A Study on the Activities of Anganwadis Based on Varapuzha Grama Panchayath

Dissertation Submitted to the

MAHATHMA GANDHI UNIVERSITY

In Partial Fulfillment of the Requirement for

M.A.Degree in Economics

By

Mary.M.G.

Reg. No.82500

Under the guidance of

MISS. SWATHY VARMA. P.R,M.A.

Department of Economics,

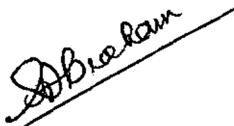
St. Teresas's College,

Ernakulam

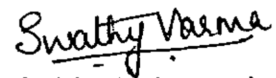
March 2006

CERTIFICATE

This is to certify that the Dissertation "**A STUDY ON THE ACTIVITIES OF ANGANWADIS BASED ON VARAPUZHA GRAMA PANCHAYATH**" submitted in partial fulfillment of the requirement for M.A.Degree in Economics to the Mahathma Gandhi University, Kottayam is a bonafide record of work done by the candidate under my supervision and guidance.



Head of the Department



Guide & Supervisor

DECLARATION

I hereby declare that the Dissertation titled **"A STUDY ON THE ACTIVITIES OF ANGANWADIS BASED ON VARAPUZHA GRAMA PANCHAYATH"** Submitted by me for the M.A.Degree in Economics is my original work.

Swathy Varma
Signature of the supervisor

Mary
Signature of the Candidate

Acknowledgement

First and foremost I thank God Almighty for the blessings ahowered upon me to complete this work successfully.

I express my deep sense of gratitude to my supervisor Miss. Swathy Varma .P.R., Department of Economics, St.Teresa's College Ernakulam for the valuable guidance and inspiration given to me in completing this project work.

I deeply express my sincere thanks to Salima Abraham, Head of the Department and other members of the department of Economics St.Teresa's College for their advice and encouragement to complete this study.

I take this opportunity to thank the Librarian of St.Teresa's College.

I greatly thank all the respondents to my Questionnaire for answering the questions properly.

Last but not least, I express my profound Gratitude towards my parents, relatives and friends for providing necessary assistance and Inspiration.

St.Teresa's College

Ernakulam **Mary.M.G.**

INDEX

CONTENTS

A. LIST OF TABLES

B. LIST OF FIGURES

C. CHAPTER –1 – INTRODUCTION

D. CHAPTER – 2 – ICDS AN OVERVIEW

E. CHAPTER-3 – ANALYSIS AND INTERPRETATION

F. CHAPTER-4- CONCLUSION AND RECOMMENDATIONS.

G. APPENDIX

H. REFERENCE MATERIALS

  a. END NOTES

  b. BIBILIOGRAPHY

List of Tables

Table No:	Title	Page No.
3.1	Age wise classification of the respondents	26
3.2	Monthly income of the respondents	28
3.3	Sex wise classification of the respondents	28
3.4	Marital status profile of the respondents	29
3.5	Educational qualification of the respondents	29
3.6	Distribution of Anganwadis according to the number of children	30
3.7	Classification of Anganwadis according to the ownership	31
3.8	Classification of Anganwadis according to the room facilities available	32
3.9	Income wise classification of Anganwadi users	33
3.10	Classification of Anganwadis according to the Latrine facilities	34
3.11	Distribution of Anganwadis according to playground facilities	35
3.12	Classification of Anganwadis according to electric facilities	36
3.13	Distribution of Anganwadis according to the toy facilities	37
3.14	Classification of Anganwadis according to the types of toys provided	38
3.15	Classification of Anganwadis according to the items of foods provided	39
3.16	Classification of Anganwadis according to the kind of foods	40
3.17	Distribution of foods to others	42
3.18	Classification according to the satisfaction level of foods provided in Anganwadis	43
3.19	Classification according to the trend of children	44
3.20	Classification showing the reasons for declining trends of children	45

List of Graphs

Graph No.	Title	Page No.
3.1.1.	Age wise classification of the respondents	27
3.6.1.	Distribution of Anganwadis according to number of children	31
3.7.1.	Classification of Anganwadis according to the ownership	32
3.8.1.	Distribution of Anganwadis according to the room facilities available	33
3.11.1.	Distribution of Anganwadis according to playground facilities	36
3.16.1	Classification according to the kind of goods	41
3.18.1	Classification according to the satisfaction level	44
3.20.1.	Reasons for the declining trends of children	46

CHAPTER - I

INTRODUCTION

Introduction

The people of a country are its most valuable asset. The strength and prosperity of nation lies in its people who are healthy, educated and economically self-reliant. Hence, in fulfilling the directions given in the constitution of India, the government is committed to provide facilities and opportunities to its citizen for education, heath and nutrition with a long term goal of ensuring freedom from disease, illiteracy and poverty.

The future of a country is vested in its children. Children of today are the citizens of tomorrow. Hence, it becomes predominantly significant to take adequate steps for the holistic development of the child right from the beginning when he is in the womb of his mother. Such development of child needs adequate facilities for health, education and nutrition. Hence an intervention namely " INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) " was launched in the country. The package of services is delivered to beneficiaries at an Anganwadi center (AWC) by a women Volunteer from the local community known as "Anganwadi Worker". The Anganwadi worker is

helped in her efforts by another women volunteer is known as the Anganwadi Helper.[1]

India is one of the very few developing countries to have a national policy on children. The national policy declares that children are a "supplementary important asset" of a nation, whose nature is, therefore, a national responsibility. It affirms that it shall be the duty of the state to provide adequate services to the children both before and after birth, and through the period of growth to ensure their full physical mental and social development.[2]

A large number of Indian children are still threatened by Malnutrition and ill health. The national policy for children (1974) recognized paramount importance of programmes for child survival and development. Taking into account the miserable nutritional and wealth conditions of children especially of those from rural poor families, government in 1976 in co ordination with the ICDS launched a comprehensive scheme to reduce infant and maternal mortality and to enhance the health and nutrition status and providing learning opportunities of pre-school children and mothers.[3]

Integrated child Development Services is a centrally sponsored scheme where in the central government is responsible for programme planning and operating costs, and the state governments are responsible for programme implementation and for provision supplementary nutrition out of states resources.[4]

The Integrated Child Development Services was conceived in 1975 with an integrated delivery package of early childhood services so that their synergistic effect can be taken full advantage of The scheme aims to Improve the nutritional and health status of Vulnerable groups including pre-school children, pregnant women and nursing mothers through providing a package of services including supplementary nutrition, pre-school education, immunization, health check-up, referral services and nutrition and health education. In addition, the scheme envisages effective convergence of inter-sectoral services in the anganwadi centers.[5] The scheme has been continued in the Tenth plan in 5652 projects with no expansion activities in view of resource constraints. As on 31-08-04, 5274 projects have become operational providing services to about 456 lakhs beneficiaries, comprising of about 380 lakhs children (0-6 years) and about 76 lakhs pregnant and lactating mothers through a network of 6.74 lakhs Anganwadi centers.[6]

The scheme targets the most vulnerable groups of population including children up to 6 years of age, pregnant women and nursing mothers belonging to poorest of the poor families and living in disadvantaged areas including backward rural areas, tribal areas and urban slums. The identification of beneficiaries is done through surveying the community and identifying the families living below the poverty line.[7]

The objectives of Integrated Child Development Services (ICDS) are: -

- To improve the nutritional and health status of pre school children in the age – group of 0-6 years
- To lay the foundation of proper psychological development of the child.
- To reduce the incidence of mortality, morbidity, malnutrition and school drop out
- To achieve effective coordination of policy and implementation amongst the various department to promote child development.
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper and health education.

