# Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa

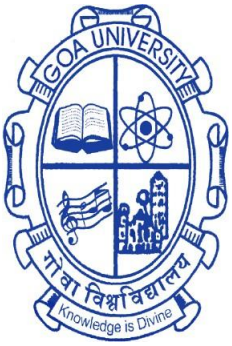
A Thesis submitted in partial fulfillment for the Degree of

DOCTOR OF PHILOSOPHY

in Political Science

in the Political science programme, D. D. Kosambi School of Social Sciences and Behavioural Studies

Goa University




By

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August *2026*

## DECLARATION

I, Siddhi Shet Mashelkar hereby declare that this thesis represents work which has beencarried out by me and that it has not been submitted, either in part or full, to any other University or Institution for the award of any research degree.

Place: Taleigao Plateau.

Date: Siddhi Shet Mashelkar

## CERTIFICATE

I hereby certify that the above Declaration of the candidate, Siddhi Shet Mashelkar istrue and the work was carried out under my supervision.

Prof. Rahul Tripathi
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**Acknowledgment**

The Integrated Child Development Services (ICDS) scheme is indeed a significant initiative by the Government of India, aimed at providing food, preschool education, and primary healthcare to children under 6 years of age and their mothers. The expansion from 33 to 7575 community blocks is an evidence to its extensive reach and impact on society. This study on "Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa" contributes in understanding the effectiveness of this programme in community specifically tribal community in south district of Goa. I would like to express my deepest gratitude to a number of individuals whose support was indispensable in the completion of this study.

Prof. Rahul Tripathi, my guide, at Political Science Programme, D. D. Kosambi School of Social Sciences and Behavioural Studies, Goa University has been instrumental in shaping my research with his invaluable guidance and the freedom to explore my ideas.

Special thanks to my subject experts, Dr. Alkananda Shringare, Associate Professor at Public Administration Programme, Manohar Parrikar School of Law, Governance and Public Policy, Goa University, and Dr. Seema Fernandes, Assistant Director at Goa Institute of Public Administration and Rural Development, Ela, Old Goa, Goa, for their constructive suggestions that significantly enhanced my research.

I am indebted to the Directorate of Higher Education, Government of Goa, for providing essential administrative support, without which this research would not have been possible.

I am thankful to Prof. Joydeep Bhatacharjee, Former Principal of Government College of Arts, Science, and Commerce, Quepem Goa, for his constant and timely support whenever needed.

I am thankful to Prof. Pravina Kerkar, Principal of Government College of Arts, Science, and Commerce, Quepem Goa, for her support which greatly aided the completion of this study.

I am grateful to the Directorate of Women and Child Development, Government of Goa, for authorizing my visits to the Anganwadi Centers selected for the study.

Gratitude is extended to the Child Development Programme Officers (CDPO) and Mukhya Sevikas (MS) from Quepem, Sanguem, and Cancona blocks for their help in

identifying Anganwadi with higher tribal enrollment and for their participation in Focus Group Discussions (FGDs).

I am thankful to all the Anganwadi Workers (AWWs) who participated in the survey and to the beneficiary respondents for sharing their valuable opinions during the survey.

Appreciation goes to the Directorate of Tribal Welfare, Government of Goa, for providing the population data of the Scheduled Tribe community in Goa.

I am grateful to the Block Development Officers (BDOs) of Quepem, Sanguem, and Cancona for allowing my interactions with the elected members of the Panchayats in their respective talukas.

A heartfelt thank you to the elected members of the selected panchayats for their cooperation and engagement in discussions about Anganwadi in their localities.

I extend my thanks to the Health Officers of Primary Health Centers of Quepem, Sanguem, and Cancona blocks for permitting interviews with the Doctors of the School Health Team of Rashtriya Bal Swastha Karykram (RBSK) visiting Anganwadi. Special mention to Dr. Supriya Patil and Dr. Hema Naik from the Primary Health Center Sanguem, Dr. Ranjita Rajadhyax from the Primary Health Center Quepem, and Dr. Deepika Naik from the Primary Health Center Cancona for sharing their insights on the ICDS scheme.

I am thankful to my colleagues Dr. Priyanka Mallik, Assistant Professor in Sociology, and Dr. Vikrant Mudliyar, Assistant Professor in Economics at Government College of Arts, Science, and Commerce Quepem Goa, for their guidance during my research.

My students, Ms. Manjita Gauns Dessai and Mr. Sushant Velip, deserve special mention for accompanying me during my field study in the Quepem, Sanguem, and Cancona talukas.

I am deeply grateful to my parents, Adv. Vishwas Naik and Smt. Suhasini Naik, for shaping me into the person I am today and for their endless support in my pursuit of higher education. I am thankful to my husband, Mr. Saidatta Shet Mashlekar and my daughters Kum Sailee Shet Mashelkar and Saanvi Shet Mashelkar for their kind-hearted support.

Last but not least, I would like to thank all my well-wishers whose good wishes have been a constant source of motivation, enabling me to complete my Ph.D. within the stipulated timeframe.

I dedicate this study to my beloved daughters, Miss Sailee Shet Mashelkar and Miss Saanvi Shet Mashelkar, whose unwavering support and resilience have been my greatest strength. Despite their tender age, their sacrifices and encouragement have played a crucial role in the successful completion of my research. Their love and inspiration have been the driving force behind this work.

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# Abbreviations

AWWs- Anganwadi Workers

AWHs- Anganwadi Helpers

BDO- Block Development Officer

CARE- Cooperative for Assistance & Relief Everywhere

CDPO- Child Development Programme Officer

CMAM- Community Management of Acute Malnutrition

CSWB- Central Social Welfare Board

DFID- Department for International Development

ECCE- Early Childhood Care and Education

ERs- Elected Representatives

EU- European Union

FDGs- Focus Group Discussions

GAIN- Global Alliance for Improved Nutrition

ICDS- Integrated Child Development Services

IDA- International Development Association

MS- Mukhya Sevikas

MWCD- Ministry of Women & Child Development

NFHS- National Family Health Services

NFSA- National Food Security Act

NEP- National Education Policy

NIPCCD- National Institute of Public Cooperation & Child Development

NITI- National Institute of Transforming India

NHM- National Health Mission

PEO- Programme Evaluation Organisation

PSE- Pre School Education

PCPNDT- Pre-Conception & Pre-Natal Diagnostic Techniques

POCSO- Protection of Children from Sexual Offences

PMMVY- Pradhan Mantri Matru Vandana Yojana

PRIs- Panchayati Raj Institutions

RBSK- Rashtriya Bal Swasthya Karyakram

RTE- Right to Education

RCH- Reproductive Child Health

SNP- Supplementary Nutrition Programme

ST- Scheduled Tribes

UNICEF- United Nations International Children's Emergency Fund

USAID- United States Agency for International Development

WB- World Bank

WFP- World Food Programme

WHO- World Health Organisation

# Chapter 1

# Introduction

*"Giving high priority to children's welfare means singling out a target group which is intermingled with the rest of the population right down to the level of individual families. Therefore, it requires building up an organization and an administrative set-up that goes all the way from international agencies to each village and town of less-developed countries".*

- ***C. Subramaniam, the former Finance Minister, Govt. of India (1970)***

## 1.1 Background of the Study

Making of public policies or welfare policies by the government is not a new phenomenon; it is as old as the government itself. Civil rights are created and used differently in different forms of government such as oligarchy, aristocracy, monarchy, dictatorship, and democracy (Watson, 1999). Each of these forms of government makes public policies and welfare policies for its people. Public policies are broad government actions affecting the general public such as taxation, criminal law, anti-corruption measures etc. whereas welfare policies are specific policies aimed at improving social welfare and addressing human needs such as food, housing, education, healthcare etc. However, the nature of making public policies and welfare policies is different in democratic and non-democratic countries. The policies in democratic countries are more citizen-oriented and based on the welfare context of the state, while in non-democratic countries, policies are less public welfare-orientated (Rabin, 2005).

Policies are important for solving certain problems of certain projects at a given time. Policies of the government is designed with short-term or long-term goals, depending on the problem and interest (Anderson, 2015). In democracies, the government initiates the process of making its policies following the political

environment after consultation with the representatives of the people, pressure groups, interest groups, and the bureaucracy on matters such as the land, population, health, and trade of the country (Bali & Halpin, 2021). Such civil rights are exercised by the relevant executive committee through the legislature.

Studying public policy is important as it have a significant impact on the daily life of the people. James Anderson in his book "Public Policymaking: An Introduction" outlines the reasons for studying public policies. The reasons cited by him were; scientific, as it enhance the knowledge of political behavior and governance; professional, as it equips individuals with the skills to analyze and implement policies effectively; and political, it promotes democratic participation of citizens. Anderson also discusses the importance of studying the evolution, growth, development, and implementation of public policies to understand how policies are formed, budgeted, implemented, and evaluated (Anderson, 2003).

It is important to evaluate policy to understand a comprehensive overview of the policy making process, its implementation, and impact. Thomas A. Birkland in his work "An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making" outlines the key stages of policy making which includes agenda setting, policy formulation, decision-making, implementation, and evaluation. He further states that actors like government bodies, interest groups, and the public influences these stages of policy making. Therefore involving their perceptions in policy making becomes important. Birkland explores the challenges of policy analysis, particularly under conditions of bounded rationality, where people are with limited knowledge and limited cognitive capacity and they choose a satisfactory option instead of the best one. In this condition the decision-makers have limited information and time to understand the needs and demands of people. Therefore, Birkland emphasizes the necessity of policy evaluation to assess effectiveness of policy and inform future decisions. He further states that policy evaluation requires multidisciplinary approach incorporating discipline like political science, economics, sociology, and other fields (Birkland, 2020).

However, there are multiple perspectives to evaluate the public policies. El Dessouky provide a comprehensive theoretical framework for evaluating public policies that helps to understand and assess public policies from multiple perspectives. The evaluative methods suggested by Dessouky are five as discussed. The first is quantitative methods to measure policy outcomes that provide an objective assessment through statistical analysis. The second method suggested by him is qualitative method to evaluate specific environment in which policies are implemented. The third method Dessouky introduced is value-based assessments, where judgments about policy effectiveness is made based on predefined criteria, ensuring that policies are not only measured but also assessed against their intended goals. The fourth method the author suggested is flexible and reflective evaluation process based on feedback. The fifth method suggested is participatory evaluation methods that involve stakeholders, ensuring evidence based experiences and perspectives. Dessouky further states that by integrating these methods a multifaceted approach can be used to assess the policies of the government and provide a comprehensive information. These evaluative methods provides the necessary tools to understand, measure, and improve public policies effectively (EI Dessouky, 2016).

India a democratic country introduced various policies for the welfare of the people. In fact the evolution of public policy in India can be traced back in the ancient times. Arthashastra, the work of Kautilya in the 4th century BCE is considered one of the earliest text on public policy. The evolution of public policies continued during British colonial rule and significantly shaped on democratic principles during post-independence. The policies in post-independence era focused on nation-building, industrialization, and addressing the social challenges. The policies formulated were based upon the guidelines of the Constitution of India. The areas where the policies focused were economic, social, and foreign policies, each addressing specific societal needs and challenges. The stages followed in policy making process were problem identification, formulation, implementation, and evaluation (Chakrabarti & Sanyal, 2017).

The Integrated Child Development Services (ICDS) scheme is a significant post-independence policy in India. It is implemented at the national level to improve societal benefits and enhance public health and educational standards. The scheme focuses on the well-being of young children, pregnant women, and lactating mothers by providing essential services such as supplementary nutrition, immunization, health check-ups, referral services, health and nutrition education, and preschool education. Since its inception in 1975, various studies evaluated its effectiveness have attracted the attention of various government agencies, NGOs, and individual researchers from the management, social sciences, and medical sciences. The National Institute of Public Cooperation and Child Development (NIPCCD) in New Delhi is continuously working on ICDS research areas and has published several studies on various aspects of ICDS.

Various studies on ICDS pointed to the success of ICDS at the implementation level. ICDS is successful in its widespread coverage by setting ICDS centres at the every corner of the villages and town (Sachdev & Dasgupta, 2001). ICDS has successfully reached rural areas as well as urban areas and benefited women and children of socially and economically disadvantaged groups such as Scheduled Caste (SC), Scheduled Tribe (ST), and Other Backward Classes (OBC) (Dixit et al., 2018). Similarly, the studies also mentioned the challenges of ICDS in its quality and quantity. Due to the lack of infrastructure, space, and human resources, many ICDS beneficiaries are affected and only those living in poor and remote rural areas enrolling their children in ICDS for preschool education and referral services (Sahoo, 2016).

Theoretical background of the study emphasizes on thorough analysis of the policies, which gives an opportunity for researcher to evaluate the ICDS scheme which is the oldest scheme of the Government of India, completed its 50 years of existence. The research focus is on the performance of ICDS scheme in rural remote areas where people live under the conditions of bounded rationality. These individuals often lack basic amenities like health, food, and non-formal education, leading them to accept satisfactory solutions rather than the best possible ones, leading the policy makers' with

limited understanding of their needs and demands. This study aims to evaluate the ICDS scheme in tribal dominated panchayats of south district of Goa to provide a comprehensive and evaluative framework, thereby opening scope for the future research.

The title of the study is "Performance Evaluation of Integrated Child Development Services Scheme in Tribal-Dominated Panchayats of South Goa". To fulfill the objectives, the study evaluate the perceptions of the ST women beneficiaries regarding the ICDS scheme. The study also takes into consideration the perceptions of Anganwadi Workers (AWWs), Child Development Programme Officers (CDPO), Mukhya Sevikas (MS), and doctors from the School Health Team under RBSK scheme of Health Services and elected representatives of Panchayati Raj Institutions (PRIs) while evaluating the scheme at the grass root level.

Methodology used for data collection in the study are both qualitative and quantitative methods and statistically analyzed the performance of ICDS scheme in tribal dominated panchayats of South Goa. In the conclusion, the study proposed recommendations and suggested roadmap based upon the findings from the analysis.

## 1.2 Literature Review Findings

The Integrated Child Development Services (ICDS) is the world's largest community-based programme aimed at improving the health, nutrition, and education of children till the age of six years, pregnant and lactating mothers, and adolescent girls (Sachdev & Dasgupta, 2001). The scheme provides integrated package of six services such as supplementary nutrition, health and nutrition education, immunization, health check-ups, preschool education, referral services by targeting children till six years of age, pregnant and lactating mothers. (Kapil & Pradhan, 2000).

The findings of literature review of this study on the Integrated Child Development Services (ICDS) scheme helps to identify the gaps in existing knowledge and provides a theoretical framework for research. The critical review of the literature

focuses on five aspects of ICDS such as policy making and policy evaluation; community participation in the ICDS scheme; Goals, process of implementation, and challenges of ICDS; stakeholders' engagement in ICDS functioning; and impact and challenges to health services of ICDS in rural areas.

### 1.2.1 Policy Making and Policy Evaluation

A literature review on Policy Making and Policy Evaluation helps to understand the process of making and evaluating the policies of the government. The literature review helps to identify gaps in policy making and its evaluation and it will help to evaluate the Integrated Child Development Services scheme.

(Dessouky, 2016) discusses the evaluation of public policy theory from the first generation to the fifth generation. The methods used to evaluate the public policy in the first generation emphasizing on the evaluation of inputs and outputs. The second generation evaluation focused on measuring impacts as well as the results of the policy. The focus in the third generation was on participatory evaluation. The focus in the fourth generation on using measurement to learn as well as to grow. The author emphasizes that the public policy theory in the fifth-generation is focusing on stakeholders, context, and complexity. This article provides an outline to evaluate the public policies by engaging stakeholder and provide evidence based recommendations.

(Weiss, 1999) in his research paper “The Interface between Evaluation and Public Policy” discusses the connection between evaluation of public policy and public coverage. The author argues that evaluation provides evidence based information to policymakers, however policymakers rarely uses it for policy assessment. The point of author is that evaluation assist the policymakers to identify the strengths and weaknesses of existing policies and programmes, and accordingly upgrade them. However, according to author, policymakers do not do evaluation in this way. Instead, policymakers uses evaluation outcomes selectively to help their pre-existing perspectives or to justify choices that have already been made. The paper also discusses

the challenges encounter during policy implementation while dealing with public rules which encompasses the issue of measuring effects of policy, the complexity of policy environments, and the political nature of policymaking. Overall, “The Interface between Evaluation and Public Policy” presents a beneficial assessment of the relationship between policy evaluation and public coverage.

(Sanderson, 2002) “Evaluation, Policy Learning and Evidence-Based Policy Making” is a study paper in Public Administration. The paper study the inter-connection between policy evaluation, policy learning, and evidence based policymaking. The author of the paper argues that policy evaluation contributes to the knowledge on policy coverage by providing feedback on the effectiveness of the policy. This feedback can be used by the policymakers to bring improvement based upon the evidence based recommendation. Additionally, the paper discusses the increasing demand to evaluate the process of policymaking. The author points that the policy evaluation should consist of the issue of measuring results, the complexity of policy environments, and the political nature of policymaking. Overall, “Evaluation, Policy Learning and Evidence-Based Policy Making” makes an important assessment of the inter-connection among policy assessment, policy knowledge, and evidence based policymaking.

(Birkland, 2020) presents an extensive picture on American public policy making. The author identifies the key stages of policy making which includes setting the objectives of the policy, formulating the policy, making a decision on policy implementation and continuous policy evaluation for its upgradation. The author further states that all the stakeholder related to policy such as government bodies, interest groups and the public should be taken into consideration while implementing and evaluating the policy. Birkland further states that policy evaluation is necessary to assess the effectiveness of policy and for its improvement. For policy evaluation author further states that a multidisciplinary approach can be used by the policymakers.

(Howlett et al., 2009) work “Studying Public Policy: Policy Cycles and Policy Subsystems” discusses the policy cycle and policy subsystems. These two are the

essential principles in public policy analysis. The author explains that the policy cycle is a model that describes the various stages of policy-making. The stages of policy making as mentioned by author includes setting the objectives of the policy, formulating the policy, implementing the policy, and continuously assessing the policy for its improvement. According to author policy subsystems are networks of actors who contribute in a particular policy area for its improvement.

(Lowi et al., 1970) in their article "Decision Making vs. Policy Making: Toward an Antidote for Technocracy" discussed the variations in decision-making and policymaking. The point of authors here is that technocracy has its influence on decision-making and policy making as policymakers rely more on technical experts rather than considering stakeholder's participation while decision making and policy making. This result into a gap in understanding the demand of the people which can be resolved through policy. Authors argue that democratic participatory principles should be indulge in policymaking. It means while making a policy decision the viewpoint of stakeholders must be considered democratically rather than fully relying on technical expertise.

(Innvær et al., 2002) in their article gives a scientific overview of research that have studied the perceptions of health policy-makers regarding their use of proof. The authors identified that health policy-makers often depend upon a various sources of evidence, including research evidence, professional opinion, and stakeholder input. They additionally found that policy-makers often face demanding situations in using evidences, which include lack of time and resources, competing pursuits and values, and political demand. Authors of this article emphasizes the need for strategies that address both the facilitators and barriers to use evidence to bridge the gap between research and policy making.

(Williams, 1997) the book "Social Policy: A New Feminist Analysis" provides a critical examination of social policies from a feminist perspective. The book emphasizes the need for policies that recognize and address the gendered nature of welfare states.

The author analysis the feminist theory and aims to uncover the ways in which social policies perpetuate gender inequalities. The author pointed that social policy which is made from feminist perspective is needed to understand the ways it affects women. The book covers a variety of issues, including welfare reforms, health care, education, and employment policy affecting women. It also discusses the ways in which feminist views may be used to broaden more equitable and simply social policies.

(Hanney et al., 2003) presents an overview of the concepts, examples, and ways of assessment associated to use of health research in policy-making. The authors argues the different forms of research that are related to policy-making, including basic research, applied research, and evaluation research. They additionally highlight upon the various approaches wherein research can be applied in policy-making, such as to inform policy growth, to assess policy implementation, and to supervise policy impact.

(Hudson & Lowe, 2009) focuses on the policy-making process as the key to change and use important concepts of policy analysis to explain this process that can be applied to any aspect of welfare policy, and public and social policy more generally. The book introduces the main themes of the policy analysis literature, demonstrates the centrality of the policy-making process to an understanding of the operational possibilities and limits of social policy, takes account of macro, meso and micro-level approaches to social policy analysis, uses clear explanations of key concepts, up-to-date illustrative case studies and examples to increase students understanding of the theory and practice of policy analysis, and uses a comparative approach.

The key findings of above literature review on policy making and policy evaluation is as follows:

- Stakeholder involvement is necessary while evaluating the policies to understand the performance of policy at the grass root level.
- Policy evaluation is necessary to gain the knowledge on the existing policies implemented and improve upon them.

- Policies should be based upon democratic values such as participation and values for the humanity rather than technical oriented.
- Viewpoint of the target group should be considered while making the policies or upgrading the existing policies

### 1.2.2 Community Participation in the ICDS Scheme

Community participation is a critical element of the ICDS scheme because it allows its smooth functioning, increases its utilization, accounts for achievement and failure, reduces authorities intervention, and creates an experience of possession as well as the sensitivity of the scheme (Kular, 2021). ICDS has been envisaged and conceptualized as a community-based programme. It calls for community involvement in its process of implementation by using local resources. Its targets are not constrained to mere delivery of services but emphasize on initiation of a process aimed towards bringing a social change within the life of the community (Kular, 2021). Thus learning the overall performance of the Integrated Child Development Services (ICDS) scheme and its relation to community participation is crucial. A literature assessment on community participation inside the ICDS scheme helps to recognize the prevailing understanding on the study topic and perceive the gaps that want to be addressed in this research.

(Sachdev & Dasgupta, 2001) highlight in their study the importance of the ICDS scheme in India in promoting the non-formal education, health, and nutrition status of children till the age of 6 years, pregnant women and lactating mothers, and women between the ages 16 to 44 years. The article states the importance of involvement of community in the planning stage of ICDS to promote its services.

(Kular, 2021) assess community involvement in the ICDS scheme in Punjab and Rajasthan States of India. The research was done on 80 village Sarpanches which included 40 village Sarpanches from Punjab and 40 village Sarpanches from Rajasthan. The research suggest training for ICDS functionaries in improving their specific skills to promote community engagement in ICDS and additionally suggest a short-duration

preparation period to increase awareness of the community with regard to ICDS services.

(Dreze, 2006) contributes significantly in understanding the impact and challenges of the ICDS programme in India. The study emphasises that ICDS can be considered as a right of children under six years of age and that the quality of ICDS services needs improvement. The study emphasizes urgent reforms to ensure that the programme effectively addresses needs of the most vulnerable children. The paper also identifies the strong monitoring and redressal mechanisms to guarantee that people can claim their entitlements. It further emphasizes that community involvement is necessary to make ICDS effective.

(Sinha, 2006) provides a critical analysis of the Integrated Child Development Services (ICDS) scheme in India. The author argues that the current coverage of ICDS is insufficient to meet the needs of the most neglected section of the population for which the author emphasises to increase community participation in ICDS to improve the efficiency and effectiveness of the services provided by the ICDS. The study also focuses that it is the responsibility of government to provide ICDS services to every child as a matter of their rights and their mothers.

(Ghosh, 1995) provides a comprehensive study on demography and socio-economic factors affecting the utilization of ICDS services. The study finds that demographic factors and socio-economic status contributes in less community participation in ICDS programme. The children from poorer households and marginalized communities are using ICDS services more as compared to rich and urban households. Gosh recommends to improve the coverage and effectiveness of ICDS services in underprivileged and rural areas by promoting community participation through awareness, improving infrastructure, and ensuring better coordination between different government departments.

(Arora & Burma, 2009) states that the Integrated Child Development Services (ICDS) programme is a country-wide programme that aims at the total development of

the child and seeks to deliver health, nutrition, and education to the target community. Community participation in ICDS is important for the smooth functioning of the programme, reaching and increasing its utilization, accounts for success and failure, reducing government intervention, and creating a sense of ownership as well as sensitivity to the programme. The present study conducted by Samridhi Arora and Madhu Burma aimed to know the awareness of ICDS services among community leaders and to analyse their participation in the ICDS programme. The sample of the study comprised of Sarpanch/ Panch and President of Mahila Mandal. The study results reveal out of the total sample 77% were aware of the nutritional and educational services of ICDS and 63% samples present in ICDS meetings. The reasons for non-participation from the community leaders were lack of intimation, overload of work, lack of time, and considering ICDS not in their purview. However, those community leaders who participated have rendered help by motivating women to come to AWC, cooperated in organizing ICDS activities, and provided raw material for supplementary nutrition, and firewood for fuel.

(Jain et al., 2022) conducted a cross-sectional community-level study in the urban block of the Patiala District in Punjab. A total of 54 AWCs were selected from a sample frame of 222 by applying a systematic random sampling technique. From each selected AWC, 20 mothers of registered beneficiaries (0-6 years) were randomly selected for interview. It was concluded that there is a need to promote community participation in ICDS and for this there is need to improve the quality of services to overcome the problem of under-utilization of services despite the wide coverage of ICDS services; regular orientation and training courses for AWWs should be conducted to ensure better service delivery to all beneficiaries.

(Feruglio & Nisbett, 2018) provides an in-depth analysis of the effectiveness of community-level social accountability mechanisms in improving health and nutrition services, in the context of the Integrated Child Development Services (ICDS) scheme in Odisha, India. A significant finding of the study is the weak community participation in

most mechanisms in the context of ICDS scheme due to failure of providing better service delivery and addressing the broader needs of its participants. The study highlight that for the success of such mechanisms, there is a need to addresses the issue of participation and empowerment of community members.

(Kuruvilla, 2019) article identify the factors affecting community participation as well as the level of community involvement in the ICDS scheme in the Thiruvananthapuram district of Kerala. The study concludes that community participation is a required component for the success of the ICDS scheme and that there is a need for more awareness programmes to be organised for the community regarding the ICDS scheme. The study mentions the active involvement of NGOs, Panchayats, and corporate institutions for the effective participation of the community in the ICDS.

(Nayar et al., 1999) the study conducted to assess community contribution to the Integrated Child Development Services (ICDS) scheme, which promotes mother and child health in the Agra district, Uttar Pradesh, India. Three rural ICDS projects in the district were selected, out of which a total of 74 Anganwadi Centres (AWCs) were chosen for the study. The study concludes that in rural area free accommodation for the AWCs and community assistance in bringing children to the AWC were the most common forms of community contribution to the ICDS scheme.

The findings from above literature on Community Participation in the ICDS scheme highlight upon the impact of community involvement in the ICDS scheme.

- Community engagement in the planning stage is essential to enhance ICDS services.
- Training for ICDS functionaries is essential to effectively engage with the community and strengthen the scheme.
- Challenges faced by the Anganwadi Centers (AWCs) can be resolved with the help of community.
- Lack of awareness about the role of community in the ICDS scheme is a major obstacle.

### 1.2.3 Goals, Process of Implementation, and Challenges of ICDS

A review of literature on goals, process of implementation and challenges of ICDS might be significant in identifying the challenges in the scheme and suggesting solutions to improve its implementation.

(Khullar, 1998) evaluated methods applied in Integrated Child Development Services (ICDS) scheme in India. The study makes the point that the evaluation methods used in ICDS's are insufficient and don't give a complete picture of the scheme's impact in achieving its targeted goals on development of children as well as its implementation process and challenges. According to the report, a more thorough evaluation strategy is required to meet its objectives to benefits its intended population. The strategy suggested is to consider the various factors that affect development of child as well as its complex character.

(Gragnolati et al., 2006) contributes significantly in understanding the goals, process of implementation, and challenges of the Integrated Child Development Services (ICDS) scheme in India. The study points that though ICDS has been successful in its goal of lowering child death rates, but under-nutrition rates have not decreased as expected. According to the research, the reasons behind this failure is poor target, inadequate coverage, and poor service delivery. The other challenges the study identifies are poor infrastructure, lack of staffing and training which hinder the ICDS programme effectiveness. To enhance ICDS, the author recommend several policy measures that includes improving quality of service delivery, and ensuring better monitoring and evaluation.

(Kapil, 2002) provides a comprehensive evaluation of the ICDS scheme, highlighting its strengths and identifying areas for improvement. The author states that the ICDS scheme is the biggest nutrition and mother and child health promotion initiative in India. In 1975, the initiative was launched as a component of the National Policy for Children. The ICDS scheme increased its blocks from 33 projects in 1975 to 5,171 blocks in 2002. The study identifies several challenges in the implementation of

the ICDS, such as inadequate infrastructure, insufficient funding, and lack of trained personnel. These challenges hinder the ICDS effectiveness and limit its impact on child health and nutrition. The study emphasises to resolve these challenges of ICDS to achieve its goals.

(Malik et al., 2015) conducted a study to assess the services and amenities that Anganwadi Workers provide at Anganwadi Centres in relation to the guidelines of the Integrated Child Development Service (ICDS) scheme. The Northeast District of Delhi, India was the site of the research. The authors discovered that the AWCs were not operating at peak efficiency and were not offering the ICDS scheme recipient's sufficient facilities and services as per its goals. The authors suggested that in order to make sure the AWCs are operating at maximum efficiency and offering the beneficiaries sufficient facilities and services, they should be routinely inspected and evaluated its implementation process and resolve the challenges.

(Joe et al., 2021) provides detail information on challenges and opportunities for improving the ICDS scheme in Palghar, Maharashtra, India. The study identifies important gaps in infrastructure facilities, such as inadequate space, lack of proper sanitation facilities, and insufficient educational materials. These gaps affecting the goals of ICDS programme due to implementation failure. The study finds that while some services are being deliver effectively, others, particularly pre-school education, face challenges due to infrastructure deficiencies. Besides there is a low uptake of pre-school education services due to factors such as lack of awareness among parents and socio-economic barriers. The study identifies that children attending AWCs with better facilities show improvement as compared to poor AWCs. The recommendations were infrastructure improvements, training for Anganwadi Workers, community awareness, and ensuring better coordination between different government departments.

(Rao & Kaul, 2018) study the ICDS scheme and its challenges in scaling up to meet the needs of India's diverse population. The challenges identified in implementation were inadequate infrastructure, insufficient training for Anganwadi

Workers, and poor monitoring and evaluation mechanisms. Various recommendation given in the study to achieve goals of ICDS. The study recommends to enhance the training and support for Anganwadi Workers, infrastructure improvement, and ensuring better coordination between different government departments to achieve the goals of ICDS scheme.

(Saxena & Srivastava, 2009) discusses the flaws in the design of ICDS and suggests practical measures to improve its implementation. It argues that the basic nature of the ICDS scheme should be changed from centre-based to outreach-based, with a focus on children under two years old. The article emphasizes changing child-rearing practices, and the control and treatment of infectious diseases to enhance ICDS efficiency. The article also argues against the provision of packaged food, as this is unpopular with young children and has led to corruption affecting the ICDS objectives.

(Bulliyya, 2005) provides valuable information on the nutritional status and growth patterns of children in a tribal area under the Integrated Child Development Services (ICDS) scheme implemented in Lanjigarh block of Kalahandi district in Orissa since 1979. The study found widespread malnutrition among children, with significant growth retardation due to socio-economic backwardness, low literacy and poor health infrastructure. To achieve the objectives of the ICDS effectively, the study recommends to enhance efforts to improve socio-economic conditions and health infrastructure for better health outcomes among children.

(Balarajan & Reich, 2016) study found that the implementation process of ICDS faces challenges due to various political and economic factors such as lack of funding, bureaucratic failure, and socio-economic barriers. These factors hindered the ICDS objectives reaching effectively to most vulnerable populations. The study recommends for sustained political commitment, adequate funding, and community involvement to improve the effectiveness of ICDS in addressing child under nutrition in India.

The above literature findings on goals, implementation process, and challenges of ICDS scheme emphasizes upon the following issues to ensure comprehensive success of ICDS scheme.

- Enhanced evaluative methods are needed to understand the challenges of ICDS scheme and ensure its comprehensive success.
- A comprehensive study is essential to evaluate the success and failures of the various goals of ICDS scheme and its implementation process.
- Addressing infrastructure issues is essential to ensure overall success of the ICDS scheme.
- The existing literature focuses that ICDS should be changed from center-based to outreach-based with a focus on child-rearing practices and family counselling.

### 1.2.4 Stakeholders Engagement in ICDS Functioning

Evaluating the stakeholder's engagement in Integrated Child Development Services (ICDS) functioning is very important. Stakeholder engagement may improve the human resources and streamline the logistics and other supplies.

(Davey et al., 2015) study aimed to gain the perceptions of community leaders, health, and ICDS functionaries toward each other in reducing under nutrition among rural children in Delhi. The study was conducted from January 1, 2015, till March 15, 2015 in one rural ICDS project in Delhi and investigated using qualitative techniques, the functioning of health care workers, and community-level stakeholders related to ICDS scheme. The study found prevalence of malnutrition among infants in the areas covered by Anganwadi Centers due to the poor efforts by AWWs in providing nutritional services to mothers and infants. The perceptions of key stakeholders, including community leaders and health functionaries, towards the ICDS programme is also considered in this study. It found that there is inadequate and uncoordinated coordination among stakeholders that led to poor service delivery. The study recommends regular

monitoring and supervision of the nutritional services provided by AWWs and ensure better coordination among stakeholders.

(Pati et al., 2018) examine the viewpoints of different parties involved in Community Management of Acute Malnutrition (CMAM) execution in Odisha, India. The authors studied between January and December 2017 the two districts of Odisha, India. They information collected from many stakeholders, such as community people, government representatives, and healthcare professionals, using qualitative research methods. Lack of knowledge among the community, insufficient training for health workers, and inadequate infrastructure are some of the issues found in the study which causes significant impact on the implementation of CMAM in Odisha. The challenges identified by authors in implementing CMAM in Odisha includes lack of cooperation from the stakeholders, a lack of money, and insufficient monitoring and assessment systems. The study concludes with some recommendations to improve the use of CMAM in Odisha by improving the infrastructure, creating community awareness, engaging stakeholders and enhancing health worker training.

(Puri et al., 2017) studied the policy content and stakeholder network of infant and young child feeding in India by reviewing four databases articles published from 2000 to 2019 and analyzed those articles by using both bibliometric and qualitative methods. The study finds the nutritional status of children is improved on one hand while on other hand noticed the ICDS services affected due to lack of training to Anganwadi Workers. For the effective functioning of ICDS scheme the study recommends the community participation. The areas where community involved in ICDS programme has shown better functioning of AWCs. The recommendation of study is training for AWWs, improved infrastructure, stakeholders engagement, and increased community participation to enhance the ICDS programme.

(Chanchani, 2022) studies the ways by which local politics can be related to decentralization of ICDS implementation. It supports decentralization mechanism for the implementation of ICDS. The study found that in Chhattisgarh, the decentralized

method in the execution of the Integrated Child Development Services has increased the involvement of local politics and local communities which helps to enhance the scheme quality and accountability. The political stakeholder's engagement essential for ICDS improvement.

(Balarajan & Reich, 2016) examine the child nutrition policy to understand the political economy of India through the ICDS scheme. Information collected from several ICDS stakeholders, including ICDS supervisors, frontline workers, and policymakers by using qualitative research methodologies. The study finds that political as well as economic factors which include corruption, bureaucratic inefficiency, and insufficient funding affect the ICDS. The study identifies lack of infrastructure facilities, lack of awareness among community, and inadequate training for ICDS functionaries as the key obstacles to the functioning of ICDS scheme. For the improvement of the ICDS scheme functioning, the study recommends strong political commitment, coordination among stakeholders, and community participation essentiality for improving child nutrition and health status.

(Patil & Doibole, 2013) conducted a cross-sectional survey in two ICDS blocks in Aurangabad district. The study found that 68.7% of the Anganwadi workers had finished secondary education. Only 38.7% of the Anganwadi workers had sufficient knowledge on child health and nutrition. The study found a number of issues that Anganwadi Workers encountered while putting the ICDS system into practice, including poor infrastructure, low community awareness, and inadequate training to health workers. The authors suggest a number of tactics to enhance the ICDS programme execution in India including improving infrastructure, raising community awareness, enhancing health worker training, and enhancing monitoring and assessment systems. Additionally, they suggest enhancing coordination among stakeholders and promoting community involvement in the ICDS scheme's implementation.

(Helena et al., 2014) this study was conducted in Vishakhapatnam, Andhra Pradesh to assess the infrastructure of Anganwadi Centers. The study identifies

numerous factors, which include insufficient funding, improper coordination among stakeholders, and insufficient monitoring and evaluation mechanisms being the obstacles in the functioning of the ICDS scheme. The other challenges of ICDS scheme includes very less awareness among community members, insufficient infrastructure, and insufficient training to health workers. Besides this the study further identifies that the facilities available at the Anganwadi centers were insufficient to meet the needs of children and their mothers. To improve the implementation of the ICDS scheme in Andhra Pradesh the study suggested various ways which includes improving the infrastructure facilities, creating awareness among community members about ICDS services, enhancing the training of health workers related to ICDS, and strengthening the monitoring and evaluation mechanisms. The study also suggest promoting of community engagement and enhancing the coordination among various stakeholders in the implementation of ICDS. The study concludes with the valuable inputs on the challenges faced by different stakeholders in the implementation of the ICDS scheme in Andhra Pradesh. The recommendations of the authors can be useful to policymakers and ICDS supervisors to improve upon the implementation of the ICDS scheme and control under-nutrition among children below the age of six years and their mothers.

