhara and Lalitha (1988) through a study, found out that ICDS was having positive effect on the nutritional, intellectual, psychological and social status of children and mothers. It was found that moderate and severe grades of malnutrition were less frequent in rural areas having ICDS projects. The nutritional services rendered through this scheme have resulted in better nutritional status of children.

UNICEF as quoted by Sharma (1987) studied overall perspective of ICDS including nutritional, medical, social and economic aspects in sixteen projects, where ICDS programme was initiated in 1978 - 79 were randomly selected to assess the overall functioning of the scheme, effectiveness of the services and the benefits against resources invested in the programme. The study brought out the positive attributes of the scheme as compared to other like Special Nutrition Programme and Applied Nutrition Programme. It concluded that

despite its wider range of services, ICDS is less expensive and therefore, should be extended in coverage and more resources allocated for the scheme.

D. Community Participation in ICDS Programme

Community Participation is the touch - stone of community development. The degree of community development in a given village or block is determined by the nature of particiaption in the development programme - People's Participation may be in the shape of donation of a plot of land or cash contribution or free manual labour. If the cost value of this participation is more than 50 per cent of the total cost of the programme of development, the progress of community development may be considered satisfactory (Nanavathy, 1967).

Participation in the broad sense, refers to the role of members of the general public as distinguished from that of appointed officials, including civil servants, influencing the activities of Governement or in providing directly for community needs. Some people pose the issue; participation by whom and it is answered by saying that it is by the target' group since, there is not one public but many public and public is not a harmonious group' but groups with conflicting interests (Sagar, Pani and Reddy, 1992).

In the context of ICDS, Community paticipation may mean

i) Awareness of the needs and problems of the child.

ii) Knowledge of schemes in operation, their objectives. services, eligibility criteria, agencies and functionaries for the delivery of services.

iii) Community's conviction about the efficacy and usefulness of the services.

iv) Community's clear understanding of its participation and contribution.

v) Active involvement of the people, their leaders, institutions and organizations etc in a) adoption of alternate strategies and practices b) Desire to adopt new practices of child care (Manual on ICDS, 1984).

Community participation is a much wide concept which involves

i) Community awareness about the needs of young children

ii) Community participation in the planning of the programme

iii) Community awareness about the scheme and conviction about the impact of the services under the scheme

iv) The community is very clear interms of nature of its support and involvement (Manual on ICDS, 1984). Community participation in the context of child development is not formality but need for effective implementation of the programme there is a strong rationale in support of community participation. The responsibility for growth and development of pre - school children is basically that of the parents and the community. It is therefore necessary that child development programme should be lowcost interms of Government's contribution and there should be much larger involvement of the community if the coverage of the programme has to increase (Manual on ICDS, 1984).

Community participation may stem the following motives :

i) Keeping the agency or association related to other important groups in the community.

ii) Maintaining contact with new developments.

iii) Keeping some control over plans for future developments in the community.

iv) Coordinating services with those of other services, or agencies.

v) Supporting cooperative planning and development of new services in the community (Dahama and Bhatnagar, 1991).

Factors influencing community participation

Many factors seem to influence the nature of community participation. The most important among them as referred by Thudipara (1993) are

i) Social awareness :

Making people aware about the facts of life as they are, serves as useful step for mobilising community participation for certain programme. When local people themselves are involved in collecting facts about the social situation which impedes the progress of the society, it will serve as an educational process for the participants.

ii) Belief in social justice :

People should be convinced that social justice is a socially approved right or every human being, irrespective of different affiliations and it should be the joint responsibility of the people and their government to ensure social justice to all.

iii) Leadership :

Effective leaders with innovative ideas seem to help community participation. Local leaders, since they are known to the people, have a greater appeal to the people than external leaders. The growth and emergence

of mass movements like Jharkhand movement the Dalit movements and peasant movements are all examples of exemplary leadership qualities.

Mukhya Sevika is the only functionary who has developed deep insight into the functioning of the ICDS Scheme. Familier with the experiences of other officials and non - officials, she is much better equipped because of her central position in the official hierarchy and her continued contacts with the community. She mobilises community support and participation for the ICDS. Community resources are important inputs responsible for the success of any people - based programme. No programme can succeed on a continued basis unless it is backed by people, unless it is conceived as "their own". The success of the ICDS would depend, to a large extent upon the ability of the officials to secure to the people's support and co - operation from planning to the Implementation stage (Singh, 1987).

The focal point that provides the ICDS package to the beneficiaries, is the anganwadi. It is run by an honourary voluntary woman worker from the local community, who is now being perceived as the key functioning for mobilising women's participation. As a

woman the anganwadi worker is able to establish better rapport with women beneficiaries and thereby motivate them to participate in various services provided at the anganwadi. Therefore, the whole process of enlisting Women's participation can be started at the level of anganwadi (NIPCCD, 1989).

NIPCCD (1986) undertook study for monitoring and evaluation of social components of ICDS scheme, in Kanjhawala, a rural ICDS block in Delhi. A workshop for its selected project functionaries was organised on 11 - 12 March, 1986. It was designed to strengthen the community participation component of the scheme. It also aimed at suggesting improved coordination mechanism and discussing practical measures and way of involving members of the community in day - to - day activities of anganwadis. It was attended by the supervisors and anganwadi workers.

The main recommendations of the workshop are

- Co-ordination committees at village level and mahila mandals should be set up in all villages. Their role expectations should be clearly spelt out
- Each anganwadi worker should identify at least one but preferable two suitable young girls from the

community who could voluntarily look after anganwadis in the absence of regular workers.