Package of Service

To achieve the above objectives, the ICDS aims at providing a package of services, consisting of

Supplementary nutrition

Supplementary nutrition to children below six years of age, nursing mothers from low income families in accordance with the guidelines for the purpose of selection of beneficiaries. This will be given for 300 days in a year.

Nutrition and Heath Education

Nutrition health education to all women in the age group of 50-55 years, priority being given to expectant and nursing mothers

Immunization

Immunization of all children, less than six years of age, in the project area against diphtheria, tetanus, whooping cough, typhoid and tuberculosis. Immunization against tetanus for all the expectant mothers. It is to be ensured that all the infants staying within the anganwadi areas are administrated vaccination like B.C.G., D.P.T., Polio and measles before they attain the age of one year.

Health Checkup

This include antenatal care of expectant mothers, post-natal care of nursing mothers, care of new born babies, and of children below six years of age.

Referral Services

Referral serious cases of malnutrition [Children suffering from third or fourth degree of malnutrition] or illness to hospitals, upgraded PHC/ community health services or district hospitals

Non – formal Pre – school education

Non- formal education to children in the age of 3 to 5 years through Anganwadis. The emphasis is on play and creative activities aimed at the mental and physical growth of the child.[8]

Survey of Literature

According to Vandana Khullar (1998) the evaluation of the ICDS conducted by NIPCO seems to overstate the utilization and impact of the scheme, and difference between ICDS and Non ICDS areas. The case studies examined by her have pointed out some major gaps in the NIPCCD study especially the large coverage of non-eligible beneficiaries, and the relatively low coverage of eligible beneficiaries, the poor quality of record keeping of growth charts and medical records, the scope for the reduction of paper work and lengthy report and finally tapping other sources for data collection and comparison.[9]

The Study undertaken by the directorate of ICDS, govt. of Maharashtra (1990) states that the available evidence leads one to conclude that the performance and impact of the ICDS programme as a whole is mixed, while there is sufficient evidence to support the fact that the ICDS scheme has the potential of enhancing child survival rates as reflected. [10]

In the study on 15 selected Panchayaths in Kerala, entitled people planning in Kerala working of Anganwadi centers in selected Panchayaths by T.N.Seema (1998) found the that the adequate capabilities for planning mother and child care services are yet to be created at the grass root level and these service have remained isolated from the rest of planning process. [11]

National Study conducted in 1992 by the National first Public Cooperation and child Development confirmed the positive impact of ICDS where the program Was operating, there were lower percentage of low birth weight babies, lower infant mortality rates, higher immunization rates of health services, and better child nutrition. The percentage of severely malnourished children declined, the positive effects of pre school training were evident and a larger percentage of mothers were getting their children medically examined. [12]

Coleman's (1966) analysis of the apparent effects of head start upon test course also suggests that supplementary or compensatory education programmes may have their greatest effects upon the most disadvantages children. [13]

Sheldon White, his studies of children's learning and attention have been mixed with practical work on governmental policy, education for the disadvantaged, early child care, children's television and museum design for children. [14]

Templin (1958) found in his study of language development of children between 3 and 8 years of age that "only the relationship between intelligence and vocabulary was substantial and was maintained through out the age span of three to eight". [15]

Barbara Notkin White (1972) has studied the effects of innovative educational curriculum for children.

Pauline Kergomard, general inspector of nursery school, explains that "Anganwadi is not a school in the ordinary sense of the world. It forms a transition from family to school, it retains the affectionate and indulgent gentle approach of the family, and at the same time introduces the child to working and to the routine of school". [16]

Eric Plaisance explains that the nursery school has thus changed from a 'productive' educational model to an 'expressive' one. In the first model, the child is assessed by results, on the technical success of his work, on his ability to work had and to concentrated. In the second, the child is valued for his

ability to exercise his 'exploratory' skills in his activities, and to develop his originality and to express his personality.[17]

Christiane Renouard (2000) professor of philosophy explains the discovery of genuine skills in the very young child and of the importance of a stimulating environment which has paved the way for a demand for early schooling which is being seen as an essential developmental factor in areas as sensitive as communication, socialization particularly through the acquisition of language, but also in independence and cognitive skills.[18]

According well known educationist Rose "child play is joyful, spontaneous and creative activity, in which man finds fullest self expression".[19]

According Juvenile Justice (care and production of children) Act 2000 'child ' means a person who has completed eighteenth year of age.[20]

According to Chopra Akash (1995) "Angawadi is a pre-school or day care center for children below 6 years".[21]

According to Patnaik " anganwadi is the center for the holistic development of women and children".[22]

CHAPTER SCHEME

Chapter I includes Introduction, definition of concepts, literature review, objectives of the study, need of the study,methodology, period of study and limitations.

Chapter II includes an overview of ICDS / Anganwadis

Chapter III includes analysis and interpretations

Conclusions and recommendations are included in Chapter IV

Terms and Concepts

Anganwadi :-

Anganwadi literally the courtyard play center is a child care center, located within the village or slum area itself. Anganwadi is the local point for the delivery of services at the community level, to children below 6 years of age, pregnant and nursing mothers and adolescent girls. [23]

Supplementary Nutrition:-

Supplementary nutrition to children below six years of age, nursing mothers and expectant mothers from low income families in accordance with the guidelines for the purpose of selection of beneficiaries. [24]

Immunuzation:-

Immunization of all children, less than six years of age, in the project area against diphtheria, tetanus, whooping cough, typhoid and tuberculosis. Immunization against tetanus for all children and expectant mothers. [25]

Referral services:-

Referral of serious cases of malnutrition or illness to hospitals, upgraded PHC/ community health services or district hospitals. [26]

Pre-school education:-

Non-formal education to children in the age of 3 to 5 years through Anganwadis. The emphasis is on play and creative activities aimed at the mental and physical growth of the child. [27]

General Feeding: -

General feeding is the method by which they encourage the mothers to have older relatives bring the little children under age 3 years at 3.30 pm for feeding when the mothers herself is to busy. [28]

Irregular feeding: -

In the absence of Anganwadi worker, feeding should be arranged and conducted by the helper, so that needy children and mothers are not deprived of the nutritious food. The objective of providing supplementary nutrition will not be defeated due to irregular feeding. [29]

Objectives

1. To analyse the infrastructure facilities available in Anganwadis in Varapuzha Panchayath.
2. To study the food items provided in Anganwadis
3. To find out the declining trends of children in Anganwadis.

Hypothesis

1. There is a declining trend of children in Anganwadis.

Need of the study

The study of the child is very important to parents, homemakers, teachers and adults who are responsible for the welfare of children and adults. Actually child study is a scientific study of the individual from his pre-natal beginnings to the early stages of his adolescence. Study of child is an important duty of the teacher and the parents. Knowledge of the children and their development contributes to human betterment. All children need love and security for developing their personality. Integrated child development services is a centrally sponsored scheme, where in the central government is responsible for programme planning and operating cost, and the state governments are responsible for programme implementation and for providing supplementary nutrition out of state resources. Actually Anganwadis provide educational, nutritional and other services to children and all other peoples. Today's government has given more importance for the development of the children. So the present study is expected to throw light on the functioning of the Anganwadis in Varapuzha Panchayath.

Area of the Study

The study is conducted in Varapuzha Panchayath. The area is a residential area having approximately 3000 families of varying financial and social status. Varapuzha Panchayath is selected for the study because there is more than 20 Anganwadis functioning in that Panchayath.