(Mishra, 2020) in his article discusses the National Education Policy (NEP), 2020 and emphasizes on significance of Early Childhood Care and Education (ECCE) through Anganwadi particularly in tribal communities. The highlight of this article is on the importance of ECCE in development of child and in what way Anganwadi will play a significant role in guaranteeing quality ECCE. The article identified the problems faced by Anganwadi Centers in ensuring quality child care education to children and recommends stakeholders engagement is the way to resolve those challenges.

(John et al., 2020) conducted a qualitative research which identifies the factors affect the performance of Anganwadi Workers in the state of Bihar in India. The study highlights the challenges faced by Anganwadi Workers in providing quality services and identifies the factors that influence their performance. The challenges AWWs face

includes limited availability of ICDS resources and challenging relationships shaped by caste dynamics, seasonal migration, and corruption which is outside of her control. The study also provides recommendations such as better incentives, working conditions, stakeholder's engagement and supportive management for improving the performance of Anganwadi Workers.

(Verma et al., 2018) examines the impact of vigilance-focused governance reforms on the service delivery of the Integrated Child Development Services (ICDS) scheme in Bihar, India. The important findings of the study is that the reforms in the scheme have led to an improvement in the service delivery of the ICDS scheme in Bihar but unfortunately have not been successful in controlling the corruption. The study also mentions that it is important to resolve the problems within the ICDS like understaffing, heavy workload, lack of stakeholder's engagement and incentives to the Anganwadi Workers. The study further recommends that there is a need for further research to understand the impact of vigilance-focused governance reforms on service delivery in other sectors and regions.

(Jain, 2015) examines the effectiveness of the Integrated Child Development Services (ICDS) scheme in addressing malnutrition in India. The finding of the study is that though ICDS scheme is successful in reducing malnutrition among children but there are still significant challenges that need to be resolved. The recommendations of the study is that there is requirement to improve the quality of services provided under the ICDS scheme, allow community participation, engage stakeholders, and strengthen the monitoring and evaluation system under ICDS.

The literature findings on stakeholders' engagement in ICDS functioning emphasizing on the following points.

- To enhance the ICDS scheme at the grassroots level, a study on the engagement of stakeholders in its implementation is required.
- The issues within the ICDS scheme can be effectively addressed through the engagement of stakeholders.

- Understanding the challenges of the ICDS requires studying the perceptions of its various stakeholders.

### 1.2.5 Impact and challenges to Health Services of ICDS in Rural Areas

A literature review on the nutritional status of children in marginalized strata of rural areas of India and the role of Integrated Child Development Services (ICDS) is required to identify the literature gaps and make a comprehensive analysis of the present research on the topic. A literature review can also help policymakers and other stakeholders to understand the impact of ICDS on child under-nutrition in India and identify ways to improve the scheme and provide recommendations for future research.

(Ghosh & Ghosh, 2020) argues that the maternal healthcare coverage is the result of the availability and utilization of health services during antenatal care at delivery, and postnatal care. The study examines the contribution of National Health Mission and suggest antenatal care visits. The study suggest removing inter and intra-state disparities in institutional delivery and ensuring at least four ante-natal visits for pregnant women, to meet the infant and maternal mortality targets set out in the Sustainable Development Goals (SDGs).

(Behera, 2020) aims to assess the impact of ICDS on the nutritional status of children. The cross-sectional quantitative data collected through National Family Health Surveys and Demographic and Health Surveys conducted in India were used for the analysis. The study found that from the literature evidences, it can be concluded that the ICDS scheme has limited impact on child under-nutrition in some areas whereas it has no impact in other areas. The survey of the study reflects that the children are consuming the supplementary food as substitute to their home food. The survey also finds that there is complete absence of home visits by the Anganwadi workers for nutrition education. The findings of the study reveal that ICDS scheme is less effective in reducing under-nutrition among children due to faulty implementation process.

(Moluguri et al., 2019) assess in his study, the health and nutritional status of below five children included under the ICDS project. The study could able to find that there is a high prevalence of malnutrition among children in both urban and rural areas of India and demand for an urgent attention from the stakeholders of ICDS to resolve this issue. The study suggests periodic studies on ICDS projects in order to evaluate the impact of interventions and suggests exploratory studies to find several risk factors of malnutrition.

(Bhandari et al., 1993) aimed to determine whether the short-term gains of ICDS continued or not. Between the periods 1981 to 1991, the proportion of children with normal nutritional status increased to 11.64%. The proportion of children with severe protein energy malnutrition declined from 14.64% to 11.3%. The study reveals that ICDS has the potential to reduce malnutrition. The study also indicates a need to improve coordination efforts between ICDS and health workers.

(Bhatnagar & Bhadra, 2015) the article argues that ICDS is one of the largest early intervention programme in India, but it remains a weak one. The article highlights the inadequacies of a scheme that has been praised for its successes and criticized for its flaws. The challenges ICDS discussed in the article are lack of funds, poor infrastructure facilities, and poor implementation of ICDS scheme affecting the health services provided under ICDS.

(Biswas et al., 2022) discusses the determinants of nutritional status among tribal women in India. The study shows 1, 66,172 data of Scheduled Tribes women in India of reproductive age group from the National Family Health Survey (NFHS-5) and categorised as underweight, normal, overweight, and obsessed. The study findings further provide evidence that certain factors such as place of residence, religion, wealth status, age group, education, marital status, and family size are some important determinants that are directly associated with nutritional status among tribal women in India. The study suggests regional and community-based development methods and

planning and executing appropriate techniques to promote holistic healthcare practices for all.

(Michi, 2021) evaluated India's the Integrated Child Development Services (ICDS) programme and its application in tribal communities in the Indian state of Maharashtra. ICDS is an important programme that ensures food, early education, and health services to children under the age of six and their mothers in rural as well as urban areas of India. The article emphasizing on improving the nutritional status of children and mothers and reducing infant mortality rate especially among marginalized section of rural areas of India. The study able to find that the ICDS scheme was successful in improving the nutritional status of children and mothers and reducing infant mortality among marginalized section of rural areas of India. However, the article also points that there are some issues which are needed to be resolved such as insufficient funds, weak infrastructure, health services and lack of awareness among the beneficiaries to strengthen ICDS for marginalized section of rural India.

(Shanthi, 2015) review the coverage of ICDS in the study district of Kanyakumari that all eligible children have been provided with nutritious food. The mothers of the child beneficiaries report the health gain that their children have acquired by regularly attending the Anganwadi programme. The present study also reveals that it is the mother's awareness of immunization programme that has affected the full coverage of immunization programme. A distinguished feature of the study area is that the literacy status of the women in the district is comparatively high (when compared with that of the state - 92.17 percent as against 80.30 percent). This helped to widen the range of awareness of scheme such as Immunization, supplementary nutrition, or pre-school education. The study points out that women's participation, women's education, women's emancipation and women's empowerment emerge as the principle factors that accomplish child survival and child development.

(Balarajan & Reich, 2016) explores how the issue of child nutrition and reform of India's longstanding Integrated Child Development Services (ICDS) scheme has been

addressed. The analysis suggests that more attention to the political economy of the policy process may help to enhance the political feasibility of future policy reform efforts of ICDS policy, and may have lessons for complementary policy reform efforts to improve child nutrition in India.

(Netragaonkar, 2015) examines the impact of Integrated Child Development Services (ICDS) on the language and cognitive development of a group of preschool children. The research sample consisted of 600 children aged 3-6 years, 300 of whom attended Anganwadi/ICDS facilities and 300 who did not attend these facilities. The main findings of this study are: (i) the ICDS scheme has a positive impact on language development in the preschool group; (ii) The ICDS scheme has a positive effect on the cognitive development of the preschool groups.

The findings of a literature review on impact and challenges to health services of ICDS in rural India emphasizing on the following points.

- Understanding beneficiaries' perceptions regarding health services in rural areas is essential.
- It is essential to know the perceptions and challenges faced by health workers delivering ICDS services in rural areas.

## 1.3 Literature Gaps

The literature gaps identified as per the five categories designed for the study are as follows:-

### 1.3.1 Policy Making and Policy Evaluation

- The available literature on public policies recognizes significance of stakeholder involvement in policy making and policy evaluation. However, there remains the lack of studies in Goa that engage stakeholders specifically related to the implementation of the Integrated Child Development Services (ICDS) scheme. Such research is essential to

understand systematically the impact of the scheme at grassroots level by involving stakeholders.

- The literature recognized importance of the policy evaluation for understanding existing policies and identifying areas for improvement. However Integrated Child Development Services (ICDS) scheme as a public policy lacks regular evaluation in Goa. This absence of evaluation hinders policy makers to understand the needs of the scheme at grassroots level. Therefore, conducting a study that will evaluate the ICDS at grassroots level becomes important.
- The existing literature emphasizes that policies should be based upon the democratic values such as participation and values of respect to the humanity rather than solely based upon technical experts' viewpoint. Similarly, the policies that are made for certain group; for example women, than it is needed to incorporate a feminist viewpoint when formulating policies for women. Studies on these aspects related to the Integrated Child Development Services (ICDS) scheme is lacking in Goa. Therefore conducting research in this area becomes essential.

Filling these literature gaps can enhance the implementation of Integrated Child Development Services scheme at the grass root level in Goa.

### 1.3.2 Community Participation in ICDS scheme

- The available literature on community participation in the ICDS scheme recognizes the benefits of community involvement in resolving ICDS challenges. However there is a gap in understanding community involvement, their perceptions and contribution to ICDS scheme in rural areas. Therefore a study in Goa on knowing the perception of local governance in resolving ICDS problems becomes important.
- The existing literature highlight upon the need of training ICDS functionaries to involve the community and increase awareness about

the ICDS services. However, there remains a gap in understanding the collaboration between Anganwadi Workers and local governance regarding ICDS services. Studying this aspect will enable to design effective training programme.

- The available literature emphasized the positive impact of community involvement in resolving challenges faced by Anganwadi Centers, there is indeed a gap in understanding how local governance can effectively address ICDS-related issues in Goa. Conducting research on this aspect would be beneficial to identify strategies and best practices for involving local governance to enhance ICDS services and outcomes in the state.
- The lack of community awareness about their role in the ICDS scheme is a major challenge. Therefore studying the perception of local governance regarding ICDS becomes important.

Filling these literature gaps can raise awareness and promote active participation of local governance in ICDS programme.

### 1.3.3 Goals, Process of Implementation, and Challenges of ICDS

- The available literature emphasizes the importance of using evaluation methods to understand the goals, implementation and challenges of ICDS scheme. However, there remains the gap of such studies in Goa on ICDS. Therefore, conducting such study in Goa will provide valuable insights into the scheme's local implementation and challenges.
- The existing literature highlights various studies that emphasize the role of ICDS in lowering child mortality rates. However, the achievement of other goals remains largely unattained. This gap is noticed in Goa as well, where no such studies have been conducted. Therefore, it is essential to conduct an evaluative study at the grassroots level to understand the broader impact of the ICDS scheme.

- The various literature highlights upon the Anganwadi Centers (AWCs) were not operating at peak efficiency and were not offering ICDS beneficiaries sufficient facilities and services which are the core issues to be given urgent attention. However, there is a lack of studies in Goa that examining the infrastructure status of AWCs in Goa. Therefore, conducting such study becomes important.
- The existing literature focus that ICDS should be changed from center-based to outreach-based with a focus on child-rearing practices and family counselling. However, such studies have not been conducted in Goa. Therefore, it is essential to understand the needs and preferences of beneficiaries regarding family counselling.

Filling these literature gaps can enhance understanding of ICDS objectives, implementation challenges, and performance in tribal areas of Goa.

### 1.3.4 Stakeholders' Engagement in ICDS Functioning

- The available literature make a point that the role of stakeholders in the implementation of ICDS is not researched much, and their perceptive to improving the ICDS scheme is not well-documented. Therefore, exploring the perception of stakeholders engaged in ICDS scheme in Goa becomes essential.
- The existing literature states that stakeholders can resolve some issues related to the ICDS. However, the impact of stakeholder engagement in resolving ICDS issues is not studied in Goa.
- The existing literature states that perspectives of different stakeholders involved in the implementation of ICDS are not well-studied, and more research is needed to understand their challenges and opportunities for improving the ICDS scheme. Therefore, a study studying different stakeholders in ICDS scheme essential.

Filling these gaps will improve understanding of stakeholder's engagement in ICDS and its impact on child health, nutrition and preschool educational needs.

### 1.3.5 Impact and challenges to Health Services of ICDS in Rural Areas

- The existing literature emphasizes the impact of nutritional services on children development but there is a lack of studies assessing beneficiaries' perceptions of the impact and benefits of home visits by Anganwadi Workers, particularly in relation to health and family counseling. Studying this aspect from center based to outreach based is essential to enhance the ICDS scheme in Goa.
- The available literature examines the nutritional growth of children benefiting from the supplementary nutrition programme of ICDS. However, there is a lack of studies on the perceptions and challenges faced by health workers involved in delivering ICDS services which is necessary to be studied.

Filling these literature gaps can enhance the impact of ICDS health services in rural areas.

## 1.4 Statement of Problem

There is a lack of comprehensive assessment and evaluation of the Integrated Child Development Services (ICDS) scheme in Goa. There is a need to evaluate the stakeholder's perceptions related to the performance of ICDS scheme at the grass root level which is the core target area under ICDS scheme. There also a need to identify and address the specific challenges and issues affecting the ICDS in tribal remote areas. Therefore, there is a need to conduct a thorough performance evaluation to identify the strengths, weaknesses, and gaps in the implementation of ICDS scheme and provide evidence-based recommendations for enhancing efficiency and effectiveness of ICDS scheme.

## 1.5 Research Questions

The research questions of the study are as follows:-

1. How to evaluate and improve the performance of ICDS in tribal panchayats of South Goa?
2. How do ST women beneficiaries in tribal dominated Panchayats of South Goa utilize and perceive the ICDS services?
3. What are the main concern and suggestions from the ST women beneficiaries related to ICDS scheme in their locality?
4. In what ways do the problems of Anganwadi Workers hinder their work in tribal panchayats of South Goa?
5. What are the challenges faced by the ICDS officers, health services and elected members of Panchayati Raj Institutions in delivering ICDS services?
6. What are the possible solutions to overcome the obstacles faced by ICDS?

## 1.6 Aim of the Study

The aim of the study to provide evidence-based recommendations for enhancing the performance of the ICDS programme in tribal panchayats of South Goa, ultimately improving the health, nutrition, and development outcomes of children and mothers in tribal communities.

## 1.7 Research Objectives

The research objectives of the study are as follows:-

1. To evaluate the historical evolution, and existing development related to the ICDS scheme contributing for the public welfare.

2. To explore the perception and satisfaction levels of tribal beneficiaries regarding the quality and impact of ICDS services.
3. To identify the barriers and challenges faced by ICDS functionaries, health workers and elected members of Panchayati Raj Institutions in delivering ICDS services in tribal areas.
4. To offer recommendations and roadmap to improve effectiveness of ICDS scheme at the grass root level.

## 1.8 Research Hypotheses

1. **H0:** There is no significant association between the frequency of utilization of ICDS services and the prior experience of using ICDS services on the satisfaction level of ST women beneficiaries.

   **H1:** There is a significant association between the frequency of utilization of ICDS services and the prior experience of using ICDS services on the satisfaction level of ST women beneficiaries.

2. **H0-** There is no significant impact of poor physical infrastructure on effective delivery of other services of ICDS.

   **H1-** There is significant impact of poor physical infrastructure on effective delivery of other services of ICDS.

## 1.9 Significance of the Study

In Goa, there are very few studies available evaluating the performance of Integrated Child Development Services (ICDS) scheme in tribal areas at grass root level. In fact, no studies have explored the perceptions of tribal people regarding the ICDS and the challenges they face in Goa. Due to limited information about the ICDS scheme's performance in tribal areas of Goa, this study aims to fill that gap. This study explore

the perceptions of beneficiaries regarding the utilization and benefits of ICDS services, highlighting both weaknesses and suggestions for improvement of the ICDS scheme. This study identifies the obstacles Anganwadi workers face while delivering the ICDS services to beneficiaries. Additionally, this study is important as it considers the viewpoints of other stakeholders such as ICDS officers, health workers and panchayats members to understand the strengths and weaknesses of the ICDS scheme in remote tribal areas and enhance it. Lastly, the study is significant as it provides evidence based recommendations with suggested roadmap to improve the scheme at the grass root level.

## 1.10 Scope of the Study

The scope of the study involve evaluating the performance of the Integrated Child Development Services (ICDS) scheme in tribal panchayats of Goa. The study aims to understand the impact of the ICDS scheme on child development, nutrition, and overall well-being of tribal children in Goa by assessing the effectiveness, efficiency, and outreach of the ICDS scheme. This study also examines the extent to which the ICDS services are reaching the target population and the challenges faced by the stakeholders in operationalizing the scheme in the tribal people locality.

## 1.11 Research Methodology

Research Methodology adopted for the study on “Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa” is as follows:

1. **Study Design:** A quantitative and qualitative methods which includes surveys, interviews, and focus group discussions is used for a comprehensive evaluation of ICDS performance in tribal panchayats of Goa.
2. **Sampling:** A purposive sampling technique used to select Scheduled Tribe women beneficiaries from tribal panchayats in South Goa.

3. **Data Collection:**

a) **Primary Sources:** The research collects data through primary sources such as survey, interview and focus group discussions.

b) **Secondary Sources:** The secondary sources includes books, journal articles, thesis, government published reports, government official websites etc.

c) **Quantitative Data:**

- **Surveys:** Conducted structured surveys with ST women beneficiaries of ICDS services to collect data on service utilization, coverage, and satisfaction levels. The survey also includes Anganwadi Workers' perceptions of the availability of resources and challenges. A questionnaire was translated into Konkani, which is the local language in Goa.
- **Document Review:** Analyzed existing documentation, such as reports and official records on ICDS scheme, to gather information on key performance indicators, budget allocation, and resource utilization.

d) **Qualitative Data:**

- **Interviews:** Conducted interviews with the Doctors of School Health Team under RBSK scheme from the Primary Health Services of each selected talukas, to gather in-depth insights of ICDS into its implementation challenges, community perceptions, and recommendations for improvement.
- **Focus Group Discussions:** Organized focus group discussions with Child Development Programme Officers, Mukhya Sevikas and elected representatives of Panchayati Raj Institutions from selected tribal populated panchayats of Quepem, Sanguem, and Cancona talukas to understand their experiences, barriers, and suggestions related to ICDS services.

4. **Data Analysis:**

a) **Quantitative Data:** Analyzed survey data using appropriate statistical techniques in Excel and SPSS, such as chi-square tests, and Mean, Medium, and Standard Deviation, to determine patterns and associations. This includes analyzing service utilization trends, challenges and satisfaction levels.

b) **Qualitative Data:** Conducted thematic analysis of interviews and focus group discussions to identify common themes, patterns, and key findings related to ICDS implementation, challenges, and recommendations.

5. **Ethical Considerations:** Necessary ethical approvals and consent was obtained from the Institutional Human Ethics Committee (IHEC), Goa University. Protected the privacy and confidentiality of participants, during data collection and analysis. Prior written consent was also taken from the Directorate of Women and Child Development, Government of Goa, and Child Development Programme Officers from Quepem, Sanguem, and Cancoana taluka of South Goa during the survey. The Block Development Office (BDO) of Quepem, Sanguem, and Cancona taluka were informed about the Focus Group Discussion that was conducted for the elected representatives of Panchayati Raj Institution.

By following these research methodologies, an evaluation of ICDS performance in tribal dominated panchayats of South Goa is presented in the study.

## 1.12 Data Collection Design

To fulfill the objectives set out and to test the hypotheses two stages were followed. In the first stage, the pilot study was conducted for the selection of the study area. In the second stage, five distinct sets of questionnaire for respondents were selected. Set-1 respondents were the ST women beneficiaries which includes Mothers of ICDS enrolled children between the ages 0-6 years, lactating mothers and pregnant women, Set-2 Anganwadi Workers from the selected Anganwadi Centers, Set- 3 interviews with the Doctors of School Health Team under RBSK scheme, Set-4 Focus Group Discussion with Child Development Programme Officers (CDPO) and Mukhya

Sevikas from the selected talukas of study, Set-5 Focus Group Discussions and interviews of the Elected Representatives of the Panchayats from Quepem, Sanguem, and Cancoana talukas of south Goa.

Each Anganwadi center is having one Anganwadi worker and since the Anganwadi centers are sparsely distributed in all three selected talukas i.e. Quepem, Sanguem and Cancona and considering the limitations, it was decided to avail the required primary data through structured questionnaire to reach the Anganwadi workers of selected Anganwadi centers of tribal panchayats of selected talukas of study i.e. Quepem, Sanguem and Cancona. The study also interacts with the elected representatives of the twelve panchayats selected for the study. In order to select the sample size of beneficiaries for the survey, a random sampling method was adopted. The following are the details of Panchayats that were selected for the survey based on purposive sampling; from each Panchayat 40 respondents from the tribal community were chosen on the basis of a simple random sampling method which includes SNP and Pre-school child beneficiary's mothers, pregnant women, and lactating mothers. Further from the selected areas, AWWs were surveyed.

## 1.13 Study Area and Sample Size of Data Collection

Table 1.1: Selected Talukas and Panchayats from South Goa

| **Talukas** | **Name of the Panchayats** | | | |
|---|---|---|---|---|
| Quepem | Balli-Adnem | Ambaullim | Cavre-Pirla | Morpila |
| Cancona | Gaondongrium | Khola | Khotigao | Sristhal |
| Sanguem | Uguem | Bhati | Kallem | Netorlium |

Table 1.1 gives the details of selected talukas and panchayats from South Goa. The researcher focused on tribal-dominated regions in South Goa, using data from the Census 2011 specifically:

- **Talukas Selected:** Three talukas in South Goa were chosen due to their tribal dominance namely Quepem, Sanguem, and Cancoana.
- **Panchayats Selection:** From each of these three talukas, four panchayats with significant tribal populations were identified based on the 2011 census data.
- **Anganwadi Centers:** The researcher further identified tribal-dominated Anganwadi centers within these selected panchayats. This identification process was facilitated by the offices of the Child Development Programme Officers and Mukhya Sevikas of each talukas selected.

This approach allowed the researcher to focus on specific tribal communities and their associated Anganwadi centers for further study. Table 1.2 gives the details of the total sample size selected for the survey purpose.

Table 1.2: Total Sample Size

| **Talukas** | **Panchayats** | **AWCs** | | **MPSE 3-6yrs** | **PL** | **LM** | **AWWs** |
|---|---|---|---|---|---|---|---|
| Quepem | Adnem-Balli | 1 | Kadde AWC | 6 | 1 | 1 | 1 |
| | | 2 | Velipwada AWC | 6 | 1 | 1 | 1 |
| | | 3 | Tak AWC | 6 | 1 | 1 | 1 |
| | | 4 | Adnem-Balli AWC | 6 | 1 | 1 | 1 |
| | | 5 | Pattem AWC | 6 | 1 | 1 | 1 |
| | Morprilla | 1 | Dabem AWC | 6 | 1 | 1 | 1 |
| | | 2 | Kajuwada AWC | 6 | 1 | 1 | 1 |
| Quepem | | 3 | Velipwada AWC | 6 | 1 | 1 | 1 |
| | | 4 | Morpirla AWC | 6 | 1 | 1 | 1 |
| | | 5 | Kanibag AWC | 6 | 1 | 1 | 1 |
| | Cavrem-Prilla | 1 | Caurem AWC | 6 | 1 | 1 | 1 |
| | | 2 | Pirla AWC | 6 | 1 | 1 | 1 |
| | | 3 | Kazur AWC | 6 | 1 | 1 | 1 |
| | | 4 | Mansal AWC | 6 | 1 | 1 | 1 |
| | | 5 | Malne AWC | 6 | 1 | 1 | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Ambaulim | 1 | Gadgal AWC | 6 | 1 | 1 | 1 |
| | | 2 | Akamol AWC | 6 | 1 | 1 | 1 |
| | | 3 | Tembi AWC | 6 | 1 | 1 | 1 |
| | | 4 | Bhamnabhat AWC | 6 | 1 | 1 | 1 |
| | | 5 | Targuegal AWC | 6 | 1 | 1 | 1 |
| **Total** | | | | **120** | **20** | **20** | **20** |
| Sanguem | Netravali | 1 | Vechundre AWC | 6 | 1 | 1 | 1 |
| | | 2 | Jacke AWC | 6 | 1 | 1 | 1 |
| | | 3 | Nune AWC | 6 | 1 | 1 | 1 |
| | | 4 | Verlem AWC | 6 | 1 | 1 | 1 |
| | | 5 | Salgini AWC | 6 | 1 | 1 | 1 |
| | Ugem | 1 | Devlamol AWC | 6 | 1 | 1 | 1 |
| | | 2 | Pansamol AWC | 6 | 1 | 1 | 1 |
| | | 3 | Cottali AWC | 6 | 1 | 1 | 1 |
| | | 4 | Valkini No 1 AWC | 6 | 1 | 1 | 1 |
| | | 5 | Mugoli AWC | 6 | 1 | 1 | 1 |
| | Bhati | 1 | Congare AWC | 6 | 1 | 1 | 1 |
| | | 2 | Villiana AWC | 6 | 1 | 1 | 1 |
| | | 3 | Kumari AWC | 6 | 1 | 1 | 1 |
| | | 4 | Valkini No. 2 AWC | 6 | 1 | 1 | 1 |
| | | 5 | Bhati AWC | 6 | 1 | 1 | 1 |
| | Kalay | 1 | Costi AWC | 6 | 1 | 1 | 1 |
| | | 2 | Voldev AWC | 6 | 1 | 1 | 1 |
| | | 3 | Kalay AWC | 6 | 1 | | 1 |
| | | 4 | Pokharmol AWC | 6 | 1 | 1 | 1 |
| | | 5 | Molunge AWC | 6 | 1 | 1 | 1 |
| **Total** | | | | **120** | **20** | **20** | **20** |
| | Shristhal | 1 | Shristhal AWC | 6 | 1 | 1 | 1 |
| | | 2 | Asali AWC | 6 | 1 | 1 | 1 |
| | | 3 | Nuve AWC | 6 | 1 | 1 | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cancona | | 4 | Vaijawada AWC | 6 | 1 | 1 | 1 |
| | | 5 | Zamblimol AWC | 6 | 1 | 1 | 1 |
| | Khola | 1 | Molorem AWC | 6 | 1 | 1 | 1 |
| | | 2 | Gawal AWC | 6 | 1 | 1 | 1 |
| | | 3 | Parykatta AWC | 6 | 1 | 1 | 1 |
| | | 4 | Kudai AWC | 6 | 1 | 1 | 1 |
| | | 5 | Payemol AWC | 6 | 1 | 1 | 1 |
| | Khotigao | 1 | Kuske AWC | 6 | 1 | 1 | 1 |
| | | 2 | Malbhate AWC | 6 | 1 | 1 | 1 |
| | | 3 | Baddem AWC | 6 | 1 | 1 | 1 |
| | | 4 | Pansulemol AWC | 6 | 1 | 1 | 1 |
| | | 5 | Yeda AWC | 6 | 1 | 1 | 1 |
| | Gaondon grim | 1 | Jiltawadi AWC | 6 | 1 | 1 | 1 |
| | | 2 | Fulamol AWC | 6 | 1 | 1 | 1 |
| | | 3 | Indrawada AWC | 6 | 1 | 1 | 1 |
| | | 4 | Naem AWC | 6 | 1 | 1 | 1 |
| | | 5 | BhuparAWC | 6 | 1 | 1 | 1 |
| **Total** | | | | **120** | **20** | **20** | **20** |
| **Grand Total** | | | | **360** | **60** | **60** | **60** |
| **Overall Total** | | | | **540** | | | |

This study presents the opinion of a sample of 480 beneficiaries which includes ST women beneficiaries of children below 6 years, expecting mothers, and lactating mothers. From each taluka, out of 480 beneficiaries (360 ST women (Mothers) beneficiaries' children below 6 years, 60 expecting mothers and 60 lactating mothers). However, the sample size is fixed from each selected panchayat for the category of preschool children, expecting mothers and lactating mothers as the beneficiaries' number was less or found more in some Anganwadi Centres (AWCs) during the visit.

The areas where the beneficiaries were interviewed also had interviews with Anganwadi Workers (AWWs).

Data collection is also conducted through Focus Group Discussions (FDGs) held with the elected Panchayat Members of Quepem, Sanguem, and Cancona taluka and ICDS government functionaries which includes Child Development Programme Officers (CDPOs) and Mukhya Sevikas (MS). Additionally, interviews were conducted with the Doctors of School Health Team under RBSK scheme. The questionnaires used in the survey, FDGs, Interviews were translated into Konkani, which is the official language of Goa. The researcher also met personally the then Director of Directorate of Women and Child Development, Government of Goa to discuss the aim and objectives of the study. The researcher also wrote an email to the Central Ministry of Women and Child Development informing about this study.

## 1.14 Chapter Classification

This study includes five chapters. The chapter classification is as follows.

**Chapter 1: Introduction**

The first chapter is an introduction to the study titled 'Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa'. It begins with a comprehensive background that sets the context and outlines the scope of research on the Integrated Child Development Services (ICDS) scheme. Following this, a thorough literature review is conducted focusing on five aspects of ICDS such as policy making and policy evaluation; community participation in the ICDS scheme; goals, process of implementation, and challenges of ICDS; stakeholders' engagement in ICDS functioning; and Impact and challenges to health services of ICDS in rural areas. The literature review identify both the contributions and the gaps in the literature that the current study aims to address.

Based on the findings and gaps identified in the literature review, this chapter

articulates the statement of the problem that clearly defining the issues and challenges that the study aims to investigate. This leads to the formulation of specific research questions for the study and setting a main aim for the research. To achieve this aim, clear research objectives are set, and proposed research hypotheses to predict potential outcomes through empirical investigation. The significance of the study is then highlighted, explaining the importance of the study for future research. The scope of the study is delineated, establishing the boundaries and limitations of the research.

The chapter gives details of the research methodology which includes primary and secondary sources, and methodological choices which includes qualitative and quantitative methods of data collection. The data collection design describing the tools and techniques used to gather data, and the study area provides geographical and demographic details of the study. Lastly, the sample size for data collection is justified, ensuring that the research findings are representative. The chapter concludes with an overview of the chapter classification, summarizing the structure of the study.

**Chapter 2: A Comprehensive Overview of Evolution of India's Integrated Child Development Services (ICDS) scheme**

The second chapter of this study is titled as 'A Comprehensive Overview of the Evolution of India's Integrated Child Development Services (ICDS) scheme'. It is important to study evolution of any scheme to understand its effectiveness and scalability. This chapter presents a detailed examination of the ICDS, tracing its evolution as a significant public policy initiative in India. This chapter has various sections. The chapter introduces the ICDS, explaining its role and importance as a public policy designed to support child development across India. The chapter delves into the historical context of ICDS, exploring its development from its inception to its current state, highlighting child welfare policies before and after India's independence.

The focus of the chapter shifts to the practical aspects of the ICDS, discussing how it has been implemented and expanded over time to reach more beneficiaries.

The chapter has a section that is dedicated to the financial aspects of the ICDS. It examines the contributions of international entities to the ICDS and also discusses how the ICDS is funded at the national and state levels. It also looks at the allocation of funds to the ICDS within the Union Budget and provides an overview of how resources are allocated to support the ICDS. The chapter also reviews the role of India's Five Year Plans and NITI Aayog in the growth and development of the ICDS.

Further the chapter examines the constitutional and legislative measures supporting ICDS, ensuring its legal and institutional framework. The focus of the chapter is also on the judicial oversight of the ICDS, with an analysis of relevant Supreme Court orders and guidelines. The chapter also has a section assessing the extent of the ICDS's coverage of beneficiaries and discusses the geographical spread of the ICDS across India. It also evaluates the effectiveness of services delivered by the ICDS. The chapter also explores the convergence of ICDS with other government departments.

The chapter also highlights the technological advancements that have been integrated into the ICDS to improve its efficiency and reach. The chapter concludes by discussing the efforts to enhance the infrastructure and human resources essential for the successful operation of the ICDS. Each section of this chapter aims to provide a comprehensive understanding of its historical evolution, operational mechanisms, financial status, and its overall impact on child development in India.

**Chapter 3: ICDS Scheme in Goa: A Focus on Tribal Community**

The third chapter of the study, titled "ICDS Scheme in Goa: A Focus on Tribal Community", provides an in-depth analysis of the Integrated Child Development Services (ICDS) scheme and its impact on the tribal communities in Goa. The chapter begins by examining the nutritional challenges and ICDS interventions for tribal communities, which is a critical aspect of the ICDS's objectives. It highlights the nutritional challenges of tribal women and children in India and specifically Goa and

how the ICDS intervention can address these needs within tribal populations.

The chapter then explores the concept of 'tribe' and its meaning within the Indian context, discussing the diverse tribal communities of India and Goa. This section provides a cultural and social backdrop against which the ICDS operates, emphasizing the unique characteristics and needs of these communities. A comparative analysis of the nutritional status of tribal community women and children in India and Goa follows, offering insights into regional variations and the challenges faced in different areas. This comparison emphasises the necessity for systematic approaches in the implementation of the ICDS. The historical background and evolution of the ICDS in Goa are then detailed, highlighting the specific developments of the scheme that have taken place in the region. This historical perspective is crucial for understanding the current structure and organization of the ICDS in the tribal panchayats of Goa, which is subsequently discussed. This section focuses on the operational framework of the ICDS, revealing how the scheme is structured and managed at the local level.

The policy and legal framework governing the ICDS in Goa are examined, highlighting the legislative and policy interventions that support the functioning of scheme. This legal context is essential for proving the scheme's authority and the guidelines it follows. An overview of the selected area for the study is presented, which includes a socio-demographic profile of the Sanguem, Quepem, and Cancona talukas. These profiles provide a detailed look at the communities served by the ICDS, offering a demographic and geographic focus through which the scheme's impact can be assessed.

In essence, Chapter 3 offers a thorough review of the ICDS's role in supporting the tribal communities of Goa, from the nutritional needs of women and children to the broader social, historical, and legal contexts that shape the scheme's implementation and effectiveness. The chapter serves as a comprehensive guide to understanding the ICDS's challenges, achievements, and aspirations in the context of Goa's tribal populations.

**Chapter 4: Analyzing the Integrated Child Development Services (ICDS) Scheme**

The fourth chapter analysis the Integrated Child Development Services (ICDS) Scheme, with a particular emphasis on its empirical data gathered from various stakeholders of ICDS. The chapter present the practical outcome of the study as observed through surveys, interviews, and the focus group discussions. The chapter presents a survey perspective analysis of the ICDS scheme. It involves a detailed examination of data collected from various stakeholders which includes tribal women beneficiaries, Anganwadi Workers (AWWs), doctors under the Rashtriya Bal Swasthya Karyakram (RBSK) School Health Team attached to Primary Health Centres, Child Development Programme Officers (CDPO) and Mukhya Sevikas (MS), and elected members of Panchayati Raj Institutions (PRI). Each data set provides insights into the effectiveness, challenges, and impact of the ICDS scheme from different perspective points within the community. Through this analytical perspective, the chapter aims to show if the ICDS working well, what problems it has, and how it affects the tribal community. By looking at all this information, the chapter tries to give a clear picture of how the ICDS is doing in helping tribal communities in Goa as a public policy at a grass root level.

**Chapter 5: Conclusion**

The fifth chapter is the conclusion of the study, bringing together all the findings and observations made throughout the research with suitable recommendations. The chapter assesses the overall influence of the ICDS on its beneficiaries and suggest action plan for its future development, considering the challenges and opportunities identified throughout the study. The part of the chapter presents the main finding and observations made during the field visits. It gives details of limitations of the study and scope of future research. The chapter validates the hypothesis which further associates to provide recommendations and suggested roadmap highlighting the

stakeholder's role in action plan for implementation of recommendations. The chapter details the study contribution to the research field. Overall, chapter 5 concludes the study by reflecting the importance of understanding stakeholder perception in analysing the scheme to bring changes for future social development.

## 1.15 Locale of the study

The study focuses mainly on the tribal regions in south district of Goa namely Quepem, Sanguem, and Cancona as per the Census 2011 record. The study mainly explore the facilities and resources available, such as educational and healthcare facilities for the ICDS scheme implementation in tribal regions. The various stakeholders involved in the study includes Scheduled Tribe (ST) women beneficiaries, Anganwadi Workers, Doctors of School Health Team from Primary Health Centres, Local government officials such as Child Development Programme Officers (CDPO), Mukhya Sevikas (MS), and Elected representatives of Panchayati Raj Institutions (PRIs).

