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Social Protection for Children, Women and Families: The Indian Experience

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I. Introduction

Social protection is not a widely used term in India, so much so that it rarely finds a mention in the textbooks of Indian economics. On the other hand, terms like social security, social safety net, poverty alleviation or social welfare are widely used. In the absence of an official definition of social protection in India, it may be broadly defined as measures aimed at reducing poverty, vulnerability and social inequalities (ex-post and ex-ante). This includes the wide range of measures attempted in India over the years aimed at reducing risk and vulnerability and bringing about a permanent improvement in the quality of life of the poor and the marginalized sections of the population. The Constitution of India includes articles that seek to protect women and children and improve the welfare of the family. Over the years numerous intervention programmes for social protection of children, women and families have been attempted in India. These include health and nutrition programmes for women and children, social safety nets for vulnerable groups and disabled persons, labour market interventions and measures for combating child labour, pensions and social funds, public distribution system etc. Successive five year plans from the first five year plan (1951-56) have placed emphasis on welfare measures for women and children such as organizing mahila mandals (women's groups) at the grass roots level, improving maternal and child health services, supplementary feeding for children and expectant mothers and other beneficiary-oriented programmes. Beginning from the Eighth Five Year Plan (1992-97) there has been a shift in emphasis from "development" to "empowerment" with reservations for women in local bodies and a closer monitoring of the benefits to women in the core sectors of education, health and employment.

The National Policy for Children adopted in 1974 forms the basis for the national policies and programmes for the survival, growth and protection of children. The National Plan of Action for Children 2005 is a commitment to protect the rights of children. India has also enacted laws such as the Child Marriage Restraint Act, 1929, Child Labour Prohibition and Regulation Act, 2000, the PNDT Regulation, Prevention of Misuse Act, 1994 etc. India has ratified various international conventions and human rights instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (1979), Nairobi Forward Looking Strategies (1985), Convention on the Rights of the Child (1989) etc. India has also been the signatory of the International Programme for Elimination of Child Labour (1991), the Beijing Declaration and the Beijing Platform for Action (1995) and the Population Plan of Action adopted by the International Conference on Population and Development (Cairo, 1999).

India has a plethora of institutions at the national, state and local levels concerned with different aspects of social protection as defined above. At the national level different ministries are responsible for activities pertaining to the departments under them. For example the Department of Women and Child Development is responsible for training of women for employment and income generation, running hostels for working women etc. The Department of Education, Ministry of Human Resource Development is the nodal agency for the Sarva Siksha Abhyan (Education for All) programme, promoting adult education and for programmes for the educationally backward groups. The Ministry of Rural Development is implementing various programmes for employment generation in rural areas, while the Ministry of Urban Development and Poverty Alleviation is responsible for similar programmes in urban areas. The

Ministry of Social Justice and Empowerment is implementing the National Initiative for Child Protection, Integrated Programme for Street Children etc. The Ministry of Health and Family Welfare is implementing the Child Survival and Safe Motherhood Programme, the Reproductive and Child Health Programme, the Universal Immunization Programme and the National Rural Health Mission.

The Integrated Child Development Services (ICDS) is a nutrition and child welfare scheme aimed at children up to the age of six. The package of services provided under this scheme included health education for mothers, growth monitoring, immunization, supplementary feeding for undernourished children, health check-ups, referral of sick children to health centers or hospitals, early childhood education etc. Another nutrition scheme is the mid-day meal scheme for children attending primary school, which has been highly successful in states like Tamilnadu. Another scheme falling in this category is the National Social Assistance Program, which included the National Old Age Pension Scheme, the National Family Benefit Scheme, National Maternity Benefit Scheme, Rural Group Life Insurance Scheme for those below poverty line, marginal farmers and land-less laborers etc. There are also programs for scheduled castes and scheduled tribes providing a wide variety of services, ranging from cash and in-kind transfers to employment generation and investment projects.

India has a large Public Distribution System (PDS) for the distribution of rice, wheat, edible oils, kerosene, etc at subsidized prices through a network of 400,000 fair price shops spread all over the country. The PDS is expected to protect both the producers and consumers from fluctuations in the prices of the most essential commodities. India is one of the few countries, which maintains an enormous "buffer stock" of food grains, sugar, edible oil etc for distribution through the PDS. In 1997 the government introduced the Targeted Public Distribution System (TPDS) to provide the poor households with 10 kg of cereals each month at half the prevailing cost price, the poor households being defined as those falling below the official poverty line in their income levels. The TPDS is particularly benefiting the poorest states of India like Uttar Pradesh (UP) and Bihar through increased allocation of commodities like wheat and rice.

The Central Social Welfare Board is active in promoting voluntary efforts for women and child care, organizing women's groups; raising awareness about women's rights etc The Indian Council for Child Welfare is an NGO active in the field of child welfare. There are similar institutions at the state level engaged in activities similar to the national level institutions. For example there is a State Council for Child Welfare in every state supported by the state and central governments. With so many institutions, there are numerous initiatives for social protection devoted to children, women, families and weaker sections of the society. A list of activities and the institutional arrangements for implementing them is given in Table 1. This is not meant to be an exhaustive list, since new schemes are introduced and old schemes are discarded, altered or modified.