- Members of health and ICDS teams should make joint tours of villages to ensure an integrated approach and

- Help of local women and youth having qualities of leadership should be sought in creating greater awareness about the supreme.

Methodology

III METHODOLOGY

The methodology for this study on the " Attitude of Mothers Towards Anganwadis (ICDS Programme)" includes the following steps :

A. Selection of the Area

B. Selection of the Sample

C. Selection of the Method

D. Construction of the Attitude Scale

E. Pretesting the Evolved Scale

F. Finalising the Attitude Scale and

G. Collection and Analysis of the Data.

A. Selection of the Area:

The Integrated Child Development Services (ICDS) Scheme is in operation in Coimbatore Corporation having four projects, with 100 anganwadis in each project. The Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore, has adopted 52 anganwadis under the National Service Scheme Programme of the University. All the 52 anganwadis were selected for the study.

B. Selection of the Sample:

A sample is the reflection of the universe and bears all the characteristics of the universe (Verma, 1989). Harper as quoted by Kumar (1983), a random sample is a sample selected in such a way that every item in the population has an equal chance of being included. From each of 52 anganwadis, five mothers were selected, which comes to a total of 260 mothers, as the size of the sample.

C. Selection of the Method:

There are three conventional methods for the measurement of attitudes. They may be termed as,

a. the method of direct questioning
b. the method of direct observation of behaviour
c. the method of using scale

Each one of these methods enjoys a few advantages and suffers from limitations also.Having them in mind, the method of using scale and questionnaire were used to collect data.

D. Construction of the Attitude Scale:

The attitude scales are constituted of various statements or items relevant to an issue. The individual

subjects respond in a particular manner to these statements (Wilkinson and Bhandarkar, 1992).

Allport as quoted by Bhatt and Advani (1970), attitude is mental and neural state of readiness organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related.

The method of summated ratings owes its origin to Rensis Likert. Remmers (1954) says that this method is an application of item analysis procedure borrowed from test construction techniques. The steps involved in this procedure are as follows :

The first step relates to the collection of a number of statements, according to certain criteria which express different shades of opinions. The carefully edited list of statements is then presented to a jury of judges and classified into two categories, as those which express a favourable attitude and those which express an unfavourable attitude. The next step is to try out the entire list on a sample of subjects, whose attitudes are to be tested later. Every statement is endorsed by the subjects on a five point scale, ranging from strong agreement to strong disagreement. The next step involves

quantifying the indicated responses. A system of arbitrary weight is usually used, so that strong agreement with favourable statements and strong disagreement with unfavourable statements are given with highest weight. A subject's score is the sum total of the weight assigned to the response he or she has made.

The items are then analysed for their discriminating power. Several statistical procedures can be developed for item analysis work. It is customary to split the whole group into two groups as having highly favourable attitude and highly unfavourable attitude. The mean score and the difference between the means are tested for significance by the use of " t " test. Items which have high critical ratio can be selected for inclusion in the final scale. The final scale should be used with the five categories of responses and scores.

The Likert type of scaling is selected for the present study for reasons of ease of construction and popularity of the method. Summated scales consist of a number of statements which express either a favourable or unfavourable attitude towards the given object to which the respondent is asked to react. The respondent indicates his agreement or disagreement with each statement in the instrument. Each response is given a

final study, were selected for the pilot study. The sample for pilot study were 20 mothers of anganwadi children. The investigator explained to the subjects about the purpose of the study and the method of answering the questions (Appendix II).

Scoring the Attitude Scale :

The favourable (positive) items were weighed as given below :

5 points for a tick in " Strongly agree " column.

4 points for a tick in "agree" column.

3 points for a tick in "no opinion" column.

2 poins for a tick in "disagree" column.

1 point for a tick in "strongly disagree" column.

The weights were in the reverse order for the negative items (unfavourable items).

Item analysis :

The main aim of the pilot study is to select items which discriminate to those with favourable attitude from those who indicate unfavourable attitude. For this purpose the item analysis was carried out as described below.

The responses of the 20 mothers to the attitude scale and questionnaire were arranged according to attitude

numerical score, indicating its favourableness or unfavourableness, and the scores are totalled to measure the respondents attitude (Kothari, 1993).

Jury opinion :

After necessary editing, the list of 92 statements were circulated to a panel of five college lecturers. Then the statements were classified as those expressing a favourable attitude towards ICDS anganwadis and those expressing unfavourable attitude. The results were tabulated and statements were classified as favourable and unfavourable according to the opinion. Many unfavourable statements were stated to favourable statements.

The questionnaire :

The study of the attitude gains meaning only when correlated with factors that are likely to affect them. Hence it was decided to use a questionnaire along with the attitude scale to investigate the factors which are likely to affect the attitudes (Appendix I).

E. Pretesting the Evolved Scale :

In order to rectify the poorly worded and wrongly understood questions and to test the effectiveness, a pilot study had been conducted. Three anganwadis from Coimbatore Corporation which were not included for the

score weights, 27 per cent of the area covered by low scores are the optimum groups for use when item analysis data are to be obtained. It was made use of the proportions of success in the highest and lowest 27 per cent of the sample, simply because those data were employed in obtaining a descrimination index. So 27 per cent of the total, viz, 6 scripts from the top indicating highly favourable attitute were taken and marked high group Similarly, 6 scripts from the bottom were also selected and marked low group. Each statement was taken and analysed to find out the frequency of different weights both in the "High" and "Low" groups. The critical ratio or "t" was calculated by using the formula

$$\text{"t"} = \frac{\Sigma FX - \Sigma fx}{\sqrt{A + B}}$$

Where,

X denotes the weight

F denotes the frequency of the weight in the "High Group"

f denotes the frequency of the weight in the "Low Group"