To sum up, chapter one sets a foundation for the comprehensive study of Integrated Child Development Services (ICDS) scheme. It gives the background of the study and provides the findings and identifies the gaps in existing literature. The statement of problem, research questions, objectives and hypothesis are guiding for the comprehensive study. The significance, scope, and methodology of the research are clearly defined to explore the evaluation of ICDS in tribal-dominated panchayats of South Goa. This introductory chapter is necessary for establishing the systematic framework for the entire study in order to explore the impact and effectiveness of the ICDS scheme in tribal regions of Goa.

# Chapter 2

# A Comprehensive Overview of Evolution of India's Integrated Child Development Services (ICDS) scheme

## 2.1 ICDS: A Historical Perspective on its Development: Pre and Post-Independence

The Integrated Child Development Services (ICDS) scheme launched on 2nd October 1975 in selected 33 Community Development Blocks of 22 States of India in the experimental phase and thereafter since 1978 it has been expanded in every corner nationwide (Kapil, 2002). The ICDS scheme launched with an aim to resolve increasing

malnutrition, morbidity, and mortality rate in India. However, various public and welfare policies in pre and post-independence India laid the foundation of ICDS scheme that will cater the needs of children. The few noteworthy policies designed for children welfare are discussed below in two phases of India's political development that is pre-independence and post-independence.

**a) Pre-Independence**

Malnutrition was a serious issue of concern to the health of women and their children in both pre and post-independence phase of India. During British rule, malnutrition was prevalent in India due to various factors such as poverty, lack of education, poor infrastructure, lack of healthcare facilities, and scarcity of nutritious food (Panda et al., 2020).

During the British rule, India witnessed many famines that led to the increasing mortality among women and children due to malnutrition and other health complications. The Great Bengal Famine of 1943 for example, resulted in the deaths of millions due to starvation and malnutrition (Mukherjee, 2015). To tackle malnutrition and reduce mortality among children and women, several policies were introduced by the British government (Harrison, 1994). However, the policies introduced by the British government were mainly with short term goals fulfilling colonial interest rather than giving it long tern holistic welfare solutions. A few key policies that were implemented for children welfare during British India are discussed below:-

**(i) Some children welfare policies during British Rule in India**

1. **The Small Pox Vaccination Act (1880):** This smallpox vaccination was passed for the compulsory vaccination of children in certain Municipalities and Cantonments in India where smallpox was severely affected to control the spread of disease. (Mushtaq, 2009).

2. **The Bombay Presidency Infant Welfare Society (1919):** It provided aid to infants, expectant mother, and mothers in childbirth, and trained nurses and traditional birth attendants (Kavadi, 2016).
3. **The Child Marriage Restraint Act (1929):** This act also known as Sharda Act enacted to restrict and prevent the practice of child marriage. This act fixed the age of marriage for girls as fourteen and for boys eighteen years of age and penalized early marriages by fine or imprisonment (Sharma, 2021).
4. **Wardha Scheme of Basic Education (1937):** This scheme was proposed by Mahatma Gandhi in Wardha in All India Educational Conference for free and compulsory education for children. However this scheme was not fulfilled by the British rule.

Although these policies aimed to address health issues in India particularly of women and children, but they were with limited coverage with more focus in urban areas. The focus of such policies were limited to specific diseases or addressing sudden health crises. Many of such policies affected by less community participation, cultural biases, regional biases, and lack of administrative interest.

**b) Post-independence**

In initial phase of post-independence, India made efforts with a welfare concern to address rising malnutrition, morbidity and mortality rate. During the period 1952 to 1973, the Indian government implemented several welfare projects specifically aimed at reducing malnutrition among children and mothers. Through these projects various efforts made to improve nutritional status of children and women. Following are some noteworthy welfare projects implemented during this period that laid to the foundation of the Integrated Child Development Services (ICDS) scheme in India in 1975.

**(i) Key Health, Nutrition, and Educational Policies for children and women: Post-Independence**

1. **Family Planning Programme (Launched in 1952, expanded in the 1960s):** The programme promoting small family and birth spacing for the health and well-being of mothers and children (Visaria & Ved, 2016).
2. **National Malaria Eradication Programme (1958):** This programme not directly focused on malnutrition but aimed to control malaria which caused morbidity and mortality, particularly among children and pregnant women (Narain & Nath, 2018).
3. **Mid-Day Meal Programme (1961):** This programme first started in Tamilnadu and later expanded. This programme is also known as School Lunch Programme. This programme was launched by the Ministry of Education. This scheme was addressing malnutrition by providing mid-day meal in schools (Maurya et al., 2018b).
4. **National Goiter Control Programme (1962):** This programme launched in the Himalayan region and iodized salt was supplied in goiter endemic areas. All the people were covered under this programme. Later in 1986 this programme was changed to National Iodine Deficiency Disorders Control Programme due to seriousness of this problem in entire country. This aimed to supply iodized salt in entire country by 1992 (Kapil et al., 1992).
5. **Applied Nutrition Programme (1962):** This programme first implement in Orissa and Andhra Pradesh and later expanded. It aimed to increase production of nutritious foods and its consumption and provide supplementary nutrition to vulnerable groups which includes 3-6 years children, pregnant women, and lactating mothers (Kapil et al., 1992).
6. **National Tuberculosis Control Programme (1962):** Under this programme the Bacillus Calmtte-Guerin (BCG) vaccination was given to new born babies at risk of getting tuberculosis (TB). The BCG vaccination started in India in 1948 which later became part of this programme (Lahariya, 2014).

7. **National Education Policy (1968):** It aimed to educational facilities to children to propel India into an advanced nations (Swargiary, 2023).
8. **National Prophylaxis Programme (1970):** This project against Nutritional Blindness due to deficiency of Vitamin A. This programme started as an urgent remedial measure to combat with blindness in the country seen in the 1950s and 1960s. This has controlled under-nutrition among children (Kapil & Sachdev, 2013).
9. **National Nutritional Anemia Prophylaxis Programme (1970):** This programme was launched during Fourth Five-Year Plan in 1970 which was renamed in 1991 as National Nutritional Anemia control programme. This programme addressing nutritional anemia which was caused by iron deficiency among children and mothers (H. P. S. Sachdev & Gera, 2013).
10. **National Nutritional Anemia Prophylaxis Programme (1970):** This programme launched for the prevention of nutritional anemia in mothers and children by the Ministry of Health and Family Welfare. Later this programme became a part of Reproductive and Child Health (RCH) programme (Maurya et al., 2018).
11. **Supplementary Feeding Programme (1970):** This programme aimed to provide 300 Kcal/day to improve the nutritional status of children in rural areas and in urban slum areas. This programme later became a part of the Integrated Child Development Services scheme (Gavaravarapu & Hemalatha, 2018).
12. **Special Nutrition Programme (1970):** This programme launched by the Ministry of Social Welfare. This programme providing supplementary nutrition to preschool children, pregnant and lactating mothers of poor socio-economic group from rural, urban and tribal areas through Balwadis.
13. **National Policy for Children (1974):** The National Nutrition Policy was introduced in 1974 to address the issue of malnutrition in India. It recognized the need for integrated efforts to improve the nutritional status of vulnerable

populations, including children, pregnant women, and lactating mothers. The ICDS scheme was launched to implement the objectives of the National Nutrition Policy (Jagannadham, 1979)

14. **Five-Year Plans:** The ICDS scheme was initiated to resolve the issues of malnutrition and poor health indicators among children and women in India. It was included in government's broader development agenda outlined in the Five-Year Plans. (Kumar Maurya et al., 2018).

The welfare policies implemented from 1952 to 1974 aimed to address malnutrition and other related issues among children and women in India were closed or replaced with other programmes due to insufficient funding, lack of coordination, weak implementation and monitoring, infrastructure and logistic challenges, cultural and social barriers, quality of services, lack of community involvement, political instability and administrative changes, inadequate focus on social determinants, and limited awareness among community.

However, it is important to note that though these policies had limitations but they laid the foundation for the Integrated Child Development Services (ICDS) scheme which was launched in 1975. This scheme was designed based on the past experiences with an aim to fulfill the comprehensive need of child and maternal development services. After the formation of ICDS various other welfare projects were initiated by the government to reduce malnutrition and improving the health outcomes of children and mothers in India. Some of the key policies of the government that associates to strengthen ICDS includes as follows:

**(ii) Policy intervention in strengthening ICDS: Aftermath 1975**

1. **National Diarrheal Diseases Control Programme (1978):** The aim of this programme is to control malnutrition, mortality and morbidity caused by diarrhea (Manchanda, 1995).

2. **National Health Policy (1983):** The National Health Policy of 1983 is the first health policy after 36 years of independence. This health policy emphasized the need for comprehensive health care, including preventive and promote health services for women and children. This policy played a crucial role in fulfilling the objectives of ICDS (Lal, 2016).
3. **National Policy on Education (1986):** The National Policy on Education aimed to promote early childhood education and emphasized the need for providing quality education and care to young children (Swargiary, 2023).
4. **Wheat Based Supplementary Nutrition Programme (1986):** It launched to extend support to existing nutrition programmes by covering additional beneficiaries such as the children, lactating mothers and pregnant women who were not covered under ICDS (Kapil et al., 1992).
5. **Mahila Samakhya Programme (1988):** The Mahila Samakhya Programme, launched in 1988 in pursuance of the goals of the New Education Policy (1986) which aimed to empower women by providing education and awareness about their rights, health, and nutrition. It recognized the vital role of women in child development and contributed to the rationale for the ICDS scheme (Narang, 2020).
6. **Scheme for Adolescent Girls (1991**): Now this scheme is known as the Kishori Shakti Yojana aimed at empowering adolescent girls by providing them with education, health care, life skills, and vocational training. It complemented the ICDS scheme by addressing the specific needs of adolescent girls (Maurya et al., 2018).
7. **National Plan of Action for Children (1992):** The National Plan of Action for Children emphasized on the overall development and protection of children in India. It prioritized issues such as health, nutrition, education, water, sanitation and environment and acted as a guiding document for the ICDS scheme (Ministry of Human Resource Development, 1992).

8. **National Nutrition Policy (1993):** It aimed to eradicate malnutrition and to achieve proper nutrition for all (Maurya et al., 2018).
9. **National Mid-Day Meal Scheme (1995):** The Mid-Day Meal Scheme, initiated in the 1995, recognized the importance of providing nutritious meals to children attending schools. This policy intervention highlighted the link between nutrition and education and influenced the inclusion of supplementary nutrition components within the ICDS scheme (Chakrabarti et al., 2021).
10. **National Policy for Children (2013):** The National Policy for Children outlined a comprehensive framework for the well-being and rights of children in India. It emphasized the importance of early childhood care and development, health, nutrition, education, and protection. The ICDS scheme remains a key component of the government's efforts to implement the policy and ensure the holistic development of children (Ali, 2013).
11. **National Nutrition Programme (2018):** This programme also known as POSHAN Abhiyan. This programme aims to improve the nutritional status of children from 0-6 years, adolescent girls, pregnant women, and lactating mothers in a time-bound manner. It also aims to reduce stunting and wasting in children and reduce anemia in women. This programme is implemented in all the States and Union Territories of India (Maurya et al., 2018)

These policies of the government are committed to address the health, nutrition, and early childhood development needs of children and women. The integration and convergence of various initiatives and policies led to the creation of the comprehensive ICDS scheme which is now called as the 'Umbrella ICDS' as it brought together various services under one umbrella to ensure better coordination and delivery of services for the holistic development of children and the well-being of women.

## 2.2 Implementation and Expansion of ICDS

Integrated Child Development Services (ICDS) scheme is a comprehensive programme of the government that aimed to cater the nutritional and developmental needs of children below the age of six in India. The implementation of ICDS is identified in mid-1970s when the Government of India launched this initiative as a pilot project in 22 States in selected 33 Community Development Blocks affected by draught across India in 1975. These 33 community development blocks included 19 rural areas, 4 urban blocks, and 10 tribal areas (Sachdev & Dasgupta, 2001b).

The origins of ICDS scheme is mainly formed due to the increasing malnutrition and poor child development that would have drastically affected the future generation of the country. The ICDS scheme was implemented to resolve these issues by integrating different services that will cater the needs of nutrition, healthcare, immunization, and early childhood education under a single umbrella (Kapil, 2002).

In 1975, to provide technical support and guidance for the implantation of ICDS, the Indian government established the National Institute of Public Cooperation and Child Development (NIPCCD). During the initial phase of ICDS, NIPCCD had conducted various research on implementation of ICDS and accordingly suggested recommendations to improve it. It developed various training modules for Anganwadi workers to empower them in non-formal education and delivering other services of ICDS. (*NIPCCD*, n.d.).

Over time, the ICDS scheme expanded its reach and coverage, extending its services to rural as well as urban areas. In 1985, the Government of India made ICDS a central sector scheme, ensuring its funding and support from the central government. By the late 1980s, ICDS had expanded to cover almost all districts in India (Kapil, 2002).

In 1990s, the ICDS scheme underwent significant reforms to improve its effectiveness. These reforms included increased emphasis on community participation, decentralization of decision-making, and strengthening monitoring and evaluation

mechanisms. Several policy changes were also implemented, such as the provision of Take-Home Ration (THR) for pregnant and lactating mothers, and the introduction of growth monitoring activities.

Presently ICDS is integrated to provide six services, those are health check-ups, formal education, nutrition, supplementary nutrition, immunization and referral services for children under the age of six and their mothers (Sachdev & Dasgupta, 2001). Following points discusses the expansion of ICDS since its inception into several phases.

**(i) The Expansion of ICDS can be divided into several key phases:**

1. **Pilot Projects (1970-1975):** Before the official launch of ICDS, various pilot projects were initiated in various states to test the impact and effectiveness of integrated services for child development. These projects were providing nutrition and education services, as well as health check-ups, immunizations, and referral services.
2. **National Launch and Expansion (1975-1990):** In October 1975, ICDS was officially launched as national scheme with the participation of twenty two states. The focus was primarily on providing supplementary nutrition, healthcare, and preschool education through Anganwadi centers. Over time, ICDS expanded its coverage to other states of India.
3. **Strengthening and Diversification (1990-2005):** During this phase, efforts were made to strengthen the ICDS infrastructure, improve the quality of services, and increase the coverage of beneficiaries. The scheme diversified to include additional services like immunization, early childhood care, and non-formal education. Maternal health and nutrition were also given more prominence.
4. **Reforms and Consolidation (2005-2013):** In 2005, significant reforms were introduced in ICDS through the launch of the “Common Guidelines” for Integrated Child Development Services. These reforms aimed to enhance the functioning and bring uniformity in the scheme, improve the quality of services,

and strengthen the monitoring and evaluation mechanisms. The focus shifted towards a life-cycle approach, covering not only children but also adolescent's girls, nursing mothers and pregnant women.

5. **Expansion and Focus on Quality (2013-2017):** In 2013, efforts have been made to expand the coverage of ICDS to reach more vulnerable populations and remote areas. The scheme has been strengthened with the inclusion of additional services like early childhood education, skill development, and support for adolescent girls. Emphasis is also given to enhancing the quality of services, strengthening community participation, and ensuring convergence with other government programmes.
6. **Restructuring of ICDS (2017-2021):** This period is crucial in recent context as India undergone to an economic changes in its planning process from Planning Commission of India to NITI Aayog which is the highest public policy think tank of the Government of India. During this period where there is much talk about achieving Sustainable Development Goals (SDGs) by 2030, in this context the Integrated Child Development Services (ICDS) programme in India has undergone several restructuring efforts since 2017.

The following points discuss in brief the key developments of ICDS from 2017-2021. This period is crucial in terms of the formation of the National Institute of Transforming India (NITI) Aayog, the highest think tank public policy forum. NITI Aayog is a replacement for the Planning Commission of India.

**(ii) A brief overview of the key developments of ICDS from 2017- 2021**

1. **Increase in Budget:** The Union Budget of 2017-18, increased the budget allocation for ICDS by 11.8% as compared to 2016-17 indicating an enhanced focus of Union government on child development.

2. **Strengthening Anganwadi Services:** The government took various crucial steps to strengthen and restructure the ICDS scheme since 2017. The emphasis of the government were to improve the functioning and infrastructure of Anganwadi centers and also aimed at providing quality services, including nutrition, health, preschool education, and early childhood care, to children aged 0-6 years.
3. **POSHAN Abhiyaan (National Nutrition Mission):** POSHAN Abhiyaan launched in March 2018, to reduce malnutrition and stunting among children, as well as to improve the nutritional status of pregnant women and lactating mothers. It integrates ICDS services to improve health and education of children under the age of 6 years and promote women empowerment.
4. **The National Education Policy (NEP) 2020:** The NEP 2020 emphasis on early childhood education. It recommends the integration of preschool education as an integral part of ICDS to ensure holistic development of children.
5. **Tech-enabled Transformation of ICDS:** From 2020 onwards, there has been a growing emphasis on using technology to improve the effectiveness and efficiency of ICDS services. Initiatives like digitized beneficiary tracking systems, mobile-based applications, and e-learning platforms for Anganwadi workers have been introduced. Smt. Nirmala Sitaram, Finance Minister of India in her budget speech 2021-22 announced 2 lakh digitized Anganwadi by 2023.
6. **Umbrella ICDS Scheme:** The government announced an "Umbrella ICDS Scheme" in February 2021 to provide integrated services for early childhood care and education, health, and nutrition. This scheme aims to adopt a comprehensive approach towards child development and consolidate various existing programmes under one umbrella.
7. **Expansion of Coverage:** Efforts have been made to expand the coverage of ICDS services to reach vulnerable and remote areas, as well as marginalized populations. Special focus has been given to children from tribal communities, areas affected by Left Wing Extremism, and urban slums.

**(Source:** Compiled By Researcher).

**Note:** Please note that the above information is from 2017 till 2021. Policy guidelines, and interventions may have changed based upon ongoing developments in specific States of India.

The historical development of ICDS shows that the scheme has evolved over time to address emerging challenges and the changing needs of the population. However, despite its significant achievements, ICDS still faces several challenges, including inadequate funding, infrastructure gaps, and the need for further strengthening of its implementation mechanisms. Efforts are underway to address these issues through policy reforms, capacity building, and increased investment in the programme. It has been supported by funding from both the national and state governments, as well as partnerships with international organizations and NGOs. Following is the detail on funding pattern of ICDS at International, National and State level.

## 2.3 Financing and Resource Allocation to ICDS

The ICDS scheme is a flagship programme of the Indian government aimed at holistic development and well-being of children under the age of six, as well as pregnant and lactating women and adolescent girls. The funding for the ICDS scheme primarily comes from the Government of India, which allocates funds through its annual budget. Integrated Child Development Services (ICDS) is a government scheme in India aimed at improving the nutritional and health status of children under six years of age and mothers. The scheme is primarily funded by the Government of India and the respective state governments. However, there are also some international funding partners that contribute to the implementation of ICDS.

### 2.3.1 International Funding Partners to ICDS

The Ministry of Women and Child Development discusses about international funding partners of ICDS (MWCD, 2015) discussed as below.

1. **United Nations International Children's Emergency Fund (UNICEF):** UNICEF is a core funding partner of the ICDS Scheme. It provide financial assistance, technical support, and expertise to strengthen the implementation and impact of the scheme.
2. **World Bank (WB):** The World Bank supports the ICDS Scheme through funding and technical assistance. It finance the projects and initiatives taken to improve the delivery of services under the ICDS, enhancing scheme efficiency, and strengthening the monitoring and evaluation systems.
3. **Department for International Development (DFID), United Kingdom:** DFID provides funding and technical assistance to the ICDS Scheme to support its efforts in reducing child malnutrition, improving child health, and enhancing early childhood development.
4. **European Union (EU):** The European Union has contributed funds to the ICDS scheme through various programmes and initiatives. It support activities that focus on improving child nutrition, health, and early learning outcomes.
5. **Global Alliance for Improved Nutrition (GAIN):** GAIN partners with the ICDS scheme to address the issue of malnutrition in children. It provide financial support and technical expertise to improve the quality of supplementary nutrition provided through the scheme.
6. **International Development Association (IDA), part of the World Bank Group:** IDA provides concessional financing to the ICDS scheme to help strengthen its delivery mechanisms, enhance the quality of services, and improve the overall well-being of children and mothers.
7. **World Food Programme (WFP):** The WFP supports ICDS by providing food and nutritional assistance to children and mothers enrolled in the scheme. It helps

in addressing malnutrition and improving the overall health and well-being of beneficiaries.

8. **World Health Organization (WHO):** The government of India directed the Ministry of Women and Child Development and Ministry of Health to adopt the New International standards of WHO from 15th August 2008 to monitor the growth of children under ICDS scheme and the National Rural Health Mission (NRHM). WHO has developed New International Standards for assessing the physical growth, nutritional status, and monitor development of children from birth to 5 years of age.
9. **Cooperative for Assistance and Relief Everywhere (CARE):** This was a non-food project concerned with implementing maternal and child health projects, girl child primary education and capacity building training of Anganwadi Workers. CARE India supporting the Ministry in strengthening ICDS Management Information System (MIS).
10. **United States Agency for International Development (USAID):** It is supporting the ICDS scheme in India through various initiatives and partnerships to improve maternal and child health, nutrition, and early childhood development.

**Note:** Please note that the specific funding partners and funding sources may vary over a time based on the priorities and agreements between the Indian government and international stakeholders.

These are some of the notable international funding partners that support the ICDS scheme in India. Their assistance plays a crucial role in improving the effectiveness and impact of the programme in addressing the needs of vulnerable children and mothers. Additionally, there are international non-governmental organizations and donor agencies that provide financial assistance and support for the ICDS scheme.

### 2.3.2 National and State Level Funding to ICDS

At the national and state level, the funding pattern of the Integrated Child Development Services (ICDS) scheme in India is a shared responsibility between the central government and state governments. At the national level, the Ministry of Women and Child Development (MWCD) is a nodal agency handling the funds for the ICDS scheme. The central government allocates the funds based on various factors such as the population of children under six years of age, the prevalence of malnutrition, and the number of districts covered under the scheme in the state.

The central government typically provides financial assistance in the form of grants-in-aid to the state governments for the implementation of ICDS. The grants are released to the states on a regular basis either as a part of the existing budget or as separate allocations.

At the state level, the Department of Women and Child Development or equivalent departments are responsible for the implementation of ICDS. The state government also contributes to the funding of the scheme. The state governments allocate their share of funds for ICDS from their budgetary allocations for social welfare and development programmes (Ministry of Women and Child Development, 2017).

Table 2.1: Cost Sharing by Central Government with States and Union Territories

| **Sr. No.** | **Component of sharing** | **Cost-sharing Ratio by Centre & State** | | |
|---|---|---|---|---|
| | | **General** | **Salary** | **NP** |
| 1 | States/UTs with Legislature | 60:40 | 25:75 | 0:50 |
| 2 | NE/Himalayan States | 90:10 | 90:10 | 0:10 |
| 3 | UT without Legislature | 100:0 | 100:0 | 00:0 |

**Source:** MWCD. (2017). *Integrated Child Development Scheme (ICDS) Manual for District- Level Functionaries*. Department of Administrative Reforms and Public Grievences. https://darpg.gov.in/

**Note:** Please note that the funding pattern may vary depending on the specific policies and guidelines issued by the central government from time to time. Additionally, the amount of funding allocated to ICDS can also vary based on the overall budgetary allocations and priorities of the central and state governments in a particular year.

### 2.3.3 Union Budget allocation to ICDS

The Union Budget allocation to the ICDS scheme in India varies from year to year. The Union Budget is presented annually by the Finance Minister of India, and it outlines the government's expenditure and revenue plans for the upcoming financial year.

The budget allocation for ICDS is a part of the allocation for the Ministry of Women and Child Development, which is responsible for the implementation of the ICDS scheme. The allocation for ICDS also includes other related programmes and schemes under the ministry (MWCD, 2015). The budgetary allocation for the ICDS scheme during X, XI, XII Five-Year Plan is as given below:-

Table 2.2: Budgetary Allocation to ICDS in X, XI and XII FYP

| Five Year Plan (FYP) | Budgetary Allocation in crore |
|---|---|
| X FYP | 10,391.75 |
| XI FYP | 44,400.00 |
| XII FYP | 1,23,580.00 |

**Source:** MWCD. (2015). *Integrated Child Development Services—ICDS Scheme | Ministry of Women & Child Development|IN|yhqcy*. https://wcd.nic.in/integrated-child-development-services-icds-scheme

The funds provided through the Union Budget are used to support various components of the ICDS scheme, which includes, supplementary nutrition, health check-ups, immunization, early childhood care and education, and other related activities. The specific allocation and utilization of funds may vary across states and regions based on their specific needs and priorities within the ICDS scheme. In table 2.3 is the details given on the funding pattern and budget allocation for ICDS.

Table 2.3: Cost Sharing by Central Government with States and Union Territories in X, XI and XII Five Year Plan

| **Sr.No.** | **Year** | **Budget Allocation (BE)** | **Budget Allocation (Revised Estimate)** | **Expenditure** | **Percentage w.r.t RE** |
|---|---|---|---|---|---|
| | | (Rs. in Crores) | | | |
| 1 | 2002-2003 | 2,740.00 | 2,030.00 | 1,970.00 | 97.04% |
| 2 | 2003-2004 | 3,150.00 | 2,255.00 | 2,215.00 | 98.22% |
| 3 | 2004-2005 | 3,455.00 | 2,760.00 | 2,740.00 | 99.27% |
| 4 | 2005-2006 | 4,010.00 | 3,594.00 | 3,574.00 | 99.44% |
| 5 | 2006-2007 | 4,628.00 | 4,081.00 | 4,061.00 | 99.50% |
| 6 | 2007-2008 | 5293.00 | 5396.30 | 5257.09 | 97.42% |
| 7 | 2008-2009 | 6300.00 | 6300.00 | 6379.36 | 101.25% |
| 8 | 2009-2010 | 6705.00 | 8162.00 | 8157.76 | 99.94% |
| 9 | 2010-2011 | 8700.00 | 9280.00 | 9763.11 | 105.20% |
| 10 | 2011-2012 | 10,000.00 | 14048.40 | 14272.21 | 101.59% |
| 11 | 2012-2013 | 15,850.00 | 15.850.00 | 15701.50 | 99.06% |
| 12 | 2013-2014 | 17,700.00 | 16,312.00 | 16267.49 | 99.73% |
| 13 | 2014-2015 | 18,195.00 | 16561.00 | 16581.82 | 100.12% |
| 14 | 2015-2016 | 8335.77 | 14,000.00 | 5001.73 | 60% |

| | | | | | |
|---|---|---|---|---|---|
| 15 | 2016-2017 | 9700.00 | 15,483.77 | 8458.20 | 62% |
| 16 | 2017-2018 | 16,720 | 15,245.00 | 8554.00 | 61% |
| 17 | 2018-2019 | 21,231 | 17,890.00 | 8455.69 | 58% |
| 18 | 2019-2020 | 21,305 | 17,705.00 | 9294.52 | 64% |
| 19 | 2020-2021 | 17,917 | 17,917.00 | 8963.21 | 60% |

**Source:** Ministry of Finance. (n.d.). *Union Budget* (Government of India) [dataset]. indiabudget.gov.in

**Note:** It is important to note that the ICDS scheme is implemented at both the Central and State levels. While the Union Budget provides the overall funding, the actual implementation and resource allocation can vary across different states based on their priorities and needs.

In the present scenario in India, the government is emphasizing its inclusive development policy namely *"Sabka Sath, Sabka Vikas"* which means the development of all. In this context, the Indian Parliament has also taken a special interest in improving the financial allocation of the ICDS scheme in the XII Five Year Plan and thereafter continued in NITI Aayog.

### 2.3.4 Resource Allocation to ICDS

Resource allocation within the ICDS programme is typically done based on the needs and priorities of different regions and communities. Here are some key aspects of resource allocation:

1. **Targeted Approach:** Resources are allocated based on the identification of high-need areas and vulnerable populations. For example, greater resources might be allocated to regions with higher levels of malnutrition or areas with limited access to basic healthcare services.
2. **Human Resources:** Adequate allocation of skilled human resources, such as Anganwadi workers and supervisors, is crucial for the effective

implementation of the ICDS scheme. Government allocate resources to recruit, train, and deploy these workers in different regions.

3. **Infrastructure Development:** Resources are allocated towards improving the infrastructure of Anganwadi centers, which are the primary service delivery points under the ICDS scheme. This may include constructing new centers, renovating existing facilities, and providing necessary equipment and supplies.
4. **Supplementary Nutrition:** A significant portion of the resources is allocated towards providing supplementary nutrition to children and pregnant/lactating women. This includes the provision of food items like cereals, pulses, oil, and local food options based on regional dietary preferences.

Overall, financing and resource allocation to ICDS involves a combination of government budget allocations, external assistance, public-private partnerships, and targeted approaches to address the specific needs of the scheme. The aim is to ensure adequate funding and resources to promote the well-being and development of young children and women in India.

## 2.4 Growth of ICDS under Five Year Plans and NITI Aayog

The provisions for the welfare of children in the Five-Year plan prioritize the overall development and well-being of children. The plan focuses on various aspects such as healthcare, nutrition, education and social protection. One significant contribution of Five-year plan to the welfare of children is the Integrated Child Development Services (ICDS) scheme. Following timeline gives details of provisions made for the welfare of children in Five-year plan that laid to the foundation of Integrated Child Development Services programme. The following timeline is compiled by the researcher by referring to sources, namely, (MWCD, 2007) (Planning Commission of India, n.d.) (NITI Aayog, n.d.).

**(i) Timeline of Five-Year Plans and Growth of ICDS**

**a. The First Five Year Plan (1951-1956)**

- The First Five-year plan focused on the expansion of primary education, including the establishment of new schools and improvements in the quality of education. It emphasized the importance of universal education and improving access to education for children.
- It focused on the rehabilitation and resettlement of children affected by the partition of India.
- To cater to the welfare needs of women and children including physically and mentally disabled children, for the first time the government introduced a comprehensive Social Welfare Programme by setting Central Social Welfare Board (CSWB) in 1953.
- In 1955, the Ministry of Education establish a National Advisory Council for the education of handicapped children. This council advised the government regarding the education, training, and employment of physically and mentally challenged children.

**Provisions for ICDS:** The ICDS scheme was not introduced during this plan.

**b. The Second Five Year Plan (1956-1961)**

- The Second Five-year plan continued the focus on expanding primary education. Efforts were made to increase enrollment in schools and improve teacher training programmes to enhance the quality of education.
- It introduced Integrated Child Welfare Services (ICWS) to address the health, nutrition, and development needs of children.
- The government also emphasized on setting the maternity and Child Health services centers.

- Another milestone in this annual plan was the formation of the National Council for Education Research and Training (NCERT) in 1961 to cater to the needs of preprimary and primary education.

**Provisions for ICDS:** The ICDS scheme was not introduced during this plan.

**c. The Third Five Year Plan (1961-1966)**

- Under the third plan, many primary schools were started in rural areas and emphasized improvement in the services of existing *Balwadis,* and provided training for *Balsevikas* to strengthen elementary education.
- The Indian Association for Preschool Education (IAPE) was formed in 1964 in the interest of early childhood education.

**Provisions for ICDS:** The ICDS scheme was not introduced during this plan.

**d. Plan Holidays (1966-1969)**

- Due to the miserable failure of the Third plan due to drought and other reasons, the government declared "plan holidays" from 1966 to 1967, 1967 to 1968, and 1968 to 1969.
- During this annual plan in 1966, recommendations were given by the Education commission to strengthen preschool education.

**Provisions for ICDS:** The ICDS scheme was not introduced during this plan.

**e. The Fourth Five Year Plan (1969-1974)**

- The fourth plan emphasized achieving the initiatives taken in the previous plans by opening *Balwadis* in both rural and urban areas, training teachers of *Balwadis*, providing necessary guides and materials,

and teaching techniques. It started Nutrition Programme through *Balwadis*.

- It has also taken initiatives to strengthen the activities of the Central Social Welfare Board and setting up primary health centers in each community development block.

**Provisions for ICDS:** The ICDS scheme was not introduced during this plan.

**f. The Fifth Five Year Plan (1974- 1979)**

- The fifth plan took a significant shift from Child Welfare Programmes to Child Development Programmes with broader perspectives.
- The Plan focused beyond the basic care by expanding and consolidating maternal and child health services, immunization, family planning, and nutrition services.
- It adopted a National Policy for Children in 1974 which included rural, urban, and tribal areas children.
- During this plan ICDS was launched in 1975 on experimental phase in 33 Community Development Blocks of 22 States.

**Provisions for ICDS:** The plan focused on providing supplementary nutrition for children and healthcare services.

**g. The Sixth Five Year Plan (1980-1985)**

- The Sixth five-year plan, adopted by the National Policy of Health in 1983 emphasized to provide access to primary healthcare for all citizens and reducing infant and child mortality rate and immunization to all by 2000.
- It adopted Early Childhood Education (ECE) under the central sector scheme, especially for girls and disadvantaged children.

**Provisions for ICDS:** The plan aimed to expand the ICDS services and cover additional 5% of the total population.

### h. The Seventh Five Year Plan (1985-90)

- The seventh five-year plan continued to support the activities of Early Childhood Education (ECE). One such initiative supporting ECE is the formation of the National Policy on Education in 1986.
- The other focus on reducing infant mortality rates, improving healthcare services, enhancing the nutritional status of children, strengthening immunization programmes, promoting education for girls, and protecting children from exploitation.

**Provision for ICDS:** The ICDS scheme continued to expand during this plan period with an emphasis on increasing the coverage of services. It sought to reach 10% of the population in terms of coverage and address regional disparities. Pre-school and supplementary nutrition needs were promoted.

### i. The Eighth Five Year Plan (1992-1997)

- The eighth plan emphasized welfare programmes for the early development of children, especially for the development of Scheduled Tribe and Scheduled Caste children and drought-prone and urban areas.
- It aimed to reduce child mortality, improve child nutrition, promote primary education, combat child labour, and enhance the welfare and protection of children.
- Established District Primary Education Programmes (DPEP) in 1994 aimed at revitalizing primary education and achieving universalization of primary education in India.

- In 1995, Mid-day Meal Scheme (MDMS) under the National Programme of Nutritional Support launched in India.

**Provisions for ICDS:** The ICDS scheme underwent further expansion in terms of coverage and quality. The focus was on improving the delivery of services, establishing additional anganwadi centres, and enhancing the training of anganwadi workers.

**j. The Ninth Five Year Plan (1997-2002)**

- Early Childhood Education (ECE) was continued along with promoting other existing programmes such as reducing child mortality, improving access to quality education, ensuring safe drinking water and sanitation, eliminating child labour, and empowering children through various interventions.
- The Ninth Plan emphasized on universalization of ICDS by promoting the overall development of the young children especially the Girl Child and the mothers all over the country without any discrimination.
- The Sarva Shiksha Abhiyan (SSA) launched in 2001 under the 86$^{th}$ Constitutional Amendment emphasizing on universal education.

**Provisions for ICDS:** During this plan, the ICDS scheme continued to expand, aiming to reach 33% of children in the age group of 0-6 years. The focus was on improving the quality of services, monitoring child growth, and strengthening local governance structures.

**k. The Tenth Five Year Plan (2002-2007)**

- The tenth five years strengthened existing Early Childhood Education (ECE) and laid emphasis on Universalization of Elementary Education on five parameters those are Universal Access, Universal Enrollment, Universal Retention, Universal Achievement, and Universal Equity.

- The major schemes of elementary education during the Tenth Five Year Plan was Kasturba Gandhi BalikaVidyalaya Scheme (KGBVS) in 2004.

**Provisions for ICDS:** The ICDS scheme experienced further expansion, focusing on increasing the number of anganwadi centers, enhancing the quality of services, and improving the nutritional status of beneficiaries.

**l. The Eleventh Five year Plan (2007-2012)**

- It focused on the convergence of formal and non-formal education. Universal enrolment of 6-14 age group children. One year of pre-school education (PSE) for children entering primary school. More emphasizes led on the universalization of Mid-Day Meal Scheme (MDMS) at the elementary level by 2008-09.
- It also focus on gender equality, and providing essential healthcare services to children.

**Provisions for ICDS:** Efforts were made to strengthen the ICDS scheme further, including increasing the number of anganwadi centers, improving infrastructure, enhancing monitoring systems, and expanding the coverage of services.

**m. The Twelfth Five Year Plan (2012-2017)**

- It emphasized on reduction of malnutrition through the National Nutrition Mission, providing elementary education among children aged 0-3 years and 0-6 years subsequently strengthening ICDS.

**Provisions for ICDS:** The ICDS scheme continued to expand, with a focus on strengthening its delivery mechanisms, improving the nutritional support system, enhancing the quality of pre-school education, and ensuring effective monitoring and evaluation.