India has accumulated a wealth of experience about different types of social protection policies and programmes. Though not all these programmes have been equally successful in achieving their goals and targets in terms of coverage and cost-effectiveness there have been several that have achieved commendable results. One such successful programme is the Integrated Child Development Services (ICDS) programme that includes the Tamilnadu Integrated Nutrition Project (TINP). Among the less successful ones are the Self Employment Programmes for Women (Employment Guarantee Scheme), Development of Women and Children in Rural Areas (DWCRA) and other safety net programmes. The Family Welfare and RCH programmes have achieved mixed results as evident from a decline in fertility and child mortality in most

states of India, while not so successful in terms of reduction in maternal mortality. The paper will try to identify the gaps in coverage and cost effectiveness of these interventions. Where this is feasible, an assessment of targeting effectiveness, administrative costs, constraints and unintended effects and sustainability will be attempted.

II. Definition of Risk and Vulnerability

Rather than defining risk and vulnerability, the approach adopted in India is to identify high risk and vulnerable populations. Vulnerable communities include those groups who suffer social and economic disadvantages such as Scheduled Castes (SCs), Scheduled Tribes (STs), those who are underserved due to problems of geographical access (even in better off States) and the urban poor. Scheduled Caste people (166.6 million) and Scheduled Tribe people (84.3 million) in India are considered to be socially and economically the most disadvantaged group. Scheduled Castes constitute 16.2% and Scheduled Tribe 8.2% of the country's population (as per the 2001 Census). Their percentages in the population and numbers however vary from one state to another. Scheduled Castes and Scheduled Tribes do not live only in homogeneous communities, but are found within heterogeneous communities both in rural and urban areas. There are six States/Union Territories (Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Dadra and Nagar Haveli and Lakshdweep) where more than 60% of the population is tribal and another 9 States (Andhra Pradesh, Assam, Jharkhand, Gujarat, Chhattisgarh, Maharashtra, Orissa and West Bengal) that have large tribal populations. Scheduled Caste population is spread over in all the States and Union Territories. However, in the States of Arunachal Pradesh, Nagaland, Manipur, Mizoram and Goa, the SC population is less than 3%. Slum populations are worse than the urban average for most socioeconomic indicators indicating greater risks and vulnerability. Moreover the growth rate of slum populations is even greater than the growth rate of the urban populations. The Government of India has therefore identified urban health as one of the thrust areas in the Tenth Five Year Plan, National Population Policy 2000, National Health Policy 2002 and the 2nd Phase of the Reproductive Child Health Programme.

Other high risk and vulnerable groups are infants, children and women. (UNICEF, 2006). Children under 5 years of age and women in the reproductive age group (15-44 years) account for 31.5 percent of the population. The infant mortality rate in India is currently over 60 per 1000 live births and nearly 60 percent of the infant deaths occur during the first month and nearly 50 percent of infant deaths occur during the first week of life. Prematurity, pneumonia, and other respiratory diseases account for over one-half of the infant deaths. Child mortality (under 5 years of age) is 29 per thousand population under 5 years of age, the main causes of child deaths being pneumonia, anaemia, typhoid, diarrheas and pneumonia. Roughly 30 percent of babies are born with low birth weight (below 2500 grams), and are exposed to greater risks of mortality and morbidity. Malnutrition among children is also rampant. The NFHS has revealed that 46 percent of children below 3 years of age were stunted in 1998-99, which was only a small improvement over the situation in 1992-93 (52 percent). The contributing factors include low birth weight, inadequate food intake, infections, lack of health care etc. The maternal mortality rate of 540 per 100000 live births in India (1998-99) is high by any standards. Maternal deaths are caused by haemorrhage, anaemia, sepsis, eclampsia and obstructed labour. Only a third of the deliveries take place in health institutions and only 40 percent attended by health professionals and 35 percent attended by traditional birth attendants. At the national level about 5 percent of children in the age group 5-14 are working for others or doing household chores more than four hours a day or doing other family work. In two states –Andhra Pradesh and Tamilnadu the child labour rates are high (18.1 percent and 15.5 percent respectively). Other vulnerable groups include children who are victims of trafficking and sexual exploitation,

those affected by HIV/AIDS and the children affected by difficult circumstances. Although very little systematic data are available regarding these groups evidences indicate that the children in need of special protection belong to communities suffering disadvantage and exclusion such as scheduled castes and tribes, and the poor. (UNICEF, 2006). It is estimated that 4.58 million people in India are living with HIV/AIDS, or about 0.8 percent of population. 85 percent of the cases were transmitted through sexual contact, and the remaining 15 percent through other means including to parent to child transmission, sharing of infected needles, transfusion of contaminated blood etc.

The poor, adolescents and disabled are identified as other high risk and vulnerable groups. The poor defined as those living below the international poverty line of 1 US\$ a day account for 44 percent of the population, or about 453 million in 2001. The poverty ratio based on the official poverty line has declined over the years from 55.5 percent in 1973-74 to 26 percent in 2000. Adolescents are the boys and girls in the age group 10 to 19 years of age. This is group is exposed to the risk of physical, psychological and emotional violence and discrimination. They are also at risk of substance abuse problems, conflict with law and commercial and sexual exploitation. According to the 2001 census they numbered 225 million and constituted 22 percent of India's population. The adolescent girls in the age group numbered 106 millions in 2001. The disabled is another group, which suffers from social exclusion and discrimination in employment and is vulnerable to poverty and illness. The disabled population according to the 2001 census was 22 million, which included 11 million visually impaired, 1.6 million speech impaired, 1.3 million hearing impaired, 6.1 million with movement disability and 2.3 million mentally handicapped persons.