Σ denotes the summation of similar terms.

$$A \text{ equals } \Sigma FX^2 \text{ .....} = \frac{(FX)^2}{N}$$

$$B \text{ equals } \Sigma fx^2 \text{ .....} = \frac{(fx)^2}{N}$$

TABLE I

CALCULATION OF CRITICAL RATIO

Statement No.23	High Score Group			Low Score Group		
Weight X	F	Fx	Fx^2	f	fx	fx^2
1	0	0	0	0	0	0
2	0	0	0	2	4	8
3	0	0	0	1	3	9
4	1	4	16	3	12	48
5	5	25	125	0	0	0
Total	6	29	141	6	19	65

A = 0.83

B = 4.83

$$t = \frac{29 - 19}{\sqrt{0.83 + 4.83}} = \frac{10}{\sqrt{5.66}} = \frac{10}{2.38} = 4.20$$

The above table is an adoption of the table suggested by Pauline (1961). The critical ratio were calculated for all the items and a preliminary selection of 60 items of high critical ratio was made. Statements with a critical ratio above 3.00 were taken.

F. Finalising the Attitude Scale :

The responses to various items in the questionnaire were then analysed with a view of finalising their wording and format, where 3 to 4 statements needed changes in wording. They were carefully worded. Thus the defects in the pilot tool were rectified (Appendix III).

G. Collection and Analysis of the Data :

The final questionnaire and attitude scale were administered to 260 selected mothers of children of 52 adopted anganwadis of Avinashilingam Deemed University, situated in urban slums of Coimbatore and data were collected. The data obtained through the questionnaire and attitude scale were consolidated and tabulated, analysed and interpreted. The results are discussed on the following headings :

1. Profile of the families of selected mothers of anganwadi children.

2. Attitude of mothers towards ICDS anganwadis.

The results of these aspects are discussed in detail in the succeeding chapter.

Results and Discussion

IV RESULTS AND DISCUSSION

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

A. General Details of the Sample and

B. Attitude Scores and Differential Studies

A. General Details of the Sample:

A sample of 260 mothers whose children were attending the anganwadis formed the basis for the present study.

The distribution of the sample according to the family type is given in Table II

TABLE II

TYPE OF THE FAMILY OF THE SAMPLE

S.No	Type of family	Percentage (n:260)
1	Nuclear	86
2	Joint	14

Among the selected sample, 86 per cent belonged to nuclear family and only 14 per cent were in joint family system.

The distribution of the sample according to their religion is given in Table III

TABLE III

RELIGION-WISE DISTRIBUTION OF THE SAMPLE

S.No	Religion	Percentage(n:260)
1	Hindu	91
2	Muslim	6
3	Christian	3

The sample consisted of 91 per cent Hindus, six per cent Muslims and three per cent Christians.

The distribution of the sample according to the community which they belonged to, is given in Table IV

TABLE IV

CASTE-WISE DISTRIBUTION OF THE SAMPLE

S.No	Community	Percentage(n:260)
1	Forward caste	5
2	Backward caste	59
3	Most Backward caste	4
4	Scheduled caste	32

It is seen from the above table that 59 per cent of mothers belonged to the backward community, 32 per cent belonged to scheduled caste, five per cent belonged to the forward community and four per cent belonged to the most backward community.

Table V gives the size of the family of the selected sample.

TABLE V

SIZE OF THE FAMILY

S.No	Family size	Percentage (n:260)
1.	Below 4 members	27
2.	4-5 members	64
3.	Above 6 members	9

It is clear from the above table that 27 per cent had small family size, 64 per cent had 4 to 5 members, and the rest, 9 per cent, had large size families, having more than 6 members.

The age-wise distribution of the sample is given in Table VI

TABLE VI

AGE-WISE DISTRIBUTION OF THE SAMPLE

S.No.	Age in years	Percentage(n:260)
1.	20 - 25	53
2.	26 - 30	12
3.	31 - 35	31
4.	36 - 40	4

From the above table it is clear that majority of the mothers (96 per cent) were below 35 years.

The distribution of the mothers, according to their educational level, is given in Table VII

TABLE VII

EDUCATIONAL LEVEL OF THE MOTHERS

S.No.	Educational level	Percentage(n:260)
1.	Illiterates	58
2.	Neoliterates	3
3.	Primary education	24
4.	High School education	12
5.	Higher Secondary education	2
6.	Degree holders	1

While analysing the educational qualification of the sample, it is seen from the above table that the majority (58 per cent) of the mothers were illiterates; only three per cent were neoliterates.

About 90 per cent of the parents of anganwadi children were coolies including male and female (34 per cent female and 56 per cent male)

Table VIII gives the income level of the families of the mothers of anganwadi children

TABLE VIII

FAMILY INCOME OF THE SAMPLE

S.No.	Monthly income range in Rs.	Percentage (n:260)
1.	Below 250	21
2.	251 - 500	79

It was found that all had the income below Rs.500 per month and it is disheartening to note that 21 per cent were earning only below Rs. 250 per month.

Reasons given by the respondents, for sending their children to the anganwadis, are given in Table IX.

TABLE IX

REASONS FOR SENDING THEIR CHILDREN TO THE ANGANWADIS

S.No.	Reasons	Percentage(n:260)
1.	Getting food	48
2.	Protection and safety to the children	34
3.	Education	13
4.	Getting education and food	5

It is seen from the above table that the majority (66 per cent) of the mothers were sending their children to anganwadis to get food and education and 34 percent of mothers expressed that they send their children to anganwadis as the children were safe in the hands of anganwadi teachers. The mothers who were working outside as coolies(34 per cent) found the programme being convenient as it is taking care of their children for all the needs.