**n. National Institute of Transforming India (NITI) Aayog**

The twelfth Five-year plan is considered as the last five-year plan under Planning Commission. The Government of India under its economic planning process replaced Planning Commission of India to National Institute of Transforming India (NITI) Aayog. Under NITI Aayog ICDS witnessed its structural changes. In 2017 ICDS scheme renamed as "Umbrella ICDS" by integrating schemes such as ICDS, SABLA, Integrated Child Protection Services, Rajiv Gandhi National Creche Scheme. Further in fiscal year 2017-2018, Umbrella ICDS was integrated to National Nutrition Mission (Poshan Abhiyan) and Pradhan Mantri Matru Vandana Yojana. In the Budget Speech of Finance Minister of India in 2022-23, Smt. Nirmala Sitaraman announced to continue Umbrella ICDS in the programme POSHAN 2.0 and setting up of 2 lakh digitized anganwadi across India.

## 2.5 Constitutional Provisions and Legislative Framework supports ICDS

The Integrated Child Development Services (ICDS) scheme in India is supported by both Constitutional provisions and legislative frameworks that provide the legal framework for its implementation. The key Constitutional provisions and legislative acts that support ICDS are given below.

**(i) Constitutional Provisions and Legislative Framework support ICDS**

**a. Constitutional Provisions:**

i. **Article 15 (3):** This provision of the Indian Constitution allows for the state to make special provisions for the welfare of children and women.

ii. **Article 45:** It makes state responsible for providing free and compulsory education for children up to the age of 14 years, and provision for childhood care and education for children under the age of 6 years.

iii. **Article 21 A:** It makes elementary education a fundamental right of all children between the age group of 6-14 years.

iv. **Article 39 (f) and (g):** The State must provide children with opportunities and facilities to develop in a healthy manner and should be protected against exploitation.

**b. Legislative Framework:**

i. **The Maternity Benefit Act, 1961:** This act provides for maternity benefits to women, including provisions for paid leave and the provisions of nutrition during pregnancy and lactation, which aligns with the objectives of ICDS.

ii. **National Policy on Children, 1974:** This policy consider the children of nation as a "Supremely Important Asset". This act provides a legal foundation for the implementation of the ICDS scheme. It outlines the objectives, structure, and responsibilities of the ICDS scheme, including the establishment of anganwadi centers, the appointment and training of workers, and the provision of various services for holistic child development.

iii. **The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994:** This act aims to ban the use of pre-natal diagnostic techniques for the purpose of sex determination leading to female feticide. It protects the rights of the girl child and supports the objectives of ICDS in addressing gender-based discrimination.

iv. **Right to Education (RTE) Act, 2009:** The RTE Act makes education a fundamental right for children aged 6-14 years and lays down provisions for the quality and accessibility of education, including provisions for early childhood education and care.

v. **Protection of Children from Sexual Offences (POCSO) Act, 2012:** The POCSO Act is a comprehensive legislation aimed at protecting children against sexual offenses. It provides mechanisms for reporting, investigation, prosecution, and rehabilitation of child victims of sexual abuse.

vi. **National Food Security Act (NFSA), 2013:** The NFSA provides a legal framework for the provision of subsidized food grains that provide nutritional support to pregnant women, lactating mothers, and children. It recognizes the role of ICDS in delivering these entitlements.

vii. **Juvenile Justice (Care and Protection of Children) Act, 2015**: This act provides for the care, protection, and rehabilitation of children in need of care and protection, including provisions for the protection of child victims and measures for their social reintegration.

**Source**: Compiled By Researcher

These constitutional provisions and legislative frameworks provide the legal basis for the ICDS scheme and its components, ensuring the rights and welfare of children in terms of health, nutrition, early childhood education, and protection. It is important to adhere to these provisions to ensure the effective implementation and functioning of ICDS in India.

## 2.6 Supreme Court orders and guidelines to ICDS

The Supreme Court of India has issued several orders and guidelines related to the implementation and functioning of the Integrated Child Development Services (ICDS) scheme. These orders and guidelines aim to address various issues and challenges pertaining to ICDS and ensure its effective implementation. Some of the notable Supreme Court orders and guidelines on ICDS are as follows.

**a. Supreme Court orders and guidelines related to ICDS**

1. In 2001, People's Union for Civil Liberties (PUCL) vs. Union of India was a Public Interest Litigation (PIL) that established the right to food as a fundamental right in the Indian Constitution. The Supreme Court ordered implementation of famine code, food schemes and midday meals in schools and also emphasized the need to improve the effectiveness of the ICDS scheme and directed the central and state governments to implement various reforms, including in relation to the provision of supplementary nutrition, monitoring, and transparency. The Court held that providing adequate nutritional support to children and pregnant and lactating mothers is a fundamental right under the Constitution of India.
2. In 2008, the Supreme Court directed all states and Union Territories to fully implement the ICDS scheme and provide necessary infrastructure, funds, and other resources to ensure its effective functioning. It directed the Anganwadi Centers to follow the nutritional norms approved that is children under 6 years of age: 300 calories and 8-10 grams of protein; Adolescent girls: 500 calories and 20-25 grams of protein; Pregnant women and nursing mothers: 500 calories and 20-25 grams of protein; Malnourished children: 600 calories and 16-20 grams of protein.
3. In 2015, in Mid-Day Meal Scheme, although not specifically related to ICDS, the Supreme Court has recognized the vital importance of the Mid-Day Meal Scheme for children's nutrition and directed the government to establish the scheme in all primary schools and schools up to VII standard across the country.
4. In 2018, the Supreme Court directed all states and Union Territories to ensure the proper implementation of the Supreme Court's earlier orders regarding ICDS, including the appointment of anganwadi workers and helpers, regular payment of their wages, and timely distribution of supplementary nutrition to children and pregnant women.

## 2.7 Beneficiaries Coverage and Geographical reach of ICDS

The Integrated Child Development Services (ICDS) is a flagship programme of the Government of India aimed at the holistic development of children under the age of six and pregnant and lactating mothers. Since its inception in 1975, the ICDS scheme has undergone various expansions and improvements to enhance its coverage and reach.

### 2.7.1 Beneficiaries Coverage

Initially, the ICDS scheme targeted only children under the age of six. However, in its later phase with the increasing scope it expanded to include pregnant women, lactating mothers, and adolescent girls through additional initiatives such as the Pradhan Mantri Matru Vandana Yojana (PMMVY) and the SABLA scheme.

Table 2.4: Present Status of the number of operational projects/AWCs/Nutrition & Education Beneficiaries

| **Year Ending** | **No. of Operational Projects** | **No. of Operational AWCs** | **No. of Supplementary Nutrition Beneficiaries** | **No. of Pre-school Education Beneficiaries** |
|---|---|---|---|---|
| **The Tenth Five Year Plan (2002-2007)** | | | | |
| 31.03.2002 | 4608 | 545714 | 375.10 | 166.56 |
| 31.03.2003 | 4903 | 600391 | 387.84 | 188.02 |
| 31.03.2004 | 5267 | 649307 | 415.08 | 204.38 |
| 31.03.2005 | 5422 | 706872 | 484.42 | 218.41 |
| 31.03.2006 | 5659 | 748229 | 562.18 | 244.92 |
| 31.03.2007 | 5829 | 844743 | 705.43 | 300.81 |
| **The Eleventh Five year Plan (2007-2012)** | | | | |
| 31.03.2008 | 6070 | 10,13,337 | 843.26 lakh | 339.11 lakh |
| 31.03.2009 | 6120 | 10,44,269 | 873.403 lakh | 340.60 lakh |

| | | | | |
|---|---|---|---|---|
| 31.03.2010 | 6509 | 11,42,029 | 884.34 lakh | 354.93 lakh |
| 31.03.2011 | 6722 | 12,62,267 | 959.47 lakh | 366.23 lakh |
| 31.03.2012 | 6908 | 13,04,611 | 972.49 lakh | 358.22 lakh |
| **The Twelfth Five year Plan (2013-2017)** | | | | |
| 31.03.2013 | 7025 | 13,38,732 | 956.12 lakh | 353.29 lakh |
| 31.03.2014 | 7067 | 13,42,146 | 1045.09 lakh | 370.71 lakh |
| 31.03.2015 | 7072 | 13,46,186 | 1022.33 lakh | 365.44 lakh |
| 31.03.2016 | 7073 | 13,49,563 | 1021.31 lakh | 350.35 lakh |
| 31.03.2017 | 7074 | 13,54,792 | 983.42 lakh | 340.52 lakh |
| **The Five year Plan under NITI Aayog (2017-2022)** | | | | |
| 31.03.2018 | 7075 | 13,83,732 | 956.12 lakh | 353.29 lakh |
| 31.03.2019 | 7075 | 13,84,109 | 957.20 lakh | 356.45 lakh |
| 31.03.2020 | 7075 | 13,86,204 | 830.20 lakh | 348.42 lakh |
| 31.03.2021 | 7075 | 13,87,432 | 831.80 lakh | 346.20 lakh |
| 31.03.2022 | 7075 | 13,88,321 | 850.36 lakh | 350.09 lakh |

**Source:** MWCD. (2023). *Press Information Bureau*. https://pib.gov.in/PressReleasePage.aspx?PRID=1910409

### 2.7.2 Geographical Reach of ICDS

The ICDS scheme has gradually expanded its geographical coverage. It started as a pilot project in 33 blocks in 1975 and later expanded to cover all states and union territories of India. Today, there are over 1.4 million Anganwadi centers spread across rural and urban areas, ensuring accessibility to remote and underprivileged communities.

Table 2.5 reveals the revised norms for the opening of AWC as per the eleventh five-year plan. The table 2.5 shows that revised norms increased the number of AWCs operating covering the maximum part of India. Presently by 31$^{st}$ March 2021 out of 1399697 sanctioned Anganwadi, 1387432 are operational. The highest Anganwadi

operational by March 2022 are in Uttar Pradesh with the number of AWCs are 189309 (Ministry of Women and Child Development, 2021).

Table 2.5: Population Norms under the ICDS scheme to set up AWCs

(Since February 2009)

**Population Norms under ICDS**

**For AWCs in Rural/Urban Projects**

- 1 AWC- Population size between 400-800.
- 2 AWCs- Population size between 800-1600.
- 3 AWCs- Population size between 1600-2400.

Thereafter in multiple of 800 1 AWC

**For Mini-AWC**

- 1 Mini-AWC Population size between 150-400.

**For Tribal/Riverside/Desert, Hilly and other difficult areas/Projects**

- 1 AWC- Population size is 300-800.

**Anganwadi on Demand (AOD)**

Where a settlement has at least 40 children under 6 years of age but no AWC.

**Source**: MWCD. (2015). *Integrated Child Development Services—ICDS Scheme | Ministry of Women & Child Development|IN|yhqcy*. https://wcd.nic.in/integrated-child-development-services-icds-scheme

ICDS is a flagship scheme of the Government of India which mainly promotes good health and well-being, gender equality, and quality education at the elementary level. ICDS succeeded in reaching every corner of India catering to the needs of children and their mothers by providing its services through its two components namely, Supplementary Nutrition Programme (SNP) and Pre-School Education (PSE). ICDS which was started with selected 33 Community development blocks in 1975 reached to 7075 blocks in 2022. The following figure 2.1 shows the number of community development blocks since the inception of ICDS.

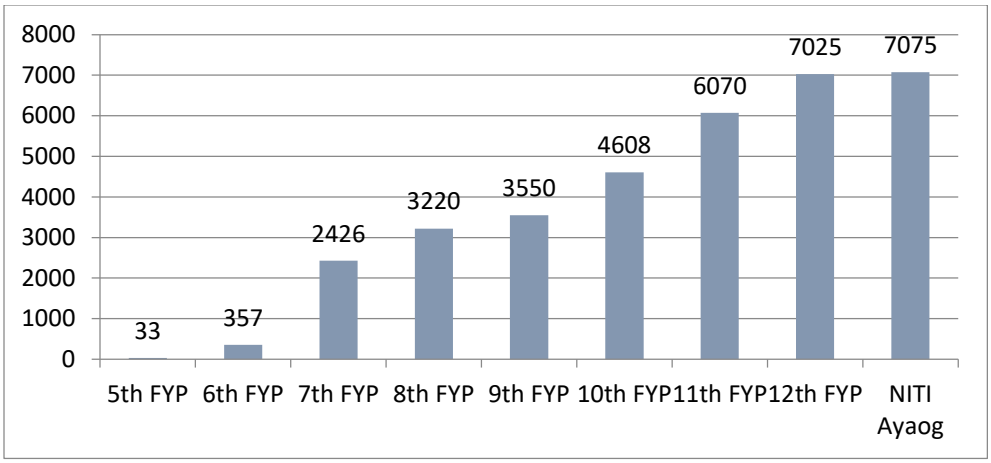



Figure 2.1: Number of blocks covered by ICDS from Fifth Five-Year Plan to NITI Aayog (1975-2021)

**Source:** Compiled by Author

The figure 2.1 reveals that ICDS started in 1975 and was implemented in 33 development blocks leading to expansion by 1980 in 150 community blocks. After fifteen years of its inception, the scheme expanded to 2499 by March 1991. The scheme was revised in the Tenth Five-year plan and the ICDS blocks increased to 4608 in 2002. The scheme became more prominent in the Eleventh Five-Year Plan due to its inclusive policy and revised norms. The number of Anganwadi centers increased by 73% is 6070 since 2005-06. Presently by 31$^{st}$ March 2021, there are around 7075 development blocks.

### 2.7.3 Service Delivery

The scheme has evolved from providing supplementary nutrition to children to offering a comprehensive package of services. These services include immunization, health check-ups, referral services, pre-school education, and nutrition counseling. The focus has shifted from purely nutrition-based interventions to a more holistic approach encompassing health, nutrition, and education.

The percentage of budget allocation to ICDS is increased every year as per table 2.3 ICDS is a universal scheme that includes all children below 6 years of age, their lactating mothers, and pregnant women without any discrimination. The scheme has no financial bar as it is made for both Below Poverty Line (BPL) and Above Poverty Line (APL) category of the population. In order to make this scheme more beneficial, the norms in ICDS were been revised and endorsed by the Supreme Court of India order dated 22nd April 2009. Following table 2.6 shows the revised nutritional norms of ICDS since February 2009.

Table 2.6: Implemented and Managed Nutritional Norms in ICDS (Since February 2009)

| Beneficiaries | Calories | Protein (g) |
|---|---|---|
| Children (6 months to 72 months) | 500 | 12-15 |
| Severely malnourished Children (SAM) (6 months- 72 months) | 800 | 20-25 |
| Pregnant women & Lactating mothers | 600 | 18-20 |

**Source:** MWCD. (2007). *ICDS and nutrition in the eleventh five year plan (2007-2012) | Source*. https://asksource.info/resources/icds-and-nutrition-eleventh-five-year-plan-2007-2012

## 2.8 Convergence with other Government Schemes

The ICDS Programme has been integrated with various other government schemes to improve its effectiveness and efficiency. It collaborates with the National Health Mission (NHM) for health-related services, the Ministry of Human Resource Development for preschool education, and the Ministry of Women and Child Development for supplementary nutrition and overall monitoring and coordination.

## 2.9 Technological Innovations

To enhance the coverage and effectiveness of ICDS, the scheme has adopted various technological interventions. These include the digitization of beneficiary data and monitoring systems, the use of mobile applications for real-time reporting of health and nutrition data, and the introduction of Aadhaar-enabled direct benefit transfers to ensure efficient delivery of benefits.

## 2.10 Strengthening of Infrastructure and Human Resources

The expansion and coverage of ICDS have significantly contributed to improving the overall well-being and early development of children and mothers in India. The ICDS scheme has made efforts to strengthen its infrastructure and human resources. This includes the construction of new Anganwadi centers under the Corporate Social Responsibility (CSR), provision of necessary equipment and supplies, recruitment and training of Anganwadi workers and supervisors, and capacity-building programmes for better scheme implementation. However, challenges remain, such as improving the infrastructure, quality of services, removing barriers to access, and addressing regional disparities to ensure that every child and mother benefits from the programme's interventions.

To sum up chapter two, the Integrated Child Development Services (ICDS) scheme is a significant policy of the government that addresses the nutritional and early development needs of children and women. Overall, the ICDS scheme has a major impact on child development, as some studies identified a gain in growth and nutrition outcomes of children, increased access to healthcare services, improved cognitive abilities, and higher preparedness for school. By raising awareness of social and health concerns, it has also helped to empower women.

However, there are still areas that require attention and improvement. Inadequate finance, service quality and accessibility, enhancing human and material resources, and poor monitoring and evaluation systems are some of the major obstacles. These areas need to be addressed to ensure the effectiveness and sustainability of the ICDS programme. Furthermore, it is important to recognize that the ICDS programme alone cannot fully address the underlying systemic issues related to poverty, unequal distribution of resources, and social inequalities. Hence, a comprehensive approach that integrates the ICDS scheme with other policies and interventions in areas such as healthcare, education, and poverty alleviation is essential for sustainable development and well-being of children.

Overall, the ICDS scheme has been instrumental in providing vital services and support to children and their families, especially those from marginalized and disadvantaged backgrounds. By continuing to address its limitations, scaling up its impact, and ensuring the equitable delivery of services, the ICDS scheme can play a crucial role in improving the welfare and future prospects of the country's children.

As this study focuses on Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa, the subsequent chapter is on ICDS Scheme in Goa: A Focus on Tribal Community.

# Chapter 3

# ICDS Scheme in Goa: A Focus on Tribal Community

## 3.1 Nutritional Challenges and ICDS Interventions for Tribal Communities

Integrated Child Development Services (ICDS) scheme is a government scheme aimed at improving the nutritional and health status of children under six years of age and the overall development of children and pregnant women. This scheme is particularly important to women and children of marginalized sections of society. Although Goa is considered the most modern and developed State of India there are marginalized sections of society particularly Scheduled Tribes who are settled in some remote and hilly areas facing specific challenges and vulnerabilities. However, this research is limited to evaluating the ICDS scheme in South Goa. The census data 2011 shows majority tribal population lives in South Goa.

Tribal communities often reside in remote and hilly areas where they face the issue of poor accessibility and scarcity of resources. Due to lack of social and health education they suffer. ICDS plays an important role in remote areas to address these issues by mobilizing especially women of the locality and empower them on social and health issues benefitting entire community.

The six services provided by ICDS include supplementary nutrition, immunization, health check-ups, referral services, preschool education, and nutrition and health education for mothers of children under age six years. The supplementary nutrition component ensures that children, lactating mothers, and pregnant women

receive adequate and proper nutrition through the provision of hot cooked meals, take-home rations, and nutrient-packed foods while pre-school component ensuring cognitive development of children through its non-formal education. Additionally, it empower women by providing social, health and nutrition education.

The study of ICDS in tribal areas is important as it requires special attention in order to improve the health status of tribal women and their children. The National Family Health Survey: NFHS 4 and NFHS 5 identify the anemia among the tribal women and their children is high. In India the tribal population is around 104,000,000 out of which 90% lives in rural areas of the country. The serious issue among tribal women is that 68.5% women suffering from anemia and 47% households are under Below Poverty Line (BPL).

According to a report by the Programme Evaluation Organisation (PEO) of Planning Commission, the performance of ICDS in Goa was mixed in terms of coverage, quality and efficiency (Planning Commission of India, 2011). Some of the findings of the report were:

- The coverage of children aged 0-6 years by ICDS was 76.5% in Goa, which was higher than the national average of 54.6%.
- The quality of supplementary nutrition provided by ICDS was poor in Goa, as only 38.8% of the beneficiaries received adequate quantity and quality of food, compared to the national average of 51.9%.
- The efficiency of service delivery by ICDS was low in Goa, as only 28.6% of the Anganwadi Centers had adequate infrastructure and facilities, compared to the national average of 40.4%.

Table 3.1 gives the details of anemia among tribal women and children in India and Goa.

Table 3.1: Anemia among Tribal Women and Children in India and Goa

| **Anemia Prevalence (NFHS4 and NFHS-5 )** | | | | |
|---|---|---|---|---|
| **State/UT** | **India** | | **Goa** | |
| | **NFHS 4** | **NFHS 5** | **NFHS 4** | **NFHS 5** |
| Children age 6-59 months who are anaemic (<11.0 g/dl) (%) | 58.6 | 67.1 | 48.3 | 53.2 |
| Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%) | 53.2 | 57.2 | 31.4 | 38.9 |
| Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%) | 50.4 | 52.2 | 26.7 | 41 |
| All women age 15-49 years who are anaemic (%) | 26.7 | 57 | 31.3 | 39 |
| Adolescent girls age 15-19 years who are anaemic (%) | 54.1 | 59.1 | 30.5 | 44.5 |
| Adolescent boysage 15-19 years who are anaemic (<13.0 g/dl) (%) | 29.2 | 31.1 | 6.6 | 15.8 |

**Source:** (Ministry of Health and Family Welfare, 2022)**.** (2022). *Anaemia Mukt Bharat* [dataset]. https://pib.gov.in/PressReleasePage.aspx?PRID=1795421

As this study revolves around the impact of ICDS on tribal community, it is essential to understand the meaning of the tribe as well as the Indian tribe and the tribes in Goa. This will help to evaluate the ICDS programme against the needs and expectations of the tribal community.

## 3.2 Meaning of Tribe

The word “tribe” is derived from the Latin word “Tribus” and it has varied definitions. Definitions on tribes as compiled in the study of Dr. B. R. Prasad Reddy (2021) is as follows.

Oxford Dictionary defines a tribe as “a group of people in a primitive or barbarous state of development acknowledging the authority of a chief and usually regarding themselves as having a common ancestor”. According to D. N. Majumdar tribe is “a social group with territorial affiliation, endogamous with no specialization of functions ruled by tribal officers hereditary or otherwise, united in language or dialect recognizing social distance with other tribes or castes”. R. N. Mukherjee defines it “tribe as that human group, whose members have a common interest, territory, language, social law, and economic occupation” (Prasad Reddy, 2021).

## 3.3 The Diverse Tribal Communities of India and Goa

India is home to a significant tribal population with various tribes spread across different regions of the country. The study of (Singh, 1994) has mentioned more than four hundred different tribal communities in India and after Africa, India has the second largest tribal population in the world (Singh, 1994). According to the 2011 Census of India, the Scheduled Tribes (STs) make up around 8.6% of the country's total population. This accounts for approximately 104 million people. According to Census 2011, Madhya Pradesh is recorded with the highest tribal population in India with around 16 million tribal people. There are many other States known for their major significant tribal population to name them, Maharashtra, Jharkhand, Odisha, Rajasthan, Chhattisgarh, Andhra Pradesh, Gujarat, West Bengal, Tamil Nadu, Karnataka, and Assam. Each of these tribes has its unique culture, traditions, and beliefs.

Goa the 25$^{th}$ State of India is located in western India and is also home to several tribal communities. These tribal communities have a rich cultural heritage, distinct languages, and unique traditions and are considered the original settlers or the first

inhabitants of Goa (Gawas & Velip, 2015). The total Scheduled Tribes population of Goa in accordance with Census 2011 is as follows in table no 3.2.

Table No 3.2: Total Scheduled Tribes Population of Goa (Census 2011)

| ST Name | R/U/T | Total Population | | |
|---|---|---|---|---|
| | | P | M | F |
| Dhodia | Rural | 79 | 40 | 39 |
| Dhodia | Urban | 194 | 113 | 81 |
| Dhodia | Total | 273 | 153 | 120 |
| Dubla (Halpati) | Rural | 0 | 0 | 0 |
| Dubla (Halpati) | Urban | 74 | 37 | 37 |
| Dubla (Halpati) | Total | 74 | 37 | 37 |
| Naikda (Talavia) | Rural | 140 | 78 | 62 |
| Naikda (Talavia) | Urban | 242 | 123 | 119 |
| Naikda(Talavia) | Total | 382 | 201 | 181 |
| Siddi (Nayaka) | Rural | 68 | 32 | 36 |
| Siddi (Nayaka) | Urban | 115 | 60 | 55 |
| Siddi (Nayaka) | Total | 183 | 92 | 91 |
| Varli | Rural | 35 | 22 | 13 |
| Varli | Urban | 83 | 51 | 32 |
| Varli | Total | 118 | 73 | 45 |
| Kunbi | Rural | 2,759 | 1,348 | 1,411 |
| Kunbi | Urban | 1,727 | 841 | 886 |
| Kunbi | Total | 4,486 | 2,189 | 2,297 |
| Gawda | Rural | 50,919 | 24,476 | 26,443 |
| Gawda | Urban | 55,740 | 26,720 | 29,020 |
| Gawda | Total | 106,659 | 51,196 | 55,463 |
| Velip | Rural | 30,694 | 15,802 | 14,892 |
| Velip | Urban | 1,338 | 679 | 659 |
| Velip | Total | 32,032 | 16,481 | 15,551 |
| All Schedule Tribes | Rural | 87,639 | 43,263 | 44,376 |

ST= Scheduled Tribe, R=Rural, U=Urban, T=Total, P=Population, M=Male, F=Female

| | | | | |
|---|---|---|---|---|
| All Schedule Tribes | Urban | 61,636 | 29,685 | 31,951 |
| All Schedule Tribes | Total | 149,275 | 72,948 | 76,327 |

**Source:** Office of the Registrar General & Census Commissioner, India. (2011). *Population Census 2011*. Table A-11 Appendix: District wise scheduled tribe population.

The Census of India, 2011 reveals the Scheduled Tribes population of Goa as 1, 49,275 which is 10.2% of the State population. Out of the total population 87,639 lives in rural areas and 61,636 lives in urban areas. Table 3.2 gives the details of the Scheduled Tribes population in Goa which shows that the notified Scheduled Tribes of Goa are Dhodia, Dubla (Halpati), Naikda (Talavia), Siddi (Nayaka), Varli, Kunbi, Gawda, and Velip. However, the Velips, Kunbis, and Gawdas were notified as the Scheduled Tribe communities of Goa by the President of India in 2003, before that they were listed in the Other Backward Classes (Velip, 2020).

As per the Census 2011 record, among the Scheduled Tribes communities of Goa; Gawda, Velip, and Kunbi are majority in number as compared to other tribes. The highest Scheduled Tribe community of Goa is Gawda, followed by Velip and Kunbi respectfully. Goa is having two districts i.e. North Goa and South Goa. Table 3.3 gives the details of district wise Scheduled Tribes population of Goa.

Table 3.3: District wise Scheduled Tribes Population of Goa (Census 2011)

| **ST Name** | **T R U** | **Total Population** | | | **ST Name** | **T/ R/ U** | **Total Population** | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **P** | **M** | **F** | | | **P** | **M** | **F** |
| **North Goa** | | | | | **South Goa** | | | | |
| Dhodia | R | 41 | 24 | 17 | Dhodia | R | 38 | 16 | 22 |
| Dhodia | U | 72 | 44 | 28 | Dhodia | U | 122 | 69 | 53 |
| Dhodia | T | 113 | 68 | 45 | Dhodia | T | 160 | 85 | 75 |
| Dubla (Halpati) | R | 0 | 0 | 0 | Dubla (Halpati) | R | 0 | 0 | 0 |
| Dubla (Halpati) | U | 23 | 12 | 11 | Dubla (Halpati) | U | 51 | 25 | 26 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Dubla (Halpati) | T | 23 | 12 | 11 | Dubla (Halpati) | T | 51 | 25 | 26 |
| Naikda (Talavia) | R | 45 | 17 | 28 | Naikda (Talavia) | R | 95 | 61 | 34 |
| Naikda (Talavia) | U | 105 | 55 | 50 | Naikda (Talavia) | U | 137 | 68 | 6 |
| Naikda (Talavia) | T | 150 | 72 | 78 | Naikda (Talavia) | T | 232 | 129 | 103 |
| Siddi (Nayaka) | R | 25 | 10 | 15 | Siddi (Nayaka) | R | 43 | 22 | 21 |
| Siddi (Nayaka) | U | 80 | 41 | 39 | Siddi (Nayaka) | U | 35 | 19 | 16 |
| Siddi (Nayaka) | T | 105 | 51 | 54 | Siddi (Nayaka) | T | 78 | 41 | 37 |
| Varli | R | 0 | 0 | 0 | Varli | R | 35 | 22 | 13 |
| Varli | U | 33 | 20 | 13 | Varli | U | 50 | 31 | 19 |
| Varli | T | 33 | 20 | 13 | Varli | T | 85 | 53 | 32 |
| Kunbi | R | 93 | 43 | 50 | Kunbi | R | 2,666 | 1,305 | 1,361 |
| Kunbi | U | 115 | 63 | 52 | Kunbi | U | 1,612 | 778 | 834 |
| Kunbi | T | 208 | 106 | 102 | Kunbi | T | 4,278 | 2,083 | 2,195 |
| Gawda | R | 5,036 | 12,294 | 12,742 | Gawda | R | 25,883 | 12,182 | 13,701 |
| Gawda | U | 27,087 | 13,294 | 13,793 | Gawda | U | 28,653 | 13,426 | 15,227 |
| Gawda | T | 52,123 | 25,588 | 26,535 | Gawda | T | 54,536 | 25,608 | 28,928 |
| Velip | R | 522 | 253 | 269 | Velip | R | 30,172 | 15,549 | 14,623 |
| Velip | U | 53 | 23 | 30 | Velip | U | 1,285 | 656 | 629 |
| Velip | T | 575 | 276 | 299 | Velip | T | 31,457 | 16,205 | 15,252 |
| All STs | R | 27,694 | 13,600 | 14,094 | All STs | R | 59,945 | 29,663 | 30,282 |
| All STs | U | 28,912 | 14,224 | 14,688 | All ST | U | 32,724 | 15,461 | 17,263 |
| All STs | T | 56,606 | 27,824 | 28,782 | All STs | T | 92,669 | 45,124 | 47,545 |

ST= Scheduled Tribe, R=Rural, U=Urban, T=Total, P=Population, M=Male, F=Female

**Source:** (Office of the Registrar General & Census Commissioner, India, 2011). *Population Census 2011*. Table A-11 Appendix: District wise scheduled tribe population (Appendix).

According to Table No. 3.3, South Goa has more Scheduled Tribes population i.e. 92,669 as compared to North Goa which is 56,606. The highest population of Scheduled Tribes communities in South Goa is Gawda, Kunbi, and Velip and they are settled in South Goa talukas are Cancona, Sanguem, Quepem (Velip, 2016).

Tribes have a unique characteristic that they are more closely connected with nature (Singh, 2017). The unique characteristics of the most dominated tribes of Goa i.e. Gawdas, Velips, and Kunbis are explained below.

*Gawdas* are primarily involved in agriculture and are known for their use of organic farming techniques. They are known for their abundant knowledge of local flora and fauna, which they have used for generations in traditional medicine. Gawdas also have their distinct art forms and handicrafts.

*Velips* have a close association with the forests and are traditionally been involved in agriculture, hunting, and fishing. The Velip community also holds its cultural festivals, showcasing its music, dance, and art forms.

*Kunbis* are primarily engaged in agriculture and are known for their rich agricultural traditions. Kunbi women are known for their vibrant attire, which includes colorful sarees and traditional jewelry.

As Scheduled Tribes communities settled in remote and hilly regions of Goa, especially in South Goa which includes Sanguem, Cancona, and Quepem, accessibility became difficult and socio-economic vulnerability increased. The ICDS has played a significant role in the socio-economic development of this region. It would be interesting to study the historical background and evolution of ICDS in Goa with special reference to an overview of the selected area.

## 3.4 Nutritional Status of Tribal Community women and Children in India and Goa

The reports of World Health Organization (WHO) and United Nations (UN), 2016 raises the concern on tackling malnutrition worldwide as every third person suffers from one form of malnutrition or another. India also raises the concern of the nutritional status especially of tribal women. According to a report by UNICEF India, tribal children in India are the most undernourished segment of the society, with 4.7 million children suffering from chronic nutrition deprivation (Dutta & Sen, 2020).

A study by (Dutta & Sen, 2020) analyzed the nutritional status of Scheduled Tribe Indian women by states and several background characteristics. The study used data from the 4th round of National Family Health Survey (NFHS 4) conducted by the International Institute for Population Sciences, Mumbai (2015-2016). Body Mass Index (BMI) was computed and recoded according to the specification of the World Health Organization (WHO). Bivariate analysis and multinomial logistic regression were used to assess the effects of socio-economic characteristics. The overall prevalence of underweight among Schedule Tribe females is 31.7%, and the prevalence of overweight/obese is 10.1%. From the west region, most of the tribal women are found to be underweight. Scheduled Tribe women belonging to the urban area are found more prone to be overweight. The factors that are protective against being underweight are them being in older ages, having higher years of education, being married, and being from households of higher wealth index.

Another study checked the nutritional status of tribal farmer women in Gujarat. The study found that tribal farm women were coming from poor socio-economic backgrounds, most of them were illiterate, their income was less, and nutritional status was poor. Their average height, weight, and BMI were lower than the national average (H. Dave et al., 2019).

Table 3.4: Child Under-Nutrition Indicators

| Sr. No. | Child Under-nutrition Indicators (Children under 5 Years of Age) | NFHS III (2005-2006) | NHFS IV ( 2015-16) | NHFS V (2019-2021) |
|---|---|---|---|---|
| 1 | Stunted | 48.0% | 38.4% | 35.5% |
| 2 | Wasted | 19.8% | 21.0% | 19.3% |
| 3 | Underweight | 42.5% | 35.8% | 32.1% |

**Source:** (Ministry of Women and Child Development, 2022) Ministry of Women and Child Development. (2022). *Nutrition indicators for children under 5 years improve* [dataset]. https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1881513

In general, tribal populations in India report poorer health status and indicators compared to the general population. The tribal population in India is more vulnerable to malnutrition and related health problems under severe socio-economic stress (Dutta & Sen, 2020). Although the prevalence of underweight is higher among tribal women than the women from the general population, the majority of the study population are found to be of normal BMI (Dutta & Sen, 2020). In some of the states like Nagaland, Mizoram, and Manipur, the prevalence of overweight tribal women exceeds the number of underweight, which slightly indicates towards the dual burden of malnutrition (Dutta & Sen, 2020).

Several initiatives have been undertaken to address the issue of under-nutrition among tribal communities in India. UNICEF India has been working to support the tribal population, especially children who suffer from malnourishment (Dutta & Sen, 2020). Efforts have been made in Odisha and Rajasthan to reclaim and regenerate the forest's untapped fruits and vegetables for use in the household hearth to improve dietary diversity. *Samagra,* an online portal of the Government of Madhya Pradesh, is supporting identification, verification, updating, and categorization of all individuals in a family by local bodies and linking households to their respective fair price shops electronically. A supplementary nutrition programme for pregnant women and lactating mothers with hot cooked meals in Andhra Pradesh and Telangana has helped improve coverage of the national Integrated Child Development Services (ICDS) scheme.

Table 3.5: NHFS 4 and NHFS 5 Report on Goa

| Types | NHFS 4 (2015-16) | NHFS 5 (2019-21) |
|---|---|---|
| Stunting | 20.1% | 25.8% |
| Wasting | 21.9% | 19.1% |
| Underweight | 23.8% | 24% |
| Women whose Body Mass Index is below normal (BMI <18.5 kg/m2) | 14.7% | 13.8% |

**Source:** (Ministry of Women and Child Development, 2021a). *Malnutrition-Free India* [dataset]. https://pib.gov.in/PressReleasePage.aspx?PRID=1781673

The prevalence of under-nutrition and stunting among tribal children is higher than that of non-tribal children. Several initiatives have been undertaken to address the issue of under-nutrition among tribal communities in Goa as well as other parts of India. However, more needs to be done to ensure that tribal communities have access to adequate and nutritious food.

## 3.5 Historical Background and Evolution of ICDS in Goa

ICDS was launched in 1975 as a pilot project in India and was subsequently expanded nationwide. According to the study of (Dias, 2004), in Goa, ICDS was implemented in 1978 in Bicholim taluka. Table 3.6 gives the details of Year of Commencement of ICDS scheme in different talukas of Goa.

Table 3.6: Year-wise commencement of ICDS scheme in different talukas of Goa

| Sr. No. | Taluka | Year |
|---|---|---|
| 1 | Bicholim | 1978 |
| 2 | Pernem | 1978-79 |
| 3 | Sanguem | 1980 |
| 4 | Sattari | 1981-82 |
| 5 | Quepem | 1982-83 |
| 6 | Canacona | 1982 |
| 7 | Ponda | 1983 |

| | | |
|---|---|---|
| 8 | Bardez | 1983-84 |
| 9 | Salcete | 1986 |
| 10 | Tiswadi | 1986 |
| 11 | Mormugao | 1988-89 |

**Source:** Domitilia Dias, A. A. (2004). *A critical evaluation of dwcra development of women and children in rural areas and icds integrated child development services programmes in goa* [Goa University]. https://shodhganga.inflibnet.ac.in/handle/10603/32422

The evolution of ICDS in Goa has been influenced by various factors. The State government has consistently emphasized the need for better nutrition and health services for women and children. As a result, ICDS has undergone several modifications and improvements over the years, addressing the changing needs and challenges faced by children and women. Some key development of ICDS in Goa include:

1. **Expansion of Infrastructure: -** The number of anganwadi centers, which are the focal points for delivering ICDS services, has increased significantly over time. In 2004 a total 1004 Anganwadi were existing which were increased to 1262 in 2023. These centers are equipped with facilities for growth monitoring, immunization, and pre-school education. Table 3.7 gives the details of the present status of AWCs in Goa.

