**International Journal in Management and Social Science**
Volume 12 Issue 04, April 2025 ISSN: 2321-1784 Impact Factor: 8.088
Journal Homepage: http://ijmr.net.in, Email: irjmss@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal

# From Policy to Practice: The Implementation Gap in ICDS Nutrition Services for SC Women in Rural India

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## Abstract

The Integrated Child Development Services (ICDS) is a flagship nutritional intervention instituted by the Government of India to improve maternal and child health outcomes. However, there remains an effective implementation gap to thwart the program's intended impact, especially on the Scheduled Caste (SC) women in rural India. Such women are often marginalized by caste, Gender, and Poverty, aggrieving their exclusion from actual entitlements of supplementary nutrition, health check-ups, and counseling under ICDS. In this study, an attempt is made to unveil the systemic, institutional, and social barriers that prohibit the effective delivery of ICDS nutrition services to SC women in rural Bihar, a land of socio-economic deprivation and caste-based inequities.

The primary objectives of this research are threefold: (i) to analyze the gaps between ICDS policy guidelines and their implementation for SC women in rural India. (ii)To identify key challenges SC pregnant and lactating women face in accessing ICDS nutritional services. (iii)To propose targeted policy recommendations for effective service delivery.

The mixed-method design was adopted. Primary data from the structured interviews with 120 SC women drawn from 15 villages across three rural blocks in Patna district—Maner, Bikram, and Dulhin Bazar—were complemented by FGDs with community members and semi-structured interviews with 12 AWWs. Secondary data came from NFHS-5 (2019–21), several government reports, and previous evaluation studies for comparative insights. Descriptive statistics and thematic coding were used for the analysis, whereas a Policy-Implementation Gap Matrix (PIGM) was developed to assess the divergence from national policy guidelines.

Some significant findings reveal that only 58% of respondents reported receiving nutritional support during pregnancy, while a mere 22% said they had received any nutrition counseling regularly. It is distressing to note that hardly 36% of these were aware of their entitlements. The qualitative data suggested widespread exclusion based on caste, such as delayed service, disrespectful behavior, or differential treatment at Anganwadi Centres (AWCs). Other deterrents included the considerable physical distance of AWCs from SC hamlets, the low quality of food, and the poor hygiene standards of Take-Home Rations (THRs). From the AWW perspective, major impediments were delayed supplies, lackluster training, and poor remuneration. Weak or

nonexistent monitoring and oversight rendered increased inefficiencies and reduced accountability.

The Policy-Implementation Gap Matrix confirmed that while the ICDS mandates the provision of 600 kcal and 18–20 grams of protein per day to pregnant and lactating mothers, most beneficiaries received significantly less. Counseling services and community engagement were similarly lacking or nonexistent, particularly for SC women. These findings reinforce the need to shift from top-down, one-size-fits-all models to community-sensitive and decentralized implementation strategies.

The study concludes that the ICDS program, though structurally sound, fails to serve its most vulnerable constituency effectively due to deep-rooted caste hierarchies, poor planning, and administrative inertia. Bridging the implementation gap requires localized nutrition planning, caste-sensitive training for AWWs, mobile AWCs in remote SC hamlets, and digitized monitoring systems. Empowering SC women through representation in AWC management and social audits can ensure accountability and foster inclusion. Without such reforms, ICDS risks perpetuating the inequalities it is designed to dismantle.

**Keywords:** ICDS, Scheduled Caste Women, Rural Bihar, Nutrition Services, Implementation Gap, Anganwadi Workers, Maternal Health, Social Exclusion, Policy Delivery

## 1. Introduction

India's nutrition security framework has long struggled with a paradox: The nation still has unacceptable rates of maternal and child malnutrition, especially among historically marginalized communities, even though it is home to one of the most significant welfare programs in the world, Integrated Child Development Services (ICDS). Of these, rural Scheduled Caste (SC) women continue to be among the most marginalized subgroups. In addition to Poverty and a lack of access to healthcare, their nutritional vulnerabilities are caused by long-standing caste-based discrimination, gender inequality, and administrative shortcomings that compromise the efficient operation of welfare programs (Deshpande, 2011; Thorat & Dubey, 2012).

In order to address the intergenerational cycle of malnutrition, the Indian government launched the historic ICDS program in 1975. The program, which was created as a comprehensive early childhood care package, provides six services: health check-ups, referral services, supplementary nutrition, vaccinations, non-formal preschool education, and nutrition and health education (Ministry of Women and Child Development [MWCD], 2012). One important element of these is supplemental nutrition for expectant and nursing mothers, which is provided through Anganwadi Centers (AWCs) and is meant to enhance maternal health outcomes while lowering low birth weight and infant mortality (Planning Commission, 2011). The program's results, particularly for

marginalized groups like SC women in rural India, have remained unequal decades after it was first implemented.

Several studies have shown that SC women continuously encounter obstacles when trying to access nutrition services through ICDS, despite the intentions of the policy and formal entitlements. These include inadequate take-home rations (THRs), active discrimination at AWCs, and a lack of awareness and outreach (Avula et al., 2013; Saxena, 2020). Systemic disparities in service delivery are reflected in the fact that 43.3% of pregnant women in rural areas receive supplemental nutrition. However, the percentage is much lower for SC women, according to the National Family Health Survey-5 (NFHS-5) (IIPS, 2021). Additionally, especially in hamlets with a high SC population, delivering health education and nutritional counseling—two crucial tactics for changing behavior—remains inconsistent or nonexistent (NCAER, 2019).

Inequity in implementation is the problem, not just coverage. Access to public services in India is still determined by caste, especially in rural areas where social hierarchies are still firmly established. According to research by Thorat and Lee (2005), SCs are more likely to be neglected, humiliated, and excluded from public service settings, such as ICDS centers. Depending on the village's caste structure and the Anganwadi Worker's (AWW) social standing, SC women are frequently forced to wait longer, receive smaller portions, or even be denied access completely (Kumar & Mishra, 2022).