About 74 per cent mothers of the anganwadi children felt that their children became healthy after attending the ICDS anganwadis and only 26 per cent were not satisfied with the improvement in the health of their children.

Mother's participation in the ICDS anganwadis:-

Among the selected sample, 98 per cent of the mothers did not face any problem in participating in the anganwadi programme and only two per cent of the mothers faced problems in the feeding programme of the anganwadi such as diarrhoea and vomitting. About 34 percent of the mothers participated in the feeding programme during their pregnancy period and nine per cent of the mothers participated in the feeding programme during their lactation period. Fortysix percent mothers agreed that they were getting sathuflours and mixed food in the anganwadis and the remaining 54 per cent were not happy with food. They were getting medicine from the anganwadis.(Figures 1-6).

B. Attitude Scores and Differential Studies

The Attitude Scores Distribution

The second part of the questionnaire is specially constructed attitude scale, in which subjects express

FIG 1

MOTHERS VISITING THE CENTRE

FIG 2

VIEWS OF MOTHERS ABOUT ANGANWADI PROGRAMME

FIG 3

PRE-SCHOOL EDUCATION IN THE ANGANWADI

FIG 4

FEEDING THE CHILDREN

FIG 5

PARTICIPATION OF MOTHERS IN THE

FEEDING PROGRAMME

FIG 6

FEEDING PROGRAMME FOR PREGNANT WOMEN AND

LACTATING WOMEN

their degree of agreement and disagreement on a five point scale. These were numerically scored and the attitude score of each subject was taken to the sum of all weights assigned to the sixty items. The lowest possible score is sixty (60) while the highest possible score is 300 (60 x 5). The sample of 260 yielded a distribution ranging from 91 - 100 to 261 - 270.

The frequency distribution of the attitude scores of the sample is given in Table X.

TABLE X

DISTRIBUTION OF ATTITUDE SCORES OF SELECTED SAMPLE

Class Interval	f	d	fd	fd^2	cf
261 - 270	3	+6	18	108	260
251 - 260	5	+5	25	125	257
241 - 250	13	+4	52	208	252
231 - 240	23	+3	69	207	239
221 - 230	24	+2	48	96	216
211 - 220	32	+1	32	32	192
201 - 210	31	0	0	0	160
191 - 200	48	-1	-48	48	129
181 - 190	38	-2	-76	152	81
171 - 180	28	-3	-84	252	43
161 - 170	11	-4	-44	176	15
151 - 160	1	-5	-5	25	4
141 - 150	1	-6	-6	36	3
131 - 140	1	-7	-7	49	2
121 - 130	0	-8	0	0	1
111 - 120	0	-9	0	0	1
101 - 110	0	-10	0	0	1
91 - 100	1	-11	-11	121	1
Total N	260		-37	1635	

The various statistical calculations for the distribution are given below:

$$\text{Mean} = \text{Assumed mean} + \frac{fd}{N} \times i$$

$$= 205.5 + \frac{-37}{260} \times 10$$

$$= 205.5 + (-1.423)$$

$$= 205.5 - 1.423$$

$$= 204.08$$

$$\text{Standard Deviation} = i\sqrt{\frac{fd^2}{f} - \left(\frac{fd}{f}\right)^2}$$

$$= 10\sqrt{\frac{1635}{260} - \left(\frac{-37}{260}\right)^2}$$

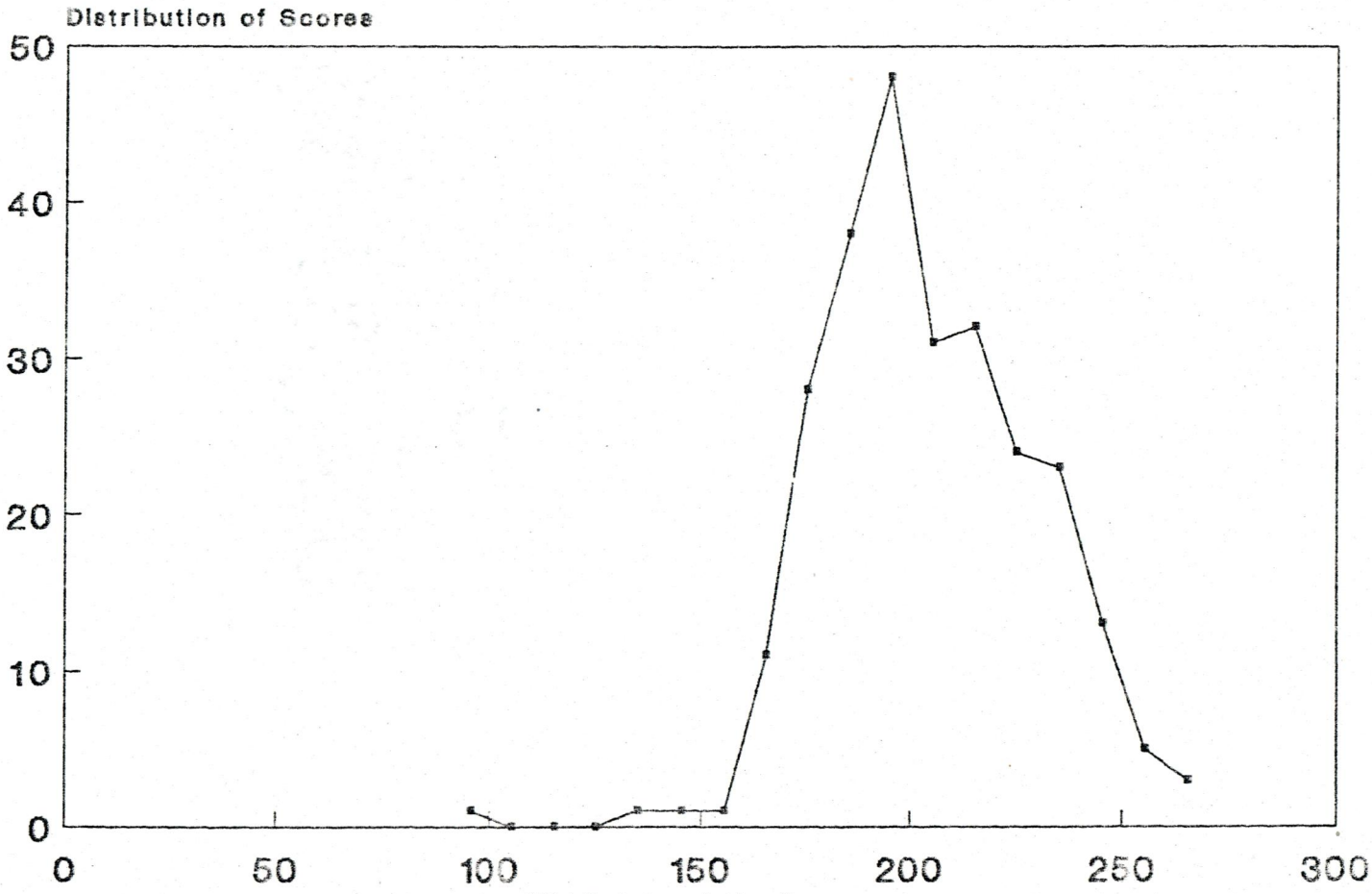
$$= 10\sqrt{\frac{1635}{260} - \frac{1369}{67600}}$$

