The Journal of Rural and Agricultural Research Vol. 18 No. 2, 49-51 (2018)
Received July 2018; Acceptance November 2018

Differential Frequency of Attending Mahila Mandal Sessions by ICDS Beneficiaries in Rural and Slum Areas of Agra District

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Abstract

ICDS is a scheme that is working to realize the dream of ensuring productive and wholesome life of women and children. Nutrition and health education is provided by ICDS centres through their mahila mandal sessions. The study was conducted on three hundred ICDS beneficiary women of Agra city. The sample was selected by multistage random sampling technique. Frequency of obtaining knowledge on health & hygiene in mahila mandal sessions during last six months was significantly higher by beneficiaries of rural anganwaries in comparison to beneficiaries of slum anganwaries (Ç2=11.52) . Beneficiaries of slum areas attended significantly more number of mahila mandal sessions where knowledge regarding neonatal care was imparted in comparison to their counterpart.

Key words: ICDS beneficiaries, mahila mandal sessions, rural and slum area

Introduction

ICDS is aims to realize the dream of ensuring productive and wholesome life of women and children. The focal point for the delivery of ICDS services is an Anganwadi which is run by an anganwari workers (AWWs) and a helper appointed from the locality. For achieving the objectives, ICDS provides a package of services consisting of Non-formal Pre-school Education, Supplementary Nutrition Service and other health services that include Immunization, Health Checks-ups, Referral Services and Nutrition & Health Education to beneficiaries.

Nutrition and health education aims to enhance the knowledge and capacities of mother and community to look after the health and nutritional needs of children. Important information and knowledge on basic health, nutrition, child care is provided through mahila mandals which are organized once a week on saturday and also through daily home visits to beneficiary groups. Nutrition and health education is imparted in mahila mandal through group discussions. (National Institute of Public Cooperation and Child Development, 2014-2015).

The present study was conducted so as to obtain the information regarding actual benefits obtained by the vulnerable groups.

Objective of the study- To study the frequency of attending mahila mandal sessions by ICDS beneficiaries on issues of women and child health .

Material and methods

(i) Sample selection:

The study was conducted on three hundred women of Agra city. The selected women were in the age range of 15 to 45 years. The sample was selected by multistage random sampling technique.

(ii)Tool used:

A self made interview schedule was used to assess the frequency of attending mahila mandal sessions by ICDS beneficiaries.

Results and discussions

Table 1 it is evident that the frequency of obtaining information on health & hygiene in mahila mandal sessions during last six months was significantly higher by beneficiaries of rural anganwari in comparison to beneficiaries of slum anganwari (Ç2=11.52). The reason for this difference could be that slum women were also equipped with additional facilities through which they could acquire the knowledge regarding health and hygiene as a result their keenness to attend mahila mandal sessions became dilute. Moreover slum beneficiaries were also

Table 1: Frequency of attending mahila mandal sessions imparting education on women health issues.

Topic discussed	Mahila mandals attended in last six months		0	1	2 – 4	*Ç2*	*df*	*P*
Health & Hygiene	Rural	N=75	26	17	32	11.52	2	<0.01
		%	34.66	22.66	42.66			
	Slum	N=75		36	26	13		
		%	48.00	34.66	17.33			
Balanced Diet	Rural	N=75	54	17	4	1.49	2	>0.05
		%	72.00	22.66	5.33			
	Slum	N=75		47	23	5		
		%	62.66	30.66	6.60			
ANC	Rural	N=75	40	25	10	0.96	2	>0.05
		%	53.33	33.33	13.33			
	Slum	N=75		34	29	12		
		%	45.33	38.66	16.00			
PNC	Rural	N=75	45	22	8	3.9	2	>0.05
		%	60.00	29.33	10.66			
	Slum	N=75		34	29	12		

literate and hence were able to take advantages of print media for acquiring knowledge. Women in the rural areas perhaps do not find health and hygiene issues compelling enough for them to seek knowledge in this regard. Similar result has been seen by Advanced Management Services Consulting, (2007) in Jharkhand .

Frequency of attending mahila mandal sessions in rural and slum areas for obtaining the knowledge of balanced diet (Ç2=1.49) , ANC (Ç2=0.96), and PNC(Ç2=3.29) was more or less same as evident from the insignificant Ç2 value. The reason for this could be that people have traditional eating habits which are not easy to change. Under such mindset perhaps both slum and rural beneficiaries exhibited poor attendance on session devoted to imparting knowledge on balance diet . Again, primary health centre also perform this job which may have been more easily accessible to them. Similar result has been reported by NIPCCD (2003).

There was no difference in rural and slum beneficiaries regarding attending mahila mandal sessions for obtaining knowledge on ANC and PNC. Perhaps the result can be attributed to their poverty where they find it difficult to squeeze out money for transportation. Mothers in law can also be very dominating and give the impression that they have all the knowledge and thereby discourage their daughters in law to attend mahila mandal sessions. . Moreover the elders in the conservative family often feel that outsiders can have a bad influence on the growth of the child. Perhaps all the women were not in primipara stage , they had already experienced the birth of a child ,which gave them the confidence and they felt no need to attend the mahila mandal sessions for it. Similar result has been reported by Pathi & Das (2005) and Dash, (2006).

Table 2 shows that there is an insignificantly association of residential status with frequency of obtaining knowledge regarding breast feeding (Ç2=0.99) and child care (Ç2=2.63). The reason for this could be the similar socio cultural factors in both rural and slum regions which had similar motivational effects on their outlook to attend these sessions. Indian families are by and large guided by the elders in the family. The pressure of elders who were performing this role satisfactory could also be the session behind it. Similarly results have been reported by Pathi and Das (2005). However Dash, (2006) reported that the beneficiaries obtained regular counseling from AWWs for child care .

Beneficiaries of slum areas attended more number of mahila mandal session where knowledge regarding neonatal care was imparted and this difference was significant at .01 level (Ç2=34.62). The reason for higher participation in slum areas could be

Table 2: Frequency of attending mahila mandal sessions imparting education on child care issues

Topic discussed	Mahila mandals attended in last six months		0	1	2 – 4	*Ç2*	*df*	*P*
Breast Feeding	Rural	N=75	34	26	15	0.99	2	>0.05
		%	45.33	34.66	20.00			
	Slum	N=75	28	30	17			
	%	37.33	40.00	22.66				
Child Care	Rural	N=75	41	22	12	2.63	2	>0.05
		%	55.66	29.33	16.00			
	Slum	N=75	32	31	12			
		%	42.66	41.33	16.00			
Neonate Care	Rural	N=75	55	16	4	34.62	2	<0.01
		%	73.33	21.33	5.33			
	Slum	N=75	21	28	26			
		%	28.00	37.33	34.66			

due to the better transport and mobility facilities in comparison to rural areas. Moreover it is possible that the beneficiaries of slum areas have better understanding of the importance of neonatal care and were therefore more strongly reported to attend. Mondal, (2013).

Conclusion

In the present study the result indicates that frequency of obtaining knowledge in mahila mandal sessions regarding health & hygiene by beneficiaries of rural areas was found to be higher than the beneficiaries of slum areas. Frequency of obtaining knowledge in mahila mandal sessions regarding neonate care by beneficiaries of slum areas was found to be higher than the beneficiaries of rural areas. Since the overall attendance in mahila mandal sessions was not very good there is a need to mobilize services to generate the awareness about the prevalence and importance of such educative sessions among target population.

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