Administrative and logistical issues make this implementation gap even worse. The smooth coordination of the federal, state, and local governments is necessary due to the decentralized nature of ICDS. However, poor infrastructure, AWWs' lack of training, irregular supply chains, and fund disbursement delays all compromise service delivery. Food contamination, stockouts, and absenteeism are caused by many AWCs functioning without hygienic cooking areas, sufficient storage facilities, or frequent supervisory visits (NITI Aayog, 2021).

In India, malnutrition remains a significant public health issue, especially for women from Scheduled Castes (SCs). These problems were intended to be addressed by the ICDS program, which offers counseling services, health examinations, and supplemental nutrition (Government of India, 2018). Evidence, however, indicates notable differences between what the policy requires and what SC women face on the ground (NITI Aayog, 2021). Examining the ICDS implementation bottlenecks in rural SC communities is crucial because of the caste-based marginalization and rural-urban divide, which worsen these disparities.

Despite policy commitments to nutritional equity, India still has a significant implementation gap in its flagship Integrated Child Development Services (ICDS) program. In rural areas, where caste,

Gender, and geography intersect to impede access to essential maternal nutrition services, the exclusion of Scheduled Caste (SC) women is especially troubling (Deshpande, 2011; Avula et al., 2013).

From the governance standpoint, ICDS also has problems with insufficient grievance redressal and monitoring systems. Although several states have piloted reforms like digitization and direct benefit transfers (DBTs) to increase transparency, these initiatives are still sporadic and have not been specifically designed to address exclusion based on caste. Further restricting SC women's ability to impact program outcomes is the fact that, despite the Scheduled Castes Sub-Plan (SCSP) and the constitutional mandate for social inclusion, little of them are represented on AWC committees and local monitoring bodies (Jodhka, 2010).

Underutilization of nutritional supplements results from the ICDS's one-size-fits-all strategy, disregarding cultural dietary preferences and regional food habits. According to research, most standard THRs distributed in many states are made of rice-based or fortified wheat mixes, which are frequently inedible or culturally inappropriate for SC communities with different eating customs (Avula et al., 2013). These discrepancies weaken the program's goals by creating a gap between entitlements and actual uptake.

Crucially, SC women are twice as disadvantaged due to the combination of caste and Gender. They are excluded from decision-making spaces and denied access to resources. Research indicates that SC women elected through reservation frequently remain token figures with no voice or influence, even within Panchayati Raj Institutions (PRIs) (Krishna, 2003). This reinforces marginalization because SC women's needs and experiences are rarely taken into account when ICDS services are planned or evaluated.

Considering these difficulties in light of India's nutrition indicators is also important. India still has the highest rate of undernutrition in the world, with 35.5% of children under five suffering from stunting, according to the Global Nutrition Report (2022). In order to address this crisis, maternal nutrition is essential, but initiatives like ICDS continue to be understaffed, underfunded, and poorly targeted, especially when it comes to socially excluded groups.

This study contends that to achieve the objectives of ICDS fully, we must examine the specific realities of service delivery among the most marginalized and move beyond broad coverage metrics. Knowing the number of individuals served is insufficient; we also need to know who is excluded, why, and what structural obstacles support this exclusion. In this regard, the inclusivity of India's nutrition policy framework is evaluated by SC women living in rural areas.

In order to identify the structural and sociopolitical factors that influence the provision of ICDS nutrition services, this study focuses on the situation of SC women in rural Bihar, a state with some

of the worst caste equity and nutrition indicators. The study attempts to map the gap between policy and practice using a mixed-methods approach that includes field surveys, focus groups, interviews with Anganwadi Workers, and a policy gap analysis.

The study adds to the expanding corpus of work that criticizes India's welfare system's technocratic and depoliticized aspects. On paper, the ICDS may be a sound administrative system, but its transformative potential is undermined when it ignores the historical and social contexts in which it functions. Thus, closing the implementation gap for SC women calls for social justice, participatory governance, an equity-sensitive perspective, and administrative effectiveness.

In summary, the ICDS program is at a turning point. It can either remain a bureaucratic service that provides unequal access to nutrition for different social groups, or it can develop into a rights-based framework that ensures fair access to nutrition for everyone, especially those who have historically been disadvantaged. This study argues that localized planning, radical rethinking of implementation strategies, and the meaningful inclusion of marginalized voices in monitoring and evaluation are all necessary to achieve the latter. Then and only then will ICDS be able to fulfill its constitutional mandate to ensure the equality, dignity, and well-being of all Indian mothers and children.

## 2. Literature Review

### 2.1 Historical Evolution of ICDS and Its Equity Commitments

Introduced in 1975, the Integrated Child Development Services (ICDS) program was India's flagship effort to combat early childhood malnutrition, morbidity, and death. Designed to provide a thorough set of six services—including extra nutrition, non-formal preschool education, and maternal counseling—through a network of Anganwadi Centres (AWCs) spread around the country, it was meant to be ICDS originated from a rights-based perspective, based on the belief that all people—especially those in vulnerable situations—have the right to sufficient nutrition and health.

ICDS was praised in its early years for its size and range. From a pilot stage, it swiftly became a national program and one of the most significant early childhood development projects (UNICEF, 2016). However, even if the coverage grew significantly, the program's capacity to reach socially excluded populations, particularly Scheduled Castes (SCs) and Scheduled Tribes (STs), stayed in question (Planning Commission, 2011). Social hierarchies in India sometimes define access to public services, according to Deshpande (2011), and SCs usually find themselves on the receiving end of exclusion and apathy.

Among the affirmative action policies in the program's mandate are prioritizing SC/ST areas for AWC establishment and including women from underprivileged communities as Anganwadi Workers. However, studies show that these clauses have not translated into fair service delivery (NCAER, 2019).

### 2.2 Caste and Public Service Delivery

The body of work on caste-based exclusion in India has repeatedly shown that Dalits (Scheduled Castes) suffer systematic discrimination in their access to social services, employment, health care, and education (Thorat & Lee, 2005; Jodhka, 2010). Often, this discrimination happens both openly and secretly. Thorat and Dubey (2012) discovered about ICDS that SC families were more likely to say AWWs or local elites' prejudicial behavior caused them to be served last or discouraged from using AWCs.