Methodology

Methodology specifies the way the researcher proceeds while collecting the data and analyzing it. In the present study the relevant data has been collected from 30 Anaganwadi workers and the remaining 20 respondents were the parents of kids coming to the anganwadi. Sources of data has been collected on the basis of convenience sampling

Sources of Data Collection

Data for the study has been collected from both primary and secondary sources. Data were collected using questionnaires. The questions pertained to the infrastructure facilities in the anganwadi, the food items provided by these centers and the trend of children in these anganwadi. Secondary data has been collected from journals, publications, magazine, internet etc. collected data were tabulated and analysed to draw conclusion.

Period of Study

The study was conducted during the period of 2005- 2006.

Limitations of the Study

1. As the number of samples is low in number no interpretation are made for the population.
2. The scope of the study is confined to Varapuzha Panchayath only
3. The sample size taken was small. A larger sample may have yielded better results.

CHAPTER - II

ICDS AN OVERVIEW

ICDS / ANGANWADI-AN OVERVIEW

BACKGROUND

India has a long history of programmatic efforts to improve the health of mothers and children and has made significant gains in the fifty years since independence. Despite these gains, maternal and child deaths constitute a significant burden of disease. According to WHO estimates, India contributes about 2.4 million of the10.8 global child deaths and 25% of 5,29,000 global maternal deaths.[30]

The Slow pace progress in infant morality and child malnutrition is an area of serious concern 69% of all infant deaths occur in the neonatal period. Malnutrition is an important cause of death in under fives. 56% of death among under- fives are due to the underlying effects of malnutrition on disease. On an average a child who is severely under weight is 8.4 times more likely to die from an infectious disease than a healthy child. Infant and child deaths are a mix of several risks factors. Proximate determinants of infant and child survival include a mix of preventive and curative interventions – maternal tetanus toxoid safe delivery, home based care of the newborn immediate breastfeeding and appropriate wearing and complimentary feeding, access to safe water and sanitation immunization, administration of vitamin A, ORT and antibiotics for neonatal spices, respiratory and other infections. Many child survival interventions can be successfully implemented through a mix of actions at the

household level/community level and a basic package of primary health care that does not rely on complex technology.[31]

For variety of reasons, (not the last being Gender inequities and consequent and disempowerment) Women throughout the life cycle face numerous obstacles in recognizing; seeking and receiving care for health problems. While well organized outreach and facility based health, care is a critical component of improving women's (and their family's) health, empowerment, leadership development, and knowledge and skill and skills are equally important. However these latter components lie outside the realm of traditional health service delivery systems. Community level action for increasing mobilization, action and behavior change process, supported by well organized primary and secondary health systems, are required to enable women cross a range of barriers, including gender enquiry and poor access to quality health services.[32]

The Department of Women and children (DWCD) is the repository of national programmers for the holistic development of women and children. It includes the Integrated Child Development Services (ICDS), to provide supplementary nutrition for pregnant and lactating mothers and children under six, and non-formal preschool education, programmes to ensure social and economic empowerment of women through collectivization, welfare and support services, training for employment and income generation and gender sensitization. At the village level, the DWCD is represented by a village level

honorary worker, the Anganwadi Worker (AWW) and her assistant, an Anganwadi helper. DWCD norms stipulate one Anganwadi Center (AWC) for a population of 1000 in plains and 700 in tribal areas. Supervision of AWW is by the Mukhiya Sevika, who is in charge of about 15-20 AWC. At the block level, the Child Development Project Officer is the functionary in charge of DWCD schemes.[33]

INTEGERATED CHILD DEVELOPMENT SERVICES IN INDIA

In 1974 India adopted a National Policy for Children to ensure the delivery of comprehensive child development services to all children. One of the first targets for the effort were poorest children found in urban slums and rural areas, particularly children in scheduled cast and tribes. Beginning in 1975 with 33 projects, Integrated Child Development Services (ICDS) has grown to 2696 projects (more than 265000 centers) in 1992, reaching about 16 million children under 6 years of age. The specific objectives of ICDS are to:

- Lay the foundation for the the psychological, physical and social development of the child:
- Improve the nutritional and health status of children, 0 to 6:
- Reduce the incidence of morality, morbidity malnutrition and school dropout:
- Enhance the capability of mothers to look after the needs of the child.

The integrated package of ICDS services works through a network of Anganwadi (literally, courtyard) Centers, each run by an Anganvadi Worker (AWW) and helper, usually selected from the local village. The AWW undergoes three – month training in one of the more than 300 training centers run by voluntary and governmental agencies. Responsibilities of the AWW include non formal pre – school education, supplementary feeding health and nutrition education parenting education through home visiting community support and participation and primary maternal and child health referrals. Support is provided to the AWW by a supervisor (1 per 20 AWW) and a Child Development Programme Officer working with 3-5 supervisor) who is directly responsible for implementation and management of each ICDS project.

All families in the area to be served are surveyed to identified the poorest. Those families with children under 6 and / or where the woman is pregnant or lactating, are served in the Anganwadis. Regular examinations are provided by Lady Health Visitors and Auxiliary Nurse Midwives. Children and pregnant women are immunized on a scheduled basis. Three hundred days a year food is distributed, the menu prepared in accordance with local foods and traditions. Families are encouraged to bring the children to the centers for regular feeding. Children's weight and height are monitored. Those with severe malnutrition are given additional food supplements, and acute cases are referred to medical services. [34]

A pre-school programme has been developed for 3-6 year olds who attend the center three hours a day. The AWW is encouraged to develop activities that stimulate the child. An additional service is non-formal training in nutrition and health organized for mothers and pregnant women. These sessions are open to all women aged 15 - 45 with priority given to pregnant and nursing women whose children suffer from repeated malnutrition.

Funding for the programme has come from both governmental and non-governmental sources. The initial costs of establishing a programme are provided by the Ministry of Social Welfare. The costs of supplementary feeding programme are borne by the state; and the on going operational costs are the responsibility of the Central government. UNICEF assisted in planning an implementation beginning in 1975. Since 1982 other international agencies, for example, the World Food Programme, the Aga Khan Foundation, CARE, NORAD, USAID and the World Bank, have been contributing in a variety of ways.

The ICDS programme uses existing services of diverse governmental departments and of voluntary agencies for the training of ICDS workers. Overall administration lies with the Department of Women and Child Development within the Ministry of as well as the All India Development. The annual unit cost per child per year was estimated at approximately US$10.00.[35]

Although the programme often operates at a minimum level of quality it has nevertheless had important effect on the under –six population. For instance, a review of 30 studies of the nutritional impact reveals nearly unanimous results documenting a positive outcome. A 1984-86 comparative study done in a number of locations shoed ICDS /non ICDS infant morality rates of 67 vs. 86 in rural areas and 80vs. 87 in urban areas. In a comparative study of effects on schooling, one researcher found that those with ICDS background had a higher primary school enrollment rate (89% vs.78%), were more regular attenders, had better academic performance and scored significantly higher on a psychological tests (Raven Colour Matrics), than non-ICDs children. Furthermore, the difference in enrollment rates was accounted for by differences among girls (more of the ICDS girls stayed in school). In another study, it was found that primary school dropout rate were significantly lower for ICDS than for non –ICDS children from lower and middle caste groups (19 vs. 35 percent for lower castes and 5 vs. 25 percent for middle castes.)