Table No. 3.7: Details of District wise Anganwadi Centers till March 2023

| Sr. No. | Project Name | Total AWCs |
|---|---|---|
| **NORTH GOA DISTRICT** | | |
| 1 | ICDS Pernem | 74 |
| 2 | ICDS Tiswadi | 109 |
| 3 | ICDS Sattari | 108 |
| 4 | ICDS Bicholim | 108 |
| 5 | ICDS Bardez | 145 |
| **Total** | | **544** |

| SOUTH GOA DISTRICT | | |
|---|---|---|
| 1 | ICDS Ponda | 167 |
| 2 | ICDS Sanguem | 52 |
| 3 | ICDS Dharbandora | 41 |
| 4 | ICDS Cancona | 83 |
| 5 | ICDS Quepem | 84 |
| 6 | ICDS Mormugoa | 114 |
| 7 | ICDS Salcete | 177 |
| **Total** | | **718** |
| **Grand Total** | | **1262** |

**Source:** Office of Directorate of Women and Child Welfare, Government of Goa.

2. **Enhanced Nutritional Support: -** The quality and quantity of Supplementary nutrition provided through the ICDS programme have been improved. Initially, the scheme primarily focused on providing supplementary nutrition for children below the age of six years, pregnant and lactating mothers. However, it has gradually expanded to include other services like early childhood care and education, immunization, health check-ups, and counseling for pregnant women and mothers. Sustained efforts have been made to ensure that children receive adequate nutrition for their growth and development.

Table No. 3.8: Details of current District wise Beneficiaries till August 2023

| **North Goa** | | **South Goa** | |
|---|---|---|---|
| **Project** | 5 | **Project** | 7 |
| **Sector** | 23 | **Sector** | 33 |
| **Anganwadi Centers** | 544 | **Anganwadi Centers** | 718 |
| **Anganwadi Workers** | 529 | **Anganwadi Workers** | 707 |
| **Pregnant Women** | 1,990 | **Pregnant Women** | 2,313 |
| **Lactating Mothers** | 2,170 | **Lactating Mothers** | 1,897 |

| | | | |
|---|---|---|---|
| **Children (0-6 Months)** | 2,044 | **Children (0-6 Months)** | 1,392 |
| **Children (6 Months-3 Years)** | 14,872 | **Children (6 Months-3 Years)** | 19,396 |
| **Children (3-6 Years)** | 7,452 | **Children (3-6 Years)** | 12,190 |

**Source:** (Ministry of Women and Child Development, n.d.)**.** *Dashboard Mission Poshan*. Retrieved August 1, 2023, from https://wcd.dashboard.nic.in/

3. **Focus on Early Childhood Care and Education: -** ICDS in Goa has increasingly emphasized the importance of early childhood care and education. Anganwadi workers have been trained to provide age-appropriate preschool education, stimulating activities, and child-friendly learning materials.

4. **Integration with Health Services: -** There has been greater integration of ICDS with health services in Goa. Regular health check-ups, immunization, and growth monitoring are conducted to monitor the health status of children and mothers.

5. **Awareness and outreach: -** Efforts have been made to increase awareness and outreach of ICDS services in Goa. Health education sessions, village-level meetings, Home Visits, and community mobilization initiatives have helped disseminate information about the benefits of ICDS and encourage participation.

6. **Convergence of various Departments: -** Convergence of various departments and agencies for better implementation of the scheme. The Goa government has actively worked towards promoting partnerships with other stakeholders, including the Health Department, Education Department, and NGOs, to ensure effective delivery of services.

7. **Community Participation and Empowerment: -** There has been a greater emphasis on community participation and empowerment in the implementation of ICDS in Goa. The government has encouraged the panchayats for the formation of Village Health and Nutrition Committees to actively involve local communities in decision-making and monitoring of the scheme. This approach

has not only improved accountability but also created a sense of ownership among the communities.

Throughout this evolution, ICDS scheme in Goa is progressing but with some challenges such as inadequate infrastructure, the shortage of trained human resources, and the need to reach marginalized communities and resolving challenges of remote areas still exist. However, the government of Goa continues to work towards addressing these issues and improving the efficacy and reach of the ICDS scheme. Table 3.9 gives the general information of ICDS in India and Goa.

Table 3.9: General Information of ICDS in India and Goa

| **India** | | | **Goa** | | |
|---|---|---|---|---|---|
| Total AWCs | 13,99697 | | Total AWCs | 1262 | |
| Operational AWCs | 13,97,523 | | Operational AWCs | 1262 | |
| **Beneficiaries** | | | | | |
| Pregnant Women | 80,40,215 | | Pregnant Women | 4,303 | |
| Lactating Mothers | 52,41,440 | | Lactating Mothers | 4,067 | |
| Children(0-6 Months) | 45,95,834 | | Children (0-6 Months) | 3,436 | |
| Children (6 Months – 3 Years) | 4,06,33,040 | | Children (6 Months – 3 Years) | 34,268 | |
| Children (3-6 Years) | 4,25,39,934 | | Children (3-6 Years) | 19,642 | |
| Total Beneficiaries | 10,10,50,463 | | Total Beneficiaries | 65,716 | |
| **Infrastructure** | | | | | |
| **Type** | **Kaccha** | **Pucca** | **Type** | **Kaccha** | **Pucca** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Govt. Buil** | Govt. Building | 39529 | 614899 | **Govt. Buil** | Govt Building | 0 | 131 |
| **Rented** | AWWs/ AWHs | 29128 | 73194 | **Rented** | AWWs/ AWHs | 0 | 101 |
| | Others | 57745 | 197711 | | Others | 2 | 642 |
| **Community** | Schools | 6100 | 222649 | **Community** | Schools | 0 | 286 |
| | Panchayat | 2109 | 72383 | | Panchayat | 1 | 28 |
| | Others | 7609 | 61219 | | Others | 6 | 65 |
| **Open Space** | Open Space | 651 | 71 | **Open Space** | Open Space | 0 | 0 |
| **Total** | | **142871** | **1242126** | **Total** | | **9** | **1,253** |

**Drinking Water and Toilet Facilities**

| **Drinking Water** | | **Toilet Facilities** | | **Drinking Water** | | **Toilet Facilities** | |
|---|---|---|---|---|---|---|---|
| **Available** | **Not Available** | **Available** | **Not Available** | **Available** | **Not Available** | **Available** | **Not Available** |
| **1,196,458** | **190,974** | **1,005,257** | **382,175** | **1228** | **34** | **1083** | **179** |

**Human Resource**

| **Human Resource** | **Sanctioned** | **Imposition** | **Vacant** | **Human Resource** | **Sanctioned** | **Imposition** | **Vacant** |
|---|---|---|---|---|---|---|---|
| CDPOs | 7075 | 4884 | 2191 | CDPOs | 12 | 12 | 12 |
| Lady Supervisor | 51312 | 34342 | 16970 | Lady Supervisor | 50 | 43 | 7 |
| Anganwadi Workers | 1399697 | 1328617 | 71080 | Anganwadi Workers | 1262 | 1169 | 93 |
| Anganwadi Helpers | 1282847 | 1179303 | 103544 | Anganwadi Helpers | 1262 | 1150 | 112 |

**Note:** The data given in Table No 3.5 is till March 2022.

**Source:** (Press Information Bureau, 2021a)**.** *Supplementary Nutrition Under ICDS* [dataset]. https://pib.gov.in/PressRelasePage.aspx?PRID=1742803

The Integrated Child Development Services (ICDS) scheme is a centrally sponsored scheme implemented by State governments and Union Territories. The scheme is universal covering all the districts of the country. The services are now offered as part of the Saksham Anganwadi and Poshan 2.0 - an umbrella scheme for all nutrition-related interventions. According to the Press Information Bureau report released in December 2021 reveals the state-wise funds released by the Central Government. Table 3.10 gives the details of fund utilization by the Goa government.

Table No. 3.10: ICDS Fund Allocation & Utilization by Goa Government (Rs In Lakhs)

| **Financial Year** | **SNP** | | **ICDS (General)** | |
|---|---|---|---|---|
| | **Funds Released** | **Funds Utilized** | **Funds Released** | **Funds Utilized** |
| 2018-2019 | 859.5 | 844.9 | 778.06 | 621.47 |
| 2019-2020 | 826.38 | 831.65 | 684.14 | 869.96 |
| 2020-2021 | 858.8 | 823.09 | 1165.27 | 892.91 |

**Source:** (Press Information Bureau, 2021b)**.** *The Details of Funds Allocated/Utilized/Released ICDS scheme* [dataset]. https://static.pib.gov.in/WriteReadData/specificdocs/documents/2021/dec/doc2021121521.pdf

The implementation of the Integrated Child Development Services (ICDS) in the tribal panchayats of South Goa has been a significant step towards addressing the developmental needs of the tribal population, especially children and women. The

allocation and utilization of funds have played a vital role in making this scheme successful and bringing positive changes in the lives of the tribal community.

## 3.6 Implementation structure and organization of ICDS in Tribal Panchayats in Goa

The implementation structure and organization of the Integrated Child Development Services (ICDS) in tribal and non-tribal areas across Goa is designed to ensure effective service delivery and coordination. The key stakeholders involved in the implementation of ICDS at the grassroots level are the Ministry of Women and Child Development (MWCD), State Governments, District Administration, Panchayats, and the local community.

At the national level, the MWCD formulates policies and guidelines for the ICDS scheme. It provides the overall framework and funding for the programme and monitors its implementation. The State Government then takes the responsibility for implementing ICDS within its jurisdiction. In Goa the Directorate of Women and Child Development (DWCD) is the nodal agency in implementing ICDS in the State. At the taluka level of each district, Child Development Programme Officer (CDPO) monitor the functioning of ICDS. Mukhya Sevikas supervise the work of Anganwadi Centers and at the base level Anganwadi Workers plays a crucial role in delivering ICDS services.

One of the important components of the ICDS implementation structure is the Anganwadi Centers. These centers act as the frontline service delivery points and are responsible for providing a range of services, including supplementary nutrition, pre-school education, health check-ups, and awareness programmes to children under six years of age and pregnant or lactating women. Each Anganwadi Center is managed by an Anganwadi Worker (AWW) who is responsible for day-to-day operations and service delivery. Additionally, an Anganwadi Helper (AWH) assists the AWW in their duties. Ministry of Women and Child Development at the Central level gives the guidelines to

each state in the setup of Anganwadi Centers based upon the Population Norms. Goa also follows the Population norms given by Central Government to set up AWCs. In Chapter 2 of this study, table 2.5 gives the details of Anganwadi Centers' setup based on population norms given by ICDS.

Panchayats, the local self-government is expected to play a crucial role in ICDS. There is a provision in panchayats to establish the Village Health and Nutrition Committee (VHNC) to ensure community participation. The VHNC comprises local leaders, parents, and community volunteers that works closely with the anganwadi workers to identify the needs of the community, plan activities, and monitor the quality of services being provided. However, VHNC is found not active in Goa.

Monitoring and supervision mechanisms are essential components of the ICDS implementation structure. Mukhya Sevikas are responsible for supervising the functioning of Anganwadi Centers and providing necessary support and guidance to the AWWs. They conduct regular visits to the centers, review records, monitor the growth and nutrition status of children, and ensure adherence to prescribed guidelines. Additionally, periodic assessments and evaluations are conducted by higher-level officials to assess the performance and impact of ICDS services in the region.

The ICDS implementation structure also includes a robust information management system. Data related to the delivery of services, child growth, nutrition status, and other indicators are collected, collated, and reported at various levels. This data helps in monitoring the progress of the scheme, identifying gaps, and making decisions for the scheme improvement. However, it is observed that there are a lot of mobile network issues in remote tribal areas of Goa.

The implementation structure and organization of ICDS in tribal panchayats in Goa involve collaboration between the MWCD, State Government, District Administration, panchayats, and the local community. The Anganwadi centers, along with the Anganwadi workers, serve as key components for delivering the required ICDS services in Goa. Regular training programmes, monitoring, and evaluation mechanisms

ensure the effective functioning of the scheme and the well-being of the tribal population in Goa.

## 3.7 Policy and Legal Framework Governing ICDS in Goa

The ICDS Scheme, launched by the Government of India, provides the operational guidelines for the implementation of ICDS across the country, including in Goa. It details the services to be provided, the organizational structure, the roles and responsibilities of stakeholders, and the monitoring and evaluation mechanisms. The policy and legal framework governing the implementation of ICDS in Goa include various national and state-level policies, guidelines, and acts. Here are some key components of the policy and legal framework of ICDS in Goa:

1. **National Policy for Children, 1974:** The National Policy for Children, 1974, provides the framework for ICDS implementation in India. In the implementation of holistic development of children through ICDS, the State government of Goa takes into consideration the objectives, strategies, and principles for the holistic development and well-being of children in Goa.
2. **The National Food Security Act, 2013:** This act plays a crucial role in ensuring the nutritional well-being of children in ICDS. It focuses on the provision of adequate and nutritious food to children, pregnant women, and lactating mothers. The act mandates the provision of hot-cooked meals and take-home rations for beneficiaries.
3. **The Goa Children's Act, 2003:** This state-level act provides a legal framework for the care, protection, and development of children in Goa. It includes provisions related to health, nutrition, education, and social welfare services for children, aligning with the objectives of ICDS.
4. **State Government Orders and Notifications:** The government of Goa issues specific orders and notifications from time to time to guide the implementation

of ICDS. These may include directions on the expansion of services, modifications in eligibility criteria, and guidelines for the engagement of human resources.

5. **Goa State Women and Child Development Department:** The Goa State Women and Child Development Department serves as the nodal agency for the implementation of the ICDS scheme in the state. It is responsible for the coordination, monitoring, and evaluation of ICDS services and ensuring compliance with the policy and legal framework.

These policies and legal provisions provide the guiding principles and framework for ICDS implementation in Goa, ensuring the delivery of essential services for children and women in a systematic and accountable manner. Services provided and beneficiaries targeted

## 3.8 Overview of a selected area of study

The selected areas of study, Sanguem, Quepem, and Canacona, are all located in the state of Goa, India. These areas offer diverse study options for students and researchers interested in various fields. This study is on the Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa, it focuses on assessing the effectiveness and impact of ICDS scheme on tribal communities.




**Figure 3.1: Map of Goa**

**Source:** (*Goa Political Map ~ ONEIROITAN1*, n.d.). Retrieved August 1, 2023, from https://oneiroitan1.blogspot.com/2010/05/goa-political-map.html

### 3.8.1 Social-Demographic Profile of Sanguem Taluka

Sanguem is a taluka situated in South Goa district. It is known for its rich cultural heritage and natural beauty. In Sanguem the scope to study is the local traditions, history, and culture. Its diverse ecosystem includes thick forest, wildlife sanctuaries, and waterfalls, providing scope for ecological studies.




Figure 3.2 Map of Sanguem Taluka

**Source**: (*Sanguem Taluka in Goa-Villages and Towns in Sanguem*, n.d.) [dataset]. Retrieved January 8, 2023, from http://www.goaholidayhomes.com/talukas-in-goa/sanguem/

The total area of Sanguem is 888.44 sq. km. with population density of 73 per sq. km. According to the Census of India 2011, Sanguem taluka has total 15068 households, and the total population was around 65147 of which 32623 are males and 32524 are females. The population of children between age 0-6 years is 7050 which is 10.82% total population. Out of total population, 82.28% of population lives in Urban areas and 17.72% lives in Rural area. There are 1.12% Scheduled Caste (SC) and 21.94% Scheduled Tribe (ST) of total population in Sanguem Taluka.

### 3.8.2 Social-Demographic Profile of Quepem Taluka

Quepem is another taluka located in South Goa district. It is famous for its Portuguese colonial architecture, ancient temples, and scenic landscapes. Quepem is an

ideal area of study for architecture and history enthusiasts. The region's unique blend of Western and Indian architectural styles provides ample opportunities for research in architectural conservation and heritage preservation. Furthermore, numerous temples in Quepem provide a rich subject area for religious studies and anthropology.

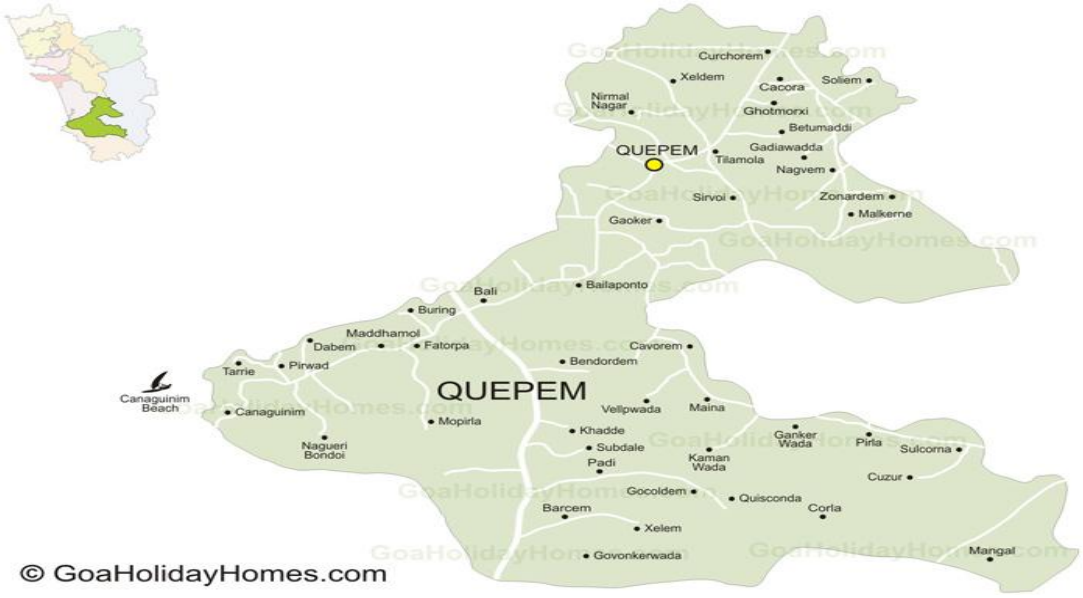



Figure 3.3 Map of Quepem Taluka

**Source:** (*Quepem Taluka in Goa-Villages and Towns in Quepm*, n.d.). [dataset]. goaholidayhomes.com

As per the Census India 2011, Quepem taluka has 19119 households, population of 81193 of which 40722 are males and 40471 are females. The population of children between the age 0-6 years is 8402 which is 10.35% of total population. The sex-ratio of Quepem Taluka is around 994 compared to 973 which is average of Goa state. The literacy rate of Quepem Taluka is 74.35% out of which 78.31% of males are literate and 70.36% of females are literate. The total area of Quepem is 318.24 sq. km with a population density of 255 per sq. km. Out of the total population, 44.63% of the population live in an urban area, and 55.37% lives in a rural area. There are 1.15% Scheduled Caste (SC) and 31.15% Scheduled Tribe (ST) of the total population in Quepem Taluka.

### 3.8.3 Social-Demographic Profile of Cancona Taluka

Canacona is a taluka situated in the extreme south of Goa. It is renowned for its pristine beaches, verdant forests, and marine biodiversity. In Canacona the scope to study is related to environmental science, marine biology, and ecotourism. The taluka encompasses the Cotigao Wildlife Sanctuary, which provides a habitat for diverse bird and animal species, making it an ideal site for wildlife research. Moreover, beaches in Canacona, such as Palolem and Agonda, attract tourists from across the globe, presenting opportunities for studying tourism management and sustainability.




Figure 3.4: Map of Cancona Taluka

**Source:** (*Canacona Taluka in Goa- Villages and Towns in Cancona*, n.d.) [dataset]. goaholidayhomes.com

Canacona taluka of South Goa district has a total population of 45,172 as per the Census 2011, out of which 22,532 are males while 22,640 are females. The total household were 10,239 out of which 27.5% lived in urban areas while 72.5% live in rural areas. The population of children of age 0-6 years in Cancona taluka is 4635 which is 10% of the total population. There are 2385 male children and 2250 female children between the age group 0-6 years.

In conclusion, chapter three provides an overview of the Integrated Child Development Services (ICDS) scheme in Goa, with a particular focus on its implementation among the tribal population in South Goa. The selected study area for this research included Sanguem, Quepem, and Canacona. The ICDS programme was introduced in Goa in 1978, aiming to provide comprehensive services for the development of children under the age of six and their mothers. It encompasses a range of interventions, including health, nutrition, early childhood education, and social services. The ICDS scheme plays a crucial role in addressing the various challenges faced by tribal communities, including malnutrition, high child mortality rates, low literacy levels, and poverty.

The study area of Sanguem, Quepem, and Canacona in South Goa was chosen due to its significant tribal population. This region comprises a diverse tribal community, including the Kunbi, Velip, and Gawda tribes. These communities experience marginalization, limited access to basic services, and inadequate infrastructure. By examining the implementation of ICDS scheme in this study area, researchers aimed to assess its effectiveness in improving the well-being and development outcomes of tribal children and their mothers. The study evaluates the availability and accessibility of ICDS services, the quality of interventions, the level of community engagement, and the impact on key outcomes such as nutrition, health, and education.

Overall, by focusing on the ICDS scheme implementation among the tribal population of South Goa, this research aims to contribute to the understanding of the scheme effectiveness in addressing the unique challenges faced by tribal remote areas. The findings from this study can help to identify gaps and areas for improvement in delivering holistic services to improve the overall well-being and development of tribal children and their mothers in the region.

# Chapter 4

# Analyzing the Integrated Child Development Services (ICDS) Scheme

## 4.1 The ICDS Scheme: A Critical Analysis

The Integrated Child Development Services (ICDS) scheme is a flagship programme of the government of India that aims to provide a comprehensive package of services for the holistic development of children and their families, with a special focus on the marginalized and oppressed sections of the society. The scheme was launched in 1975 and has been recognized as one of the world's largest and most unique programme for early childhood development. The scheme offers six integrated services those are; supplementary nutrition, immunization, health check-up, referral services, pre-school education, and nutrition and health education that delivered through Anganwadi Centers at the grassroots level.

The literature review of this study highlights the necessity for a thorough evaluation of government welfare programmes, and emphasizing on evidence-based recommendations. In light of this, the current study seeks to analyze the Integrated Child Development Services (ICDS) scheme within the tribal-dominated panchayats of South Goa. The primary research question guiding this study is:

1. How to evaluate and improve the performance of ICDS in tribal panchayats of South Goa?

Based on this research question, this study examines the Integrated Child Development Services (ICDS) scheme by adopting qualitative and quantitative methods of data collection which includes survey, interview, and focus group discussion. The aim of the study is to analyze the effectiveness and impact of the ICDS scheme and provide evidence based recommendation to promote sustainability of the scheme.

## 4.2 Quantitative and Qualitative Analysis of the ICDS Scheme

The survey results is used to analyze the effectiveness and impact of the Integrated Child Development Services (ICDS) scheme with reference to tribal dominated panchayats of South Goa. The survey conducted among the beneficiaries of the scheme, which includes ST women beneficiaries such as enrolled mothers of children in AWCs between the age of 3 to 6 years, lactating mothers, and pregnant women and anganwadi workers. The survey aims to assess the quality and accessibility of the ICDS services, the satisfaction, feedback and suggestions from the beneficiaries.

By analyzing the survey results, the strengths and weaknesses of the ICDS scheme is identified, as well as the opportunities and challenges that it faces. This has helped to suggest the recommendations that will enhance its impact and sustainability of the ICDS scheme.

### 4.2.1 Data Analysis from the Tribal Women Beneficiaries

The study evaluated the performance of the Integrated Child Development Services scheme based on the feedback of the tribal women beneficiaries from Quepem, Sanguem, and Cancona taluka of South Goa. The beneficiaries shared their opinions on the ICDS scheme's services, their satisfaction with the Anganwadi Centers, their concerns and suggestions for the Anganwadi Centers. The beneficiary's views were crucial for the assessments, who can best judge the functioning and the impact of the ICDS services. The survey included the following tribal women beneficiaries from the Scheduled Tribes dominated panchayats of Quepem, Sanguem, and Cancona talukas.

1. Tribal Women (mothers) of children between the age groups of 3 to 6 years.
2. Lactating Mothers
3. Pregnant Women

The percentage of ICDS beneficiaries in each of the three categories in shown in Figure 4.1 as given subsequently.

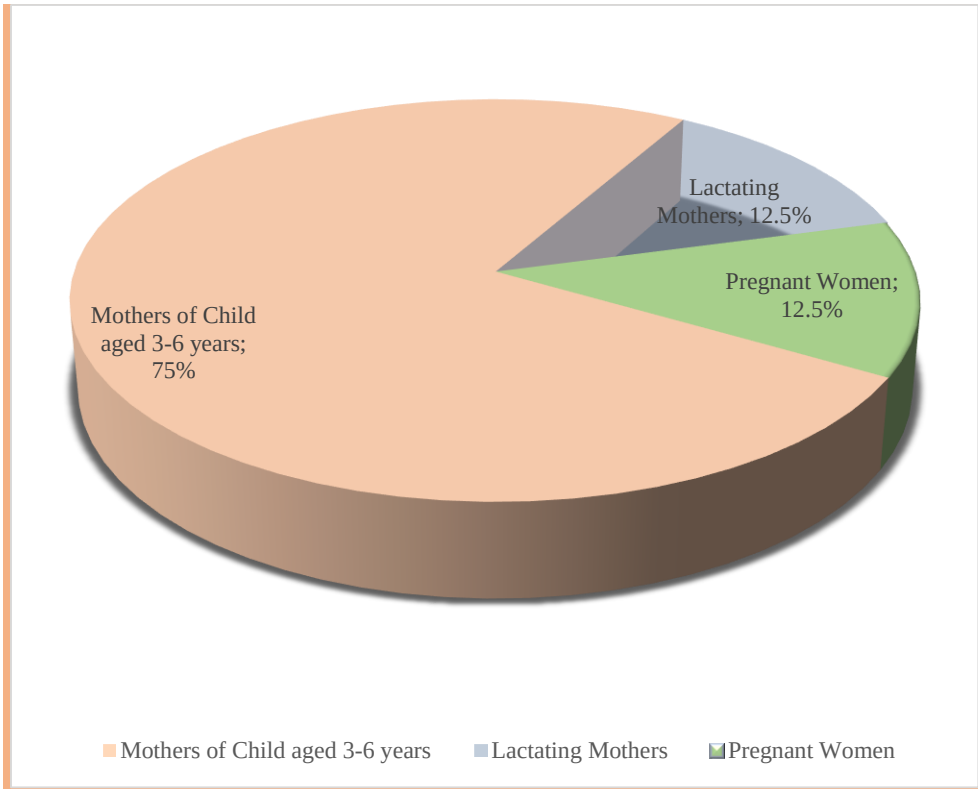



Figure 4.1: Details of the Beneficiary Category

The survey focused on ST women beneficiaries of the ICDS scheme from 12 tribal panchayats in Quepem, Sanguem, and Cancona talukas. It included mothers of preschool children (3-6 years), lactating mothers, and pregnant women. Figure 4.1 shows that the proportion of lactating and pregnant women was similar across the panchayats, but the proportion of mothers of preschool children varied. The survey interviewed 480 women, of whom 75% were mothers of preschool children and 12.5% each were lactating and pregnant women. The general information of the women respondents are discussed in table 4.1.

Table 4.1 shows the demographic characteristics of 480 Scheduled Tribe (ST) women beneficiaries who received supplementary nutrition and preschool education services under the ICDS scheme in tribal dominated panchayats of South Goa. The ICDS scheme is a government initiative that aims to improve the nutritional and health status

of children, pregnant and lactating women, and adolescent girls by providing them with various services such as supplementary nutrition, immunization, health check-up, preschool education, referral services, and nutrition and health education. The table 4.1 shows the distribution of the respondents by age group, religion, ST community, educational qualification, and family structure.

Table 4.1: General Information of the ST Women Respondents

| # | Particulars | Number (N=480) | Percent (%) |
|---|---|---|---|
| 1 | Age Group of the ST Women Beneficiary Respondents | | |
| | • 18-30 | 234 | 48.75% |
| | • 31-45 | 246 | 51.25% |
| 2 | ST Community | | |
| | • Velip | 177 | 36.9% |
| | • Gawda | 214 | 44.6% |
| | • Kunbi | 89 | 18.5% |
| 3 | Educational Qualification | | |
| | • Primary School | 30 | 6.3% |
| | • SSC | 337 | 70.2% |
| | • HSSC | 83 | 17.3% |
| | • Graduate | 16 | 3.4% |
| | • Post Graduate | 10 | 2.0% |
| | • Diploma | 4 | 0.8% |
| 4 | Family Structure | | |
| | • Joint Family | 200 | 41.7% |
| | • Nuclear Family | 280 | 58.3% |

The data for the table 4.1 was obtained to evaluate the performance of ICDS scheme in the tribal dominated panchayats of South Goa and for this, survey was

conducted by the researcher among the ST women beneficiaries from twelve selected tribal majority populated panchayats of Quepem, Sanguem, and Cancona talukas.

The table reveals that the majority of the respondents belong to the age group of 26-35 years is 51.2%, followed by 35.2% in the age group of 18-25 years and 13.6% belongs to the age group of 36-45 years. The highest representation of ST community in the survey is Gawda (44.6%), followed by Velip (36.9%) and Kunbi community (18.5%). Most of the respondent's educational qualification is SSC (Secondary School Certificate) with 70.2%, followed by HSSC (Higher Secondary School Certificate) with 17.3%. Only a small percentage of the respondents have higher education such as Graduate (3.4%), Post Graduate (2.0%) and Diploma (0.8%). The family structure of the respondents is more than half of the respondents (58.3%) live in nuclear families, while 41.7% live in joint families.

The table 4.1 suggests that the ICDS scheme has reached a diverse group of ST women in South Goa, who have different backgrounds, preferences, and needs. The table 4.1 also indicates that there is scope for improvement in the educational attainment and skill development of the ST women beneficiaries, as most of them have only completed secondary education or less. The table 4.1 also implies that the family structure of the respondents may have an impact on their nutritional and health outcomes based upon the flexibility and autonomy in the families.

The ST community is one of the most marginalized and vulnerable groups in India, facing various challenges such as poverty, illiteracy, malnutrition, and poor access to health care etc. According to the 2011 census, the ST population in India is about 10.4 crores, constituting 8.6% of the total population. Goa is one of the smallest states in India, with a population of about 14.6 lakh, of which 12.2% belong to the ST community. The ST community in Goa with major tribal population is among Velip, Gawda, and Kunbi, who have their distinct culture, language, and traditions.

The study analyses the two research question related to tribal women beneficiaries. Those are:

1) How do ST women beneficiaries in tribal dominated Panchayats of South Goa utilize and perceive the ICDS services?
2) What are the main concern and suggestions from the ST women beneficiaries related to ICDS scheme in their locality?

Table 4.2: Cross tabulation of Experience and Frequency of Usage of ICDS services by ST Women Respondents

| **Duration of Use of ICDS services** | **Frequency of Using ICDS Services** | | | | |
|---|---|---|---|---|---|
| | **Weekly** | **Monthly** | **Occasionally** | **Rarely** | **Total** |
| First Time | 48 | 64 | 122 | 54 | 288 |
| Used Before | 37 | 86 | 48 | 21 | 192 |
| Total | 85 | 150 | 170 | 75 | 480 |

The study examines the frequency of utilization of ICDS services among ST women beneficiaries in rural areas in Goa. The independent variable was the experience of ICDS beneficiaries and the dependent variable was the frequency of using ICDS services. A sample of 480 women who had accessed an Anganwadi center in the past months were surveyed about their frequency of using ICDS services: weekly, monthly, occasionally, and rarely. They were also asked whether they had any previous experience of using ICDS services or not. Table 4.2 presents the cross tabulation of the responses.

A chi-square test of independence was performed to examine the hypothesis that there was a dependence between the frequency of utilization of ICDS and the prior experience of using ICDS services by the ST women. The null hypothesis was that the utilization of ICDS was independent of the prior experience of the women. The alternative hypothesis was that the utilization of ICDS was dependent on the prior

experience of the women. The chi-square test of independence result was $\chi 2$ (3,N=480)=33.5229. The p-value is <0.00001. The result is significant at $p < .05$.

The result indicates that there is a significant association between the frequency of utilization of ICDS and the prior experience of using ICDS by the ST women. The first-time users tended to use the ICDS services occasionally or rarely more than the experienced users. The finding suggests that the prior experience of the women influenced their utilization of ICDS services. The women who had used the services before might have been more satisfied with the quality and outcomes of the services, and thus more inclined to use them regularly. The women who were using the services for the first time might have been less informed of the availability and significance of the services, and thus are using them infrequently.

The implication of the test is that the ICDS scheme should take into account the different needs and preferences of the women based on their prior experience and customize the services accordingly. The ICDS scheme authority should take steps to enhance the awareness and outreach of the services among the women who were using the ICDS services for the first time, and provide more incentives and feedback of the women who had used them before. This will help to improve the effectiveness and efficiency of the ICDS scheme in achieving its objectives of improving the health and well-being of children and mothers in rural areas.

The subsequent question for the beneficiaries on availing the ICDS services at AWCs and their satisfaction on those services. Table 4.3 gives the details.

Table 4.3: Status of ICDS services availed by the ST Women Respondents at AWCs

| # | Particulars | Number (N=480) | Percent (%) |
|---|---|---|---|
| 1. | Reasons for visiting AWC (Multiple Response Question) | | |
| | • Nutrition and Health Education | 390 | 81.3% |
| | • Early Childhood Education | 350 | 72.9% |
| | • Antenatal Care Services | 245 | 51.0% |
| | • Immunization Services | 315 | 65.6% |
| | • Family Counselling and support | 190 | 39.5% |
| 2. | Percentage of women satisfy with the work of Anganwadi workers. | 460 | 95.8% |
| 3. | Percentage of women mentioned the home visits are beneficial. | 412 | 85.8% |
| 4. | Percentage of women mentioned that Anganwadi is needed to them. | 480 | 100% |

The implication of the table 4.3 are as follows:

- The ST women have a high demand for nutrition and health education, as well as early childhood education, which are the most common reasons for visiting AWCs. This implies that the ICDS scheme is addressing some of the key needs and preferences of the ST women in rural areas of Goa.
- The ST women are highly satisfied with the work of the Anganwadi workers and consider the Anganwadi as a valuable resource for them. This implies that the ICDS scheme is delivering quality and effective services to the ST women and building trust and rapport with them.
- The ST women visiting AWCs least for a programme on family counselling and support reason. This implies that the ICDS programme may need to improve the awareness and outreach of this service among the ST women and address any barriers or challenges that may prevent them from accessing it.

- The ST women also find the home visits by the Anganwadi Workers beneficial which indicates that the ICDS scheme is providing personalized and convenient services to the ST women and enhancing their well-being.
- The ST women unanimously agree that the Anganwadi is needed to them, which shows that the ICDS scheme is full filling a crucial role in the lives of the ST women and empowering them.

Anganwadi Centers (AWCs) provide a package of six services to children, pregnant women and lactating mothers. These six services are supplementary nutrition, pre-school education, health check-up, immunization, referral services and nutrition and health education. These services are aimed at improving the health and well-being of the beneficiaries and reducing malnutrition and mortality rates. However, the quality and utilization of these services may vary across different regions and groups of women. Therefore, it is important to understand how women perceive and value the services offered by AWCs and what factors influence their satisfaction.

The Figure 4.2 below shows the percentage of women who ranked AWC services as very useful by service type, based on a survey conducted. The graph 2 reveals some interesting insights into the preferences and needs of women with respect to AWC services. The data is based on multiple responses.