This exclusion affects program design, community involvement, and access. According to Jodhka and Naudet (2017), developmental projects frequently overlook the lived reality of caste hierarchies, which creates a discrepancy between formal inclusion and material equality. For example, although SC women may technically qualify for ICDS services, the absence of culturally appropriate food, physical distance of AWCs, and stigma inside villages all contribute to underutilization (Kumar & Mishra, 2022).

### 2.3 Gendered Dimensions of Malnutrition

Women from SC in rural India face more complex vulnerabilities at the crossroads of caste and Gender. Studies in public health regularly highlight that social inequality, not only food shortage, causes malnutrition in India (Sen & Drèze, 2013). Women from underprivileged castes are more likely to be undernourished, anemic, and poorly informed about maternal health because of a lack of targeted outreach and social support systems (NFHS-5, 2021).

Saxena (2020) argues that state welfare programs sometimes presume a "neutral" female beneficiary without thinking about how caste and gender co-construct marginalization. This leads to unequal outreach whereby dominant caste women gain more from welfare programs than their SC counterparts. SC women's voice and visibility in ICDS decision-making are further limited by the lack of SC representation in Anganwadi monitoring committees and local governance bodies (Krishna, 2003).

### 2.4 Quality and Cultural Acceptability of Nutrition Services

The cultural mismatch between ICDS food offerings and the dietary preferences of marginalized communities is another important problem underlined in the literature. Avula et al. (2013) found that many rural recipients, especially in areas where millet or maize is more culturally relevant,

dislike take-home rations (THRs), which are usually produced from wheat or rice flour. Though administratively easy, the uniformity of THR packets across states causes significant food waste and program inefficiency.

Moreover, many AWCs provide poor-quality food in terms of hygiene and nutrition. NITI Aayog's (2021) study reveals that more than 30% of backward district AWCs sampled fell short of the minimum food safety criteria. Women interviewed in NCAER (2019) and Saxena (2020) studies said they frequently skipped gathering or eating ICDS food because of spoilage, infestation, or blandness, particularly in the summer when food storage gets more challenging.

### 2.5 Monitoring, Accountability, and Administrative Challenges

ICDS's success depends on the efficient application of its decentralized governance system. On the other hand, this distributed system also causes notable administrative variability. While some states, such as Tamil Nadu and Kerala, have shown effective ICDS service delivery, others, such as Bihar, Uttar Pradesh, and Jharkhand, show persistent administrative problems (Planning Commission, 2011; NITI Aayog, 2021).

One of the main issues in the literature is the absence of real-time monitoring and responsibility. The supervisory cadre is sometimes overworked or under-trained. Often absent for field visits, Child Development Project Officers (CDPOs) are responsible for overseeing many AWCs. The lack of grievance redress systems isolates SC women even more from reporting service failures or discrimination (Kumar & Mishra, 2022).

Mobile monitoring apps and direct benefit transfers (DBTs) are among the technological interventions suggested to address these difficulties. Still, studies indicate that technology is not a cure-all. Such changes risk strengthening exclusion without simultaneous investments in digital literacy and infrastructure (Jha et al., 2017). Furthermore, as Roy et al. (2021) contend, digital tools sometimes lack field validation, data inaccuracy, and exclusion errors.

### 2.6 Social Audits and Participatory Governance

Scholars underline the need for community-based monitoring systems to counter top-down service distribution. Welfare programs like MGNREGA, social audits, and participatory governance models have demonstrated the potential for increasing openness and responsibility (Drèze & Khera, 2015). Such frameworks on ICDS, especially by including SC women's collectives or self-help groups (SHGs), could improve oversight and culturally sensitive service delivery.

However, studies also show that the effectiveness of participatory models depends on pre-existing power hierarchies. Bawa and Sanyal (2020) reveal that in SHG federations and gram sabhas, dominant caste members frequently control decision-making spaces. Community-based

monitoring will help ICDS if SC women are intentionally included via capacity-building, quota-based representation, and legal protections.

### 2.7 Comparative Global Perspectives

Around the world, nutrition initiatives aimed at underprivileged women have embraced community-based and culturally adaptive approaches. For example, Brazil's Bolsa Família program combines community health monitoring and culturally appropriate nutrition education with conditional cash transfers. Likewise, Peru's Vaso de Leche program sends milk and nutritional supplements to low-income women via localized women's committees (World Bank, 2015).

By contrast, ICDS is quite centrally designed and offers little community-level flexibility. This inflexibility compromises the scheme's sensitivity to local requirements. Haddad et al. (2014) and other academics support a "nutrition-sensitive" framework that combines social protection, agriculture, and women's empowerment into a single policy reaction; this approach is still missing in India's ICDS structure.

### 2.8 Gaps in Existing Literature

Although national and state levels have been thoroughly examined, relatively few studies provide an intersectional analysis of caste and Gender in the ICDS program's execution. Fewer still use a bottom-up approach that prioritizes SC women's voices. Most large-scale assessments use aggregate data, which hides intra-group differences (NCAER, 2019; Planning Commission, 2011).

Furthermore, little study is particularly on Bihar, one of India's most caste-stratified and poorest states. Bihar has one of the highest concentrations of rural SC populations and ranks low on all maternal nutrition indicators. Academic and policy debate has yet to thoroughly investigate this geographic and demographic particularity.

Focusing specifically on SC women in rural Bihar, this paper fills in these gaps by combining quantitative and qualitative approaches to map the policy-practice gap in ICDS delivery and to capture their lived experiences. Grounded in both statistical data and testimonial evidence, the study also suggests a new implementation gap matrix that provides a repeatable model for upcoming assessments of welfare programs.

## 3. Objectives and Methodology

### 3.1 Objectives

- To analyze the gaps between ICDS policy guidelines and their implementation for SC women in rural India.

- To identify key challenges faced by SC pregnant and lactating women in accessing ICDS nutritional services.
- To propose targeted policy recommendations for effective service delivery.

### 3.2 Methodology

#### 3.2.1 Research Design and Rationale

This study adopts a **mixed-methods research design** to explore the policy-practice gap in implementing ICDS nutrition services for Scheduled Caste (SC) women in rural India. A mixed-methods approach efficiently captures the scale and depth of service delivery failures, especially in socially stratified contexts. Quantitative data provides measurable indicators of service access and utilization, while qualitative insights help uncover the socio-cultural and institutional dynamics underpinning these patterns (Creswell & Plano Clark, 2011).

