Supply Chain Management of Icds Programme through Anganwadi and Their Impact on Child Health

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Abstract— The present study was conducted at Bilaspur district of Chhattisgarh state. Total 80 Anganwadi children were survey through structured interview schedule by the researcher. It was observed that out of total 80 respondents, majority of them (76.25%) were belonged to Hindu religion, majority of them (52.50%) were belonged to scheduled caste, 55 per cent were living in pakka house, 53.75 per cent had attendance more than 20 days in a month, children's face (78.75%) observed normally, 43.75 per cet teeth appeared white, 32.5 per cent hairs were appeared rough, 27.5, 15 and 7.5 per cent of the respondent's nails were observed easily break down, white spot and pale respectively.

Keywords— ICDS, AWWs, Pre-school, Anganwadi

I.   INTRODUCTION

India is the world's second largest populated country after sixty years of independence, India still has a large number of people residing in slums, villages and are deprived from basic amenities. Time and again the government of the country has taken several steps to help the poor, the needy and the helpless. The integrated child development scheme is one of such initiatives taken by government [2]. Integrated child development services, a flagship programme of the government of India provides health, nutrition and pre-school education to children aged three years to six years. Even after 35 years of implementation, the success of ICDS in tackling childhood and maternal problems remains a matter of concern [5].

ICDS was launched on 2nd October 1975, on the auspicious occasion of the 106th birth anniversary of Mahatma Gandhi, the Father of the Nation. In the initial stages ICDS was implemented in 33 selected community development blocks all over India. ICDS has expanded considerably in subsequent years and at present there are 7076 sanctioned projects, 7025 operational projects in India and 155 sanctioned and 154 operational projects in Punjab [3]. The Anganwadi worker (AWW) is the community based voluntary frontline worker of the ICDS programme selected from the community, she assumes a pivotal role due to her close and continuous contact with the beneficiaries (National health programme series 7).

AWW is the central points for the delivery of services at community levels to children below six years of age, pregnant women, nursing mothers and adolescent girls. AWWs help the children to get into the right from the preschool age. AWW educates to family especially mothers to ensure effective health and nutrition care, early recognition and timely treatment of ailments [1]. Today's child is father of tomorrow's man. It is the child who will carry the present day's genes to future generation. Pre-school children are the most vulnerable groups constituting 36 percent of the total population of India. The rate of growth and development of pre-school children depend to a large measure on the adequacy of the diet assumed by them [6].

Pre-school educational and supplementary nutrition Ration are very important activities of the ICDS Program. This focuses on the total development of the children from 3 to 6 years. Children 3-6 years have the benefit of non formal pre-school education through the institution of Anganwadi set up in each village. Non formal pre-school education is the most joyful play-way daily, visibly sustained for three hours a day. It does not impart formal learning but develops in the child desirable attitudes, values and behaviour patterns and aim at providing environmental stimulation. Good pre-school education increases cognitive abilities, school achievements and improve class behaviour among children [3].

Growth assessment is the single most useful tool for defining health and nutritional status in children at both the individual and population level [8]. To measurement of appearing the face, skin, teeth, hairs, nails etc. are reliable means to

evaluate the progress of normal child and for early detection of health deviations. Malnutrition on early childhood affects the mental, physical and emotional development of children and their future productivity [7]. Thus the present study was formulate with the objective to know the progress of normal Anganwadi child health through their physical appearance.

II. METHODOLOGY

The present research work was conducted at Bilaspur district of Chhattisgarh state. For collection of primary data total 80 children were surveyed from the four Anganwadi centres (2 Anganwadi form rural area and 2 Anganwadi from urban area) through pre-structured interview schedule. 20 children were randomly selected from each Anganwadi centres. The collected data were coded, classified, tabulated and analysed by using appropriate statistical tools.

III. RESULTS AND DISCUSSION

Table 1: Distribution of the Anganwadi children according to their religion

S. No.	Religion	Rural		Urban		Total	
		f	%	f	%	f	%
1.	Hindu	40	100	21	52.50	61	76.25
2.	Muslim	0	0	19	47.50	19	23.75
	Total	**40**	**100**	**40**	**100**	**80**	**100**

The data illustrated in the Table 1 regarding religion of Anganwadi Children. It was observed that out of total 80 respondents, majority of them (76.25%) were belonged to Hindu religion and remaining 23.75 per cent belonged to Muslim religion.On the basis of separated analysis, it was noted that 100 percent respondents of rural area anganwadi were belonged to Hindu religion, whereas, in case of urban area Anganwadi, it was noted that 52.50 per cent of the respondents were belonged to Hindu community and 47.50 per cent were belonged to Muslim community. From the above results, it may be conclude that majority of the surveyed children were belonged to Hindu religion.