III. The Integrated Child Development Services (ICDS)

Evolution and Financing

The ICDS is perhaps the most important child protection scheme attempted in India and probably the largest childcare programme in the world. This was initiated in 1975 following the adoption of the National Policy for Children and was planned to be a preventive and promotive measure. It was stated in the National Policy on Children:

"It shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development, The State shall progressively increase the scope of such services so that, within a reasonable time, all children in the country enjoy optimum conditions for balanced growth"

The policy spelled out the priorities and measures to be adopted in areas such as child health, child nutrition and welfare of the handicapped and destitute children. A number of schemes were introduced including the ICDS scheme, programmes for supplementary feeding, nutrition education, production of nutritious food, National Awards for children's welfare, welfare of the handicapped and destitute children, Child Survival and Safe Motherhood (CSSM) programme etc. Currently the ICDS covers almost all blocks in the country and has adopted a multi-sectoral approach to child care which included health, education and nutrition interventions. It is therefore well designed and well-placed to address the underlying causes of under nutrition in the country. (Gragnotati et.al, 2006)

The objectives of ICDS are the following:

1. To improve the nutritional and health status of the children in the age group 0-6 years

2. To lay the foundation for the proper physical, social and psychological development of the child;
3. To reduce mortality, morbidity, malnutrition and school drop out;
4. To enhance the capability of the mother through proper nutrition and health education;
5. To achieve better coordination between different departments implementing programmes for child development.

The different components of ICDS are the following:

1. **Immunization:** The immunization of children against six vaccine preventable diseases is mandatory, while the immunization of women against tetanus is recommended.
2. **Supplementary nutrition:** Supplementary nutrition is given to children below 6 years of age and nursing and expectant mothers from low income group. The type of food varies depending upon local conditions and food habits, and usually about 200 calories and 8-10 grams of protein are given to children under 1 year, 300 calories and 15 grams of protein for children between 1-6 years and 500 calories and 25 grams of protein are given to pregnant women and nursing mothers.
3. **Health check up:** Children are weighed every month and supplementary therapeutic feeding is done for children suffering from 2nd and third degree malnutrition. Expectant mothers are provided antenatal care, and nursing mothers are given postnatal care, and at least three examinations are done. They are also given iron and folic acid tablets and protein supplements.
4. **Medical and referral services:** Children suffering from fourth degree malnutrition are recommended hospitalization. High risk mothers are referred to the nearest primary health centre (PHC), community health centre (CHC) or other government institutions for special care.
5. **Nutrition and health education for women:** Anganwadi workers imparted nutrition and health education to all women in the age group 15-45 years, priority being given to expectant and nursing mothers.
6. **Non-formal education of children up to 6 years, and pregnant and nursing mothers:** Children under 6 years of age are imparted non-formal pre school education in the anganwadis (childcare centres).

Implementation, Capacity building and scaling up

These services are provided in an integrated manner at the anganwadi or child care centre covering an area having about 1000 population. Each centre is run by an anganwadi worker (AWW) and a helper (AWH) who is usually selected from the community where they will serve. They undergo three months of institutional training and four months of community based training. The cost of ICDS programme averages US\$10-US\$22 per child per annum. The administrative set up for the ICDS comprises of a Child Development Project Officer (CDPO) at the Block level (approximately 35000 population in the plains and 100000 population in tribal areas), under him/her there are 4 Mukhya Sevikas (supervisors) who in turn supervise 20-25 anganwadis. Each anganwadi has an anganwadi worker who is responsible for implementing the multiple tasks assigned to her. Starting from 33 selected blocks (4 urban, 19 rural and 10 tribal) in 1975, the scheme has expanded to practically cover the entire country. In 2005, there were 5671 ICDS projects with 744000 AWCs in operation, benefiting 41 million children under 6 years of age and 9 million pregnant and nursing mothers spread all over India. (MWCD, 2006). UNICEF helped to launch the programme and continues to provide financial and technical assistance along with World Bank. The World Bank is assisting in the implementation of 922

ICDS projects in four states - Andhra Pradesh, Bihar, Orissa and Madhya Pradesh. 461 new projects and 188055 AWCs were sanctioned in 2005 to fulfill the commitments of the National Common Minimum Programme and in compliance with the Supreme Court's directive. As against an expenditure of Rs. 2271.28 crores during the eighth plan, (1993-1997) a sum of Rs. 4556.52 crores (\$1012 million) was spent on ICDS in the Ninth Plan (1997-2002). The plan allocation for ICDS in the Tenth Plan (2002-2007) is Rs. 10391.75 Crores (\$2310 million). The sanctioned additional projects will cost Rs. 467.15 crores per annum. (MWCD, 2006) The Adolescent Girls Scheme addresses the needs of adolescent girls for self-development, nutrition and health, literacy and numerical and vocational skills etc by ensuring convergence with the schemes of other ministries, notably the Ministry of Health. This scheme was first implemented in 507 ICDS projects benefiting 351000 adolescent girls in the age group 11-18 years. This scheme has since been extended to all the 6108 blocks in the country.