The rationale for using this design stems from the need to investigate how many SC women are excluded from ICDS nutrition services and why these exclusions occur. Integrating field-level narratives with survey-based data enables triangulation and increases the internal validity of the research findings.

#### 3.2.2 Study Area

The study was conducted in **Patna district, Bihar**, one of India's poorest and most caste-stratified regions. Bihar ranks among the lowest human development indicators and has one of the highest proportions of SC populations in rural areas (Census of India, 2011). Within Patna, three rural blocks were selected purposively:

- **Maner**
- **Bikram**
- **Dulhin Bazar**

These blocks were chosen based on three criteria:

1. High SC population density (above 25%)
2. Poor ICDS performance as indicated by NFHS-5 district-level data
3. Relative remoteness from urban ICDS administrative units

Each area has a network of Anganwadi Centres (AWCs) and existing ICDS infrastructure, making them suitable for comparative implementation assessment.

### 3.2.3 Sampling Strategy

#### 3.2.3.1 Sampling Framework

A **purposive sampling** strategy was employed to select participants most likely to be affected by ICDS implementation gaps—namely, **SC women who were either pregnant or lactating** and living in rural villages. The sampling universe consisted of 15 villages across the three blocks (5 villages per block).

#### 3.2.3.2 Sample Size

- **Total respondents (quantitative)**: 120 SC women (8 per village × 15 villages)
- **Qualitative participants**:
    - 5 Focus Group Discussions (FGDs) with SC women (8–10 per group)
    - 12 semi-structured interviews with **Anganwadi Workers (AWWs)** across the 15 villages

Given the resource constraints of fieldwork and the need for deep qualitative engagement, the sample size balances representation with feasibility.

### 3.2.4 Data Collection Tools and Process

#### 3.2.4.1 Quantitative Data

A structured questionnaire was developed and pre-tested before field deployment. The survey included sections on:

- Socio-demographic profile
- Awareness of ICDS entitlements
- Frequency and quality of service utilization
- Satisfaction and perceived discrimination
- Barriers to access (distance, availability, quality)

Enumerators fluent in Hindi and local dialects administered the questionnaires face-to-face to ensure clarity and consistency.

#### 3.2.4.2 Qualitative Data

**(a) Focus Group Discussions (FGDs)**

FGDs were conducted in neutral village settings to elicit shared community perspectives. Each session lasted approximately 60–90 minutes and was audio-recorded with informed consent. Themes included:

- Experiences at Anganwadi Centres
- Social stigma or discrimination
- Cultural acceptability of THRs
- Suggestions for improvement

**(b) Semi-Structured Interviews**

Twelve AWWs were interviewed to gain insights into operational challenges, institutional support, caste dynamics, and training adequacy. The interviews followed a thematic guide but allowed flexibility to probe deeper into emergent issues.

### 3.2.5 Ethical Considerations

The study adhered to ethical standards appropriate for social research:

- **Informed Consent**: All participants were informed of the study's purpose and their right to withdraw at any point.
- **Confidentiality**: Identifying details were anonymized during transcription and analysis.
- **Voluntary Participation**: Respondents received no monetary incentive but were offered refreshments and thanked for their time.

Ethical approval was obtained from the Institutional Ethics Committee of the host institution prior to fieldwork initiation.

### 3.2.6 Analytical Framework

#### 3.2.6.1 Quantitative Analysis

The survey data were digitized and analyzed using **SPSS** and **MS Excel**. Descriptive statistics (percentages, frequencies, and means) were used to summarize:

- Awareness and receipt of entitlements
- Frequency of ICDS visits
- Incidence of food quality complaints

- Distance and time taken to reach AWCs

Key indicators were disaggregated by block and age group to identify geographic and generational variations.

#### 3.2.6.2 Qualitative Analysis

Audio recordings from FGDs and interviews were transcribed and translated into English. A **thematic analysis** was conducted using NVivo:

- **Open coding**: To identify broad categories (e.g., access barriers, social stigma)
- **Axial coding**: To link themes (e.g., caste-based treatment ↔ food distribution patterns)
- **Selective coding**: To develop core narratives and draw analytical conclusions

The qualitative findings were integrated with the survey data to build a **Policy-Implementation Gap Matrix**, categorizing the extent and nature of deviations from ICDS norms across four dimensions:

| Policy Domain | Mandated Standard (Policy) | Observed Practice (Field) | Gap Level |
|---|---|---|---|
| Nutrition Supply | 600 kcal + 18g protein daily | Often, less than half the ration | High |
| Counseling | Weekly sessions | Rare or irregular | Severe |
| Infrastructure | Clean, accessible AWCs | Poor hygiene; distant location | Moderate |
| Participation | SC women in AWC committees | Absent | High |

### 3.2.7 Limitations of the Study

While the methodology was designed to ensure robustness, certain limitations must be acknowledged:

- **Non-random sampling** limits the generalizability of findings beyond the selected districts.
- **Self-reporting bias** may affect responses on sensitive issues like caste discrimination.
- **Resource constraints** prevented follow-up visits or longitudinal tracking of beneficiaries.

Despite these limitations, the study provides strong indicative insights into structural barriers within ICDS service delivery for SC women in Bihar.

### 3.2.8 Justification for Methodological Choices

Two principles guided the methodological framework adopted in this study:

1. **Contextual sensitivity**: Given marginalization's intersectionality, capturing narratives and statistics was essential.
2. **Policy relevance**: By aligning questions and observations with official ICDS norms, the study maintains actionable relevance for policy stakeholders.

## 4. Findings and Analysis

This section presents and critically analyses the empirical findings from the field study conducted in the three rural blocks of Patna district—Maner, Bikram, and Dulhin Bazar—focusing on how Scheduled Caste (SC) women experience Integrated Child Development Services (ICDS) on the ground. The results are organized under five primary themes emerging from both quantitative data and qualitative insights: (i) access and coverage, (ii) quality of nutrition services, (iii) caste-based exclusion, (iv) awareness and counseling, and (v) institutional and administrative challenges. Each subsection draws on field data, narratives from focus group discussions (FGDs), and interviews with Anganwadi Workers (AWWs) to demonstrate the gap between ICDS policy mandates and implementation realities.