$$= 10 \times \sqrt{6.288 - 0.020}$$

$$= 10 \times \sqrt{6.268}$$

$$= 25.035$$

The Arithmatic mean is found to be 204.08 which is higher than the demarcating score of 3 x 60 = 180 which shows that mothers taken for the sample who were having more favourable attitude towards anganwadis, (Fig.7) there were 43 mothers whose attitude scores are below 180



HISTOGRAM SHOWING THE DISTRIBUTION OF ATTITUDE SCORES OF SELECTED SAMPLE

Fig-7

indicating that they have an unfavourable attitude towards anganwadis and they are those who were mostly illiterates.

Distribution of scores of mothers below 30 years and above 30 years of age are given in Table XI

TABLE XI
DISTRIBUTION OF ATTITUDE SCORES OF MOTHERS BELOW THIRTY YEARS AND ABOVE THIRTY YEARS

Class Interval	Below Thirty years	Above Thirty years
261 - 270	2	1
251 - 260	5	1
241 - 250	8	5
231 - 240	13	8
221 - 230	14	10
211 - 220	21	12
201 - 210	20	11
191 - 200	33	14
181 - 190	25	13
171 - 180	16	12
161 - 170	8	3
151 - 160	0	1
141 - 150	0	1
131 - 140	2	0
121 - 130	0	0
111 - 120	0	0
101 - 110	0	0
91 - 100	1	0
Total	168	92
Arithmetic mean	204.31	205.04
Standard Deviation	26.02	24.37

The mothers who were 30 years and below have a mean of 204.31 and Standard Deviation is 26.02, where as mothers whose age was above 30 years mean score is 205.04 and Standard Deviation is 24.37.

While comparing the attitude scores of mothers who were above 30 years and below 30 years, the critical ratio was found out using the following formula

$$CR = t = \frac{D}{SE}$$

Where D is the difference between the means and SE is Standard Error

$$D = 204.31 - 205.04 = 0.73$$

$$\text{Standard Error} = \sqrt{\frac{SD_1^2}{N_1} + \frac{SD_2^2}{N_2}}$$

$$= \sqrt{\frac{26.02^2}{168} + \frac{24.37^2}{92}} = 3.24$$

$$CR = t = \frac{D}{SE}$$

$$t = \frac{0.73}{3.24} = 0.23$$

Since the critical ratio is found to be 0.23 which is less than 2.65, it can concluded that there is no significant difference in the means. Hence, there is no significant difference between the attitudes of the mothers who were 30 years and below and above 30 years. Distribution of attitude scores of mothers having family income below Rs.300 and above Rs.300 are given in Table XII.

TABLE XII

DISTRIBUTION OF ATTITUDE SCORES OF MOTHERS HAVING FAMILY INCOME BELOW Rs.300 AND ABOVE Rs.300

Class Interval	Below Rs.300	Above Rs.300
261 - 270	1	2
251 - 260	1	4
241 - 250	2	11
231 - 240	13	9
221 - 230	15	9
211 - 220	14	18
201 - 210	12	19
191 - 200	20	28
181 - 190	13	25
171 - 180	14	14
161 - 170	3	8
151 - 160	1	0
141 - 150	1	0
131 - 140	0	2
121 - 130	0	0
111 - 120	0	0
101 - 110	0	0
91 - 100	0	1
Total	110	150
AM	205.154	204.039
SD	23.164	26.761

mothers whose income was Rs.300 and below have a mean of 205.154 and Standard Deviation is 23.164, where as mothers whose income was above Rs.300 attitude mean score is 204.039 and Standard Deviation 26.761.