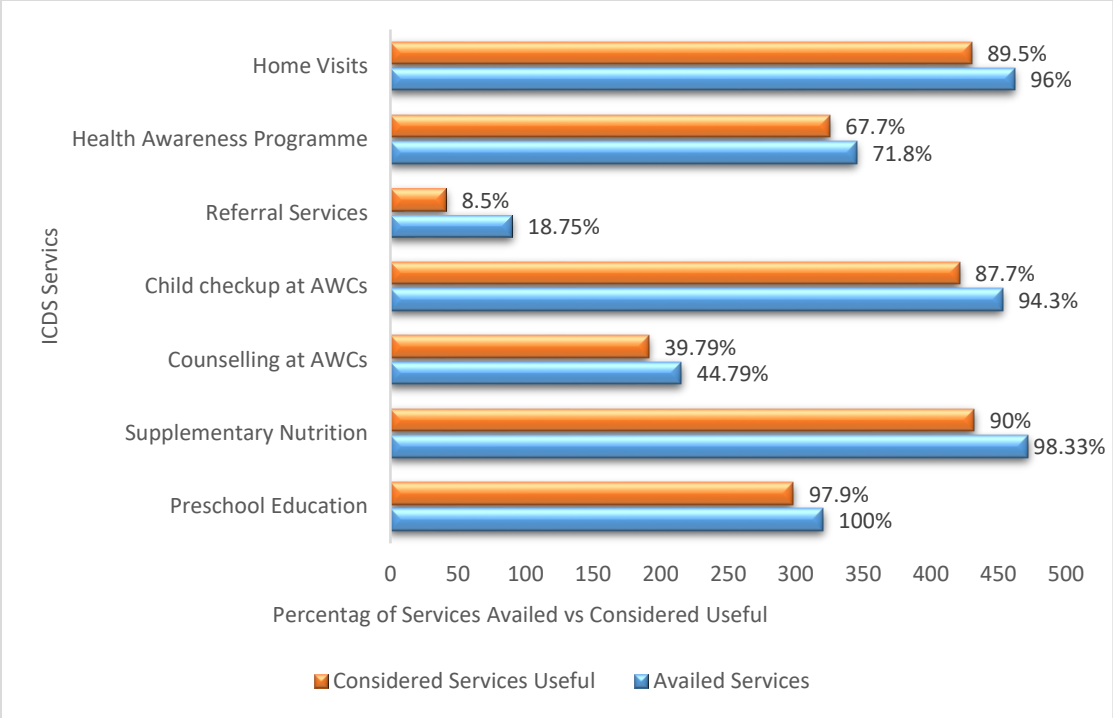



Figure 4.2: Percentage of Women who Ranked AWC Services as Very Useful by Service Type

Figure 4.2 shows how different types of ICDS services are perceived and utilized by women in rural areas. ICDS stands for Integrated Child Development Services, a government scheme that provides nutritional meals, preschool education, primary healthcare, immunization, health check-up and referral services to children under 6 years of age and their mothers.

Figure 4.2 compares the percentage of women who availed each service with the percentage of women who ranked each service as very useful. The services are: Home Visits, Health Awareness programme, and Referral Services, Child checkup at AWCs, Counselling at AWCs, Supplementary Nutrition, and Preschool Education. Anganwadi Centers are the delivery units of ICDS serivices at the village level.

Figure 4.2 reveals that most services are availed and considered useful by a high proportion of women, with Supplementary Nutrition and Preschool Education being the most valued. These two services aim to improve the nutritional and educational status

of children and mothers, which are crucial for their well-being and development. However, the Figure 4.2 also shows that Referral Services is the least availed service, but still considered very useful by more than half of the women. Referral Services refers to the process of linking the beneficiaries with the appropriate health facilities for further diagnosis and treatment. The main reason for the low availing of this service is the lack of accessibility and affordability of transport for the beneficiaries, who live in remote and poor areas.

The implication of Figure 4.2 result is that ICDS scheme should continue to provide and improve Supplementary Nutrition and Preschool Education, which are the most demanded and appreciated services by the women. ICDS scheme should also address the transport challenges that prevent the women from accessing referral services, which are important for their health care needs.

The six services of ICDS are delivered through Anganwadi Centers, which are at the grass root level. The main beneficiaries of ICDS are children under six years of age, pregnant and lactating women, and adolescent girls. The aim of ICDS is to improve the health, nutrition, and education status of the beneficiaries and to empower them for their holistic development. However, the effectiveness and impact of ICDS depend largely on the awareness, utilization, and satisfaction of the beneficiaries towards the services offered by the Anganwadi Centers. Therefore, it is important to assess the knowledge, utilization, level of satisfaction, and perception of the beneficiaries regarding the ICDS services. The next aspect of the study is focuses on the satisfaction level of ST women beneficiaries towards the ICDS services in the South district of the state of Goa.

To analyze the satisfaction level of ST women beneficiaries towards the ICDS services, this study measures how well the services meet or exceed their expectations and needs, and how they perceive the quality and effectiveness of the services. For this, the satisfaction level of each service type is analyzed into two level i.e. ‘Satisfied’ and ‘Not Satisfied’. Table 4.4 presents the data of the ‘Satisfied’ respondents.

Table 4.4: Satisfaction Level of ST Women Beneficiaries (Multiple Response)

| # | Service Type | Number (N=480) | Percent (%) |
|---|---|---|---|
| 1. | Supplementary Nutrition Programme | | |
| | • The quality & quantity of the food provided | 390 | 81.25% |
| | • The frequency & regularity of the food delivery | 210 | 43.75% |
| | • The hygiene & safety of the food preparation | 403 | 83.95% |
| | • The accessibility & Convenience of the food distribution | 425 | 88.54% |
| | • The impact of the food on their health & nutrition status | 396 | 82.5% |
| 2. | Preschool Education | | |
| | • The availability and adequacy of physical infrastructure (Building, Electricity, Water, Toilet, Space, Furniture) | 103 | 21.4% |
| | • The conduct & Quality of Non-formal Preschool Activities (Indoor/outdoor non-formal activities) | 295 | 61.4% |
| | • The availability & utilization of learning activities (Teaching Aids and Toys) | 265 | 55.2% |
| | • Cognitive, social, emotional & physical development of child. (Identifying, speech, social behavior) | 425 | 88.5% |
| 3. | Health Services | | |
| | • The availability & quality of Health Services (Health check-ups, Immunization, Common Illness, Referral Services). | 296 | 61.6% |
| | • Growth Monitoring & Nutrition Education | 368 | 76.6% |
| | • The awareness & Utilization of Health and Family welfare services. (Antenatal care, Institutional Delivery, Postnatal Care, and Family Planning) | 453 | 94.3% |

The data provided in table 4.4 shows the number and percentage of ST women beneficiaries who are satisfied with various ICDS services in South district of State of Goa. To analyze the satisfaction level of the beneficiaries, the researcher calculated the

mean and median of the data and interpreted the results to validate the hypothesis to signify the impact of poor preschool infrastructure on effective delivery of other services of ICDS. Table 4.5 gives the details of the results of Mean, Median, and Standard Deviation on Satisfaction Level of ST women beneficiaries on Supplementary Nutrition Programme, Preschool Education and Health Services.

Table 4.5: Mean, Median, and Standard Deviation of Satisfaction Level of ST Women Beneficiaries

| **Sr. No** | **Service Type** | **Mean (%)** | **Median (%)** | **Standard Deviation (%)** |
|---|---|---|---|---|
| 1 | Supplementary Nutrition Programme | 75.998 | 82.5 | 17.23 |
| 2 | Preschool Education & its infrastructure | 56.625 | 58.3 | 26.77 |
| 3 | Health Services | 77.5 | 76.6 | 13.68 |

Based on the table 4.5, the results of each service type interpreted to signify the impact of poor preschool education infrastructure on other services of ICDS.

**1. Supplementary Nutrition Programme**

- **Mean (75.998%):** The mean score shows around 76% of respondents are satisfied with the various aspects of Supplementary Nutrition Programme.
- **Median (82.5%):** The medium value indicates that at least half of the respondents are satisfied at 82.5%.
- **Standard Deviation (17.23%):** This relatively high standard deviation suggests a significant variation in responses, indicating mixed perceptions among the respondents.

The satisfaction with high percentage is for the quality, hygiene, and accessibility of food indicates that ICDS is effectively addressing nutritional needs, which is important

for the child development. However, the lower percentage variability in frequency and regularity of food delivery highlights the need for improvement. Ensuring consistent delivery can enhance the reliability and impact of scheme on beneficiaries.

**2. Preschool Education and its infrastructure**

- **Mean (56.625%):** About 57% of respondents are satisfied with the preschool education services provided at the Anganwadi Centers.
- **Median (58.3%):** This percentage shows that at least half of the respondents satisfied at 58.3% with the preschool education.
- **Standard Deviation (26.77%):** This high standard deviation indicates a wide range of satisfaction levels, suggesting diverse experiences and opinions among respondents towards the facilities of preschool education at the Anganwadi Centers.

The low percentage towards the satisfaction level of preschool education facilities is due to less availability and adequacy of physical infrastructure. This indicates the significant challenges in providing suitable learning environment at the Anganwadi Centers. Addressing these infrastructure gaps is essential for improving education outcomes which adversely affect the other services of ICDS.

**3. Health Services**

- **Mean (77.5%):** On average, 77.5% of respondents are satisfied with the health services provided.
- **Median (76.6%):** The middle value indicates that at least half of the respondents rated their satisfaction at 76.6%.
- **Standard Deviation (13.68%):** This lower standard deviation compared to the other services indicates more consistent responses, suggesting a more uniform perception of health services among respondents.

The high percentage for awareness and utilization of health and family welfare services indicates effective engagement with the community. The relatively high and consistent satisfaction with health services suggests that these services are generally well-regarded and effective. Continued focus on maintaining and improving these services can further enhance community health.

The analysis of the mean, median, and standard deviation for the various services provided under the ICDS scheme reject the null hypothesis and indicates that poor infrastructure significantly impact the satisfaction levels of other services. The high variability in responses suggests that addressing infrastructure issues could lead to more consistent and higher satisfaction across all services, thereby improving the overall effectiveness of the ICDS scheme in tribal dominated areas of Goa.

The other factor needed to assess the beneficiaries' satisfaction on Anganwadi Workers (AWWs) who are the community-based frontline workers of the Integrated Child Development Services (ICDS) scheme. AWWs are responsible for delivering the six services of the ICDS at the Anganwadi Centre (AWCs), which are the village-level units of ICDS. AWWs also act as a mediator between the government and the targeted beneficiaries, by creating awareness, mobilizing participation, and providing guidance and support.

To understand the satisfaction level of beneficiaries on AWWs, following questions were asked to the ST women beneficiaries in south district of the State of Goa, who are the main recipients of the ICDS services. The possible answers were "Yes" or "No". The purpose of this questions was to measure how well the AWWs meet or fulfill the expectations and needs of the beneficiaries, and how they perceive the quality and effectiveness of the AWWs. The satisfaction level of the beneficiaries on AWWs can indicate the strengths and weaknesses of the AWWs, and the areas of improvement or intervention needed to enhance their performance and impact.

Table 4.6: Satisfaction Level of ST Women Beneficiaries on AWWs

| # | Service Type | Number (N=480) | Percent (%) |
|---|---|---|---|
| 1. | The attitude & behavior of the Anganwadi Workers towards the beneficiaries (Responsiveness, Communication, Empathy, Respect) | 475 | 98.9 |
| 2. | The knowledge & skills of the AWWs (Awareness of the ICDS scheme, their training, professional etiquettes, health related competencies) | 386 | 80.4 |
| 3. | Conducting timely ICDS activities (Awareness Programme, Coordination, Communication, conducting mothers meetings, & Home visits) | 456 | 95 |

The data in Table 4.6 indicates the number and percentage of ST women beneficiaries who are satisfied with the services offered by each aspect of the AWWs. The researcher has only included the responses that expressed "Yes" to all the services performed by the AWWs in each aspect. Based upon the data, further the researcher calculated the Mean, Median, and Standard deviation of the percentage values for each aspect of the AWWs, and compared them to see which aspect has the highest or lowest satisfaction level. The higher the mean and median, the more satisfied the beneficiaries are with the service. The lower the mean, and median, the less satisfied the beneficiaries are with the service. The lower the standard deviation, the less the data vary from the mean. The higher the standard deviation, the more the data vary from the mean. The mean, median, and standard deviation of the data help to analyze the satisfaction level of the beneficiaries and identify the strengths and weaknesses of the AWWs.

Table 4.7: Mean, Median, and Standard Deviation of Satisfaction Level of ST Women Beneficiaries on AWWs

| Sr. No | Service Type | Mean (%) | Median (%) | Standard Deviation (%) |
|---|---|---|---|---|
| 1 | Attitude & behavior of the AWWs | 91.43 | 95 | 9.47 |

| | | | | |
|---|---|---|---|---|
| 2 | Knowledge & skills of the AWWs | 86.1 | 95 | 8.16 |
| 3 | Conducting timely ICDS activities | 91.43 | 95 | 9.47 |

The data in table 4.6 shows that the majority of the beneficiaries are satisfied with the performance of the AWWs, especially on their attitude and behavior, and conducting timely ICDS services. However, the data also reveals some areas of improvement, such as the knowledge and skills of the AWWs.

Based on the table 4.7, the following interpretations were drawn:-

- The beneficiaries are most satisfied with the attitude and behavior of the AWWs, as it has the highest mean (91.43%), and median (95%).
- The beneficiaries are least satisfied with the knowledge and skills of the AWWs, as it has the lowest mean (86.1%), and median (95%).
- The beneficiaries are equally satisfied with conducting the timely ICDS activities, as it has the same mean (91.43%), and median (95%) as the attitude and behavior of the AWWs.
- The attitude and behavior of the AWWs and the conducting timely ICDS activities have the same standard deviation (9.47%), which is higher than the knowledge and skills of the AWWs (8.16%). This means that the data for these two service types are more spread out from the mean than the data for the knowledge and skills of the AWW.

This implies that the high satisfaction levels across all categories suggest that ST women beneficiaries are generally very satisfied with the performance of Anganwadi Workers. The low variability in individual categories indicates consistent positive perceptions. The overall perception was that AWWs are effectively meeting the needs of the community. However, continuous training and support for AWWs should be maintained to sustain these high satisfaction levels.

As the beneficiaries are the recipients of the ICDS services it is essential to take their feedback as well as allow them to give suggestions from their perspective. The table 4.8 shows the areas of improvement for the Integrated Child Development Services (ICDS) scheme as suggested by the Scheduled Tribe (ST) women beneficiaries in rural areas of South district of Goa. This table lists the different service types, such as supplementary nutrition, preschool education, health services, etc., and the percentage of beneficiaries who mentioned them as areas of improvement. The table also shows the total number of responses and the number of beneficiaries who gave multiple responses. The table helps to understand the needs and preferences of the ST women beneficiaries and the gaps and challenges in the ICDS scheme.

Table 4.8: Areas of Improvement as suggested by ST Women Beneficiaries (Multiple Responses)

| # | Suggested Areas of Improvement | Number (N=480) | Percent (%) |
|---|---|---|---|
| 1. | Enhance Training for the AWWs | 215 | 44.79% |
| 2. | Improve Infrastructure | 456 | 95% |
| 3. | Improve Nutritional Support | 323 | 67.29% |
| 4. | Availability of Teaching Aids and Toys | 236 | 49.16% |
| 5. | Access to healthcare services | 193 | 40.20% |
| 6. | No suggestion | 93 | 19.3% |

The interpretation drawn from the table 4.8 is as follows:

- Nearly 45% of respondents believe that enhancing the training of Anganwadi Workers is essential. This indicates that the work of AWWs are generally well-regarded but there is a scope for improvement in their skills and knowledge to make them work more efficiently.

- A significant 95% of respondents emphasized on need of improvement in infrastructure. This implies that poor infrastructure is a major obstacle to the effective delivery of ICDS services.
- Over 67% of respondents opined that nutritional support needs improvement. This indicates that though current nutritional programme is beneficial but there is a gap either in quality, quantity, or consistency of the food provided.
- Almost 49.16% drawn the attention towards better teaching aids and toys. This shows that the current resources for preschool education are insufficient which will affect the quality of early childhood education.
- About 40% of respondents pointed to the need for better access to healthcare services. This indicates that though healthcare services are available but they may not be easily accessible or adequate for all beneficiaries.

The following are some of the implications based on the survey.

- The Anganwadi Workers (AWWs) need more regular and comprehensive training on child development, nutrition, health, and education.
- The Anganwadi Centers need better facilities such as space, ventilation, sanitation, water, and electricity.
- The supplementary food provided to children and pregnant and lactating mothers needs to be improved in terms of quality and quantity.
- The pre-school education component of ICDS needs to be strengthened by providing sufficient and appropriate learning materials and toys to the Anganwadi centers.
- The coordination and convergence of ICDS with the health department needs to be improved to facilitate the provision of immunization, health check-ups, and referral services to children and mothers.

- Some respondents did not have any specific suggestion for the improvement of ICDS scheme or were satisfied with the current status of the scheme.

The feedback from the ST women beneficiaries shows that they appreciate and benefit from the ICDS services. However, it also indicates that some aspects need to be improved. The next chapter will present the future plan based on the suggestions from the ST women beneficiaries.

### 4.2.2 Data Analysis of the information collected from the Anganwadi Workers (AWWs)

The Anganwadi Workers (AWWs) are the frontline workers who deliver the ICDS services at the Anganwadi Centers. To evaluate and enhance the quality and impact of the ICDS scheme, it is important to analyze the data collected from the AWWs. The data collected from AWWs includes various aspects of their work, such as their knowledge, attitude, their concern, and suggestions for the improvement of ICDS scheme. The data analyzed was collected using survey method and analyzed by using statistical techniques. The data analyzed provide valuable insights into the strengths and weaknesses of the AWWs and the ICDS scheme, and suggest ways to improve their performance and outcomes.

According to the guidelines of the Integrated Child Development Scheme (ICDS), AWWs need to have a matriculation degree or higher, and the age between 18-35 years old, to apply for the job. Besides this AWWs should work in the same village where they live, so that they can understand the local issues and communicate with the people better. The selection of AWWs is done by a Selection Committee constituted by the State Government/UT Administration (Press Information Bureau, 2022).

This study selected 60 Anganwadi Centre from twelve panchayats with a high proportion of tribal population in three talukas of South Goa those are Quepem,

Sanguem, and Cancona. The survey included all the Anganwadi Workers (AWWs) from these Centre. Table 4.9 presents the general background of the AWWs.

Table 4.9 General Background of Anganwadi Workers (AWWs)

| # | Particulars | Number (N=60) | Percent (%) |
|---|---|---|---|
| 1 | Age Group of the AWWs | | |
| | • 20-30 | 6 | 10% |
| | • 31-40 | 16 | 26.67% |
| | • 41-60 | 38 | 63.33% |
| 2 | Caste | | |
| | • ST | 39 | 65% |
| | • OBC | 13 | 21.67% |
| | • General | 8 | 13.33% |
| 3 | Educational Qualification | | |
| | • High School | 50 | 83.33% |
| | • Higher Secondary | 10 | 16.67% |
| 4 | Is AWWs from the same village? | | |
| | • Yes | 22 | 36.67% |
| | • No | 38 | 63.33% |

From table 4.9 following observations were made:-

1. The majority of the AWWs (63.33%) are in the 41-60 age group which indicate more experienced AWWs. A smaller proportion (10%) are in the age group of (20-30 years).
2. A significant proportion of AWWs belong to the ST category (65%), which is beneficial for community engagement in tribal areas. The presence of OBC (21.67%) and General (13.33%) categories indicates some diversity.

3. Most AWWs have a high school education (83.33%), with a smaller percentage having completed higher secondary education (16.67%). This suggests a basic level of education among the workers.
4. A majority of AWWs (63.33%) are not from the same village, which could impact their familiarity with local issues and community trust.

The data and observations from table 4.9 reveal some important insights about the current status and challenges of AWWs in South Goa. Based on these, some implications are drawn and suggested some future roadmap in next chapter for improving the situation of AWWs and the AWCs they serve. The implications based on table 4.9 is as follows:-

- The age distribution of AWWs shows that most of AWWs are experienced which is beneficial for the scheme enhancement. However, it also highlight upon a potential training schedule on appointment of new AWWs on retirement of old.
- The significant representation of ST AWWs is advantageous for working in tribal areas, as it can enhance rapport as belonging to same community.
- The basic educational qualification of AWWs suggests that additional training and capacity-building initiatives are essential to enhance their skills and effectiveness in delivering ICDS services.
- The fact that most AWWs are not from the same village could affect their ability to connect with the community.

The general background of AWWs in this study indicate that experienced workforce and significant representation of ST AWWs are positive aspects. However, there is a need for continuous training and community engagement to attract beneficiaries.

The other important factor required by AWWs is their experience to effectively deliver and remain connected with the community. Experienced AWWs will be in better position to develop rapport with the community even if they are not from the same

village. They will have a better understanding of the local problems and can interact with the local people more easily. Experienced AWWs are more likely to have better knowledge of the ICDS guidelines and can provide better quality services to the beneficiaries. Figure 4.3 gives the details of the experience of AWWs from the selected study areas.

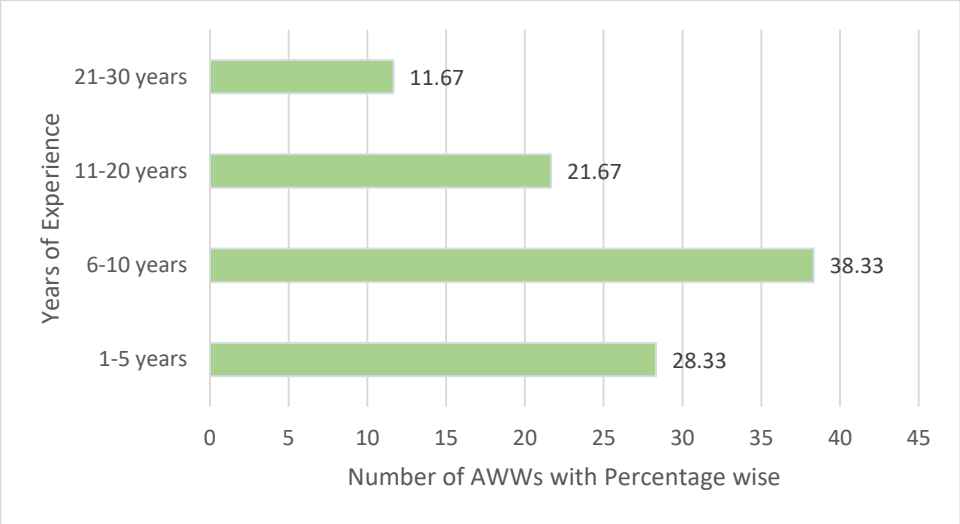



Figure 4.3 Experience of Anganwadi Workers (AWWs)

The figure 4.3 shows the distribution of AWWs by their years of experience. The majority of AWWs have 6 to 10 years of experience, followed by those with 1 to 5 years. Fewer AWWs have 11 to 20 and 21 to 30 years of experience. This implies a workforce with a mix of new and moderately experienced individuals. The implication based upon figure 4.3 is as follows:-

- The experience level of AWWs may affect their performance and quality of service delivery. Experienced AWWs may have more knowledge, skills, and confidence in their work, as well as better rapport with the community. New AWWs may need more training, guidance, and support to cope with the challenges and expectations of their work.

The availability of resources is a crucial factor that can affect the quality of ICDS services. According to a sub-national review of the ICDS scheme in India, the financial

provision for the ICDS scheme by both Central and State authorities is disproportionate to the norms of the policy. Poorer regions with higher levels of malnutrition have received less funding as compared to the wealthier regions with better nutrition status over time (Kumar et al., 2022). This could be one of the factors contributing to the gap between policy and implementation, which has hindered the effectiveness of the scheme (Kumar et al., 2022).

In addition to funding, the availability of human resources such as trained personnel, equipment, and infrastructure also impact the quality of ICDS services. A study conducted in India found that the availability of infrastructure and equipment was significantly associated with the utilization of ICDS services (Joe et al., 2021). The study also found that the availability of trained personnel was positively associated with the utilization of ICDS services (Joe et al., 2021). Another study conducted in India found that the availability of resources such as food, medicines, and equipment was positively associated with the quality of ICDS services (Meena et al., 2017). The study also found that the availability of trained personnel was positively associated with the quality of ICDS services. Therefore, it is important to ensure that adequate resources are available to provide quality ICDS services. This includes ensuring that there is sufficient funding, trained personnel, equipment, and infrastructure to support the scheme.

The literature review also highlights that ICDS faces various challenges in terms of coverage, training, population, and governance. However, among these challenges infrastructure is a critical component of the ICDS scheme, and inadequate infrastructure negatively impact the quality of services provided by ICDS. According to a report by Civils Daily, the ICDS scheme faces infrastructural challenges, such as the lack of functional sanitation facilities, access to potable water, and adequate physical infrastructure in many Anganwadi Centers (Civils Daily, n.d.). Addressing these infrastructural gaps is crucial for improving service delivery and overall scheme effectiveness. Based upon this literature findings the research question is:

1. What are the challenges faced by Anganwadi Workers that hinder their work in tribal dominated panchayats of South Goa?

Table 4.10: Challenges Faced by AWWs in Delivering ICDS services (Multiple Response)

| # | Challenges Faced by AWWs | Number (N=60) | Percent (%) |
|---|---|---|---|
| 1. | Lack of Resources and Infrastructure | 45 | 75% |
| 2. | Limited Community awareness and Participation | 20 | 33.33% |
| 3. | High workload and limited manpower | 39 | 65% |
| 4. | Cultural or social barriers | 11 | 18.33% |
| 5. | Less area population | 24 | 40% |

Based on the data in table 4.10, the following interpretations can be made:

- The most common challenge faced by AWWs is the lack of resources and infrastructure, such as adequate space, equipment, and supplies. This challenge affects 75% of the AWWs which indicates inadequate facilities and materials hindering the effective delivery of the ICDS services.
- The second most common challenge faced by AWWs is high workload and limited manpower with 65%. This indicates that the current workforce is overburdened, which can affect the quality and efficiency of service delivery.
- The third most common challenge, about one third (33.33%) of AWWs face challenges related to limited community awareness and participation. This shows that there is a need for better community engagement and awareness to ensure active participation.
- The fourth most common challenge faced by AWWs is the cultural or social barriers is around 18.33%. This challenge is not as prevalent but it still pose significant challenges in certain contexts.

- The fifth most common challenge, 40% of AWWs report challenges related to serving less populated areas. This could imply difficulties in reaching and effectively serving scattered populations.

The implications based upon the data in table 4.10 is as follows:-

- The lack of resources and infrastructure affect the quality and accessibility of the services provided by AWWs, such as nutrition, health, education, and referral. AWWs face difficulties in storing and distributing food, maintaining hygiene and sanitation, conducting health check-ups and immunizations, and providing learning materials and activities. Therefore, there is a need to improve the physical and operational conditions of the AWCs and provide adequate equipment and supplies to AWWs.
- The limited community awareness and participation affect the demand and utilization of the services provided by AWWs, as well as the trust and cooperation between AWWs and the beneficiaries. AWWs face challenges in mobilizing and educating the community, especially the women and community, about the importance and benefits of the AWCs. Therefore, there is a need to increase the community involvement and ownership of the AWCs and provide effective communication and outreach strategies to AWWs.
- The high workload and limited manpower affect the efficiency and productivity of the AWWs, as well as their health and well-being. AWWs have to perform multiple tasks and responsibilities, often beyond their capacity and scope, without adequate support and assistance. Therefore, there is a need to reduce the workload and increase the manpower of the AWWs and provide them with proper training and supervision.
- The cultural or social barriers affect the acceptance and satisfaction of the services provided by AWWs, as well as the respect and recognition of the AWWs.

There is a need to address the cultural or social barriers and provide a conducive and inclusive environment for the AWWs and the beneficiaries.

- The less area population affect the sustainability of the AWCs. There is a threat the AWC may be closed due to no children enrollment. It is needed to do a systematic study on this issue to resolve.

The infrastructure and facilities of AWCs are crucial for the effective and efficient delivery of ICDS services. AWCs should have adequate space, ventilation, lighting, water, electricity, toilets, and storage facilities. They should also have essential equipment and supplies, such as weighing scales, growth charts, food, medicines, vaccines, learning materials, toys, etc. AWCs should be accessible and safe for the beneficiaries. Table 4.11 evaluates the infrastructure of AWCs based on the availability of building.

Table 4.11: Distribution of Anganwadi Centers by Types of Building

| **AWC Building** | **Quepem** | **Sanguem** | **Cancona** | **Total** |
|---|---|---|---|---|
| Own Building | 1 | 6 | 1 | 8 |
| Rented | 17 | 12 | 14 | 48 |
| Govt. Primary School Building | 0 | 1 | 1 | 2 |
| Govt. High School Building | 1 | 0 | 0 | 1 |
| Community Hall | 0 | 0 | 4 | 4 |
| Anganwadi Workers House | 0 | 1 | 0 | 1 |
| Anganwadi Helpers House | 1 | 0 | 0 | 1 |
| Total | 20 | 20 | 20 | 60 |

The table 4.11 shows the type of building used by AWCs in the tribal panchayats of Quepem, Sanguem, and Cancona taluka. The table 4.11 is used to compare the status and quality of AWC building across the three talukas namely Quepem, Sanguem, and Cancona and identify the gaps and challenges that need to be addressed. The interpretation of table 4.11 is as follows:-

- The table 4.11 shows that the majority of AWCs (80%) are operating in rented buildings, which may affect their stability and security. Only 13.33% of AWCs have their own buildings. The rest of the AWCs are using government school buildings, community halls, or houses of AWWs or AWHs, which affect their space and autonomy.
- The table 4.11 also shows that the AWCs in Sanguem taluka have relatively better building status than the AWCs in Quepem and Cancona taluka. For example, Sanguem has more AWCs with own buildings (30%) and fewer AWCs with rented buildings (60%) than Quepem and Cancona. However, Sanguem also has some AWCs using government school buildings or houses of AWWs or AWHs.

The implications based on table 4.11 is as follows:-

- The type of building used by AWCs has implications for the effectiveness and quality of the services provided by AWWs and the outcomes of the beneficiaries. AWCs with own buildings can offer more stable and secure services to the beneficiaries, such as supplementary nutrition, immunization, health check-up, referral services, pre-school education, and nutrition and health education1. AWCs with own buildings can also create a more conducive and supportive work environment for the AWWs, and a more attractive and engaging learning environment for the beneficiaries, especially the children.
- The type of building used by AWCs also has implications for the satisfaction and motivation of the AWWs and the beneficiaries. AWCs with own buildings can provide more space and autonomy for the AWWs and the beneficiaries, and enhance their sense of ownership and identity. AWCs with own buildings can also increase the trust and cooperation between the AWWs and the beneficiaries, and acknowledge and appreciate their contributions and achievements.

- The type of building used by AWCs also has implications for the sustainability of the ICDS scheme. AWCs with own buildings can ensure the continuity and quality of the services, and attract more beneficiaries and stakeholders to participate and support the scheme. AWCs with own buildings can also reduce the operational costs and risks of the scheme, and increase the efficiency and productivity of the AWWs.

The support of Panchayati Raj Institutions (PRIs) to Anganwadi Centers (AWCs) is crucial for the effective implementation of the Integrated Child Development Services (ICDS) scheme, which aims to provide a package of services for the holistic development of children under six years of age, pregnant and lactating mothers, and adolescent girls. The PRIs can play a vital role in monitoring, supervising, coordinating, and facilitating the functioning of AWCs and the delivery of ICDS services. The PRIs can also mobilize and involve the community in the planning and management of AWCs and the utilization of ICDS services.

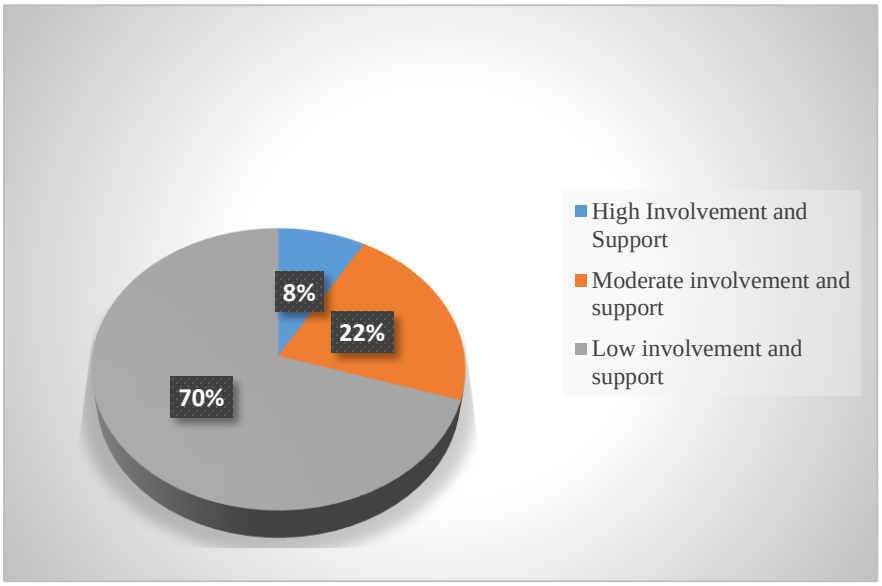



Figure 4.4: Support & Involvement of Panchayati Raj Institutions

The Figure 4.4 shows the level of involvement and support provided by Panchayati Raj Institutions (PRIs) to Anganwadi Centers (AWCs) according to Anganwadi

Workers (AWWs). The figure can be used to compare the status and quality of PRI-AWC collaboration across the three talukas of Quepem, Sanguem, and Cancona and identify the gaps and challenges that need to be addressed.

The interpretation of figure 4.4 is as follows:-

- The Figure 4.4 shows that the majority of AWCs (70%) receive low involvement and support from PRIs, which indicates a lack of collaboration and assistance. This may affect the infrastructure and service delivery of AWCs, as well as the trust and cooperation between AWWs and PRIs.
- The Figure 4.4 also shows that only 8% of AWCs receive high involvement and support from PRIs, which indicates a high level of collaboration and assistance. This may enhance the infrastructure and service delivery of AWCs, as well as the trust and cooperation between AWWs and PRIs.
- The Figure 4.4 further shows that 22% of AWCs receive moderate involvement and support from PRIs, which indicates a moderate level of collaboration and assistance. This may indicate some scope for improvement and upgradation of the infrastructure and service delivery of AWCs, as well as the trust and cooperation between AWWs and PRIs.

The implications of Figure 4.4 is as follows:-

- The level of involvement and support from PRIs to AWCs has implications for the effectiveness and quality of the services provided by AWWs and the outcomes of the beneficiaries. AWCs with high involvement and support from PRIs can offer more comprehensive and integrated services to the beneficiaries, such as supplementary nutrition, immunization, health check-up, referral services, pre-school education, and nutrition and health education.
- The level of involvement and support from PRIs to AWCs also has implications for the satisfaction and motivation of the AWWs and the beneficiaries. AWCs with high involvement and support from PRIs can provide more space and

autonomy for the AWWs and the beneficiaries, and enhance their sense of ownership and identity.

- AWCs with high involvement and support from PRIs can also increase the trust and cooperation between the AWWs and the beneficiaries, and acknowledge and appreciate their contributions and achievements.
- The level of involvement and support from PRIs to AWCs also has implications for the sustainability of the ICDS scheme. AWCs with high involvement and support from PRIs can ensure the continuity and quality of the services, and attract more beneficiaries and stakeholders to participate and support the scheme with high involvement and support from PRIs can also reduce the operational costs and risks of the scheme, and increase the efficiency and productivity of the AWWs.

Anganwadi Centre (AWCs) are the frontline delivery units of the Integrated Child Development Services (ICDS) scheme, which aims to provide health, nutrition, and education services to children and women, especially in rural tribal areas. The quality and availability of AWC infrastructure, such as building, electricity, water, toilet, weighing machine, medicine kit, etc., are crucial for the effective implementation and utilization of the ICDS services. However, many AWCs in India face challenges and gaps in terms of infrastructure, such as lack of space, equipment, and supplies, which hamper the quality and delivery of the ICDS services. Table 4.12 compare the status and quality of AWC infrastructure in selected tribal dominated talukas of South district of Goa, namely Quepem, Sanguem, and Cancona, and identify the gaps and challenges that need to be addressed. The data in table 4.12 is based on a survey of 60 AWCs from these talukas, using a questionnaire to collect information on various indicators of AWC infrastructure, such as the availability of building, electricity, water, toilet, weighing machine kit, etc.

The table 4.12 shows the availability and quality of various infrastructure and facilities at the AWCs in the selected tribal panchayats of Quepem, Sanguem, and

Cancona taluka. The table 4.12 can be used to compare the status and quality of AWC infrastructure across the three talukas and identify the gaps and challenges that need to be addressed.