Table 2: Distribution of the Anganwadi children according to their caste

S. No.	Caste	Rural		Urban		Total	
		f	%	f	%	f	%
1.	General	0	0	22	55	22	27.50
2.	OBC	0	0	5	12.5	5	6.25
3.	SC	34	85	8	20	42	52.50
4.	ST	6	15	5	12.5	11	13.75
	Total	**40**	**100**	**40**	**100**	**80**	**100**

The data presented in the Table 2 show that out of total 80 respondents majority of them (52.50%) were belonged to

scheduled caste, followed by 27.50 per cent were general caste, while 13.75 percent were scheduled tribe and only 6.25 per cent were belonged to other backward class.The data further reveal that most number of the respondents (85%) in rural area Anganwadi were belonged to schedule caste, followed by schedule tribe (15 %). Similarly urban area Anganwadi centre's respondents, majority of them (55%) were belonged to general caste, followed by schedule caste (20%) and 12.5 per cent were belonged to other backward caste and scheduled tribe(each).On the basis of above finding, it may be concluded that more than half per cent of the respondent children were belonged to scheduled caste.

Table 3: Distribution of the Anganwadi children according to their types of house

S. No.	Type of house	Rural		Urban		Total	
		f	%	f	%	f	%
1.	Pakka	19	47.5	25	62.5	44	55
2.	Kachha	21	52.5	15	37.5	36	45
	Total	**40**	**100**	**40**	**100**	**80**	**100**

The data demonstrated in the Table 3 regarding children's percent house type. The data reveal that out of total 80 respondents, majority of them (55%) were living in pakka house and 45 per cent were living in kachha house.On the base of separate observation, it was noted that majority of the rural area respondents (52.5%) were living in kachha house, followed by pakka house (47.5%).Similarly, in case of urban area Anganwadi centres, majority of respondents children to (62.50%) were living in pakka house, followed by kachha house (37.5%).From the above result, it may be said that the living condition of urban area.

Table 4: Distribution of the Anganwadi children according to their attendance

S. No.	Attendance	Rural		Urban		Total	
		F	%	f	%	f	%
1.	Upto 10 days	4	10	6	15	10	12.5
2.	11 to 20 days	15	37.5	12	30	27	33.75
3.	More than 20 days	21	52.5	22	55	43	53.75
	Total	**40**	**100**	**40**	**100**	**80**	**100**

If the children are regularly attending the anganwadi activities, definitely it's creating the positive input on children procurement. Thus to know the children regularity to attend the anganwadi centres, the data was collected and deputed in the Table 4. the data express that out of 80 respondents, majority of them (53.75%)had attendance more

than 20 days in a month, followed by 33.75 and 12.5 per cent had attendance 11 to 20 days and upto 10 days respectively.As regards to rural anganwadi children, it was noted that 52.5 per cent of the respondents had attendance more than 20 days in a month followed by 37.5 and 10 per cent had 11 to 20 days and upto 10 days, respectively.Similarly , majority of the urban area anganwadi children (55%) had attendance, more than 20 days in a month, followed by 30 and 15 per cent had attendance 11 to 20 days and upto 10 days, respectively.

From the above findings, it may be said that about half per cent of the children were regularly coming at anganwadi centre. The anganwadi workers should give more attention towards influencing the children to regularly coming at anganwadi centre. Thus the main objectives of the Anganwadi centre will fulfil.

Table 5: Distribution of the Anganwadi children according to their face appearance

S. N o.	Appeara nce of face	Rural		Urban		Total	
		f	%	f	%	f	%
1.	Normal	33	82.5	30	75	63	78.75
2.	Wrinkled	0	0	0	0	0	0
3.	Dry skin	7	17.5	10	25	17	21.25
	Total	40	100	40	100	80	100

The data given in the Table 5 regarding children's face appearance. The data show that out of total respondents, majority of the children's face(78.75%)observed normally. However 21.25 per cent of the children's face had with dry skin.Regarding to rural Anganwadicentre's respondents, it was observed that majority of the children's face (82.5%) had normal condition, however 17.5 per cent children's face had observed with dry skin. Similarly, 75 per cent of the urban anganwadi centres respondents face appeared normally and 25 per cent children's face had observed with dry skin.On the basis of the results it may be seen that most of the respondent children's faced observed normal skin, but still some major steps should be taken for remedial for dry skin of the children.