While comparing the attitude scores of mothers whose income was Rs. 300 and below Rs.300 the critical ratio is found to be 0.360 which is less than 2.65, it can be concluded that there is no significant difference in the means. Hence there is no significant difference between the attitude of the mothers whose income was below Rs.300 and above Rs.300.

The attitude scores of the mothers the anganwadi children of different religions are given in Table XIII

TABLE XIII

RELIGION-WISE DISTRIBUTION OF THE ATTITUDE SCORES OF THE MOTHERS

Class Interval	Muslim	Christian	Scheduled Caste	Caste Hindus
261 - 270	0	0	1	2
251 - 260	0	0	5	0
241 - 250	1	0	4	8
231 - 240	0	0	8	14
221 - 230	1	0	6	18
211 - 220	3	1	10	17
201 - 210	4	0	10	17
191 - 200	5	2	16	25
181 - 190	1	2	10	24
171 - 180	1	2	10	15
161 - 170	0	0	2	10
151 - 160	0	1	0	0
141 - 150	0	0	0	1
131 - 140	0	0	1	1
121 - 130	0	0	0	0
111 - 120	0	0	0	0
101 - 110	0	0	0	0
91 - 100	0	0	0	1
	16	8	83	153
AM	205.462	204.885	205.961	203.847
SD	15.996	16.583	25.888	25.882

The Mothers who were muslims have a mean of 205.462 and Standard Deviation is 15.996 where as mothers who were Christians, attitude mean score is 204.885 and Standard Deviation is 16.583.

While comparing the attitude scores of the mothers who were muslims and the christians, the critical ratio is found to be 0.081 which is less than 2.65, it can be concluded that there is no significant difference between the attitude of the mothers who were Muslims and Christians.

The mothers who were scheduled caste have a mean of 205.961 and Standard Deviation is 25.888. Where as mothers who were caste Hindus, attitude mean score is 203.847 and Standard Deviation is 25.882.

While comparing the attitude scores of mothers who were scheduled castes and caste Hindus, the critical ratio is found to be 0.598, which is less than 2.65, it can be concluded that there is no significant difference between the attitude of the mother who were scheduled caste and who were caste Hindus.

Summary and Conclusion

V SUMMARY AND CONCLUSION

The study attmepts to findout the attitude of mothers towards anganwadis (ICDS Programme). The sample for the study consisted of selected mothers of children of anganwadis adopted by the NSS programme of Avinashilingam Deemed University. The questionnaire and an attitude scale developed by the investigator were the tools used in collecting the data. The major findings are summarized below:

1. Majority of the mothers (86 per cent) belonged to nuclear family; 64 percent of the families had four to five members.
2. Out of the Selected mothers (260), 91 per cent belonged to Hindu religion; 59 per cent belonged to backward caste.
3. Fifty eight per cent of the mothers were illetrates and only 24 percent had primary education.
4. The major occupation for 90 per cent was cooli; all the families had the income below Rs.500 per month.
5. Sixty six per cent were sending their children to anganwadis to get food and education; 74 per cent of the mothers realised that their children became healthy after attending the anganwadis.

6. Ninety eight per cent of the mithers did not face any problem in participating in the anganwadi programme.
7. About 34 per cent participated in the feeding programme during their pregnancy period and nine percent participated in the feeding programme during their lactation period; 46 Per cent of the sample agreed that they were getting sathu flour and mixed food from the Anganwadis and 54 per cent of the sample agreed that they were getting medicine from the anganwadi.

Attitude Scores and Differential Studies:

1. In general, the selected mothers had highly favourable attitude towards ICDS anganwadis.
2. Age of the mothers had no association with their attitude towards ICDS anganwadis.
3. Caste of the mothers has no association with their attitudes towards ICDS anganwadis.
4. Income of the families had no association with the attitude of mothers towards ICDS anganwadis.

The investigator would like to give the following suggestions for the betterment of the ICDS anganwadis.

1. The number of Anganwadi workers should be increased for the proper functioning of the Anganwadi programme.
2. Local participation should be increased for the improvement of the Anganwadis.
3. Mothers and children should be motivated by the Anganwadi workers to participate in the Anganwadi programme.

Based on this study, the investigator would like to recommend the following points for future research work in the ICDS Anganwadis:

1. A comparative study between the Anganwadis adopted by Avinashilingam Deemed University and other Anganwadis.
2. A study on the people's participation in integrated child Development Services Scheme and other feeding programmes.
3. A study on the local participation in Anganwadi programme.
4. Role of University in improving the Anganwadi programme.
5. A study on the influence of University students in the improvement of the Anganwadi programme.

CONCLUSION:

In conclusion, it can be stated that the mothers of Anganwadi children do have positive attitude towards the Anganwadis. At the same time, it is suggested by the investigator that the mothers need motivation, education and guidance for better participation in the programme.

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Appendices

APPENDIX I

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY) COIMBATORE - 43.

QUESTIONNAIRE TO ELICIT INFORMATION ON THE FAMILY BACKGROUND OF THE SELECTED MOTHERS

Part-A Date:

I.

1. Name of the interviewer:
2. Name of the interviewee:
3. Address:

II. Back ground information about the respondent:

1. Name of the Head of the Family:
2. Type of Family Nuclear [ ] Joint [ ]
3. Religion:
4. Community:
5. Caste:

III.DETAILS OF FAMILY MEMBERS :

S.NO.	Name of family members	Relation to the head of the family	Age in year	Sex	Education						Occupation	Monthly income
					Illiterate	Neoliterate	Primary school	High school	Higher sec. school	college		

IV. INFORMATION ABOUT CHILDREN PARTICIPATION IN THE ANGANWADI PROGRAMME.

S.No.	Birth order	Age in years	Sex of the child		Reasons for participating in the Anganwadi Programme
			Male	Female	
1.					
2					
3.					