Table 4.12: Status and Quality of Anganwadi Center Infrastructure

| **Tangible Element** | **Response** | **Quepem** | **Sanguem** | **Cancona** | **Total** |
|---|---|---|---|---|---|
| Electricity | Yes | 13 | 18 | 10 | 41 |
| | No | 7 | 2 | 10 | 19 |
| Fan | Yes | 8 | 16 | 10 | 34 |
| | No | 12 | 4 | 10 | 26 |
| Tap | Yes | 9 | 14 | 5 | 28 |
| | No | 11 | 6 | 15 | 32 |
| Toilet | Yes | 10 | 12 | 5 | 27 |
| | No | 10 | 8 | 15 | 33 |
| Toys | Yes, adequate | 4 | 5 | 4 | 13 |
| | Yes, not adequate | 16 | 15 | 15 | 46 |
| | Not available | 0 | 0 | 1 | 1 |
| Teaching Aid | Yes, adequate | 4 | 7 | 4 | 15 |
| | Yes, not adequate | 14 | 13 | 13 | 40 |
| | Not available | 2 | 0 | 3 | 5 |
| Wall Painting | Yes | 1 | 4 | 3 | 8 |
| | No | 19 | 16 | 17 | 52 |
| Separate Kitchen | Yes | 13 | 12 | 5 | 30 |
| | No | 7 | 8 | 15 | 30 |
| Storage Issue | Yes | 16 | 15 | 16 | 47 |
| | No | 4 | 5 | 4 | 13 |
| Utensils | Yes, adequate | 14 | 17 | 12 | 43 |
| | Yes, not adequate | 6 | 3 | 8 | 17 |
| First Aid | Yes, adequate | 0 | 1 | 7 | 8 |
| | Yes, not adequate | 11 | 19 | 13 | 43 |

| | | | | | |
|---|---|---|---|---|---|
| | Not available | 9 | 0 | 0 | 9 |
| AWC accessibility | Yes, adequate | 19 | 19 | 12 | 50 |
| | Yes, not adequate | 1 | 1 | 8 | 10 |
| Infrastructure | Good | 3 | 9 | 3 | 15 |
| | Average | 14 | 6 | 8 | 28 |
| | Poor | 3 | 5 | 9 | 17 |
| Space of AWC | Adequate | 3 | 9 | 6 | 18 |
| | Not adequate | 17 | 11 | 14 | 42 |
| Baby Weight machine | Yes, functional | 18 | 12 | 14 | 44 |
| | Yes, not functional | 2 | 7 | 5 | 14 |
| | Not available | 0 | 1 | 1 | 2 |
| Weight machine | Yes, functional | 20 | 18 | 19 | 57 |
| | Yes, not functional | 0 | 2 | 1 | 3 |
| Growth monitoring scale | Yes | 20 | 20 | 20 | 60 |
| | No | Nil | Nil | Nil | Nil |

The table 4.12 shows that the AWCs in the three talukas have varying levels of infrastructure and facilities, with some common strengths and weaknesses. The interpretation of table 4.12 is as follows:-

- The common strengths include the availability of electricity, fan, tap, toilet, utensils, weight machine, and growth monitoring scale in most of the AWCs. These are essential for providing basic services such as nutrition, health, and education to the beneficiaries.
- The common weaknesses include the lack of adequate toys, teaching aids, wall painting, separate kitchen, storage space, first aid, and baby weight machine in

most of the AWCs. These are important for creating a child-friendly and stimulating environment for the beneficiaries, especially the children.

- The table 4.12 also shows that the AWCs in Sanguem taluka have relatively better infrastructure and facilities than the AWCs in Quepem and Cancona taluka. For example, Sanguem has more AWCs with good infrastructure, adequate space, functional baby weight machine, and adequate first aid than Quepem and Cancona. However, Sanguem also has some AWCs with not adequate accessibility, which may affect the reach and utilization of the services.

The implications of the table 4.12 is as follows:-

- The infrastructure and facilities of AWCs have implications for the effectiveness and quality of the services provided by AWWs and the outcomes of the beneficiaries. AWCs with better infrastructure and facilities can offer more comprehensive and integrated services to the beneficiaries, such as supplementary nutrition, immunization, health check-up, referral services, pre-school education, and nutrition and health education.
- The infrastructure and facilities of AWCs also have implications for the satisfaction and motivation of the AWWs and the beneficiaries. AWCs with better infrastructure and facilities can create a more conducive and supportive work environment for the AWWs, and a more attractive and engaging learning environment for the beneficiaries, especially the children.
- The infrastructure and facilities of AWCs also have implications for the sustainability of the ICDS scheme. AWCs with better infrastructure and facilities can ensure the continuity and quality of the services, and attract more beneficiaries and stakeholders to participate and support the scheme.

The demand of AWWs for the effective functioning of ICDS in their locality in tribal areas of South Goa is high, as these areas face several challenges and vulnerabilities, such as poverty, malnutrition, illiteracy, morbidity, mortality, and social

exclusion. AWWs play a crucial role in addressing these challenges and improving the health and well-being of the tribal population, especially the women and children. However, AWWs also face various constraints and difficulties in performing their duties, such as lack of resources and infrastructure, limited community awareness and participation, high workload and limited manpower, cultural or social barriers, and less area population. Therefore, there is a need to strengthen the capacity and support of AWWs to enable them to deliver quality and effective ICDS services in their locality in tribal areas of South Goa.

The table 4.13 shows the recommendations given by AWWs for the overall improvement of functioning of the AWCs. The table 4.13 can be used to understand the needs and challenges of AWCs and AWWs, and to identify the possible actions and solutions to address them.

Table 4.13: Anganwadi Workers Recommendations for Enhancing Anganwadi Centers Performance (Multiple Response)

| # | Recommendations by AWWs | Number (N=60) | Percent (%) |
|---|---|---|---|
| 1. | Enhance the Physical and Operational Conditions (Water, Electricity, Toilets, Floor, Roof, floor mats, Storage room etc.) | 60 | 100% |
| 2. | Own Building | 49 | 81.67% |
| 3. | Teaching Aids | 60 | 100% |
| 4. | Educational Toys | 60 | 100% |
| 5. | Provide Uniform to the children | 36 | 60% |
| 6. | Panchayati Raj Institutions support to Anganwadi Centers | 41 | 68.33% |
| 7. | Provide skill based training | 52 | 86.67% |
| 8. | Provide regular health check-ups and insurance coverage for Anganwadi Workers and Anganwadi Helpers | 60 | 100% |

| | | | |
|---|---|---|---|
| 9. | Involve parents and community leaders in the monitoring and evaluation of Anganwadi Centers and Anganwadi Wokers | 51 | 85% |
| 10. | Organize exposure visits and exchange programmes for Anganwadi Workers to learn from best practices and innovations of other Anganwadi Centers | 58 | 96.67% |

The interpretation of table 4.13 is as follows:-

- The table 4.13 shows that all the AWWs (100%) recommended to enhance the physical and operational conditions of the AWCs, such as water, electricity, toilets, floor, roof, floor mats, storage room, etc. This indicates that the infrastructure and facilities of AWCs are inadequate and insufficient, and need urgent improvement and upgradation.
- The table 4.13 also shows that most of the AWWs (81.67%) recommended to have own building for the AWCs, instead of renting or using other buildings. This indicates that the stability and security of the AWCs are compromised, and need to be ensured and protected.
- The table 4.13 further shows that all the AWWs (100%) recommended to have teaching aids and educational toys for the AWCs, to enhance the quality and effectiveness of the pre-school education and the nutrition and health education provided by the AWCs. This indicates that the learning and development of the beneficiaries, especially the children, are not adequately supported and stimulated, and need to be enhanced and enriched.
- The table 4.13 also shows that more than half of the AWWs (60%) recommended to provide uniform to the children, to instill a sense of belonging and identity among them, and to promote their attendance and participation in the AWCs. This indicates that the social and emotional development of the beneficiaries, especially the children, are not sufficiently fostered and nurtured, and need to be improved and encouraged.

- The table 4.13 further shows that more than two-thirds of the AWWs (68.33%) recommended to have PRI support to AWCs, to strengthen the collaboration and coordination between the PRIs and the AWCs, and to enhance the quality and effectiveness of the services provided by the AWCs. This indicates that the involvement and assistance of the PRIs to AWCs are low and limited, and need to be increased and facilitated.
- The table 4.13 also shows that most of the AWWs (86.67%) recommended to provide skill based training to AWWs and AWHs, to enhance their capacity and competency, and to improve their performance and quality of service delivery. This indicates that the skills and knowledge of AWWs and AWHs are not updated and relevant, and need to be developed and refreshed.
- The table 4.13 further shows that all the AWWs (100%) recommended to provide regular health check-ups and insurance coverage for AWWs and AWHs, to ensure their health and well-being, and to protect them from any health risks or hazards. This indicates that the health and safety of AWWs and AWHs are not guaranteed and secured, and need to be ensured and protected.
- The table 4.13 also shows that most of the AWWs (85%) recommended to involve parents and community leaders in the monitoring and evaluation of AWCs and AWWs, to increase their awareness and participation in the AWCs and the services provided by AWWs, and to provide feedback and support to AWWs. This indicates that the engagement and ownership of the parents and community leaders in the AWCs and AWWs are low and limited, and need to be enhanced and empowered.
- The table 4.13 further shows that most of the AWWs (96.67%) recommended to organize exposure visits and exchange programme for AWWs to learn from best practices and innovations of other AWCs, to improve their skills and knowledge, and to share their experiences and challenges. This indicates that the learning

and development of AWWs are not adequately supported and stimulated, and need to be enhanced and enriched.

The implications of table 4.13 is as follows:-

- The recommendations given by AWWs have implications for the effectiveness and quality of the services provided by AWCs and AWWs, and the outcomes of the beneficiaries. AWCs and AWWs with better infrastructure and facilities, skills and knowledge, and support and collaboration can provide more comprehensive and integrated services to the beneficiaries, such as supplementary nutrition, immunization, health check-up, referral services, pre-school education, and nutrition and health education.
- The recommendations given by AWWs also have implications for the satisfaction and motivation of AWWs and the beneficiaries. AWCs and AWWs with better infrastructure and facilities, skills and knowledge, and support and collaboration can create a more conducive and supportive work environment for AWWs, and a more attractive and engaging learning environment for the beneficiaries, especially the children.
- The recommendations given by AWWs also have implications for the sustainability of the ICDS scheme. AWCs and AWWs with better infrastructure and facilities, skills and knowledge, and support and collaboration can ensure the continuity and quality of the services, and attract more beneficiaries and stakeholders to participate and support the scheme.

The feedback from the AWWs suggests that the ICDS scheme needs better infrastructure and incentives to work effectively.

The literature review of this study reveals that the progress of ICDS scheme is being obstructed by difficulties encountered by its functionaries. This investigation aims to identify these obstacles and develop a strategic plan to overcome them. The research question posed is:

1. What obstacles do ICDS functionaries and elected members of Panchayati Raj Institutions face when providing ICDS services?

The next sections of this chapter will discuss the above research question to identify the challenges in detail, focusing on the experiences of health workers, ICDS government officials such as Child Development Programme Officers and Mukhya Sevikas, and elected representatives of Panchayati Raj Institutions. The data is collected by using qualitative methods which includes interviews and the focus group discussions.

### 4.2.3 Data Analysis of the information collected from the Rashtriya Bal Swasthya Karyakram (RBSK) School Health Team visiting Anganwadi Centers

Health Services play a crucial role in delivering health and immunization services of ICDS. Health services of Government of Goa has given the responsibility of delivering health services of ICDS to the health workers who are appointed to work with Primary Health Centers under the national scheme; Rashtriya Bal Swasthya Karykram (RBSK).

The Rashtriya Bal Swasthya Karyakram (RBSK) scheme was launched in 2013 under the National Health Mission to provide child health screening and early intervention services to children between the ages of 0-18 years. The scheme aims to provide comprehensive care to all children in the community, improve the overall quality of life of children, and enable all children to achieve their full potential. The services provided by RBSK include screening of children for 32 common health conditions, immunization, health check-up, referral services, pre-school non-formal education, and nutrition & health education.

The information related to this study is collected through interviews of Ayush Doctors of School Health Team under RBSK scheme from Quepem, Sanguem, and Cancona and analyzed in details**.** The interviews of doctors of School Health Team under

RBSK scheme give their perceptions, the challenges, and recommendations to enhance the scheme. The interpretation of the data collected through interviews is as follows:-

**a) Perceptions:**

- The interviews show that the doctors have a positive perception of their role and impact in improving child health and nutrition, and promoting community health awareness and holistic health approach. The doctors recognize the importance of early identification and intervention of the four Ds: Diseases, Deficiency, Developmental Delay, and Defects, which are the leading causes of morbidity and mortality among children, especially in the tribal areas. The doctors also acknowledge the significance of preventive care and health education, which can help to prevent and reduce the occurrence and severity of the health issues. The doctors also appreciate the holistic health approach, which takes into account the physical, mental, and social aspects of health, and provides comprehensive and integrated services to the beneficiaries.

**b) Challenges**

- The interviews also reveal that the doctors face several challenges in delivering the health services, such as access and reach, less attendance from the SNP beneficiaries, resource constraints, and less cooperation from the beneficiaries. The doctors report that they have low attendance and participation from the SNP beneficiaries, who do not always attend the visits of the doctors, or follow the advice and referrals of the doctors. The doctors also report that they have limited resources and supplies, such as infrastructure, space, equipment. As per the guidelines, doctors have to identify four ‘Ds’ among children and not to provide any medicines, to which many beneficiaries shows dissatisfaction as their expectation is to provide them at least mild diseases medicines. Due to which doctors report that they have less cooperation and support from the beneficiaries, who do not always follow up with the doctor’s visits.

**c) Recommendations**

- The recommendations from the doctors for improving the functioning of the AWCs and the health services, such as comprehensive training, regular monitoring and evaluation, community mobilization and involvement, and convergence and coordination. The doctors recommend that the AWWs should be provided with comprehensive training on various aspects of health and nutrition, such as identification and management of the four Ds, preventive care and health education, holistic health approach, etc. The doctors also recommend that the AWCs and the health services should be regularly monitored and evaluated, to assess the performance and quality of the services, and to identify the gaps and priorities for improvement and up gradation. The doctors also recommend that the community, especially the parents and the community leaders, should be mobilized and involved in the planning and management of the AWCs and the health services, to increase their awareness and participation, and to provide feedback and support to the AWWs and the doctors.

The implications of the data collected from the interviews with the Doctors of School Health Team under RBSK scheme is as follows:-

- The interviews of doctors have implications for the effectiveness and quality of the health services provided by the AWCs and the School Health Team, and the outcomes of the beneficiaries. The interviews indicate that the health services have some strengths, such as positive perception, community health awareness, and holistic health approach, which can be enhanced to improve the health and well-being of the beneficiaries. The interviews also indicate that the health services have some weaknesses, such as access and reach, less attendance, resource constraints, and less cooperation, which need to be addressed and resolved to improve the health and well-being of the beneficiaries.
- The interviews of doctors also have implications for the satisfaction and motivation of the doctors, who are the frontline workers of the health services.

The interviews indicate that the AWWs and the doctors have some challenges, such as access and reach, resource constraints, and less cooperation, which affect their work environment and performance, and may lead to frustration. The interviews also indicate that the doctors have some recommendations, such as comprehensive training, regular monitoring and evaluation, community mobilization and involvement, and convergence and coordination, which can help to improve their work environment and performance, and to increase their satisfaction and motivation.

### 4.2.4 Data Analysis of the information collected from the Child Development Programme Officers (CDPO) and Mukhya Sevikas (MS)

The focus group discussion with the Child Development Programme Officer (CDPO) and Mukhya Sevikas provides valuable insights into their perceptions, challenges, and recommendations regarding the delivery of Integrated Child Development Services (ICDS) in South Goa. The focus group discussion can be used to understand the strengths and weaknesses of the existing ICDS system, and to identify the possible actions and solutions to improve the quality and effectiveness of the ICDS services. The interpretation of the data based upon the focus group discussion with the CDPOs and Mukhya Sevikas is as follow:-

**a) Perception:**

- The focus group discussion shows that the CDPO and Mukhya Sevikas have a positive perception of their responsibility, community link, and holistic approach in delivering ICDS services. The CDPO and Mukhya Sevikas recognize the importance of their role in ensuring child health, nutrition, and early education in their block, and in supervising and supporting Anganwadi Workers (AWWs) in their allotted Anganwadi Centers (AWCs). The CDPO and Mukhya Sevikas also

acknowledge the significance of their community link, which helps them to bridge the gap between the ICDS scheme and the local beneficiaries to promote ICDS services. The CDPO and Mukhya Sevikas also appreciate the holistic approach, which helps them to address the health, education, and nutrition interventions for children up to age 6 years and care for pregnant and lactating women.

**b) Challenges:**

- The focus group discussion also reveals that the CDPO and Mukhya Sevikas face several challenges in delivering ICDS services, such as resource constraints, service delivery challenges, community engagement challenges, training needs, workload, and monitoring and evaluation challenges. The CDPO and Mukhya Sevikas report that they have limited resources, such as infrastructure, staff, and supplies, which affect the quality and effectiveness of the ICDS services. The CDPO and Mukhya Sevikas also report that they have difficulties in reaching and providing consistent services to the remote tribal communities, due to inadequate infrastructure and challenging terrain, and in convincing the tribal families, due to their social and cultural barriers. The CDPO and Mukhya Sevikas also report that they have training needs, such as continuous learning and capacity building, to enhance their skills and knowledge in child nutrition, health, and early education. The CDPO and Mukhya Sevikas also report that they have a significant workload, due to supervising multiple AWWs, and balancing administrative tasks, training, and fieldwork. The CDPO and Mukhya Sevikas also report that they have challenges in data collection and quality assessment, due to network issues in remote areas.

**c) Recommendations**

- The focus group discussion also suggests that the CDPO and Mukhya Sevikas have some recommendations for improving the functioning of the AWCs and the ICDS services, such as strengthening training programme, improving

infrastructure and supplies, increasing staff and incentives, enhancing community involvement and awareness, and ensuring convergence and coordination. The CDPO and Mukhya Sevikas recommend that the AWWs and AWHs should be provided with regular and relevant training programme, to enhance their skills and knowledge in child nutrition, health, and early education, and to stay updated on best practices. The CDPO and Mukhya Sevikas also recommend that the AWCs should be provided with adequate and appropriate infrastructure and supplies, such as buildings, water, electricity, toilets, space, equipment, food, materials, etc., to improve the quality and effectiveness of the ICDS services. The CDPO and Mukhya Sevikas also recommend that the community, especially the parents and the community leaders, should be involved and aware of the ICDS services, and their benefits, and should provide feedback and support to the AWWs and the CDPO and Mukhya Sevikas.

The implications of the data collected from the focus group discussion with the CDPO is as follows:-

- The focus group discussion with the CDPO and Mukhya Sevikas has implications for the effectiveness and quality of the ICDS services provided by the AWCs. The focus group discussion indicates that the ICDS services have some strengths, such as positive perception, community link, and holistic approach, which can be leveraged and enhanced to improve the health and well-being of the beneficiaries. The focus group discussion also indicates that the ICDS services have some weaknesses, such as resource constraints, service delivery challenges, community engagement challenges, training needs, workload, and monitoring and evaluation challenges, which need to be addressed and resolved to improve the health and well-being of the beneficiaries.
- The focus group discussion with the CDPO and Mukhya Sevikas also has implications for the satisfaction and motivation of the AWWs and the CDPO and

Mukhya Sevikas, who are the frontline workers of the ICDS services. The focus group discussion indicates that the AWWs and the CDPOs and Mukhya Sevikas have some challenges, such as resource constraints, service delivery challenges, community engagement challenges, training needs, workload, and monitoring and evaluation challenges, which affect their work environment and performance. The focus group discussion also indicates that the CDPO and Mukhya Sevikas have some recommendations, such as strengthening training programme, improving infrastructure and supplies, increasing staff and incentives, enhancing community involvement and awareness, and ensuring convergence and coordination, which can help to improve their work environment and performance, and to increase their satisfaction and motivation.

### 4.2.5 Data Analysis of the information collected from the Elected Members of Panchayati Raj Institutions (PRIs)

The focus group discussion with the Elected Representatives (ERs) of Panchayati Raj Institutions (PRIs) provides valuable insights into their perception, challenges, and recommendations regarding the delivery of Integrated Child Development Services (ICDS) in their locality. The focus group discussion can be used to understand the strengths and weaknesses of the existing ICDS system, and to identify the possible actions and solutions to improve the quality and effectiveness of the ICDS services. The interpretation of the data collected from the focus group discussion with the elected representatives of Panchayati Raj Institutions is as follows:-

**a) Perception:**

- The focus group discussion shows that the ERs have a positive perception of the usefulness of ICDS services, especially for people living in rural and remote areas. The Elected Representatives (ERs) recognize the importance of ICDS services in

improving the health, nutrition, and education of children below six years of age, mothers, and adolescent girls. The ERs also acknowledge the benefits of ICDS services in creating awareness among the people about their social and health issues.

**b) Challenges**

- The focus group discussion also shows that the ERs have a mixed perception of their role in AWCs. The ERs are unaware about their role in ICDS and perceive their role in ICDS scheme is not much. The ERs also report that most AWCs are rented, which makes renovation a challenge, and that the panchayat has no land to donate for AWCs.

**c) Recommendations**

- The focus group discussion shows that the ERs are satisfied with the ICDS services, but they also highlight certain issues persisting in AWCs which hinder the ICDS functioning and need to be improved. The ERs report that the lack of adequate infrastructure, such as space, electricity, fans, toilets, storage, separate kitchen, and wall painting, is the main reason for the poor quality of services which are needed to be upgraded on urgent basis. ERs also recommended for government action plan that will coordinate their role with AWWs in solving the problems of ICDS at the grass root level.

The implications of the data collected from the elected representatives on implementation and challenges of ICDS scheme is as follows:-

- The focus group discussion with the ERs has implications for the effectiveness and quality of the ICDS services provided by the AWCs. The focus group discussion indicates that the ICDS services have some strengths, such as usefulness and awareness, which can be leveraged and enhanced to improve the health and well-being of the beneficiaries. The focus group discussion also indicates that the ICDS services have some weaknesses, such as infrastructure,

which need to be addressed and resolved to improve the health and well-being of the beneficiaries.

- The focus group discussion with the ERs also has implications for the role and participation of the PRIs in the ICDS scheme. The focus group discussion indicates that the PRIs have some potential, such as problem-solving, supervision, and monitoring, which can be utilized and strengthened to improve the functioning and quality of the AWCs. The focus group discussion also indicates that the PRIs have some gaps, such as lack of land and guidance, which need to be filled and enhanced to improve the functioning and quality of the AWCs.

To sum up chapter four, the Integrated Child Development Services (ICDS) scheme is a flagship programme of the Indian government that aims to provide holistic care and development for children under six years, pregnant women, and lactating mothers. The scheme has been operational since 1975 and covers various aspects such as nutrition, health, education, and social protection. However, the scheme faces several challenges in terms of implementation, monitoring, evaluation, and impact. Some of the major challenges are inadequate infrastructure, poor quality of services, lack of community participation, and lack of skilled training. These challenges affect the effectiveness and efficiency of the scheme and limit its potential to achieve its objectives. Therefore, there is a need to strengthen the ICDS scheme by addressing these challenges and adopting best practices from successful models. The possible recommendations and roadmap given in the next chapter based upon the findings and observations.

# Chapter 5

# Conclusion

## 5.1 Future Directions for ICDS

The Integrated Child Development Services (ICDS) scheme is a flagship programme of Government of India launched on 2nd October 1975 with an aim to develop holistic development of children between the age group of 0-6 years, pregnant women, lactating mothers, and adolescent girls. The ICDS provides six services to its beneficiaries which includes supplementary nutrition, immunization, health checkups, preschool education, Nutrition and Health Education and referral services. The research indicates that the ICDS significantly influences the lives of beneficiaries, yet it faces several challenges. Addressing these issues requires a comprehensive assessment of the scheme at the grass root level and provide with evidence based recommendations to enhance the scheme.

This is the conclusion chapter of the study on the Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa. The study aimed to assess the performance and impact of the ICDS scheme on the beneficiaries which includes ST women beneficiaries. For its comprehensive assessment and to meet the study objectives it includes other stakeholders those are Anganwadi Workers (AWWs), Child Development Programme Officers (CDPO), Mukhya Sevikas (MS), and Health Workers from School Health Team and elected representatives of Panchayati Raj Institutions (PRIs).

To provide evidence based recommendations, the study used both qualitative and quantitative methods for data collection and analyzed the scheme to assess its effectiveness and challenges in delivering the six designated services, and its outcomes and feedback from the stakeholders. The study also proposed recommendations based on the findings and observations. The literature review of the study gives the direction

to conduct the comprehensive evaluation of performance of ICDS scheme in tribal dominated panchayats of South Goa.

The literature review conducted for this study highlights several critical gaps in the existing knowledge regarding the performance of the ICDS scheme in tribal dominated areas of South Goa. These gaps provide a foundation for understanding the challenges and areas of improvement to enhance the effectiveness of scheme.

The research identifies a significant lack of studies on the policy making process and evaluation of ICDS while implementing it in the tribal areas of Goa. Understanding perception of stakeholders on strengths and weaknesses of implementation processes of ICDS at the grass root level is crucial for providing evidence based recommendations for policymaking and effective implementation of the scheme. Similarly the literature shows, there is limited research on the role of community involvement in the ICDS scheme. Understanding perception of community is essential for improving effectiveness of scheme. Literature has shown gaps on achievement of objectives of ICDS, its implementation, and challenges it faces. The implementation has various barriers in remote areas with geographical and infrastructural challenges, which need to be studied to enhance success of the scheme. The literature gap identifies the need to explore possibilities of engaging stakeholders in ICDS functioning to improve the scheme. The literature gaps also specifically identifies the lack of studies on health and nutritional challenges faced by rural areas that need to be studied.

Based on the literature gaps identified, the study has been designed to evaluate the scheme at the tribal dominated panchayats of South Goa based on qualitative and quantitative methods. The findings of the survey as discussed subsequently.

## 5.2 Major Findings and Observations

### (a) Findings

The following findings are analyzed from the data collected by using qualitative and quantitative methods which includes survey, interviews and focus group discussions.

1. **Effect of Prior Experience on ICDS Utilization**

The chi square result of the Table 4.2 reveals that the prior experience of the women affected their use of ICDS services. Women who had used them before were more regular, while women who were new to them were more irregular. The positive experience of prior users will encourage the new users to use ICDS services. It is important to consider the feedback and experiences of beneficiaries while bringing changes in the scheme.

2. **ICDS Scheme: Meeting the Needs of ST Women in Goa, But Not Enough**

Based on the table 4.3, the ST women have a high demand and satisfaction for some of the services, but a low utilization and awareness for others. The table 4.3 reveals that the ICDS scheme is meeting some of the important needs and preferences of the ST women in Goa, such as nutrition and health education, early childhood education, antenatal care, and immunization. The ST women are also very satisfied with the work of the Anganwadi workers and the home visits they provide. The ST women value the Anganwadi as a vital resource for them and their children. However, the table also shows that the ICDS scheme needs to improve its service delivery and outreach for family counselling and support, which is the least common reason for visiting AWCs among the ST women.

### 3. The Gap Between Availability and Utilization of Referral Services for Rural Women

Graph 2 shows that Supplementary Nutrition and Preschool Education are the most popular and beneficial services utilized by rural women and their children. However, Referral Services, which can also help them access health care and other resources, are rarely used. This is because of the difficulties and expenses of travelling from remote areas.

### 4. Satisfaction Level of Beneficiaries of ICDS Services

The Integrated Child Development Services (ICDS) is a government scheme that provides various services to rural women and children, such as supplementary nutrition, preschool education, health and family welfare, and referral services. Based on the table 4.4 and 4.5, the beneficiaries are most satisfied with the health and family welfare services, and least satisfied with the physical infrastructure of the ICDS centers. The beneficiaries have similar satisfaction levels for the supplementary nutrition programme and the preschool education, except for some variations in the availability and utilization of learning activities and the quality of health services. The data for the physical infrastructure and the preschool education have more variability than the data for the other service types, which indicates that the satisfaction level of the beneficiaries may depend on the location and condition of the ICDS centers.

### 5. Satisfaction Level of Beneficiaries with AWWs Performance

The table 4.6 and 4.7 shows the satisfaction level of the beneficiaries with the performance of the Anganwadi Workers (AWWs) on three service types: attitude and behavior, knowledge and skills, and conducting timely ICDS activities. The beneficiaries are most satisfied with the attitude and behavior of the AWWs, and least satisfied with the knowledge and skills of the AWWs. The beneficiaries have similar satisfaction levels

for the attitude and behavior of the AWWs and the conducting timely ICDS activities, but these two service types have more variability than the knowledge and skills of the AWWs.

### 6. Beneficiaries' Suggestions for Improving ICDS Services

The table 4.8 shows the areas of improvement for the Integrated Child Development Services (ICDS) programme as suggested by the Scheduled Tribe (ST) women beneficiaries in rural areas of Goa. The table shows that the beneficiaries want more improvement in the infrastructure of the Anganwadi Centers, which is the most common suggestion, and less improvement in the training of the Anganwadi Workers, which is the least common suggestion. The table also shows that the beneficiaries are happy with the performance of the Anganwadi Workers, but they want more improvement in the quality and availability of the ICDS services, such as nutritional support, teaching aids and toys, and healthcare services.

### 7. AWWs' Status and Challenges in South Goa

The table 4.9 shows the age, religion, caste, education, and village of origin of the Anganwadi Workers (AWWs) in South Goa, who provide various services to rural women and children under the Integrated Child Development Services (ICDS) scheme. The table indicates that most of the AWWs are older, have high school education which is minimum educational qualification, and are not from the same village where they serve the Anganwadi Centers (AWCs) as per the ICDS guidelines. This suggests that they have more experience and seniority, but also face some challenges such as they limited only to high school education which is a required qualification and not motivated for higher education, travel difficulties, and low community connection as not from same village. This may affect their availability, accessibility, motivation, trust, rapport, and

communication, and consequently, the quality and effectiveness of their services and the outcomes of the AWCs.

**8. Experience Level of AWWs in South Goa**

The figure 3 shows the distribution of Anganwadi Workers (AWWs) by their years of experience in South Goa, where they provide various services to rural women and children under the Integrated Child Development Services (ICDS) scheme. The graph 3 shows that most of the AWWs have 6 to 10 years of experience, followed by those with 1 to 5 years. Fewer AWWs have 11 to 20 and 21 to 30 years of experience. This indicates a workforce with a mix of new and moderately experienced individuals. The figure 3 also suggests that the experience level of AWWs may affect their performance, retention, and succession. Experienced AWWs may have more knowledge, skills, confidence, and rapport, but also more satisfaction, commitment, or opportunities. New AWWs may need more training, guidance, and support, but also more motivation and enthusiasm. There may be a need to recruit, train, and retain more AWWs in the younger age groups.

**9. Challenges Faced by AWWs in South Goa**

The table 4.10 shows the challenges faced by the Anganwadi Workers (AWWs) in South Goa, who provide various services to rural women and children under the Integrated Child Development Services (ICDS) scheme. The table shows that the most common challenges are the lack of resources and infrastructure, the high workload and limited manpower, the limited community awareness and participation, the cultural or social barriers, and the less area population. The table suggests that these challenges affect the quality and delivery of the ICDS services, as well as the stress, productivity, and satisfaction of the AWWs.

**10. Building Status of AWCs**

The table 4.11 compares the building status of AWCs in three talukas of Goa which are tribal dominated those are Sanguem, Quepem, and Cancona. The table 4.11 reveals that most AWCs (80%) do not have their own buildings and operate in rented premises, which compromises their quality and security. As per the data of table 4.11, only 13.33% of AWCs have their own buildings, while the remaining AWCs use other public or private spaces, which limit their space and autonomy. There is a need to improve the infrastructure and facilities of AWCs.

**11. PRI Involvement and Support to AWCs**

The figure 4 shows the level of involvement and support from Panchayati Raj Institutions (PRIs) to Anganwadi Centers (AWCs) in three talukas of Goa. The interpretation reveals that most AWCs (70%) receive low involvement and support from PRIs, which may hamper their infrastructure and service delivery, as well as their trust and cooperation with Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs). Only 8% of AWCs receive high involvement and support from PRIs and 22% of AWCs receive moderate involvement and support from PRIs. The level of involvement and support from PRIs to AWCs has a significant impact on the sustainability of the Integrated Child Development Services (ICDS) scheme, which aims to provide holistic development to children and women in rural areas.

**12. Status of Infrastructure and facilities in AWCs of selected areas**

Table 4.12 compares the infrastructure and facilities of 60 Anganwadi Centers (AWCs) in three tribal dominated talukas of South district of Goa, namely Quepem, Sanguem, and Cancona. The interpretation of table 4.12 shows that most of the AWCs have the availability of electricity, fan, tap, toilet, utensils, weight machine, and growth monitoring scale which is considered as the strengths of AWCs. However, most AWCs lack the facilities like toys, teaching aids, wall painting, separate kitchen, storage space,

first aid, and baby weight machine. Beside there is lack of space, storage issues, no separate kitchen in most of the AWCs.

### 13. Recommendations of AWWs for Improving AWCs in Tribal Areas of Goa

Table 4.13 presents the recommendations of Anganwadi Workers (AWWs) for improving the infrastructure, facilities, and services of Anganwadi Centers (AWCs) in tribal areas of Goa, based on a survey of 60 AWWs. The data in table 4.13 shows that the AWWs recommended to enhance the physical and operational conditions of the AWCs, to have own building for the AWCs, to have teaching aids and educational toys for the AWCs, to provide uniform to the children, to have Panchayati Raj Institution (PRI) support to AWCs, to provide skill based training to AWWs and Anganwadi Helpers (AWHs) rather than just lectures, to provide regular health check-ups and insurance coverage for AWWs, and to organize exposure visits and exchange programmes for AWWs.

### 14. Health Workers Views on AWCs and Health Services in Tribal Areas of Goa

The interviews with the doctors reveal their perceptions, challenges, and recommendations regarding the Anganwadi Centers (AWCs) and the health services they provide to the Scheduled Tribe (ST) women and children in rural areas of Goa. The summary is organized into three main sections: perceptions, challenges, and recommendations.

#### a) Perceptions

The doctors have a positive perception of their role and impact in improving child health and nutrition, and promoting community health awareness and holistic health approach. They recognize the importance of early identification and intervention of the four Ds: Diseases, Deficiency, Developmental Delay, and Defects, which are the

major causes of ill health and death among children, especially in the tribal areas. They also acknowledge the significance of preventive care and health education, which can help to prevent and reduce the incidence and severity of the health problems. They also appreciate the holistic health approach, which considers the physical, mental, and social aspects of health, and provides comprehensive and integrated services to the beneficiaries.

**b) Challenges**

The doctors face several challenges in delivering the health services, such as access and reach, less attendance from the SNP beneficiaries, resource constraints, and less cooperation from the beneficiaries. They report that they have low attendance and participation from the SNP beneficiaries, who do not always attend the visits of the doctors, or follow the advice and referrals of the doctors. They also report that they have limited resources and supplies, such as infrastructure, space, equipment, and medicines, which hinder the effective delivery of the health services.

**c) Recommendations**

The doctors have some recommendations for improving the functioning of the AWCs and the health services, such as comprehensive training, regular monitoring and evaluation, community mobilization and involvement, and convergence and coordination. They recommend that the AWWs should be provided with comprehensive training on various aspects of health and nutrition, such as identification and management of the four Ds, preventive care and health education, holistic health approach, etc. They also recommend that the AWCs and the health services should be regularly monitored and evaluated, to assess the performance and quality of the services, and to identify the gaps and priorities for improvement and up gradation. They also recommend that the community, especially the parents and the community leaders, should be mobilized and involved in the planning and management of the AWCs

and the health services, to increase their awareness and participation, and to provide feedback and support to the AWWs and the doctors. They also recommend that the AWCs and the health services should be converged and coordinated with other schemes and programmes, such as ICDS, Poshan Abhiyaan, Beti Bachao Beti Padhao, Swachh Bharat Mission, etc., to enhance the comprehensiveness and integration of the services, and to leverage the resources and capacities of different stakeholders.

## 15. Perceptions, Challenges, and Recommendations of CDPO and Mukhya Sevikas on ICDS Services

The summary is based on the focus group discussion with the Child Development Project Officer (CDPO) and Mukhya Sevikas, who are the supervisors and coordinators of the Integrated Child Development Services (ICDS) programme in rural areas of Goa. The summary covers three main aspects: perceptions, challenges, and recommendations.

### a) Perceptions

The CDPO and Mukhya Sevikas have a positive perception of their responsibility, community link, and holistic approach in delivering ICDS services. They recognize their role in ensuring child health, nutrition, and early education, and in supervising and supporting Anganwadi Workers (AWWs). They also acknowledge their community link, which helps them to connect the ICDS program and the local beneficiaries, and to engage with the families and caregivers. They also appreciate the holistic approach, which helps them to address the health, education, and nutrition interventions for children and pregnant and lactating women.

### b) Challenges

The CDPO and Mukhya Sevikas face several challenges in delivering ICDS services, such as resource constraints, service delivery challenges, community engagement challenges, training needs, workload, and monitoring and evaluation challenges. They report that they have limited resources, such as infrastructure, staff, and supplies, which affect the quality and effectiveness of the ICDS services. They also report that they have difficulties in reaching and providing consistent services to the remote tribal communities, due to inadequate infrastructure and challenging terrain, and in convincing the tribal families, due to their social and cultural barriers. They also report that they have challenges in building trust and awareness among the beneficiaries, and in tailoring the interventions to the tribal cultural practices. They also report that they have training needs, such as continuous learning and capacity building, to enhance their skills and knowledge in child nutrition, health, and early education. They also report that they have a significant workload, due to supervising multiple AWWs, and balancing administrative tasks, training, and fieldwork. They also report that they have challenges in data collection and quality assessment, due to network issues and remote areas.