Table 6: Distribution of the Anganwadi children according to their teeth appearance

S. No.	Appear ance of teeth	Rural		Urban		Total	
		f	%	f	%	f	%
1.	White	17	42.5	18	45	35	43.75
2.	Pain	9	22.5	7	17.5	16	20
3.	Decay	14	35	15	37.5	29	36.25
	Total	40	100	40	100	80	100

The data show in the Table 6 narrated that out of the total 80 respondents, most of them (43.75%) teeth appeared white, while 36.25 per cent respondent's teeth were decay and 20 per cent felt the pain in their teeth.On the basis of separate analysis, it was noted that that 42.5 per cent of the rural Anganwadi respondent's teeth were appeared white, but 35 and 22.5 per cent of the respondent's teeth were appeared decay and felt pain, respectively. As regard to urban anganwadi centre respondents, 45 per cent of children's teeth were appeared white, but 37.5 and 17.5 per cent children's teeth were appeared decay and felt with pain, respectively.

From the above findings, it may be concluded that more than 50 per cent of the anganwadi children's teeth had not appeared in normal condition. Thus it is great responsibility of anganwadi workers to take care of children teeth as well as to aware the children and their parents also for regular brushing of their teeth.

Table 7: Distribution of the Anganwadi children according to their hairs appearance

S. N o.	Appeara nce of hairs	Rural		Urban		Total	
		f	%	f	%	f	%
1.	Normal	26	65	28	70	54	67.5
2.	Rough	14	35	12	30	26	32.5
	Total	40	100	40	100	80	100

The data demonstrated in the Table 7 related to appearance of anganwadi children's hairs. It was noted that out of the total respondents, 67.5 per cent of the respondent's hairs were appeared normal but 32.5 per cent hairs were rough. The data further reveal that majority of the rural anganwadi centre's respondents (65%) hairs were observed normal condition. Whereas,35 per cent hairs were rough. Similarly, 70per cent of the urban area anganwadi centre's respondents hairs were appeared normal but 30 per cent hairs were rough.

On the basis of findings it may be concluded that the urban areas Anganwadicentre children's hairs were appeared normally as compare to rural area. The Anganwadi workers should give proper consideration to aware the children for taking care of their hairs and applying oil regularly.

Table 8: Distribution of the Anganwadi children according to their nails appearance

S. No.	Appearance of nails	Rural		Urban		Total	
		f	%	f	%	f	%
1.	Normal	23	57.5	17	42.5	40	50
2.	Pale	0	0	6	15	6	7.5
3.	White spot	6	15	6	15	12	15
4.	Easily break	11	27.5	11	27.5	22	27.5
	Total	40	100	40	100	80	100

The data depicted in the Table 8 related to nails appearing of anganwadi children's. The data express that 50 per cent of the children's nails were appeared normal, however 27.5, 15 and 7.5 per cent of the respondent's nails were observed easily break down, white spot and pale respectively.On the basis of separate analysis, it was seen that 57.5 per cent of the rural area anganwadi respondent's nails were normal in condition, but 27.5 per cent nails were easily breakdown and 15 per cent respondent's nails were appeared white spot.As regards to urban area anganwadi children, it was noted that 42.5 per cent respondents nails were appeared normal in condition, but 27.5 per cent of the respondents nails were appeared easily break down, however 15 per cent of children's nails were appeared white spot and pale(each).

The above results show that half percent of the children were not aware about nails sanitation. It is well known that the children's nails growth and bacterial disease in children has a positively and significant relationship. Many of the children faced lots of problem due to not adopting the sanitation. The anganwadi workers must aware the children and their parents to cut their nails in regular intervals and wash their hand properly.

IV.   CONCLUSION AND FUTURE SCOPE

From the above findings, it may be concluded that the anganwadi children's teeth, hairs, nails had not appeared in normal condition. It is well known that the children's nails growth and bacterial disease in children has a positively and significant relationship. Many of the children faced lots of problem due to not adopting the sanitation. Thus it is great responsibility of Anganwadi workers to aware the children and their parents also for adopting sanitation.

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