V. MOTHER'S PARTICIPATION IN THE ICDS PROGRAMME.

1. Does your child become healthy after sending to Anganwadi

2. Do you have any problem in participating in the Anganwadi programme

3. Do you participate in the feeding programme

   If yes, Pregnant Lactating

4. Do you get nutritious food in the Anganwadi

   yes No

5. List the items you are getting in the feeding programme.

APPENDIX II

ATTITUDE SCALE - PILOT STUDY

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly Disagree
1.	Foods provided in the anganwadi is highly nutritious					
2.	Anganwadi provides adequate supplementary nutrition to children and nursing and expectant mothers					
3.	In anganwadi attention is given to children below three years of age.					
4.	Anganwadi provides protein rich foods to children					
5.	In anganwadi centre special attention is not given to mal-nourished children					
6.	Anganwadi protects the children from poverty.					
7.	Anganwadi is not protecting the children from mal-nutrition and other deficiency diseases					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
8.	Foods provided at anganwadi is not good for health					
9.	In anganwadi method of food preparation is not good					
10.	Anganwadi children are immunised against diptheria whooping cough, tetanus, polio myelitis and tuberculosis					
11.	All expectant mothers are immunised against tetanus					
12.	Immunisation against measles will be given if necessary					
13.	Children's health is not good after sending them to anganwadi					
14.	Anganwadi is not providing essential services to mothers					
15.	Anganwadi protects the children from communi-cable diseases					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
16.	Anganwadi is not providing essential services to pregenant mothers					
17.	Children are getting infectious diseases due to their participation in the programme					
18.	Anganwadi is providing essential medicine against diseases					
19.	Anganwadi children are getting common cold after sending them to anganwadi					
20.	Children are getting diarr-hoea after sending them to anganwadi					
21.	Anganwadi is not motivating the mothers to send their children to anganwadi centre					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
22.	Anganwadi is not providing non-formal preschool education to children					
23.	Anganwadi helps to promote over all development of the child					
24.	In anganwadi there is no formal structured curriculam					
25.	Anganwadi is not motivating the children to study					
26.	Anganwadi helps in developing the vocabulary of the children					
27.	Anganwadi is not helping the children to develop mental health					
28.	Anganwadi is preparing the children for primary education					
29.	Anganwadi teachers are teaching alphabets and sons to the children					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
30.	Anganwadi is not providing anti-natal care for expectant mothers					
31.	Anganwadi provides post-natal care for nursing mothers					
32.	Anganwadi provides care for new born					
33.	In anganwadi centre attention is not given to children under six years of age.					
34.	Anganwadi is not providing non-formal health and nutrition education to women					
35.	Special care is taken to ensure attendance of pregnant and nursing mothers					

S.No.	Statements	Strongly Agree	Agree	No OPininon	Dis Agree	Strongly disagree
36.	Anganwadi helps to promote smooth transition of the child from nursery school					
37.	Mothers of children who suffer from repeated illness of malnutrition serval methods are employed to reach mothers					
38.	Individual discussions group meetings home visits are used to carry the messages of health and nutrition					
39.	Anganwadi is not helping the children to develop good habits					
40.	Anganwadi workers are taking care of the children					
41.	Anganwadi is not helping the children to learn					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
42.	Anganwadi is providing play materials to children					
43.	Anganwadi workers are not teaching simple play games to children					
44.	Anganwadi helps to develop the children's social ability					
45.	Anganwadi helps the children to mingle with other children					
46.	Surrounding of the anganwadi is not kept clean in many anganwadis					
47.	Anganwadi is not providing extra curricular activities to the children					
48.	In many anganwadis there are no adequate play materials for children					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
49.	Children are biting nails after sending them to anganwadi					
50.	Anganwadi is taking efforts in promoting sound development of early child hood.					
51.	Anganwadi helps to reduce the the incidence of mortality, morbility					
52.	Anganwadi helps to reduce the incidence of school dropouts					
53.	At the anganwadi children, pregnant women and nursing mothers are examined at regular intervals by the lady health visitor					
54.	The anganwadi worker maintains a register of every house hold in the village and his register is anually up dated					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
55.	Anganwadi helps in creating awareness and increasing the capabilities of mothers to look after the children					
56.	Anganwadi workers are not able to maintain the record of age and data of birth of children properly					
57.	Anganwadi worker is not knowledgeable enough to arouse interest among children					
58.	Anganwadi is not providing the environmental conditions necessary for the mental, physical and social develop ment of children					
59.	Children are getting skin and eye infections after sending them to anganwadi					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
60.	Anganwadi educates the mothers to prepare lowcost nutritious foods					
61.	The anganwadi workers are not very clear with regard to what should be the curricular of an anganwadi					
62.	In anganwadi children are learning through play					
63.	Pregnant women are not utilising the anganwadi					
64.	Anganwadi is not helping the children to learn basic things					
65.	Anganwadi helps to increase the interest of the children					
66.	Anganwadi is increasing the mother's interest					
67.	In anganwadi special attention is not given for female children					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
68.	Anganwadi increases the chances of getting diseases					
69.	In anganwadi they are not providing nutritious flour to children					
70.	In many anganwadis there are no proper teaching aids.					
71.	Anganwadi advices the mother on nutrition and environmental sanitation					
72.	Pregnant women's health improves after getting nutritious flour from anganwadi					
73.	Children are developing their reading habits after attending anganwadi					
74.	Children are not developing their writing skills after attending anganwadi.					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
75.	The services Provided in an anganwadi is not based on local needs.					
76.	The services provided in an anganwadi is not based on their customs, habits and seasonal variations in activities of local people.					
77.	Anganwadi is not providing referral services to children.					
78.	Anganwadi is not helping the children to build up basic skills necessary for pre-school education.					
79.	Anganwadi is not helping the children to express his/her thoughts					
80.	Anganwadi helps the children to express his/her feelings in fluent correct and clear speech.					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly Disagree
81.	Non-formal education in nutrition and health is organised at the anganwadi for mothers and pregnant women.					
82.	Women between 15 and 45 are invited and special care is taken to ensure attendance of pregnant and nursing mothers.					
83.	Anganwadi is not creating a good environment for the children to study.					
84.	Anganwadi advices the lactating mothers on immunisation.					
85.	Nursing mother's health improves after getting nutritious flour from anganwadi.					
86.	One of the felt need of the community is being met through the anganwadi.					
87.	Anganwadi is not providing required calories of food to the children					