The ICDS, the largest programme of it's kind, illustrates the power of political commitment to achieve significant rates of coverage in an integrated programme of attention to children ages 0 to 6, with important effects on health and education and at a reasonable cost. [36]

Expansion of ICDS

The ICDS Scheme was sanctioned during 1975-76 in just 33 blocks of the country. At present, there are 4200 Operational ICDS Projects in the Country. Approval of the Cabinet has been obtained for the operationalisation of 462 new ICDS blocks under World Bank assisted in ICDS III and ICDS -APER projects during the next three years. In addition to this proposal for operationalisation of 390 ICDS Projects in a phased manner during IXth Plan period under General ICDS scheme has been submitted to CCEA for approval.[37]

Expenditure on ICDS

Alongside gradual expansion of the Scheme, there has also been a significant increase in the Central Government's spending on implementation of the Scheme. As against the expenditure of only Rs.1190.21 crores during 17 years i.e., 1975-1976 to 1991 - 1992, the expenditure during the five years of the 8th plan period was Rs.2271.28 crores representing 191% increase in during just 5 years period as compared to 17 years period. The expenditure of Rs.2271.28 crores during VIII th plan was against the approved VIII the Plan outlay of Rs.1285.74 crores for ICDS. During 1999-2000, against the budgetary allocation of Rs.855.76 crores, an amount of approximately Rs.772. crores has been released up to Sept.1999.[38]

Coverage

The number of beneficiaries under the ICDS Scheme have also significantly increased over the period. As against 1.66 crores beneficiaries up till March 1992, there are at present 2.77 crores beneficiaries as on June 1999.[39]

WORLD BANK ASSISTED ICDS PROJECTS

ICDS –1

The World Bank evinced interest in funding schemes significantly contributing towards raising the status of health, nutrition and education of Women and children and funded Tamil Nadu Integrated Nutrition Project (TINP), a State sector Project for Tamil Nadu during the period 1980-89. Subsequently encouraged with the success of the Project, the World Bank funded the ICDS programme. The first World Bank assisted ICDS Project covering 110 blocks in Andhra Pradesh and 191 blocks in Orissa was launched in 1990-91. The Project covered tribal blocks and socio-economically backward rural blocks in the two States. The World Bank committed assistance to the tune of to US $74 million. The project closed on 31st December 1997. The available credit the Project has been fully utilized.[40]

ICDS -II

The Second World Bank Assisted ICDS II Project came into operation in Predominantly tribal and socio economic backward areas covering 210 blocks in Bihar and 244 blocks in Madhya Pradesh a Project period of seven years. The Project became operational in 1993-94 and would continue up to the year 2000-2001. The available World Bank credit for the Project is US $194 million for the Project period.

Government of India has an amount of Rs.450 crores to the States of Bihar and Madhya Preadesh since commencement of the Project. The State Govt. of Bihar and Madhya Pradesh have filed the disbursement claims amounting to Rs.306 crores to date. [41]

ICDS-III

The World Bank Assisted ICDS -III Project was approved in March 1999 covering the states of Uttar Pradesh, Tamil Nadu, Maharashtra, Rajasthan and Kerala. The project proposes to strengthen and improve the quality of ICDS services and management in the 685 existing ICDS blocks and introduces ICDS services in 318 new blocks. The project would cover tribal blocks, rural disadvantaged blocks and urban blocks with poor outreach of basic services in these States. With this coverage the ICDS would be universalized in the States of Kerala, Maharashtra and Rajasthan. Tamil Nadu

is already fully covered under ICDS. The project aims to bring about a substantive impact on health and nutrition states of children and women in the project states. World Bank credit of US $ 300 million is available for the project. Government of India has released total fund of Rs.75.90 crores to the states to date, for implementation of the project. [42]

CHAPTER - III

ANALYSIS AND INTERPRETATIONS

ANALYSIS AND INTERPRETATIONS

The respondents in the present study are the teachers in charge of the Anganwadis and the parents of kids coming to the Anganwadi.

Age Structure

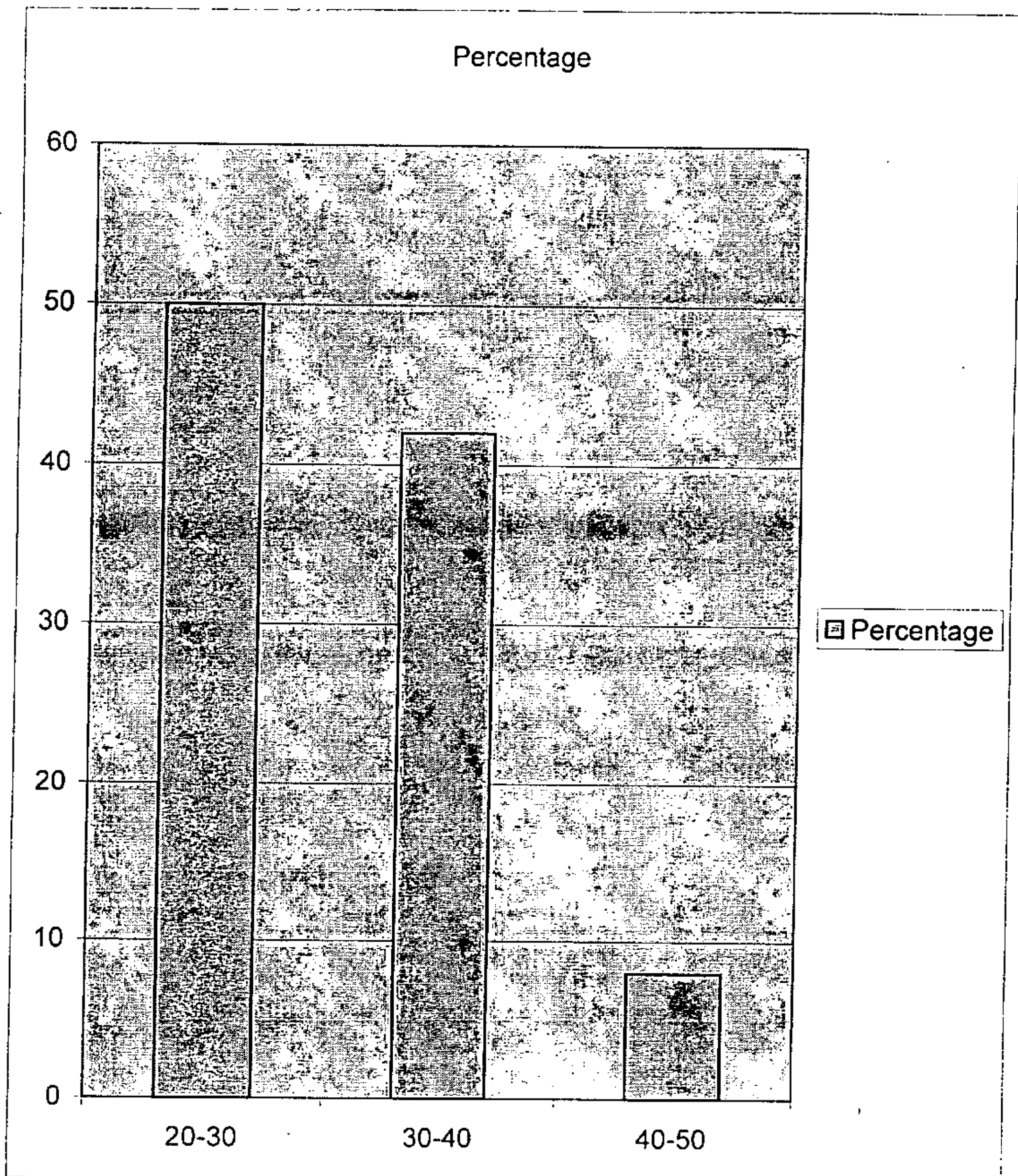
Table 3.1: The following table presents the age wise classification of the respondents

Age	No. of respondents	Percentage
20-30	25	50
30-40	21	42
40-50	4	8
Above 50	Nil	0
Total	50	100

Source: Primary data

From the table, it is clear that 50 percent of the respondents belong to the age group of 20-30 years. 42 percent of the respondents belong to the age group of 30-40 years. 8 percent of respondents belong to the age group of 40-50 years:

Figure 3.1.1: - Following figure illustrates the age wise classification of the respondents.