In October 1999, the World Bank assisted ICDS III project came into operation in five states (Kerala, Maharashtra, Rajasthan, Tamilnadu, and Uttar Pradesh). The project covered 685 old blocks and 318 newly established blocks, intended upon improving the nutrition and health of pre-school children and women. The aim of this project was to strengthen the ICDS programme in all states by improving the quality of training of ICDS staff. The project also provided support for some additional activities not covered under the general ICDS programme, which included civil works, provision of equipment (baby weighing scales, display boards, play materials, water filters etc), baseline and end line surveys, operations research, monitoring activities etc. Six more states (Madhya Pradesh, Bihar, Chattisgarh, Jharkand, Orissa and Uttaranchal) were included in this project in October 2002 and the project duration extended up to March 2006. The actual expenditure under the ICDS during the Ninth plan was Rs.4557 crores against a total outlay of Rs 4880 crores. In addition, the expenditure under the World Bank assisted ICDS projects during 1997-2002 was Rs. 884 crores (\$200 million) against an outlay of Rs 1164 crores (\$260 million). The outlay under ICDS for the Tenth plan period (2002-2007) has been enhanced to Rs 10392 crores (\$2309 million) for the main ICDS project and to Rs. 1293 crores (\$287 million) under the World Bank project.

ICDS: An Evaluation

Evaluation studies on ICDS have found that, despite some unevenness in the quality of services, the ICDS programme has had a positive impact on the survival, growth, and development of young children. For example, a study conducted in rural areas of three southern states (Tamil Nadu, Andhra Pradesh and Karnataka) found that the programme had a significant impact on the psycho-social development of children, for both boys and girls. The study also showed that undernourished ICDS beneficiaries attained higher developmental scores than well-nourished children who were not enrolled in the programme. A national study conducted in 1992 by the National Institute of Public Cooperation and Child Development confirmed the positive impact of ICDS. Where the programme was operating, there were lower percentages of low-birth-weight babies, lower infant mortality rates, higher immunization coverage, larger utilization rates for health services, and better child nutrition. The NFHS II had revealed that the presence of anganwadi centre has contributed to a substantial decline (17 percent) in under-five mortality rate. This association is found only for the poorer states, but for all levels of maternal education. See Figure 1. (World Bank, 2004b). The World Bank had also examined the relationship between ICDS and child malnutrition from the NFHS I data and found that the percentage of under weight children is lower in the ICDS villages than in the non-ICDS villages. See Figure 2. (World Bank, 2004b).

Figure 1

Under – Five Child Mortality Rate, by Presence of ICDS anganwadi center in village, 1988 - 92

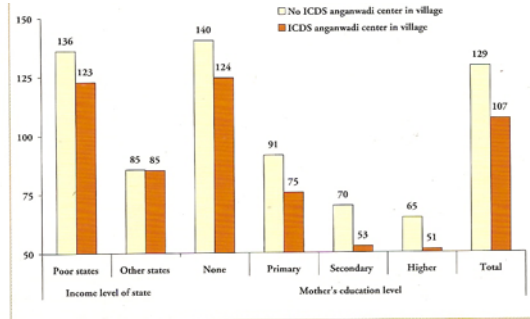
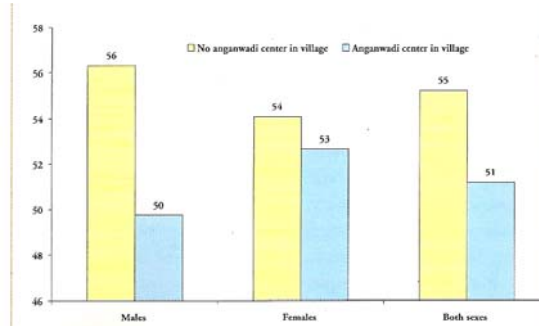


Figure 2

Present of Children less than 4 years who are underweight, by sex and presence of ICDS anganwadi center in village, 1992 - 93



Based on a multivariate analysis of the NFHS I data, the study found that the presence of an anganwadi centre in the child's village was associated with a reduction of about 5 percent in the child's underweight rate, but this association was only observed for boys. There was no significant association between the presence of ICDS anganwadi center and the prevalence of malnutrition among girls aged 0-3 years. This surprising finding may indicate one of two possibilities. Parents are selective in bringing boys than girls for supplementary feeding, or that anganwadi workers give preferential treatment to boys than girls. (World Bank, 2004b). The former is more likely since the situation in an anganwadi at feeding time will not permit such favoritism by the staff towards male babies.

Even after 30 years of its implementation, 47% or about 37 million children less than three years of age are underweight in India (NFHS II: 1998-99). Furthermore, the benefits of the programme do not appear to reach the marginalized sections of the population and the backward areas of the country that are much more vulnerable. The IMR among SCs and STs was found to be 83 and 84 respectively as opposed to 68 per 1000 live births observed for those of non-scheduled castes and tribes (Barik and Kulkarni: 2004). Backward regions all over the country have higher levels of undernourished children reflecting the poor quality of functioning of ICDS in these regions (Kumar, 2006) Moreover, ICDS programme coverage is low in the poorer states and states having higher levels of malnutrition (Gragnolati et.al, 2006).

There is great scope for increasing the coverage and for improving the quality of this vital programme. The Supreme Court of India (Order dated 28 November 2001) directed the Central and State governments to ensure that there is a functional Anganwadi "in every settlement". Supplementary nutrition is to be provided to each child under the age of 6 years as well as to all pregnant or nursing mothers. However, only one fourth of India's 170 million children in the 0 to 6 years age group are covered under the supplementary nutrition component of ICDS. The coverage of settlements is also highly inadequate- there are about 700000 Anganwadis in the country, compared with an estimated 1700000 required for universal coverage based on existing norms. The quality of services and implementation varies greatly across the country, and some states have fared much better than others and within each state some areas have performed better than others. Even the targeting of beneficiaries of ICDS needs radical improvement if the programme is to achieve its full potential. For example girl babies and babies from vulnerable groups need to be targeted. Greater attention should be paid to the vital component of pre school

education as well as effective services for children under three years of age consistent with the integrated approach to early childhood that UNICEF advocates.