### 4.1 Inadequate Access and Uneven Coverage

The most significant finding was that **only 58%** of SC women surveyed reported receiving any form of supplementary nutrition from Anganwadi Centres (AWCs) during pregnancy or lactation. This is lower than the rural average of 65% as per NFHS-5 data (IIPS, 2021), indicating that SC women are less likely to be served than their general caste counterparts.

Further, **42%** of respondents never visited an AWC or discontinued after initial visits. The primary reasons cited included **distance from their residence**, **inconvenient operating hours**, and **perceived discrimination**. In Dulhin Bazar block, three of the five villages surveyed had AWCs located over 1.5 kilometers from SC hamlets. This distance becomes a significant barrier to access for pregnant women or those with infants, especially when no public transport is available.

One respondent shared:

“The Anganwadi is too far. In the last month of pregnancy, I could not walk, and nobody from the center came to our homes.”

*(Respondent, FGD – Maner Block)*

The literature corroborates this pattern. Avula et al. (2013) found that physical distance is one of the most cited structural barriers to ICDS utilization, particularly in marginalized communities.

According to NFHS-5 data, approximately **65%** of rural Indian women receive supplementary nutrition during pregnancy. In contrast, only **58% of SC women in Bihar** surveyed in this study reported receiving such support, indicating a **seven percentage point gap**. Moreover, **42% of respondents** never visited an AWC or discontinued visits due to distance (often >1.5 km), social stigma, or restrictive family norms.

"The Anganwadi is too far. In the last month of pregnancy, I could not walk, and nobody from the center came to our homes."

*(FGD – Maner Block)*

This spatial disparity aligns with findings by Avula et al. (2013), who noted that physical proximity is a key determinant in AWC utilization, particularly for socially marginalized women.

### 4.2 Quality and Acceptability of Nutrition Services

A persistent complaint across FGDs was the **poor quality of Take-Home Rations (THRs)** and cooked meals. Of those who received food, **41% said** they discarded it due to taste, lack of hygiene, or spoilage. Women in all three blocks noted that THRs were **repetitive, bland, and nutritionally inadequate**. In summer months, packets were often infested or spoiled, and no refrigeration or safe storage was available at AWCs.

AWWs acknowledged these problems:

"We receive bulk supplies every two weeks. By the time we distribute them, some packets are already spoiled."

*(Interview with AWW – Bikram Block)*

Saxena (2020) highlights similar issues in her study of food insecurity among SC women, attributing them to centralized procurement and lack of quality monitoring. Moreover, the standardization of food packets fails to account for local dietary preferences. Many SC families traditionally consume maize, lentils, or millet-based meals, which are absent from current THR offerings.

Field data revealed that **41% of SC women** discarded their Take-Home Rations (THRs) due to spoilage, taste, or hygiene concerns. In contrast, **46%** of rural respondents nationally reported satisfaction with food quality (NFHS-5). The most cited issues were:

- Bland or unpalatable food
- Infestation during summer
- Lack of culturally preferred items (e.g., sattu, lentils)

"We receive bulk supplies every two weeks. By the time we distribute them, some packets are already spoiled."

*(AWW – Bikram Block)*

The **19 percentage point gap** in THR satisfaction highlights the failure of centralized food procurement to consider local dietary diversity, as noted in Saxena (2020).

### 4.3 Caste-Based Discrimination and Social Exclusion

One of the most troubling findings was the **persistence of caste-based discrimination** at the point of service delivery. In several villages, SC women reported **being served last**, **receiving smaller portions**, or **being discouraged** from staying at the center during meal distribution. Although ICDS guidelines prohibit such behavior, its informal practice remains entrenched in caste-hierarchical rural societies.

"Upper caste women sit inside the Anganwadi and eat. We are told to wait outside. Sometimes, we do not get food at all."

*(FGD, Dulhin Bazar)*

This aligns with the findings of Thorat and Lee (2005), who documented caste-based disparities in access to food distribution systems across India. Despite administrative guidelines mandating inclusion, social dynamics in rural Bihar continue to mediate access to public services based on caste.

AWWs interviewed in Maner block confirmed this indirectly:

"If we ask upper caste families to sit with Dalits, they stop coming to the center. What can we do? We try our best."

*(AWW – Maner Block)*

This quote illustrates the **institutional complicity** and normalization of discriminatory practices, even among service providers.

Despite ICDS being a universal program, **39% of SC women** reported facing caste-based discrimination at AWCs—nearly double the **20% national rural average**. Standard practices include being served last, sitting outside the center, or denying food entirely.

“Upper caste women sit inside the Anganwadi and eat. We are told to wait outside. Sometimes, we do not get food at all."

*(FGD – Dulhin Bazar)*

“If we ask upper caste families to sit with Dalits, they stop coming to the center. What can we do? We try our best.”

*(AWW – Maner Block)*

Such institutional complicity reflects the **normalization of structural discrimination**, previously observed by Thorat and Lee (2005) in public food and health systems.

### 4.4 Lack of Awareness and Nutritional Counselling

Another significant gap lies in providing **nutrition education and counseling**, one of the six essential services under ICDS. Among respondents, **only 36% reported being aware of their entitlements**, and even fewer—**22%**—had ever received **any counseling session** on pregnancy nutrition or infant feeding.

Counseling sessions, if conducted, were often delivered in group formats without tailored advice or interaction. Several women reported that "counseling" consisted of one-time lectures during food distribution days in the Bikram block. Many were not aware of iron and folic acid supplements or the need for increased calorie intake during lactation.

This mirrors national data from the Ministry of Women and Child Development (MWCD, 2018), which notes that nutrition counseling remains one of the weakest components of ICDS due to staff shortages and low prioritization.

"Nobody told me what to eat or avoid. We eat what we have at home."

*(FGD – Maner Block)*

The lack of tailored nutritional guidance for SC women, who already face economic and cultural marginalization, severely undermines ICDS’s behavioral change goals (Sen & Drèze, 2013).

Only **36% of SC women** were aware of their ICDS entitlements, compared to **48% nationally** (NFHS-5), while only **22%** received any form of nutrition counseling (versus 34% rural average).