Monthly Income of the respondents

Table 3.2. The following table presents the monthly income of the respondents.

Monthly Income	No. of respondents	Percentage
1000-2000	26	52
2000-4000	16	32
Above 4000	8	16
Total	50	100

Source: Primary data

52 percent of the respondents belong to the income group of Rs.1000-2000. 32 percent of the respondents belong to the income group of 2000-4000. 16 percent of the respondents belong to the income group of above 4000.

Sex wise classification of the respondents.

Table 3:3. The following table shows the sex wise classification of the respondents.

Sex	No. of respondents	Percentage
Male	Nil	0
Female	50	100
Total	50	100

Source : Primary data

The above table shows that all the respondents were females.

Marital status profile of the respondents

Table 3.4: Table showing marital status profile of the respondents.

Marital Status	No. of respondents	Percentage
Single	10	20
Married	40	80
Total	50	100

Source: Primary data

From the above table, it can be seen that 80 percent of the respondents are married and the remaining 20 percent of the respondents are single
Educational qualification of the respondents

Educational qualification of the respondents

Table 3.5: Table showing the educational qualification of the respondents

Educational	No. Of respondents	Percentage
Below SSLC	4	8
SSLC	26	52
Pre Degree	17	34
Degree	3	6
Total	50	100

Source : Primary data

From the table, it can be seen that about 8 percent of the respondents were in the level of below S.S.L.C. –52 percent of the respondents were in the level of S.S.L.C. 34 percent were in the group of pre degree and the remaining 6 percent of the respondents were in the level of Degree qualification.

Distribution of Anganwadis according to the number of children

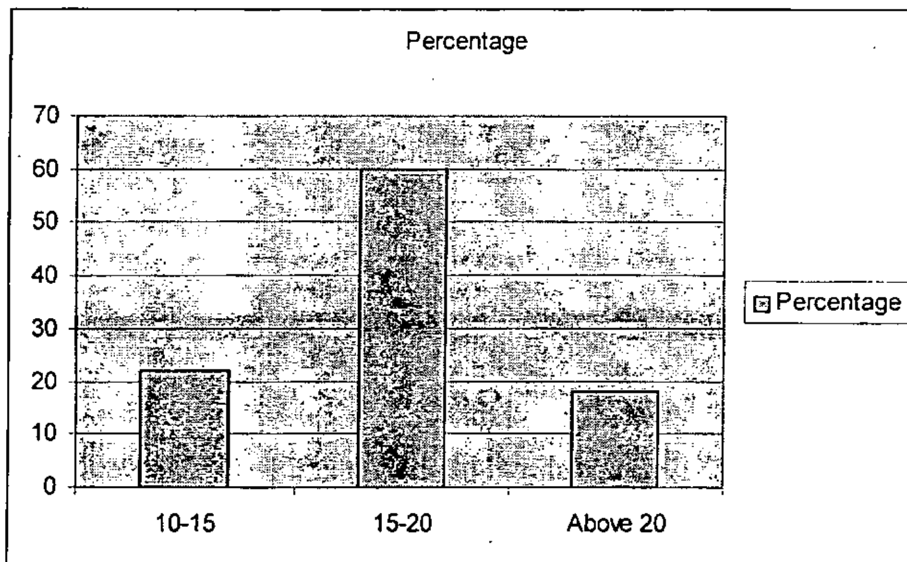
Table 3.6: Table showing the Distribution of Anganwadis according to the number of children in their rolls.

No. Of children	No. Of Respondents	Percentage
5-10	Nil	0
10-15	11	22
15-20	30	60
Above 20	9	18
Total	50	100

Source: Primary data

From the table it is clear that 60 percent of the anganwadis had in their yolls 15-20 children. 22 percent of them had number of children between 10-15. 18 percent of them had number of children between above 30.

Figure : 3.6.1 : Figure shows the distribution of anganwadis according to number of children



Ownership of Anganwadis

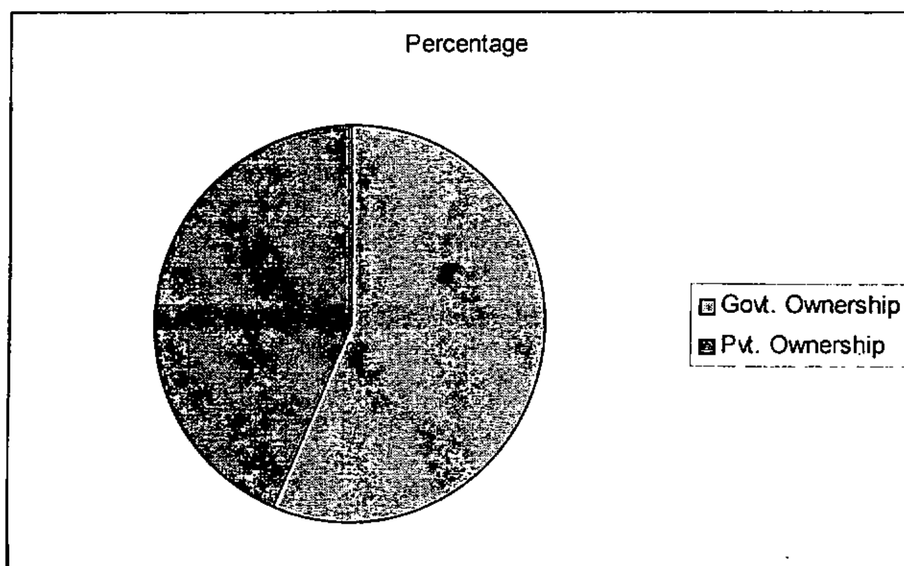
Table 3.7. : Table showing the classification of Anganwadis according to the owenership

Ownership	No.of respondents	Percentage
Govt. Ownership	28	56
Pvt. Ownership	22	44
Total	50	100

Source : primary data

From the table, it is clear that 56 percent of the Anganwadis falls under the ownership of govt. And the remaining 44 percent falls under the private ownership.

Figure: 3.7.1: - Figure showing the classification of Anganwadis according to the ownership.



Classification of Anganwadis according to the room facilities available

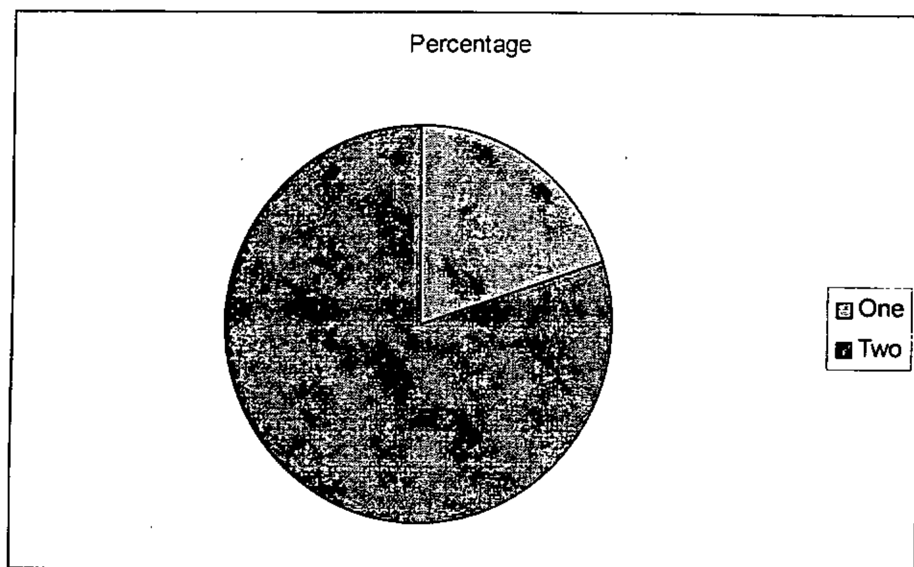
Table 3.8 : Table showing the classification of Anganwadis according to the room facilities available

Rooms	No.of respondens	Percentage
One	10	20
Two	40	80
Three	Nil	Nil
Total	50	100

Source : Primary data

The above table shows that 80 percent of anganwadis has two rooms and 20 percent of the anganwadis has only one room.