II. Reproductive and Child Health (RCH) Programme

Evolution and Financing

In 1952 India was the first country in the world to launch a nationwide family planning programme. The objective of the programme was rather modest – establishment of family planning centres, preparation and distribution of educational materials and training and research. The Third Five Year Plan (1961-66) accorded family planning a central place in planned development and the emphasis was shifted from the “clinic approach” to a more pro-active “extension education approach”. In 1966 with the introduction of the intra-uterine device (IUD), there was a major expansion of the programme and a separate Department of Family Planning was created in the Ministry of Health. During this period the family planning infrastructure was strengthened at the grassroots level, namely the district bureaus, urban family planning centres, primary health centres (PHCs) sub-centres etc. During the Fourth Five Year plan (1969-74) family planning was made an integral part of the MCH activities of PHCs and sub-centres. In 1970 the All-India Post-partum Programme was established and in 1972 the Medical Termination of Pregnancy was introduced. In April 1976 the first National Population Policy was adopted. Among other things, it called for an increase in the legal minimum age of marriage from 15 to 18 for females and from 18 to 21 for males. The 42nd Amendment to the Constitution of India made population control and family Planning a concurrent subject of the centre and states. The change of government in 1977 led to major changes in population policy and abandonment of coercive measures for family planning. The Department of Family Planning became the Department of Family Welfare and the family planning programme was renamed family welfare programme. The Rural Health Scheme was launched in 1977 adopting a participatory approach involving local opinion leaders, health guides, trained dais (midwives) etc. The National Health Policy adopted in 1983 had set the long-term demographic goal of achieving a net reproduction rate (NRR) of one by 1995 at the national level and by 2000 by all states.

In 1994 the Government of India carried out a review of the approach and strategies of India’s family planning programme. Following the International Conference on Population and Development (ICPD) held in Cairo in 1994, there was a paradigm shift in the approach and strategy adopted. The new programme came to be known as Reproductive and Child Health (RCH) Programme. (Government of India, 1997). The RCH concept integrates all interventions of fertility regulation, maternal and child health care with reproductive health of both men and women. This shift was to a great extent influenced by a report of the World Bank. (World Bank, 1995). The Government of India constituted a National Commission on Population in 2000 and also adopted a National Population Policy (NPP, 2000) reflecting the changes adopted. The National Population Policy 2000 stressed the importance of the small family norm and reaffirmed the commitment of the government to a target free approach to family planning based on an informed choice by the people of family planning and reproductive health services. The objective of NPP is to bring the total fertility rate to the replacement level, reduction of infant mortality rate to 30 per 1000 and maternal mortality rate to 100 per 100000 live births by the year 2010.

The outlay of the Family Planning programme in the First Five year Plan (1951-56) was a meager Rs. 65 lakhs (US\$144000), this was increased to Rs.5 crores (\$1.1 million) in the

Second Five Year Plan (1956-71), Rs. 27 crores (\$6 million) in the Third Five Year Plan and to Rs. 1010 crores (\$224 million).. The outlay for RCH in the Ninth Five Year Plan (1997-2002) was Rs.14170 crores (US\$3150 million) and it has been further increased to Rs, 27125 crores. (\$6028 million) in the Tenth Five Year Plan (2002-2007).

Implementation, Capacity Building and Scaling up

In the early 1970s the infrastructure for providing maternal and child health and family planning services was poor at the primary health care level and insufficient in the secondary and tertiary care levels. In order to remedy the situation, the Department of Family Welfare created and funded post-partum centres, urban family welfare centres and health posts and sanctioned additional staff for the then existing PHCs. at the block level and the posts of ANMs in the sub-centres.. The Department also created state and district level infrastructure for carrying out the programmes and set up training institutions for pre/in-service training of personnel. Over the last three decades, there has been considerable expansion and strengthening of the health care infrastructure. Family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions. The staff funded by the Department of Family Welfare under the scheme of rural family welfare centres and post partum centres were functioning as part of the infrastructure.

In the early stages of RCH all districts were provided child survival and safe motherhood interventions. The child survival interventions are immunization, distribution of Vitamin A to prevent blindness, oral re-hydration therapy, and treatment of pneumonia. The safe-motherhood interventions included antenatal check up, tetanus toxoid immunization, anemia control, safe delivery and postnatal care. Information, Education and Communication (IEC) activities, facilities for MTP and treatment for RTI/STD in district hospitals and community participation by NGOs, panchayats, and women's groups were provided in all districts. In selected districts additional interventions such as essential obstetric care, emergency obstetric care, improved delivery services, facility for transporting pregnant women to the first referral units (FRUs), screening and treatment for RTIs and STDs etc were provided. Under the RCH programme additional funds have been provided to recruit staff and to procure equipment and medicines for the CHCs so as to ensure that the services provided conform to the Indian Public Health Standards (IPHS)

Beginning 1995-96 the strategy adopted in the RCH programme was to integrate all the components of the family welfare programme and the child survival and safe motherhood (CSSM) programmes. All the previous programmes such as the universal immunization programme, oral re-hydration therapy, acute respiratory infection (ARI) control etc were also brought under the umbrella of RCH programme. It further included two additional components, one relating to reproductive tract infections (RTIs) and the other relating to prevention and management of sexually transmitted diseases (STDs). It was expected that the integrated programme would reduce costs and increase the synergy between the different components. The earlier approach of setting targets for the number of sterilizations, IUD insertions, condom distribution etc was abandoned and with effect from 1 April 1996 the Target Free Approach (TFA) was adopted. Beginning 1 April 1997 the TFA was renamed as the Community Needs Assessment Approach (CNAA), which included preparation of annual project implementation plans (PIPs) at the district and state levels based on the assessed needs of the community. The decentralized participatory planning strategy adopted under this approach involves *inter alia* close association of the panchayat functionaries, community leaders, women's groups etc in the

preparation of the PIPs. This approach was expected to bring about an improvement in the quality of services and client satisfaction (MHFW, 2004).