S.No.	Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly disagree
88.	Anganwadi advices the mothers on methods of child care and child rearing.					
89.	Anganwadi is not taking efforts for the growth and development of the poor children.					
90.	Anganwadi is not providing micro-nutrients to the children.					
91.	Anganwadi is not motivating the parents to participate in anganwadi activities					
92.	In anganwadi the method of sathu flour making is not good.					

APPENDIX III

PART B

ATTITUDE SCALE - FINAL STUDY

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
1. Foods provided in the anganwadi is highly nutritious.					
2. In the anganwadi method of food preparation is not good.					
3. Anganwadi provides adequate supplementary nutrition to children and nursing and expectant mothers.					
4. Anganwadi is not motivating the children to study.					
5. Anganwadi is not providing non-formal preschool education to children					
6. Anganwadi provides care for new born.					
7. Children are getting infectious diseases due to their participation in the anganwadi programme.					
8. Anganwadi helps in developing the vocabulary of the children					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
9. The anganwadi workers are not very clear with regard to what should be the curriculam of an anganwadi.					
10. Anganwadi is not creating a good environment for the children to study.					
11. Anganwadi provides protein rich foods to children.					
12. In the anganwadi centre, special attention is not given to malnourished children.					
13. Anganwadi is providing required calories of food to the children.					
14. Anganwadi advices the lactating mothers on immunisation.					
15. Anganwadi is increasing the mother's interest.					
16. In the anganwadi centre, attention is not given to children under six years of age.					
17. Foods provided at anganwadi is not good for health.					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
18. Anganwadi is not providing essential services to pregnant women.					
19. Anganwadi is preparing the children for primary education.					
20. Anganwadi teachers are teaching alphabets and songs to the children.					
21. Anganwadi is not helping the children to build up basic skills necessary for pre-school education.					
22. Anganwadi increases the chances of getting disease.					
23. Anganwadi helps to promote overall development of the child.					
24. In the anganwadi, the method of 'Sathu flour' making is not good.					
25. In the anganwadi, attention is given to children below three years of age.					
26. Anganwadi is providing essential medicines for diseases.					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
27. Nursing mother's health improves after getting nutritious flour from anganwadi.					
28. Anganwadi is not motivating the parents to participate in the Anganwadi activities.					
29. Anganwadi workers are not knowledgeable enough to arouse interest among children.					
30. Anganwadi educates the mothers to prepare low cost nutritious foods.					
31. Anganwadi is not motivating the mothers to send their children to anganwadi centre.					
32. Anganwadi is not providing non formal health and nutrition education to women.					
33. Anganwadi helps in creating awareness and increasing the capabilities of mothers to look after children.					
34. Anganwadi is not providing extra curricular activities to the children.					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly Disagree
35. Anganwadi is not helping the children to express his/her thoughts.					
36. Anganwadi helps to promote smooth transition of the child from nursery					
37. Anganwadi children are getting common cold after sending them to anganwadi.					
38. Anganwadi helps to reduce the incidence of mortality and morbidity.					
39. Anganwadi is providing play materials to children.					
40. Anganwadi workers are not able to maintain the record of age and date of birth of children properly.					
41. Anganwadi helps to increase the interest of the children.					
42. Foods provided to anganwadi is not good for health.					
43. Anganwadi is not providing essential services to mothers.					
44. Pregnant women's health improves after getting nutritious flour from anganwadi.					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
45. Anganwadi is not helping the children to develop mental health.					
46. Individual discussion, group meeting, home visits are used to carry the messages of health and nutrition.					
47. Anganwadi helps the children to mingle with other children.					
48. Anganwadi helps to develop the children's social ability.					
49. In anganwadi they are not providing nutritious flour to children.					
50. Anganwadi workers are taking care of the children.					
51. In anganwadi special attention is not given for female children.					
52. Anganwadi is not helping the children to learn basic things.					
53. In the anganwadi children, pregnant women and nursing mothers are examined at regular intervals by the lady health visitor.					

Statements	Strongly Agree	Agree	No Opinion	Dis Agree	Strongly dis Agree
54. Children's health is not good after sending them to anganwadi.					
55. Anganwadi is not providing anti-natal care for expectant mothers.					
56. Anganwadi is not helping the children to develop good habits.					
57. Anganwadi helps to reduce the incidence of school drop outs.					
58. Anganwadi is not helping the children to learn.					
59. Anganwadi is taking efforts in promoting social development of early childhood.					
60. Anganwadi is providing referral services to children.					