Figure : 3.8.1 : Figure showing the distribution of anganwadis according to the room facilities available.



Income wise classification of anganwadi users

Table 3:9 : Table showing the income wise classification of anganwadis users.

Category	No.of respondents	Percentage
Lower Income	22	44
Middle Income	26	52
Upper Income	2	4
Total	50	100

Source : primary data

The above table reveals that 52 percent of children are coming from the middle income group and 44 percent of children are coming from the lower income group.

Classification of Anganwadis according to the Latrine Facilities

Table 3.10 : Table showing the classification of Anganwadis according to the Latrine Facilities.

Latrine facilities	No.of respondents	Percentage
Available	23	46
Not available	27	54
Total	50	100

Source : primary data

The above table depicts that 46 percent of the Anganwadis has the Latrine Facilities and the 54 percent of Anganwadis did not have the Latrine facilities.

Distribution of Anganwadis according to playground facilities

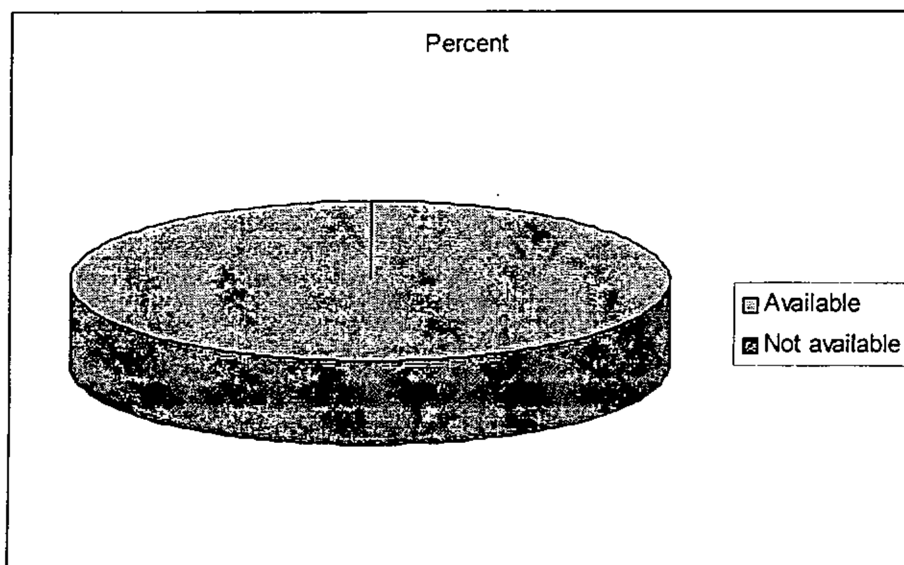
Table 3.11: Table showing the distribution of anganwadi according to the playground facilities.

Pay ground	No.of respondents	Percent
Available	50	100
Not available	Nil	0
Total	50	100

Source: Primary Data

From this table it is clear that all 100 percent of anganwadis provide courtyard, for playing the children.

Figure 3.11.1: Figure showing the distribution of anganwadis according to playground facilities.



Classification of anganwadis accordiong to Electric facilities

Table 3.12: Table showing the classification of Anganwadis according to electric facilities.

Elecricity	No.of respondents	Percentage
Available	31	62
Not available	19	38
Total	50	100

Source: primary Data

From the table it is clear that 62 percent of anganwadis have electricity facility and 38 percent of anganwadis did not have electricity facility.

Distribution of Anganwadis according to the toy facility

Table 3.13 : Table showing the distribution of anganwadis according to the provision of toy facility.

Toys	No.of respondents	Percentage
Yes	50	100
No	nil	0
Total	50	100

Source : primary data

The above table shows that all 100 percent of the anganwadis provide toys to the children for the improvements of their mental and fiscal abilities.

Classification of anganwadis according to the types of toys provided.

Table 3.14 : Table showing the types of toys provided in anganwadis

Types of Toys	No.of respondents	Percentage
Ball	25	50
Swing	9	18
See Saw	14	28
Others	2	4
Total	50	100

Source: primary data

The data revealed that 50 percent of the anganwadis had toy facility like balls for the children and 28 percent of them have only see saw facility.

Classification of anganwadi according to the items of foods provided

Table 3:15: Table showing the classification of anganwadis according to the items of foods provided.

Items	No.of respondens	Percentage
Uppummavu	29	58
Bread	5	10
Milk	4	8
Other items	12	24
Total	50	100

Source : Primary data

From the table it is clear that 58 percent of the anganwadis provide uppummavu to the children. 10 percent of item provide Bread to the children.

Classification of anganwadi according to the kind of foods

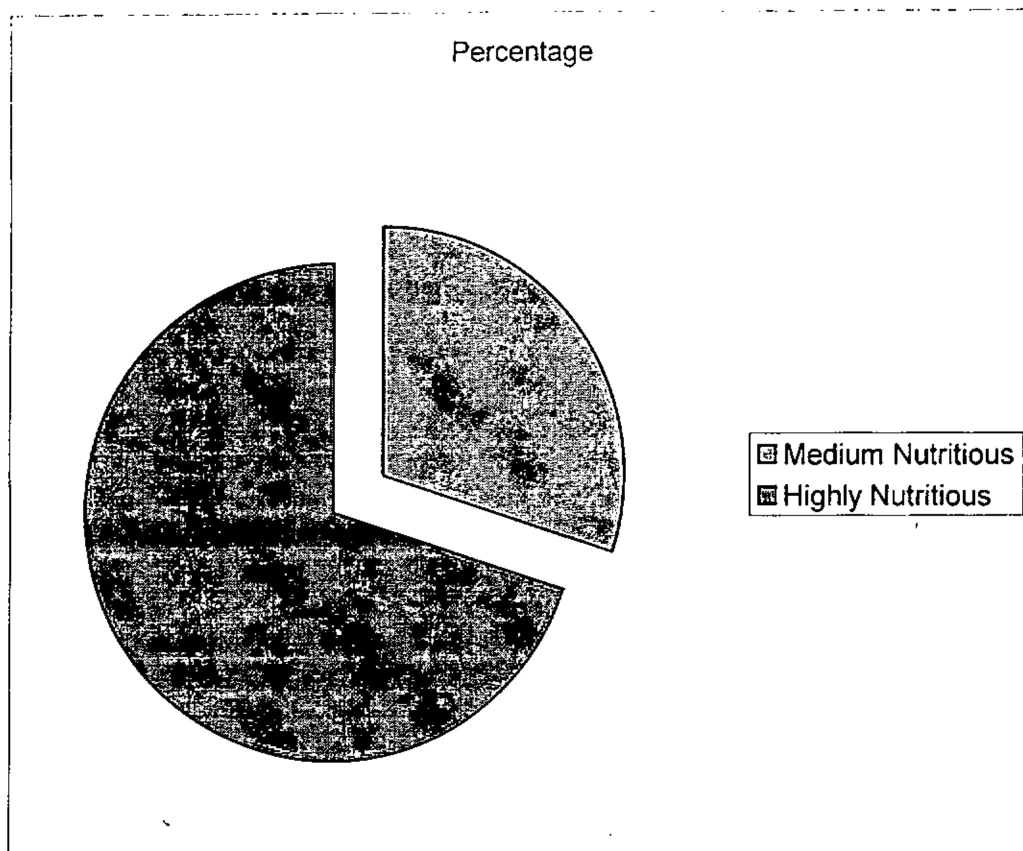
Table 3.16: Table showing the classification anganwadi according to the kind of foods.