The RCH II programme implemented from 1 April, 2005 was based on the lessons learned from RCH I and included improvements in the conceptualization and implementation of the programme (MHFW, 2006). In April 2005 the RCH programme became an integral part of the National Rural Health Mission (NRHM) and is being implemented through the primary health care system comprising 142655 subcentres, 23109 Primary Health Centres (PHCs) and 3222 Community Health Centres (CHCs). The Subcentre is the first peripheral contact point between the community and the PHC system. The Subcentre has the following staff: one Female Auxiliary Nurse Midwife (ANM) and one Male Health Worker. There is one PHC for every 6 subcentres and is staffed by a Medical Officer and 14 auxiliary staff. It has 4 to 6 beds. The PHC is the first contact point between the community and the medical officer and caters to promotive, preventive and curative health and family welfare services. The Lady Health Visitor (LHV) attached to the PHC visits the six subcentres (within the jurisdiction of the PHC) and plays a supervisory and supportive role to the Subcentre staff. The CHCs run by the state governments have 4 medical specialists (a surgeon, a general physician, a gynecologist and a pediatrician) and 21 paramedical and other staff. The CHCs have 30 indoor beds and is equipped with an operation theatre, X-ray, labour room and laboratory facilities for emergency obstetric care and specialist consultations. Since ANMs are crucial for increasing the outreach of the programme the posts of ANM are fully funded by the Department of Family Welfare with effect from 1st April 2002. It was expected that this would ensure that the States employ the required number of ANMs, streamline their functioning and improve the coverage, content and quality of maternal and child health care. (Planning Commission, 2002).

The strategies adopted in RCH II included essential obstetric care, 24-Hour delivery services at the PHCs and CHCs, emergency obstetric care, strengthening of the referral system, medical termination of pregnancy and prevention of RTIs and STDs. The essential obstetric care included institutional delivery and skilled attendance at delivery. Emergency obstetric care required equipping the first referral units, and operationalizing PHCs and CHCs for 24-hour delivery services. In RCH I the panchayat raj institutions (PRIs) were required to provide assistance to the poor in the case of obstetric emergencies. In RCH II, the referral services can be outsourced to other NGOs, Self Help Groups (SHGs) and others. Since transport is an important factor in obstetric emergencies, a corpus fund was provided to panchayats through the District Family Welfare offices. RCH II also included a component called vulnerable groups RCH to improve the health status of the urban slum population, tribal population and general vulnerable groups and the poor living outside the urban slums and notified tribal areas. The PIPs of the states and union territories were specifically required to ensure accessibility and availability of quality health care and family welfare services to these groups.

Evaluation of RCH

Institutional mechanism for monitoring and evaluation of the RCH programme was built-into the programme itself. There are 17 Regional Directors of the MHFW functioning in different regions of India, whose function is to monitor the centrally sponsored health and family welfare schemes besides liaison and coordination of these programmes with the states and carrying out inspections in the field. Eight regional evaluation teams located in different major cities function under the technical guidance of the Monitoring and Evaluation Division of the Ministry of Health and Family Welfare, Government of India. Each evaluation team undertakes tour of 20 days every month and covers 6 randomly selected centres in two adjoining districts (2 rural and

one urban centre in each district) and conducts field verification of approximately 700 RCH beneficiaries. The teams undertake both qualitative and quantitative assessment in order to verify the genuineness of the beneficiaries, the services provided and their problems and complaints if any. (MHFW, 2004). In addition evaluations have been carried out external agencies such as International Institute for Population Sciences, Mumbai (IIPS) and National Council for Applied Economic Research, New Delhi (NCAER).

The study by IIPS covered two “forward states” (Maharashtra and Tamilnadu) and two “backward states” (Bihar and Jharkand). The survey found an increase in contraceptive prevalence in all four states since 1998-99 (NFHS 2) but the increase was greater in the forward states- 12 percentage points in Maharashtra and 15 percentage points in Tamilnadu. and smaller in the backward states- six percentage points in Bihar and seven percentage points in Jharkand. (IIPS & Johns Hopkins, 2005) The survey also observed qualitative differences in the services provided in the four states, and between the public and private health facilities. In the backward states, the respondents had expressed preference for private health facilities to public health facilities almost 3 to 1, while their preference was more balanced in the forward states. The women who had visited both private and public facilities felt that the private facilities were better in quality than the public health facilities, although they were more expensive... In Maharashtra, Bihar and Jharkand only a minority of male and female acceptors of sterilization was fully informed about the side effects of the procedure, while in Tamilnadu, over three-fifths of the sterilized couples had received information on the side effects of sterilization. In all four states, there was little increase in the BCG protection to children 12-23 months. In the backward states it had remained around 40-45 percent, while in the forward states it was over 90 percent. In the backward states the coverage of DPT had remained low (20 percent for DPT3), but because of the Polio Plus campaign, the percentage of children who had received three or more doses of polio vaccine more than doubled during the three years between the two surveys (IIPS and Johns Hopkins, 2005).