### c) Recommendations

The CDPO and Mukhya Sevikas have some recommendations for improving the functioning of the AWCs and the ICDS services, such as strengthening training programmes, improving infrastructure and supplies, increasing staff and incentives, enhancing community involvement and awareness, and ensuring convergence and coordination. They recommend that the AWWs and AWHs should be provided with regular and relevant training programmes, to enhance their skills and knowledge in child nutrition, health, and early education, and to stay updated on best practices. They also recommend that the AWCs should be provided with adequate and appropriate infrastructure and supplies, such as buildings, water, electricity, toilets, space, equipment, food, materials, etc., to improve the quality and effectiveness of the ICDS

services. They also recommend that the AWWs and AWHs should be provided with adequate staff and incentives, such as honorarium, insurance, health check-ups, etc., to reduce the workload and increase the motivation of the AWWs and AWHs. They also recommend that the community, especially the parents and the community leaders, should be involved and aware of the ICDS services, and their benefits, and should provide feedback and support to the AWWs and the CDPO and Mukhya Sevikas.

### 16. Perceptions, Satisfaction, and Issues of ERs on ICDS Services

The summary is based on the focus group discussion with the Elected Representatives (ERs), who are the local leaders and decision-makers in rural areas of Goa. The summary covers three main aspects: perceptions, satisfaction, and issues.

#### a) Perceptions

The ERs have a positive perception of the usefulness of ICDS services, especially for people living in rural and remote areas. They recognize the importance of ICDS services in improving the health, nutrition, and education of children, mothers, and adolescent girls. They also acknowledge the benefits of ICDS services in creating awareness among the people about their social and health issues.

#### b) Satisfaction

The ERs are satisfied with the ICDS services, but they have a mixed perception of their role in AWCs. The ERs perceive their role in ICDS scheme as not much, but they also state that they should ensure the effective functioning of AWCs and support in problem-solving, supervision, and monitoring. The ERs also state that they should extend their guidance to the ICDS staff whenever they approach them.

#### c) Issues

The ERs highlight certain issues persisting in AWCs which hinder the ICDS functioning. The ERs report that the lack of adequate infrastructure, such as space, electricity, fans, toilets, storage, separate kitchen, and wall painting, is the main reason for the poor quality of services. The ERs also report that most AWCs are rented, which makes renovation a challenge, and that the panchayat has no land to donate for AWCs. ERs also pointed that since Anganwadi Centers are located in private spaces, there is reluctance to utilize MGNREGA funds for renovation purposes.

**(b) Observations by Researcher**

Researcher made observations during the field visits. Researcher has interacted 480 women beneficiaries, 60 Anganwadi Workers, CDPOs, Mukhya Sevikas, Doctors of School Health Team from Primary Health Centers, and elected representatives of PRIs from Sanguem, Quepem, and Cancona block, and the following observations are made.

1. **Food Supply and Nutrition**
    - **Change in pattern of food supply to AWC: -** It has been observed that the food supply pattern is changed at AWCs. The AWCs have switched from providing food grains to ready-made mixture of food grains powder.
    - **Beneficiaries refusing to accept: -** The beneficiaries reject the ready-made mixture of food grain powder at the AWCs and the Take Home Ration services. They want the previous food supply pattern with better quality. They claim that the packed food causes weight loss and health problems for the children.
    - **Children are not consuming cooked packed food at AWC: -** It has been informed that the children do not eat the food cooked using food grain powder at the AWCs because they find it unpalatable.
    - **Stand of ICDS Authority: -** The ICDS authorities have decided to revert to the previous food supply pattern of providing food grains to the AWCs for home-

like cooked food, but the Take Home Ration services will continue to offer food grain powder packets.

2. **Preschool Education**

- **More emphasis only on Supplementary Nutrition: -** The AWWs reported that the ICDS focuses more on Supplementary Nutrition and less on Preschool education. They have to submit many reports and surveys, which leaves them with little time for the children. This affects the AWCs and the parents complain. Besides there is lack of teaching aids, toys, floor mats, first aids etc. which are essential commodity for conducive school environment.
- **No Job Training to newly recruited AWWs: -** The survey also revealed that the newly recruited AWWs lack adequate training in providing preschool education. AWWs even with five years of experience have not received Job training or Refresher training, which hinders their ability to deliver non-formal education. Regular online training is conducted for all the AWWs but it is not beneficial to them in non-formal education.
- **Lack of teaching aids and toys: -** Some Anganwadi centers lack adequate or functional teaching aids for non-formal education as well as toys. Providing these would improve the quality of non-formal education.

3. **Infrastructure and Enrollment**

- **Poor Infrastructure-** The researchers observed that some Anganwadi in the mining belt were built or renovated by the mining company or NGOs like Vedanta under the CSR project, or by Mineral Foundation of Goa or under the scheme Atal Gramin Yojna. There are some premises which are given by Self Help Groups for running the AWCs. However, many are in rented premises and in a very poor conditions lacking with basic facilities like electricity, proper flooring, adequate space etc.

- **Issue of sustainability of AWCs: -** The AWWs reported that many migrant families left the mining belt after the mining ban, which resulted in low enrollment of children. Besides some areas have very less population which raising the issue of sustainability of AWCs.

4. **Health and Referrals Services**
    - **Demand for improved Healthcare services: -** The Primary Health Center (PHCs) of each taluka provide regular and timely health services, but the people also want some medicines for their children provided during doctors' visits.
    - **Referral services: -** The AWWs also reported that some parents do not follow up on the referrals given by the doctors for their children due to transportation or cost issues and social barriers.
    - **Weekly Home Visits: -** The AWWs visit pregnant women and lactating mothers every Saturday to monitor and advise them. The AWHs take care of the children at the AWCs in their absence of AWWs.

5. **Community Participation and Convergence**
    - **AWWs are not from the same village: -** The survey found that most of the AWWs are not from the same village.
    - **Community Leaders Participation Negligible: -** The AWWs informed that the community leaders hardly participate in the AWCs. They do not pay attention to the AWCs' needs and may not be interested or aware of the value of the services offered by the AWCs. The AWWs also said that community leaders' involvement in the Anganwadi activities would be beneficial.
    - **Less engagement by the Panchayats: -** Panchayat is a convergent department with the ICDS. Panchayat can help with infrastructure support

under MGNREGS. However, some panchayat members are not active and do not attend the AWCs activities even when invited as informed by AWWs.

6. **Anganwadi Workers: Demands and Suggestions**

- **Demand for Skill-Based Training: -** The AWWs were highly satisfied with the five-day training organized in collaboration with the Sarva Shiksha Abhiyan. They want regular training like this to enhance their non-formal teaching skills. They prefer skill-based training over lecture based training.
- **Demand for a monthly supply of food supply: -** The survey reveals that the food supply is once every two months. The AWWs and the beneficiaries request to change it to once every month.
- **Relive from Additional Charge to AWWs and AWHs at the earliest: -** The survey identifies few cases where the AWWs or AWHs have been handling additional charge of AWCs for more than five months. The demand is not to extend the additional charge beyond one month as it affects their services at the AWCs.
- **Make available First Aid kit: -** The AWCs visited reported that they have had no first aid kit since reopening from Covid-19. They request to provide the first aid kit.
- **Replacement of non-functional Weighing Machines: -** Some Anganwadi visited during the survey had non-functional weighing machines, especially the infant baby weighing machines.

Findings and observations of the study provides valuable insights to the policy making on the strength and weaknesses of ICDS scheme that has been functioning in remote tribal areas of Goa. It also proves the importance of studying stakeholder's perceptions in knowing the grassroots reality and work accordingly to improve upon it. However, the study lacks certain limitations which are discussed below that will shape the future scope of the study

## 5.3 Limitations of the Study

The research provides an in-depth analysis of the Integrated Child Development Services (ICDS) scheme with specific tribal regions of South Goa. However, it is important to note the following constraints that bound the scope of the study:

1. **Accessibility Challenges:** The study faced challenges in accessing Anganwadi Centers (AWCs) due to the improper pathways. AWCs visited were in remote areas and many not having direct routes to reach them.
2. **Transportation Issues:** Limited public transport and poor road conditions hindered the timely and consistence visits to the AWCs.
3. **Beneficiary Engagement Challenges:** Convincing beneficiaries to participate in the study was another major limitation. General mistrust of outsiders made it difficult to engage with the community. Additionally, beneficiaries were not available due to their household commitment leading to the further delay.
4. **Unavailability of AWWs:** Due to the official commitment AWWs were unavailable that resulted in delays and cancellations of scheduled visits.

## 5.4 Future Scope of the Study

1. Future research should focus on longitudinal studies to track the long-term impact of ICDS services on child development, explore innovative community-based models for engagement, and assess the effectiveness of policy changes aimed at improving infrastructure and service accessibility.
2. Additionally, studies should evaluate the role of local governance in the implementation of ICDS to enhance accountability and responsiveness to community needs.

The findings of the study validate the hypothesis and provide a comprehensive recommendations for the enhancement of ICDS scheme in tribal dominated panchayats of South Goa.

## 5.5 Validating Hypothesis

1. The present study has proven that there is a significant association between the frequency of ICDS utilization and the prior experience of users. Those users who used the ICDS services previously have developed a habit and build a trust which encourages them to use these services more frequently as compared to new users who might still be in the process of understanding and evaluating the ICDS services. The positive experience of prior users will encourage and motivate the existing users to utilize the ICDS services frequently and their feedback certainly help to bring changes in ICDS services.
2. The study hypothesis concerning infrastructural issues affecting the other services of ICDS has been validated by considering several aspects of ICDS. The inadequate infrastructure, such as poor building, lack of space and lack of sanitation facilities hinder the smooth functioning of various ICDS services. Poor infrastructure make it challenging for Anganwadi workers to perform their duties effectively, leading to reduce motivation and job satisfaction which affects the overall quality of ICDS services. Parents are also reluctant to send their children to Anganwadi Centers that lack basic amenities, which reduce the impact of ICDS services. Lack of proper sanitation facilities also lead to health problems. Poorly constructed roads and lack of transportation facilities from the location of the Anganwadi Centers make it difficult for beneficiaries to reach Anganwadi centers, particularly in remote tribal areas. Addressing these infrastructural challenges is crucial for enhancing the effectiveness and reach of ICDS services, ultimately improving the health and development outcomes for children and mothers in tribal areas.

## 5.6 Recommendations

The literature review has significantly shaped the direction of the study, providing comprehensive findings derived from both qualitative and quantitative

methods, and observations. The literature review highlights the critical need to understand the strengths and weaknesses of the ICDS at the grassroots level that will provide a basis for evidence-based recommendations. It also pointed the importance of community involvement and the need to understand the challenges faced during the implementation process from the stakeholders' perspective. Additionally, the review emphasizes exploring opportunities for community engagement and identifying obstacles to health and nutritional services. This study addresses a gap in the existing literature on ICDS in Goa by administering these aspects and offering evidence-based recommendations based on findings and improve the effectiveness of the Integrated Child Development Services (ICDS) scheme in tribal areas of Goa.

1. **Considering Feedback of stakeholders**
    - Policymakers should consider the feedback of stakeholders while bringing any changes in the existing policy implementation in order to avoid failure of the scheme. This will help the policymakers to design or upgrade the policy as per the needs and preferences of the beneficiaries.

2. **Food Supply and Nutrition**
    - Ensure that the Take Home Ration (THR) is supplied to beneficiaries on a monthly basis to meet their nutritional need consistently.
    - Enhance the quality of food provided in the THR to ensure it meets nutritional standards and beneficiaries' preferences.

3. **Pre-School Education**
    - Provide more learning material, such as teaching aids and toys, to make the learning process more engaging and enjoyable for children. This can help in better cognitive and social development.

**4. Infrastructure and Enrollment**

- Improve the infrastructure of Anganwadi Centers (AWCs) by ensuring better facilities such as adequate space, proper ventilation, sanitation, water supply, and electricity. This will create a comfortable environment for children and staff.
- Provide AWCs with essential equipment and supplies, such as teaching aids, educational toys, uniforms, etc., and ensure their regular and timely delivery.
- Conduct a comprehensive and participatory assessment of the existing infrastructure and facilities of AWCs, and identify the gaps and priorities for improvement and up gradation.
- Implement strategies to increase the enrollment of children at AWCs. This could include community outreach programmes and awareness campaigns to highlight the benefits of early childhood education.
- The Building as Learning Aid (BALA) concept is a way to holistically plan and use the school infrastructure. This concept can be introduced to improve the infrastructure of AWCs to provide child- friendly and conducive learning environment.

**5. Fund Allocation**

- Allocate sufficient funds and resources to improve and maintain the infrastructure and facilities of AWCs, and ensure their availability and functionality.
- Allocate sufficient funds and resources to construct and maintain own buildings for AWCs, and ensure their availability and functionality. The construction of AWC buildings can be done under MGNREGS.

**6. Health and Referral Services**

- Enhance the quality and accessibility of health services provided at AWCs. This include regular health check-ups, immunizations, and nutritional assessments.
- Raise awareness about the availability and importance of referral services. Provide more information, guidance, support, and transport options to help beneficiaries' access healthcare and other resources.
- Regular monitoring of growth and immunization, and timely referral and follow-up of cases.
- Increase the awareness and accessibility of the family counselling and support service, by providing more information, guidance, and support to the ST women.
- Continue and expand the home visits by the Anganwadi workers by giving them more training on family counselling and other relevant services.

**7. Workload and Staffing**

- Address the issue of Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs) handling additional charges for extended periods. Limit the additional charge to a maximum of one month to ensure they can focus on their primary responsibilities at the AWCs.

**8. Health and Safety**

- Ensure that all AWCs are equipped with a first aid kit, especially since many have reported not having since reopening post-Covid-19.
- Replace non-functional weighing machines, particularly infant baby weighing machines, to ensure accurate monitoring of children's growth and development.

**9. Training and Education**

- Organize regular skill based training sessions for AWWs. The workers have expressed high satisfaction with the five-day training organized in collaboration with the Sarva Shiksha Abhiyan and prefer such practical training over lecture-based sessions.
- Provide AWWs and AWHs with regular and relevant skill based training, such as nutrition, health, education, communication, management, etc., and ensure their regular and timely delivery and completion.
- Capacity building and sensitization of PRIs and AWWs on the importance and value of their role in supporting AWCs, and the benefits and outcomes of the ICDS programme. Develop training modules and materials for PRIs and AWWs on various aspects of AWCs management and service delivery.
- Provide adequate Job Induction training to newly recruited AWWs and conduct timely refresher training for all the AWWs by giving more focus on skill based training related to supplementary nutrition programme and preschool education programme.
- Provide AWWs with regular and relevant comprehensive training on various aspects of health and nutrition and identification of four 'Ds' that is Developmental Delays, Deficiencies, Diseases, and Defects.

**10. Community Participation and Convergence**

- Recruit AWWs from the same village or nearby village to ensure better understanding and rapport with the community.
- Encourage community leaders to actively participate in the functioning of AWCs. Their involvement can enhance trust and cooperation.
- Foster greater involvement of the Panchayat in the activities and management of AWWs to ensure better support and resource Allocation.

- Involve and empower the parents and community leaders in the monitoring and evaluation of AWCs and AWWs, and enhance their awareness and participation in the AWCs and the services provided by AWWs. Organize regular meetings and workshops to solicit their feedback and suggestions, and to acknowledge and appreciate their contributions and achievements.
- Organize programme for the elected representative of PRI on utilization of MGNREGA funds for the restructuring Anganwadi Centers.

**11. Motivation to AWWs**

- Organize exposure visits and exchange programmes for AWWs to learn from best practices and innovations of other AWCs, and to improve their skills and knowledge, and to share their experiences and challenges.
- Recognize and reward the outstanding performance and contribution of the AWWs and AWHs and provide them with career advancement.
- Establish linkages and partnerships with other organizations and institutions that can provide AWWs with exposure and learning opportunities, such as NGOs, Universities, research institutions etc.
- Ensure that AWWs are from the same village as the AWCs they serve, or at least from nearby villages, by revising the selection criteria and process of AWWs, and by transferring or relocating the existing AWWs as per the need and feasibility.
- Ensure additional charge given to AWWs and AWHs is not extended longer and resolving such issues on urgent basis.
- Streamline the roles and responsibilities of AWWs.

**12. Monitoring and Evaluation**

- Establish a robust monitoring and evaluation system to regularly assess the performance of AWCs and identify areas for improvement.
- Monitor and evaluate the quality of the building type of AWCs and ensure their compliance with the standards and guidelines.

**13. Feedback Mechanisms**

- Collect the feedback of beneficiaries on various services of ICDS, and consider their perceptions to upgrade the scheme on regular timely basis.
- Similarly the feedback of AWWs and other ICDS staff should be considered to understand the needs and resolve it accordingly by designing the action plan.

**14. Enhancing PRI involvement in ICDS**

- Promote PRI involvement in ICDS activities by creating awareness through trainings.
- Strengthen the collaboration and communication between PRIs and AWCs, and enhance their mutual understanding and respect. Organize regular meetings and workshops to discuss the needs and challenges of AWCs, and to share the best practices and innovations of PRIs.

**15. Collaboration with NGOs**

- Partner with non-governmental organizations (NGOs) to benefit from their expertise and resources in improving the services provided by AWCs.

**16. Promoting CSR Activities**

- Promoting Corporate Social Responsibility (CSR) activities for Anganwadi Centers can significantly enhance their effectiveness and reach in

educational development, health and nutrition, educational initiatives, and community engagement.

- Collaborate with private companies, NGOs, etc. under their Corporate Social Responsibility (CSR) to mobilize resources and support for the AWWs and the ICDS services.

**17. Promoting Inter-sectoral and inter-departmental Coordination**

- Government Primary school buildings which are vacant and are not being used can be utilized for running Anganwadi Centers.
- Coordination with the panchayats to provide community halls, and other supports in resolving difficulties.

**18. Improving the Utilization and Impact of ICDS Services**

- Maintain the quality of Supplementary Nutrition and Preschool education services by ensuring adequate supply of food and educational materials and by enhancing the capacity and motivation of the Anganwadi Workers.
- Explore the reasons behind the lower availing of certain services despit their perceived usefulness, such as Home Visits, Health Awareness Programme, Counselling at AWCs, by conducting surveys, interviews, and focus group discussions with the beneficiaries and the Anganwadi Workers.

## 5.7 Roadmap to implement recommendations

To implement above recommendations the policy makers can follow the following roadmap.

1. **Assessment and Planning (Step 1)**
    - **Meeting with stakeholders':** Conduct the meeting with stakeholders to identify the grassroots challenges of ICDS.
    - **Detail Assessment:** Conduct detail assessment through surveys and focus group discussions to identify the infrastructure needs and other supply and logistics.
    - **Urgent attention to poor AWCs buildings:** Need to conduct urgent survey of AWCs whose building is in very poor conditions and the replacement with priority.
    - **Planning of Fund utilization:** Plan the funding to provide supply and logistics to AWCs which are lacking and rebuilt the infrastructure.

2. **Action Plan (Step 2)**
    - **Setting the objectives:** Set the clear and precise objectives based upon the assessment and planning.
    - **Plan of action:** Design the training modules for AWWs and Mukhya Sevikas to enhance their practical skills and knowledge in handling ICDS services and social behavior of the community. Proper planning for infrastructure improvement by promoting inter-sectoral and inter-departmental coordination. Promoting community engagement in ICDS activities by creating awareness.

3. **Implementation of Plan (Step 3)**
    - **Pilot Project:** Start the plan in a selected areas with sustainable population growth and AWC having poor infrastructure. This approach will provide valuable feedback on how infrastructure impacts the sustainability of Anganwadi Centers and future enrollment rates. This will also help to streamline the methodology of non-formal education.

- **Monitoring and Evaluation:** Continuous monitoring and evaluation of pilot project is essential to streamline the other erupted weaknesses of the plan.

4. **Expansion of Plan (Step 4)**
    - **Expansion to other areas:** Based on the feedback of pilot project gradually expand the plan to other areas by giving priority to AWCs with poor infrastructure.

5. **Continuous Monitoring on implementation (Step 5)**
    - **Feedback from stakeholders:** At a regular interval collect the feedback from stakeholders of ICDS and update it accordingly without much longr gap.

## 5.8 Role of Stakeholders in Action Plan

Table 5.1: Role of Stakeholders in Action Plan

| **Department** | **Local Officials** | **AWWs** | **Community** | **Local Governance** |
|---|---|---|---|---|
| **Assessment and Planning** | | | | |
| Conduct need assessment and allocate resources | Gather the local data | Collect local data | Share feedback | Provide local insights |
| **Service Delivery** | | | | |

| | | | | |
|---|---|---|---|---|
| Ensure timely services and funds | Supervise service delivery and address issues | Deliver service effectively | Use the services and give feedback | Support in ICDS enrollment |
| **Infrastructure Enhancement** | | | | |
| Allocate budget and Monitor | Monitor renovation and construction projects | Report on Building conditions and needs | Monitor project and give feedback | Infrastructure and resource support |
| **Capacity Building and Training** | | | | |
| Promote community involvement policies | Engage local leaders and community groups | Mobilize people for meetings | Actively participate and support ICDS activities | Mobilize community support |
| **Monitoring and Evaluation** | | | | |
| Develop monitoring framework and evaluate progress | Inspect and report | Report the grassroots reality | Provide Feedback | Extend support |

## 5.9 Contribution to Research

This study addresses the critical literature gap of evaluating the Integrated Child Development Services scheme in Goa to understand its effectiveness in tribal dominated areas of South Goa. The scheme is evaluated by involving stakeholders which

includes ST women beneficiaries, Anganwadi Workers (AWWs), Child Development Programme Officers (CDPO), Mukhya Sevikas (MS), and Health Workers of RBSK scheme of Health Services. This research provides comprehensive analysis of the present state of infrastructure and other ICDS services along with the challenges in tribal areas of South Goa. This research contributes in following way:

1. **Theoretical Contribution:** This research contributes to the literature by emphasizing the importance of involving stakeholders in policy evaluation to enhance the effectiveness of government policies. By evaluating the ICDS scheme through stakeholder involvement, this study introduces a new perspective on policy success, highlighting how addressing challenges from stakeholders' viewpoints can significantly improve outcomes.
2. **Practical Contribution:** The practical contribution of research is evidence based recommendations with suggested action plan. The study gives details of existing challenges to ICDS scheme in tribal areas of South Goa which need to address on urgent basis for the sustainability of scheme and also opens a scope to conduct such evaluative study in entire Goa.
3. **Methodological Contribution:** The methodological contribution of this research is collecting the data by using the qualitative and quantitative methods by involving all stakeholders and assessing the data by using statistical techniques. Such techniques with advanced statistical tools can be utilized in future such research.
4. **Societal Contribution:** This research opens a scope in a research in the field of public health, social policy, and community development. This study proves that evaluation of policies are essential for social development and thus opens up a scope for researcher to conduct such evaluative study of policies.

## 5.10 Concluding Remark

To sum up, the Integrated Child Development Services (ICDS) scheme is a flagship programme of the Government of India that aims to improve the health, nutrition and education of children and mothers in the country. The scheme has been implemented in various parts of India, including the tribal areas of Goa. However, the performance and impact of the scheme in these areas have not been adequately assessed and documented. Therefore, this study attempted to evaluate the performance of ICDS in tribal dominated panchayats of South Goa, using both quantitative and qualitative methods.

The study found that the beneficiaries of ICDS in South Goa had high perceptions and satisfaction with the scheme and its services. The scheme had positive effects on the nutritional status, health awareness, immunization coverage, and preschool enrolment of the children and mothers. The scheme also helped to empower the women and enhance their participation in the community. The study also identified some challenges and gaps in the implementation of ICDS, such as inadequate infrastructure, staff shortage, irregular supply of food and medicines, low coordination among stakeholders, and lack of monitoring and supervision. The study suggested some recommendations to improve the performance and impact of ICDS, such as strengthening the infrastructure, human resources, and logistics, enhancing the quality and diversity of food and education, ensuring regular and timely delivery of services, improving the convergence and collaboration among different departments and agencies, and establishing a robust and effective monitoring and evaluation system.

The study concluded that ICDS is a vital and beneficial scheme for the tribal communities of South Goa, as it addresses their multiple needs and challenges. The scheme has the potential to improve the overall development and well-being of the children and mothers, and contribute to the achievement of the Sustainable Development Goals. However, the scheme needs to overcome some operational and structural issues, and adopt a more holistic and participatory approach, to ensure its optimal performance and impact in the tribal areas of Goa.

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# Annexure-I

# Questionnaire for Scheduled Tribes Women Beneficiaries

**Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa**

**Note:** This questionnaire aims to evaluate the performance of Integrated Child Development Services (ICDS) in tribal dominated panchayats of South Goa from the perspective of Anganwadi scheme beneficiaries. Please answer the following questions based on your experience and opinions. Your responses will remain confidential. Thank you for your participation.

Integrated Child Development Services (ICDS) Block-

Name of the Panchayat-_____

1. Name of the beneficiary (Optional):
2. Age: 1) 18-30 2) 31-45
3. Which community of Tribes? 1) Velip 2) Gawda 3) Kunbi
4. Educational Qualification of Mother- 1) Up to Primary 2) High School 3) Higher Secondary 4)Graduate 5) Post Graduate 6) Diploma
5. Family Structure:- 1) Joint family [ ] 2) Nuclear Family [ ]
6. Duration of Use of Integrated Child Development Services 1) First time 2) Used before
7. Frequency of using Integrated Child Development Services? 1) Weekly 2) Monthly 3) Occasionally 4) Rarely

8. Reasons for Integrated Child Development Services enrollment of your child? (Multiple Response)

    1) Nutrition & Health Education

    2) Early Childhood Education

    3) Antenatal Services

    4) Immunization Services

    5) Family counselling and support

9. Are you satisfy with the work of Anganwadi Workers? 1) Yes 2) No

10. Do you think Home Visits are beneficial to you? 1) Yes 2) No

11. Is Anganwadi needed in your village? 1) Yes 2) No

12. Which services you are using and you finds them useful?

| # | Services | Are you using (Yes/No) | Do you find the service useful (Yes/No) |
|---|---|---|---|
| 1 | Home Visits | | |
| 2 | Health Awareness Programme | | |
| 3 | Referral Services | | |
| 4 | Child Checkup at Anganwadi Centers | | |
| 5 | Counselling at Anganwadi Centers | | |
| 6 | Supplementary Nutrition | | |
| 7 | Preschool Education | | |

13. Satisfaction Level of Scheduled Tribe Women on Integrated Child Development Services (Multiple Response)

| # | Service Type | Satisfied/Not Satisfied |
|---|---|---|
| **1.** | **Supplementary Nutrition Programme** | |
| | • The quality & quantity of the food provided | |
| | • The frequency & regularity of the food delivery | |
| | • The hygiene & safety of the food preparation | |
| | • The accessibility & Convenience of the food distribution | |
| | • The impact of the food on their health & nutrition status | |
| **2.** | **Preschool Education** | |
| | • The availability and adequacy of physical infrastructure (Building, Electricity, Water, Toilet, Space, Furniture) | |
| | • The conduct & quality of non-formal preschool activities (Indoor/outdoor non-formal activities) | |
| | • The availability & utilization of learning activities (Teaching Aids and Toys) | |

| | | |
|---|---|---|
| | • Cognitive, social, emotional & physical development of child. (Identifying, speech, social behavior) | |
| **3.** | **Health Services** | |
| | • The availability & quality of Health Services (Health check-ups, Immunization, Common Illness, Referral Services). | |
| | • Growth Monitoring & Nutrition Education | |
| | • The awareness & utilization of health and family welfare services. (Antenatal care, Institutional Delivery, Postnatal Care, and Family Planning) | |

14. Satisfaction Level of Scheduled Tribe Women Beneficiaries on Anganwadi Workers (Multiple Response)

| # | Service Type | Satisfied/Not Satisfied |
|---|---|---|
| 1. | The attitude & behavior of the Anganwadi Workers towards the beneficiaries (Responsiveness, Communication, Empathy, Respect) | |
| 2. | The knowledge & skills of the Anganwadi Workers(Awareness of the Integrated Child Development Services scheme, their training, professional etiquettes, health related competencies) | |
| 3. | Conducting timely Integrated Child Development Services activities (Awareness Programme, Coordination, Communication, conducting mothers meetings, & Home visits) | |

15. Areas of Improvement (Multiple Response)

| # | Suggested Areas of Improvement | Yes/No |
|---|---|---|
| 1. | Enhance Training for the Anganwadi Workers | |
| 2. | Improve Infrastructure | |
| 3. | Improve Nutritional Support | |
| 4. | Availability of Teaching Aids and Toys | |
| 5. | Access to healthcare services | |

| | | |
|---|---|---|
| 6. | No suggestion | |

# Annexure-II

# Questionnaire for Anganwadi Workers

**Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa**

**Note:** This questionnaire aims to evaluate the performance of Integrated Child Development Services (ICDS) in tribal dominated panchayats of South Goa from the perspective of Anganwadi workers. Please answer the following questions based on your experience and opinions. Your responses will remain confidential. Thank you for your participation.

Block: _____ Panchayat:_____ AWC: _____

1. Name of the beneficiary (Optional):
2. Age: 1) 20-30 2) 31-40 3) 41-60
3. Caste (Optional) 1) Scheduled Tribe 2)Scheduled Caste 3) Other Backward Classes 4) General
4. Educational Qualification of Mother-1) High School 3) Higher Secondary 4)Graduate 5) Post Graduate 6) Diploma
5. Is Anganwadi Workers from the same village? 1) Yes 2) No
6. Experience of Anganwadi Workers. 1) 1-5 Years 2) 6-10 Years 3) 11-20 Years 4) 21-30 Years
7. Challenges faced by Anganwadi Workers (Multiple Response)

| # | **Challenges Faced by AWWs** | **Yes/No** |
|---|---|---|
| 1. | Lack of Resources and Infrastructure | |
| 2. | Limited Community awareness and Participation | |
| 3. | High workload and limited manpower | |
| 4. | Cultural or social barriers | |
| 5. | Less area population | |

8. Distribution of Anganwadi Centers by Types of Building

    1) Own Building

    2) Rented

    3) Government Primary School Building

    4) Government High School Building

    5) Community Hall

6) Anganwadi Workers House

7) Anganwadi Helpers House

9. Do you get support from Elected Representatives of Panchayati Raj Institutions?

1) High Involvement and support

2) Moderate Involvement and Support

3) Low Involvement and Support

10. Status and Quality of Anganwadi Centre Infrastructure

| **Tangible Element** | **Responses** | | |
|---|---|---|---|
| Electricity | Yes | No | |
| Fan | Yes | No | |
| Tap | Yes | No | |
| Toilet | Yes | No | |
| Toys | Yes, adequate | Yes, not adequate | Not available |
| Teaching Aid | Yes, adequate | Yes, not adequate | Not available |
| Wall Painting | Yes | No | |
| Separate Kitchen | Yes | No | |
| Storage Issue | Yes | No | |
| Utensils | Yes, adequate | Yes, not adequate | |
| First Aid | Yes, adequate | Yes, not adequate | Not available |
| AWC accessibility | Yes, adequate | Yes, not adequate | |
| Infrastructure | Good | Average | Poor |
| Space of AWC | Adequate | Not adequate | |
| Baby Weight machine | Yes, functional | Yes, not functional | Not available |
| Weight machine | Yes, functional | Yes, not functional | |

| | | |
|---|---|---|
| Growth monitoring scale | Yes | No |

11. Anganwadi Workers Recommendations for Enhancing Anganwadi Centers Performance (Multiple Response)

| # | Recommendations by Anganwadi Workers | Tick Mark |
|---|---|---|
| 1. | Enhance the Physical and Operational Conditions (Water, Electricity, Toilets, Floor, Roof, floor mats, Storage room etc.) | |
| 2. | Own Building | |
| 3. | Teaching Aids | |
| 4. | Educational Toys | |
| 5. | Provide Uniform to the children | |
| 6. | Panchayati Raj Institutions support to Anganwadi Workers | |
| 7. | Provide skill based training | |
| 8. | Provide regular health check-ups and insurance coverage for Anganwadi Workers and Anganwadi Helpers | |
| 9. | Involve parents and community leaders in the monitoring and evaluation of Anganwadi Centers and Anganwadi Workers | |
| 10. | Organize exposure visits and exchange Programmemes for AWWs to learn from best practices and innovations of other Anganwadi Centers | |

# Annexure-III

# Questionnaire for School Health Team

**Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa**

**Note:** This questionnaire aims to evaluate the performance of Integrated Child Development Services in tribal dominated panchayats of South Goa from the perspective of Anganwadi scheme beneficiaries. Please answer the following questions based on your experience and opinions. Your responses will remain confidential. Thank you for your participation.

Integrated Child Development Services (ICDS) Block-

1. Are you familiar with the Integrated Child Development Services (ICDS) programme?
   1) Yes 2) No

2. How often do you refer children to Integrated Child Development services?
   1) Often 2) Rarely 3) Not referred

3. What specific Integrated Child Development services do you often refer children to?

   _____

4. Have you noticed any positive outcomes or improvements in children who have accessed Integrated Child Development services?
   1) Yes 2) No

5. What are the main challenges or barriers you face when referring children to Integrated Child Development services?

   _____

   _____

   _____

   _____

6. Are you satisfied with the quality and accessibility of Integrated Child Development services in your area?
   1) Yes 2) No. If No what are the reasons?_____

7. How effective do you think the Integrated Child Development programme is in addressing the health and nutritional needs of children?
   1) Very Effective 2) Moderately Effective 3) Not Effective

8. Have you received adequate training or information on Integrated Child Development services to make informed referrals?
   1) Yes 2) No

9. In your opinion, what could be done to improve the delivery and effectiveness of Integrated Child Development services?
   _____
   __

10. Do you have any suggestions or recommendations to enhance the collaboration between healthcare providers and Integrated Child Development services for improved child health and development?
    _____
    _____
    ____

# Annexure-IV

# Questionnaire for Child Development Officers (CDPOs) & Mukhya Sevikas (MS)

**Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa**

**(Focus Group Discussion)**

**Note:** This questionnaire aims to evaluate the performance of Integrated Child Development Services (ICDS) in tribal dominated panchayats of South Goa from the perspective of Anganwadi scheme beneficiaries. Please answer the following questions based on your experience and opinions. Your responses will remain confidential. Thank you for your participation.

1. Integrated Child Development (ICDS) Block-
2. How many times do you visit the Anganwadi Centers in a year? _____
3. According to you, what are the three activities that Anganwadi Workers need to improve?
   _____
   _____
4. According to you, what are the three activities that Anganwadi Helpers need to improve?
   _____
   _____
   _____
5. What are the major challenges that you face which hinder in improving the functioning of the Anganwadi Centers?
   _____
   _____

6. What are your suggestions for the improvement of Integrated Child Development Services?

   _____
   _____
   ____

# Annexure-V

# Questionnaire for Elected Members of Panchayati Raj Institutions

**Performance Evaluation of Integrated Child Development Services Scheme in Tribal Dominated Panchayats of South Goa**

**(Focus Group Discussion)**

**Note:** This questionnaire aims to evaluate the performance of Integrated Child Development Services (ICDS) in tribal dominated panchayats of South Goa from the perspective of Anganwadi scheme beneficiaries. Please answer the following questions based on your experience and opinions. Your responses will remain confidential. Thank you for your participation.

1. Integrated Child Development Services (ICDS) Block- _____
2. Are you aware of the Anganwadi centre in your village? 1) Yes 2) No
3. Are you aware of number of Anganwadi Centres are there in your Panchayat Area?
   1) Yes 2) No
4. Are you satisfied with the services of the Anganwadi Centers in your locality? 1) Yes 2) No
5. If No what are the reasons? _____
6. How many times in a month do you visit the Anganwadi Centers?
   1) Never 2) Once in a month 3) Fortnightly 4) Weekly 5) Not fixed, as and when required

7. Do you believe you have any role at the Anganwadi Centers? 1) Supervision 2) Guidance 3) Support and problem solving 4) Ensuring effective functioning of AWC 5) Not much role
8. Have you seen Anganwadi worker doing home visits to beneficiaries or conducting group meeting? 1) Yes 2) No 3) Not sure
9. Are the Anganwadi services useful to the villagers? 1) Yes 2) No
10. Which services of the Anganwadi Centers are very useful according to you?
    1) Pre-school Education 2) Supplementary Nutrition 3) Maternal Health 4) Child Health 5) Adolescent Health 6) Hygiene and Sanitation
11. What are your concern for the Anganwadi Centers?
    1) Anganwadi Workers is not sincere and efficient 2) Helper is not sincere and efficient 3) Staff is good but infrastructure is not adequate 4) Issues with supply and funds 5) Training of staff should be done 6) Lack of supervision and monitoring from the senior officials 7) Don't know
12. Does any time Anganwadi Workers approached you with their problem? 1) Yes 2) No
13. If yes, Have you solved their problem? 1) Yes 2) No
14. How panchayat can play its role in solving infrastructure issue of Anganwadi Centers?

    _____

    _____

    ____
15. What are your suggestions for improving the functioning of Anganwadi Centers?
    1) Anganwadi workers should be changed 2) Helper should be changed 3) Infrastructure should be improved 4) Supply and Funds should be streamlined and improved 5) Training of staff should be done 6) Supervision and monitoring from the senior officials should be improved 7) No suggestions