Counseling was either tokenistic or merged with food distribution events, often lacking personalization or scientific rigor.

"Nobody told me what to eat or avoid. We eat what we have at home."

*(FGD – Maner Block)*

The **12-point awareness and counseling gap** limit behavioral change—one of ICDS's core mandates (MWCD, 2018; Sen & Drèze, 2013).

### 4.5 Institutional and Administrative Constraints

Anganwadi Workers function under extreme duress, as evidenced through interviews:

- **Delayed food supplies**
- **Irregular or delayed salaries**
- **Lack of caste-sensitivity training**
- **Refresher training missing in 7 out of 12 AWWs**

None of the surveyed SC women knew of grievance redressal options, and no SC woman had ever served on an AWC management committee.

**Policy-Implementation Gap Matrix**

| ICDS Norm (Policy) | Field Practice | Gap Severity |
|---|---|---|
| 600 kcal + 18g protein per day | Quantity inconsistent, spoiled THRs | High |
| Weekly counselling sessions | Group-based, irregular, generic advice | Severe |
| Equal service for all castes | SC women are often sidelined or shamed | Critical |
| Community monitoring by VHSNCs | No SC participation or awareness | High |
| AWWs to receive regular training | Most lacked refresher or equity training | Moderate |

(Source: Field Data, ICDS Guidelines 2012; MWCD)

These administrative bottlenecks reflect profound governance failures, confirming Roy et al. (2021) critique of digital-first, equity-blind reforms in India's nutrition ecosystem.

### 4.6 Intersecting Vulnerabilities: Caste × Gender × Poverty

The findings affirm that SC women face **layered structural disadvantages**:

- **Caste** restricts physical and social access.
- **Gender** marginalizes decision-making capacity.
- **Poverty** limits nutritional alternatives beyond ICDS.

"Even if the food is bad, we take it because we cannot afford more."

*(FGD – Bikram Block)*

ICDS's "universal" design often fails to account for these intersectional barriers (Crenshaw, 1991; Jodhka, 2010), rendering the intervention **structurally exclusionary**.

### 4.7 Quantitative Summary: NFHS-5 vs. Field Findings

**Table: Enhanced ICDS Access Gaps – NFHS-5 vs Field Data**

| Access Indicator | NFHS-5 Rural Avg (%) | SC Women in Bihar (%) | Gap (%) |
|---|---|---|---|
| Received Supplementary Nutrition | 65 | 58 | 7 |
| Regular Nutrition Counseling | 34 | 22 | 12 |
| Aware of Entitlements | 48 | 36 | 12 |
| Faced Discrimination at AWC | 20 | 39 | -19 |
| Satisfaction with THR Quality | 46 | 27 | 19 |

**Note**: A negative gap in discrimination indicates over-representation of exclusion among SCs.

These disparities highlight **coverage**, **quality failures**, and **social bias**, confirming a **systemic pattern of inequity** in ICDS implementation.

### 4.8 Community Insights and Policy Feedback

SC women proposed low-cost, practical improvements:

- Local food customization (e.g., sattu, seasonal vegetables)
- Inclusion in AWC oversight and grievance mechanisms
- Home-based counseling in local dialects
- Relocation of AWCs closer to SC basis

"Give us respect, and we will come. We are not beggars."

*(FGD – Dulhin Bazar)*

These voices demand a **bottom-up redesign of ICDS**, echoing calls for **equity-sensitive and participatory governance** (Drèze & Khera, 2015).

### 4.9 Conclusion of Findings

The empirical evidence confirms that ICDS in Bihar remains **unequal in coverage, exclusionary in practice, and weak in responsiveness** to SC women. The program fails to meet its minimum service guarantees due to **institutional limitations** and **social hierarchies**. Gaps in access, satisfaction, and equity demonstrate that current models are ill-suited for the needs of historically marginalized populations.

Bridging this gap requires:

- **Localized food design**
- **Caste-sensitivity training**
- **Mobile AWC units**
- **Representation of SC women in committees**
- **Monitoring by SHGs and community-based audits**

Without targeted structural reform and social accountability, ICDS risks perpetuating the inequalities it was designed to overcome.

## 5. Discussion and Policy Recommendations

The results of this study reveal a strongly ingrained implementation gap in the ICDS system that disproportionately affects Scheduled Caste (SC) women in rural Bihar. Although the ICDS policy structure seems inclusive on paper—providing nutritional entitlements, health education, and community involvement tools—the reality on the ground exposes systematic obstacles, including caste-based discrimination, administrative inefficiencies, and socio-cultural exclusion. This paper investigates the consequences of these results under the more general framework of public service

delivery, equity in social policy, and nutrition governance. It also describes thorough, evidence-based suggestions meant to ensure the efficient, inclusive, and transforming execution of ICDS.

### 5.1 ICDS and the Problem of "Paper Rights."

ICDS is a clearly defined social policy that lowers maternal and child malnutrition using six primary services, including counseling and additional nutrition. For SC women in rural India, however, these rights frequently remain "paper rights"—codified in law but practically unreachable because of social hierarchies and government failures (Jenkins & Manor, 2017). Caste structures' influence on access to state resources is shown by the fact that only 58% of SC women in Bihar used extra nutrition services—against a national rural average of 65% (NFHS-5, 2021).

These results reflect studies like Kabeer (2005), who defines social exclusion as denial of agency, dignity, and institutional responsiveness rather than simply lack of access to a service. In this regard, ICDs fall short as a means of delivering nutrition and as a tool for social equity.

### 5.2 Structural Violence and Caste-based Exclusion

One important finding of this study is the systematic discrimination SC women suffer at Anganwadi centers. Almost 39% of those polled said they were mistreated—using delayed service, verbal disrespect, or spatial exclusion. These results validate prior research by Thorat and Lee (2005) and Deshpande (2011), who contend that caste functions as a structural axis of inequality in public services despite the legal end of untouchability.

Discrimination inside ICDS continues to show the shortcomings of technocratic government in tackling social inequalities. Rao and Walton (2004) point out that increasing services can perpetuate current exclusions if power relations are not addressed. ICDS, therefore, cannot produce fair results without directly addressing caste-based hierarchies.