The observations of the NCAER study (MHFW, 2006).were:

1. The number of villages and population covered by a sub centre is very high, and needs to be brought down by establishing additional subcentres.
2. Most subcentres did not have permanent structures and consequently the subcentres are relocated frequently. Establishment of permanent structures in a central location within the community is essential for improving the quality of delivery of services and their better utilization.
3. Almost one-half of the subcentres were functioning without a male health worker, and in many subcentres no ANMs were posted.
4. The training provided to ANMs was inadequate to cope with additional responsibilities placed on her. They also expressed the need for a mobile phone to enable their patients to contact them while in the field.
5. Monitoring visits by the Medical Officer of the PHCs to the subcentres should be more frequent to improve the performance of the subcentres.
6. The disbursement of salaries of the staff was irregular and there was shortage of equipment and medicines. These problems were noted particularly in the backward states of Jharkand, Bihar, Orissa and Uttar Pradesh.

Based on the various evaluative studies the Planning Commission of India had identified some areas of concern in the RCH programme (Planning Commission, Tenth Plan Chapter 2):

- Inter-state differences in fertility and mortality were substantial and fertility and mortality rates were high in the most populous states;
- There are large gaps in infrastructure, manpower and equipment and mismatch between infrastructure and manpower in primary health centres (PHCs)/Community Health Centres (CHCs) besides lack of referral services;
- The goals set for fertility and mortality in the Ninth Five Year Plan were not achieved, and in particular, there is little decline in neonatal mortality and maternal mortality.
- Routine service coverage had declined, perhaps because of the emphasis on campaign mode operations for individual components of the programme;
- In spite of the emphasis on training to improve skills for the delivery of integrated reproductive and child health services, there was little progress in in-service training and the anticipated improvement in the content and quality of care had not taken place;
- Evaluation studies had shown that the immunization coverage was not universal even in the best performing states while coverage rates were very low in states like Bihar; elimination of polio is yet to be achieved;
- The logistics of drug supply had improved in some states but remained poor in the more populous and poorer states;
- Decentralized district-based planning, monitoring and mid-course correction utilizing the locally generated service data and civil registration had not yet been effectively implemented.

In order to address these concerns the Government decided to distinguish between “better-performance” districts and “poor-performance” districts and is adopting additional measures for improving antenatal care, delivery care and child health care in the poor-performance districts. In addition special efforts are being made to address the needs of vulnerable populations such as scheduled tribes, urban slum residents and population of remote areas. Strategies for improving the efficiency of health care adopted include training of managers in programme management including decentralized planning, implementation, monitoring and midcourse corrections. Skill upgradation of all categories of health care professionals and paraprofessionals was also envisaged for improving the quality of screening and management of persons with complications, and making referrals as and when required. Greater coordination between workers of different departments is envisaged to increase the synergy in the implementation of the programme. Panchayati raj (local administration) institutions and NGOs are also required to play a greater role in advocacy, improving access to services and monitoring the activities of the health workers

III. Poverty Alleviation Programs in India

Evolution and Financing

India has accorded great importance to poverty alleviation since independence. The anti-poverty strategy adopted is to create opportunities for self employment and wage employment through various schemes and a public distribution system for the poor. (Planning Commission, 2002) Special programmes for vulnerable sections of the population-scheduled castes and tribes and the disabled were also implemented. Investments in agriculture and rural development were enhanced in successive Five Year Plans to increase in employment opportunities and income. Following the publication of the Committee of Experts on Unemployment (the Bhagwati Committee) in 1973 a number of schemes were introduced in the Fourth Five Year Plan (1969-74) such as the following:

Food for Work Programme- for construction of civil works of a permanent nature in rural areas;

Marginal Farmers and Agricultural Labourers Assistance Scheme- to support supplementary occupations like dairy, poultry, piggery, horticulture etc

Small Farmers Development Agencies- to provide credit to small farmers to improve their farm practices;

Integrated Dryland Agricultural Development- to undertake permanent works like soil conservation, land development and water harnessing;

Agro-service Centres- to provide employment to graduates and diploma holders for establishing workshops and for providing technical services such as supply of spares for agricultural machinery;

Area Development Schemes- for developing infrastructure facilities like roads, market complexes etc;

Crash Programme for Rural employment- to create a network of rural projects such as land reclamation, flood control, minor irrigation etc

The IRDP which was started in 1978-79 in selected blocks and expanded to cover the entire country in 1980 was providing the rural poor subsidy and credit for productive employment. Subsequently other schemes such as Training of Rural Youths for Self employment (TYRSEM), Development of women and children in rural areas (DWCRA), Supply of Improved Tool Kits for Rural Areas (SITRA) and Ganga Kalyan Yojana (GKY) were introduced as sub programmes of IRDP. (Planning Commission, 2002) .Following a mid term appraisal of the Ninth Plan in 1999, these schemes were merged into a single programme known as Swarnjayanthi Gram Swarozgar Yojana (SGSY). The SGSY was a holistic programme for organizing the rural poor into self help groups, building their capacities by providing them technical and financial support and credit and marketing facilities. The programme is meant to provide safeguards for accommodating the weaker sections-women, SCs and STs. The implementation of the programme between 1999-2000 and 2000-2001 revealed some weaknesses- the DRDAs lacked the skills in social mobilization and the NGOs who could have facilitated this were not in place, therefore the programme received a set-back during the initial years. Obviously the District Rural Development Agencies, state administrations, banks, NGOs and panchayat raj institutions required strengthening for implementing the SGSY programme. (Planning Commission, 2002)