Kind of Food	No.of respondents	Percentage
Medium Nutritious	15	30
Highly Nutritious	35	70
Total	50	100

Source: primary data

From the table it can be seen that 70 percent of the respondents said that the anganwadi provide highly nutritious foods to the children. 30 percent of the respondents said that it provides medium nutritious foods to the children.

Figure 3.16.1: Figure shows the Classification of anganwadi according to the kind of foods.



Distribution of food to others.

Table 3.17 : Table showing the distribution of foods to the other people

Category	No.of respondents	Pecentage
Below 34 yrs	12	24
3-6 yrs	16	32
Teenages	6	12
Adults	11	22
Old people	5	10
Total	50	100

Source : Primary data

The above the shows that anganwadi provide 24 percent of foods to the children below 3 years of age. 32 percent of that to the children between 3-6 years. 10 percent of foods to the old people.

Classification according to the satisfaction level of foods provided in Anganwadis

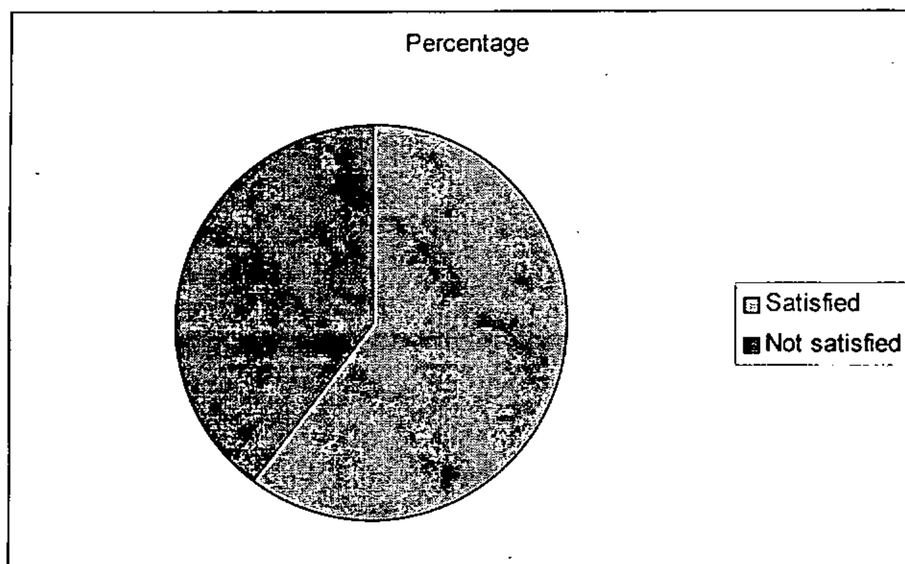
Table 3.18 : Table showing the classification according to the satisfaction level of foods provided in anganwadis.

Satisfaction	No. of respondents	Percentage
Satisfied	30	60
Not satisfied	20	40
Total	50	100

Source : Primary data

The above table shows that 60% of the respondents are satisfied with the foods provided by the government and 40% of the respondents are not satisfied with the foods provided by the government.

Figure : 3.18.1 :- Figure showing the classification of anganwadis according to the satisfaction level.



Classification of anganwadis according to the trend of children

Table : 3:19: Table showing the classification of anganwadis according to the trend of children

Declining trend	No.of respondents	Percentage
Yes	50	100
No	Nill	0
Total	50	100

Source : Primary data

The above table shows that in all the anganwadis, there is a declining trends of children

Classification of anganwadis showing the reasons for declining trends of children.

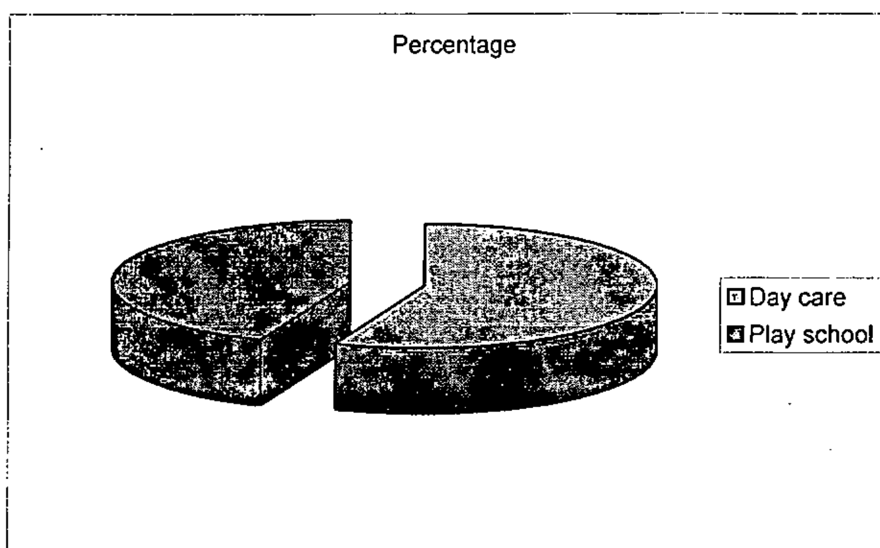
Table 3.20: - Table showing the reasons for the declining trends of children

Reasons	No.of respondents	Percentage
Private Day care	28	56
Play school	22	44
Total	50	100

Source : primary data

The above table shows that 56% of the respondents said that declining trend of children is due to the factor of Private Nurseries, Daycare Centers and play school etc.

Figure : 3.20.1 :- Figure showing the declining trends of children is anganwadi



Presentation of Results / Findings

The study relates to the functioning of ICDS programme. The study is based on 20 Anganwadis in Varapuzha Panchayath. The study was conducted using primary data collected from the respondents in Varapuzha Panchayath. Following are the findings of the study

Age profile of the respondents shows that 50% of them were below the age of 20-30 years.

Income wise classification shows that 52 percent of the women belongs to the monthly income group of 1000-2000 and 16 percent of women belongs to the monthly income of above 4000.

Marital status profile of the respondents reveals that 80% of the women are married and 20% of the women are single.

Education wise classification of the respondents reveals that 52% of the women respondents have completed their SSLC level of education. 33% of the respondents completed their Pree-Degree course.

The study shows that the majority of Anganwadis had in their rolls 15-20 children. And the most of the Anganwadis buildings are the under the ownership of Govt.

From the study it can be seen that all the Anganwadis have playground and they provide sufficient toys to the children.

The study reveals that Anganwadis provide nutritious food to the children. It can help to improve their health.

From the study it can be seen that Anganwadi provide sufficient food to the children who are studying there and also to other people.

The study depicts that in all anganwadis the trend of children is declaring over the years. This may be because of the increase in private nurseries like day care, play school etc.

CHAPTER - IV

CONCLUSION AND RECOMMENDATIONS

Conclusion

The ICDS is a major part of the programme aimed at improving the conditions of women and children. It provides health benefits to mothers and children. Adolescent girls are covered through a related scheme. The activities of this scheme centre around the 'Anganwadi' where children upto six years as well as pregnant women and feeding mothers.

The study revealed that the majority of the anganwadi buildings are owned by the govt. The analysis shows that there are also another facilities like electricity and latrine facilities. Anganwadis also provide certain play materials, which improve the mental and physical abilities of the children.