### 5.3 Institutional Failures and Weak State Capacity

Another major constraint identified is the administrative fragility of ICDS infrastructure. AWWs are underpaid, overburdened, and inadequately trained. Many lack refresher training and operate in AWCs without adequate storage, cooking space, or monitoring systems. These constraints echo findings by NCAER (2019) and Drèze and Khera (2015), who have criticized the under-resourced nature of India’s social sector programs.

Furthermore, grievance redressal mechanisms, lack of accountability structures, and poor data verification contribute to an ecosystem of impunity and inefficiency. Without adequate oversight, frontline workers adapt to dominant caste norms rather than uphold legal equality mandates (Goetz & Jenkins, 2005).

### 5.4 The Limits of Standardization in Nutrition Services

ICDS provides THRs and hot-cooked meals designed centrally and distributed uniformly. While this may simplify logistics, it leads to cultural misalignment, wastage, and non-utilization, particularly among SC communities with distinct dietary preferences. This phenomenon, referred to by Avula et al. (2013) as the "cultural blindness" of food programs, undermines interventions' acceptability and nutritional impact.

The World Bank (2015) has emphasized the importance of contextual, community-driven planning in nutrition programs. Successful models from Brazil (Bolsa Família) and Peru (Vaso de Leche) show that food-based interventions are more effective when they reflect local tastes, seasons, and household needs. The ICDS must embrace flexibility to seek behavioral change and trust among marginalized users.

### 5.5 Intersectionality in Nutrition Governance

The experiences of SC women in rural Bihar reflect what Crenshaw (1991) famously described as *intersectionality*—a condition in which multiple forms of oppression (caste, gender, poverty) coalesce to produce more profound marginalization. Despite being eligible for services, these women face not only institutional failure but also social disdain and familial constraints that limit their agency.

Sen and Drèze (2013) argue that any serious attempt at human development must go beyond material provisioning to include dignity, participation, and freedom. In this view, ICDS should be seen not merely as a food delivery platform but as a social justice intervention that requires institutional transformation and participatory governance.

### 5.6 Community Engagement and Participatory Accountability

Participation in ICDS governance remains extremely low among SC women. None of the surveyed women were part of AWC committees or VHSNCs. This contradicts the participatory principles enshrined in the 73rd Constitutional Amendment and the ICDS Guidelines (MWCD, 2012). Bawa and Sanyal (2020) argue that actual participation must be structured, supported, and protected—especially for historically excluded groups.

Social audits, community scorecards, and SHG-led evaluations have successfully improved outcomes in programs like MGNREGA and PDS (Drèze & Khera, 2015). Such tools can be adapted for ICDS to enhance downward accountability and real-time grievance redressal.

**Policy Recommendations**

Based on the empirical findings and supported by a wide array of scholarly literature, the following policy recommendations are proposed:

### 5.6.1 Localized Food Design and Decentralized Procurement

- Allow AWCs to procure ingredients locally and prepare culturally appropriate meals (e.g., sattu, green leafy vegetables, and local grains).
- Encourage State Nutrition Missions to incorporate region-specific THR menus and seasonal diversity, as Avula et al. (2013) suggested.

### 5.6.2 Caste-Sensitivity Training and Legal Enforcement

- Institutionalize caste-sensitivity and anti-discrimination training modules for AWWs, CDPOs, and supervisors.
- Implement legal accountability for caste-based exclusion under the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989.
- Develop community awareness campaigns about caste-neutral service mandates.

### 5.6.3 Mobile Anganwadi Units and Satellite Service Points

- Deploy mobile AWC vans in remote or SC-dominated hamlets, especially for late-stage pregnant women and mothers with infants.
- Create satellite service points or doorstep delivery systems in hard-to-reach or socially segregated areas.

### 5.6.4 Representation of SC Women in Governance Structures

- Mandate a minimum of 33% SC women representation in AWC Management Committees and VHSNCs.
- Build capacities through SHGs, local NGOs, and Dalit women's collectives to support their leadership and monitoring roles.

### 5.6.5 Counselling as a Core ICDS Pillar

- The shift from group lectures to individualized, home-based counseling delivered in local dialects.
- Incorporate ICT tools like short videos or phone-based reminders tailored to low-literacy users (Roy et al., 2021).

### 5.6.6 Social Audits and Transparency Platforms

- Institutionalize quarterly social audits of AWCs led by independent third parties or community federations.
- Publicly display stock availability, food calendars, and grievance contacts outside every AWC.

### 5.6.7 Improve Working Conditions of Frontline Workers

- Ensure timely honorarium, provide functional workspaces, and reduce non-ICDS administrative burden.
- Include AWWs in policy feedback loops through biannual state-level reviews.

### 5.6.8 Use Data for Equity Auditing

- Disaggregate ICDS data by caste, Gender, and geography to identify service exclusion trends.
- Publish equity audit reports at district and block levels to foster transparency.

## 5.7 Future Research and Policy Directions

While this study offers a grounded understanding of the ICDS implementation gap for SC women in Bihar, further research is needed in the following areas:

- Comparative studies across states to evaluate how local politics and caste configurations shape ICDS performance.
- Longitudinal impact assessments of localized interventions (e.g., mobile AWC units, SHG monitoring).
- Evaluations of nutrition governance using intersectional and feminist policy frameworks.

## 5.8 Conclusion

The ICDS program is at a critical juncture. While its policy goals are commendable, its field execution—especially among SC women in rural Bihar—is marred by systemic exclusion, weak accountability, and social discrimination. Without deliberate, equity-centered reforms, ICDS will continue reinforcing, rather than reducing, caste-based nutritional disparities.

This discussion clarifies that bridging the implementation gap is not simply a managerial challenge but a normative imperative rooted in the constitutional promise of justice, equality, and dignity for

all. The future of ICDS must be shaped not only by administrators but by those it was designed to serve—particularly the women at the very bottom of India's social pyramid.

## 6. Conclusion

ICDS is still a key tool for handling maternal malnutrition. Its transforming power, though, stays unfulfilled without tackling the ongoing implementation gaps, especially among SC women in rural India. Essential is a change from top-down policy rhetoric to ground-level, community-sensitive implementation. Bridging this gap requires structural changes, focused outreach, and a dedication to social justice and fairness.

Though a persistent policy-practice gap lessens its effect, the ICDS program has promised to address the nutritional deficit among SC women. Fundamental transformation calls for bottom-up changes, caste-conscious programming, and empowering local stakeholders. Bridging this gap is a question of service efficiency and social justice.

With particular emphasis on Scheduled Caste (SC) women in rural Bihar, the current study explored the ongoing implementation gap in the Integrated Child Development Services (ICDS) program. Though one of India's most ambitious and long-standing welfare programs, the ICDS still has uneven influence across caste, Gender, and geographic axes. The results of this study show the systematic character of these inequalities by stressing how institutional design, social hierarchies, and administrative failures interact to create layered exclusions for SC women. The research helps clarify welfare governance in India beyond coverage measures to emphasize inclusiveness, equity, and responsibility.

The core of the problem is the gap between policy and practice—what is promised versus what is provided. On paper, ICDs is a rights-based program dedicated to universal access to maternal and child nutrition, with favorable clauses for socially disadvantaged populations. However, as this study shows, SC women in rural Bihar frequently find these rights merely nominal entitlements. Though 65% of rural women nationwide say they get extra nutrition (NFHS-5, 2021), just 58% of SC women in our sample used these services. Likewise, although the ICDS requires community outreach and weekly counseling, just 22% of those polled said they got any nutritional guidance. These disparities reflect more profound structural inequalities based on caste-based marginalization, not only administrative ones.

In rural India, caste is a major deciding factor for resource access. Who accesses public services, how they are treated, and whether their voices are heard in decision-making are shaped by historical disadvantage and daily discrimination. The study records ongoing discrimination in Anganwadi Centres (AWCs), where SC women are subjected to verbal slights, served smaller portions, or made to wait longer. These results agree with earlier studies by Thorat and Lee (2005)

and Deshpande (2011), demonstrating that exclusion is often socially enforced rather than only bureaucratically generated. This shows that unless legal enforcement and behavioral change training specifically address caste-based exclusion, programs like ICDS will keep benefiting the privileged more than the marginalized.

The second important result relates to the cultural relevance and quality of services offered. Many said Take-Home Rations (THRs) were unappetizing, nutritionally deficient, or spoiled. Although ICDS presumes a universal food standard, dietary habits in rural Bihar differ significantly, and standardized rations sometimes fall short of local needs or preferences (Avula et al., 2013; Saxena, 2020). Indeed, 41% of SC women in the study threw away their rations not out of ignorance but rather because the food was of low quality or culturally inappropriate. Such results challenge the top-down approach of nutrition programs and highlight the critical need for decentralized procurement and community input in menu planning.

From a governance standpoint, the study revealed several administrative flaws in ICDS. Overworked, underpaid, and underqualified, Anganwadi Workers (AWWs) are the front line of service delivery. Many have not had refresher training in years, particularly on sensitive issues like caste discrimination or equity-sensitive outreach. Poor supervision, inadequate grievance redressal systems, and a lack of participatory accountability aggravate this administrative inertia. Many villages surveyed found SC women either ignorant of complaint procedures or lacking representation in monitoring bodies. Goetz and Jenkins (2005) contend that institutional gaps foster clientelism, elite capture, and service avoidance.

Program design seldom addresses the overlapping vulnerabilities of SC women—as members of a stigmatized caste, as rural residents, and as women living in a patriarchal society. This study confirms what Crenshaw (1991) called "intersectionality"—the convergence of several axes of disadvantage that cannot be addressed separately. The experience of SC women in ICDS, therefore, is not only about lack of access but about systematic invisibility. Their needs are ignored, their voices silenced, and, at best, their involvement is tokenistic. This supports Saxena's (2020) thesis that while neglecting to consider how caste and Gender interact to mold exclusion, welfare programs often presume a universal female beneficiary.

The study also highlights the insufficiency of technological solutions in tackling these deep-rooted problems. Although digitization and direct benefit transfers (DBTs) have been implemented to cut leakages and increase efficiency, they do not significantly handle the social aspects of exclusion. Technology can even reinforce inequalities, as Roy et al. (2021) warn if used without regard to ground reality. Digital tools are sometimes inaccessible or misused in areas with poor connectivity, low literacy, and deep-rooted hierarchies. Furthermore, data systems frequently overlook disaggregated experiences, hiding inequalities under total indicators.

The study suggests changing welfare governance from a technocratic to a socio-political viewpoint to close the gap between policy and lived experience. Programs such as ICDM have to go beyond the logic of scale and uniformity to adopt the values of justice, dignity, and democratic involvement. This implies understanding that nutrition is about agency, cultural belonging, and institutional trust, not only calories and proteins.

The results of the study highlight this change in focus. Every proposal, from mobile AWCs to caste-sensitivity training and SC representation in government, is meant to make ICDS more inclusive, accountable, and responsive. Backed by field evidence and worldwide best practices, these are not utopian dreams but practical strategies. For instance, Brazil's Bolsa Família program combines community-based nutritional education with conditional transfers; Peru's Vaso de Leche uses women's committees to customize food delivery. These models demonstrate that practical answers are not only ethical requirements but also ones of involvement and context-awareness.

This study claims that ICDS can only live up to its constitutional promise if it becomes a platform for social change rather than only service delivery. That means recognizing and correcting how caste, Gender, and geography influence access to entitlements. It means changing power from administrators to communities, norms to rights, and tokenism to true inclusion. Until then, the ICDS will stay, at best, a partial success and, at worst, a bureaucratic illusion.

Dealing with the nutritional disparities SC women experience has to be a national priority as India moves toward the target year 2030 for the Sustainable Development Goals (SDGs). Aggregate measures by themselves will not help one reach Goal 2 (Zero Hunger), Goal 3 (Good Health and Well-being), or Goal 10 (Reduced Inequality). They need detailed attention to the most excluded and a dedication to change as structural as it is symbolic. This paper is a call to action—for legislators, academics, and practitioners all—to reimagine welfare not as a gift from the state but as a claim of justice by its most underprivileged people.

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