The study shows that anganwadis provides the nutritious foods to the children and other people. Anganwadi provide foods to other categories like children below 3 years, Adults, Teenagers and old people. The items of food include Uppumavu, Rice, Wheat and other items like Bread, Egg and Milk.

Regarding the trends of children in anganwadis it is very clear that there is a declining trend. The most important reason for the declining trends of children is that parents wishes to provide better education for their children. For attaining better education the parents will choose better school for their education. Parents feel that Anganwadi doesn't provide sufficient education to the children. So they have strong tendency towards the Private Day Care Center and the play school.

Recommendations.

To improve the service of Anganwadis and to reduce the declining trends of children in Anganwadis , the Following suggestions should be made: -

1) Anganwadis must provide more nutritious foods to the people.
2) Improve the present conditions in Anganwadis and introduce new services which will be beneficial for the children and the mothers.
3) Increase the supply of foods in Anganwadis
4) Government should take initiative steps to improve the present Infrastructural facilities in Anganwadis

APPENDIX

QUESTIONNAIRE

(Please tick ☑ appropriately)

1. Name :

2. Locality

3. Address :

4. Age 20-30 ☐ 40-50 ☐ above 50 ☐

5. Occupation :

6. Monthly Income : 1000-2000 ☐ 2000-4000 ☐ above 4000 ☐

7. Sex : Male ☐ Female ☐

8. Marital Status : Single ☐ Married ☐ Widowed ☐ Seperated ☐

9. Educational Qualification : below S.S.L.C. ☐ S.S.L.C. ☐
   Pre Degree ☐ Degree ☐ Any other ☐

10. Number of children in this Anganwadi
    5-10 ☐ 10-15 ☐ 15-20 ☐ above 20 ☐

11. Working time of this Anganwadi :

12. Is this Anganwadi building owned by the Govt.
    Govt.Ownership ☐ Pvt. Ownership ☐

13. How many rooms are there 1 ☐ 2 ☐ 3 ☐

14. Which Category of children are studying here ?

Lower Income ☐ Middle income ☐ Upper income ☐

15. Do you have any Latrine facilities in the Anganwadi?

Available ☐ Not Available ☐

16. Do you have any Playground in the Anganwadi

Available ☐ Not Available ☐

17. Does the Anganwadi have electricity?

Available ☐ Not Available ☐

18. Does the Anganwadi provided sufficient toys to the children?

Yes ☐ No ☐

19. What types of toys provided to the children?

Ball ☐ Swing ☐ See Saw ☐ Others

20. What kind of foods are provided in Anganwadi?

Less Nutritious ☐ Medium ☐ Highly ☐

21. What are the items of foods?

Uppumavu ☐ Bread ☐ Milk ☐ Other ☐

22. Are you satisfied with these food items?

Yes ☐ No ☐

23. Would you like to increase the quantity of foods provided by the Govt?

Yes ☐ No ☐

24.Do this foods items provided to children other than those who are studying here ?

Yes ☐ No ☐

25.If so, which category of children?

Below 3 yrs ☐ 3-6 yrs ☐ Teenages ☐ Adults ☐

Old People ☐ Other ☐

26.Is there any decline in the number of children?

Day Care ☐ Playing School ☐ Others ☐

27.Does this Anganwadi provide sufficient education to the children?

Yes ☐ No ☐

(Thank you for spending your valuabel time)

REFERENCE MATERIALS

End Notes

1. www.icds.govt.in / anganwadi.html
2. Salma. "nutrition in anganwadis" journal of social welfare, Vol VI. No.10 July 1995.
3. Srinivas, (1999) "An assessment of icds programme" journal of Rural development vol.10, page 21-22.
4. www.icds.gov.in / anganwadi html
5. M. Qureshi Ecological saints of Deserts 2004" page 117.
6. Economic survey 2004-05 page 241
7. www.icds.gov.in / anganwadi.html
8. Sujatha verma, Journal of kerala calling, May 1997, page 42.
9. M. Lingaraju, Journal of social welfare, April – 1993
10. George Loyid, "Journal of social welfare, April-2000, page 33.
11. Akash chopra, "Journal of kerala calling "June –1998- page 21.
12. Ibid
13. Victor H. Deneberg, Education of the infant and young child
14. Sheldon white, Barbara white, "childhood pathways of Discovery" multimedia publication inc willerostad 1980
15. Label, News Magazine of the ministry of foreign affairs April 2004.
16. Ashok K. Sharma, child development the India perspective National council of Educational Research and Training 1998.
17. Ibid
18. Dr. Digumarti Bhaskara Rao, Case The child Vol 2, 1997.
19. Ibid
20. Ibid
21. Hongs "Integrated child development services, India case study Italy 1989.
22. Ibid
23. Ibid

24. National institute of public cooperation and child Devpt, New Delhi Nipccd 1992.
25. Ibid
26. Ibid
27. Ibid
28. George Richard "Nutritional programmes in Anganwadis" Journal of economic Review April 15-2001
29. Patnaik prabha "Anganwadis children" Journal of Social welfare Vol XiX No. 6 August 1990
30. Siva Kumar "Awareness of health needs for adolsents Vol 15, No. 1, April 2003.
31. Dr. Digumart : Bhaskara Rao, Case The Child Vol 2, 1997.
32. Ibid
33. Ibid
34. Ashok K. Sharma, Chid devpt the India perspective 1998
35. Ibid

Bibliography

1. Sheldon white, Baskara Notkin white "childhood pathways Discovery" Multimedia publications Inc Willemstad 1980.
2. Ashok K Sharma, child Development The Indian perspective National Council of Educational Research and Training 1998.
3. Dr. Digumarti Bhaskara Rao, case the child, Vol 2, Discovery publishing house 1997.
4. Hong s, "Integrated child Devp services "India case Italy 1989.
5. National Institute of public corporation and child Devpt New Delhi NIPCCD 1992.
6. J.L. Singh Need for the strategies to eradicate poverty" 1999 page 182.
7. Rajammal P Devadas "child Devpt" 1984.
8. Debendra K. Das "Indian economy after 50 years of Independence" page 74.
9. Malcom s "Education as a Tool for economic change" page 2.
10. India social Devpt Report –2006 page: 15
11. India 2005
12. Loyid. "Immunizatin programme" journal of social welfare, Vol XIV April 2000.
13. Ima. "nutrition in anganwadis" journal of social welfare, Vol VI. No.10 July 1995.
14. Srinivas, (1999) "An assessment of icds programme" journal of Rural development vol.10, page 21-22.
15. M. Qureshi Ecological saints of Deserts 2004" page 117.
16. Sujatha verma, Journal of kerala calling, May 1997, page 42.
17. M. Lingaraju, Journal of social welfare, April – 1993
18. George Loyid, "Journal of social welfare, April-2000, page 33.
19. Akash chopra, "Journal of kerala calling "June –1998- page 21.
20. Victor H. Deneberg, Education of the infant and young child
21. Sheldon white, Barbara white, "childhood pathways of Discovery" multimedia publication inc willerostad 1980
22. Dr. Digumarti Bhaskara Rao, Case The child Vol 2, 1997.

23.George Richard "Nutritional programmes in Anganwadis" Journal of economic Review April 15-2001

24.Patnaik prabha "Anganwadis children" Journal of Social welfare Vol XiX No. 6 August 1990

25.Siva Kumar "Awareness of health needs for adolsents Vol 15, No. 1, April 2003.

26.Dr. Digumart : Bhaskara Rao, Case The Child Vol 2, 1997.

27.Ashok K. Sharma, Chid devpt the India perspective 1998