During the 1980s the Government restructured the Food for Work Programme and renamed it as the *National Rural Employment Programme (NREP)* while all the other programmes were combined to form the *Integrated Rural Development Programme (IRDP)*. The NREP was implemented by the centre and states on a 50:50 cost sharing basis. The aim was to create community assets including drinking water wells, minor irrigation works, village tanks, balwadis, schools etc contributing to the creation of additional employment of 300-400 million man days per year. While the programme had achieved its goals of employment generation during the Sixth Five Year Plan (1979-84), there was a cost over run of over Rs. 200 crores. In 1983 the *Rural Landless Employment Guarantee Programme (RLEGP)* was introduced with the avowed objective of generating gainful employment, creating productive assets in rural areas and improving the quality of life. This programme was fully funded by the central government and resources were allocated on the basis of the number of agricultural labourers, marginal farmers and marginal workers and persons below the poverty line. Wages were paid to the workers according to the schedule of wages prescribed under the Minimum Wages Act. Part of the wages was required to be paid in the form of subsidized food grains. It was also stipulated that the wage component on a project should not be less than 50 percent of the total expenditure of the project. The RLEGP included the projects for social forestry, construction of houses

(Indira Awas Yojana) and the construction of drinking water wells (Million Wells Scheme). The IRDP superseded the multiplicity of programmes implemented by different agencies and replaced them by an integrated programme (Dutt and Sundharam, 2005).

The NREP and IRDP thus became the two major programs for poverty alleviation under the sixth plan (1980-85), the NREP for generating wage employment and IRDP for generating self-employment for the poor. The NREP was intended to provide wage employment during the slack agricultural seasons, times of natural calamities and periods of sporadic unemployment. The IRDP was based on the premise that economic growth can benefit the poorest and vulnerable sections of society only if they are provided support to acquire productive assets and skills required to enhance their incomes. In 1989 RLEGP was merged with the NREP because of the similarities of objectives and implementation modalities. The combined programme became known as the Jawahar Rozgar Yojana (JRY).

Over the years India has established probably the world's largest and most complex poverty alleviation program. A total amount of Rs.317237 million at constant (1981-82) prices has been spent on these programs during 1980-95 covering a cumulative total of 47 million poor families and generating an aggregate employment of 10297 million man-days (Thmarajakshi, 1997). By the year 2000 these programs were covering 3 million additional families and creating employment of 1000 million man-days annually. The annual outlay on this program is Rs. 250 billion (US\$5 billion). As proportion of the central government budget the outlay had increased from 5 percent in 1990-91 to close to 7 percent in 1997-98. In addition the state governments contribute 25-50 percent (World Bank, 1998). These cover a wide range of activities such as job creating public works, small loan schemes, and training of youth, social welfare and nutrition projects and food subsidies. The intervention programs in rural and urban areas, their executing agencies, target groups and the type of assistance provided are summarized in Table 2. The expenditures under the various programmes during the Eighth and Ninth Five Year Plans and the number of beneficiaries are shown in Table 3.

Implementation, Capacity Building and Scaling up

The interventions for poverty alleviation in India can be broadly grouped into two categories:

(i) Interventions for creating self employment; (ii) Interventions for creating wage employment.

Self employment

This category includes the following on-going programs for rural areas: (i) Integrated Rural Development Program (IRDP), (ii) Training of Rural Youth for Self Employment (TRYSEM), (iii) Development of Women and Children in Rural Areas (DWCRA). The target group for IRDP, the largest credit based program are the small and marginal farmers and agricultural laborers who are below the poverty line. It is envisaged that at least 50 percent of the assisted families are Scheduled Castes (SC) and Scheduled Tribes (ST), 40 percent are women and 3 percent are physically handicapped. This program is currently providing loans to about 2.5 million families in a year, and has so far benefited over 50 million families. TRYSEM, a sub-plan of IRDP is aimed at imparting technical and entrepreneurial skills to youth 18-35 years from families below poverty line. The training is carried out in formal training institutions or in non-formal settings to enable them to take up self-employment or wage employment. This program is currently benefiting 300000 annually. The DWCRA is another sub program of IRDP which specifically targets women in poor rural households The DWCRA helps formation

of self-help groups of women and provides them skill training and grants for undertaking any viable economic activity. This program is benefiting half million women annually.

Wage employment

The major wage employment programmes are the Jawahar Rozgar Yojana (JRY) and Employment Assurance Scheme (EAS). The main objective of JRY is the creation of additional employment opportunities in rural areas through the strengthening of the infrastructure in rural areas and the creation of community and social assets. These are expected to have a positive impact on wage rates and in the quality of life. At least 30 percent of the beneficiaries were required to be women. Of the total funds, 75 percent is devoted to infrastructure development such as construction of wells and houses. In 1993 three streams of JRY were introduced, the first stream included the Indira Awas Yojana for construction of houses and the Million Wells Scheme for the construction of wells. The second stream provided additional support to backward areas and the third one supported special and innovative projects. Since inception the JRY had generated 270 million man days of employment per year; however there has been a decline since 1993-94 when 1030 million man days of employment were generated. This program is implemented through the panchayats (village councils), who are required to tailor the program to the felt needs of their communities subject to some basic guidelines. The JRY generates an estimated one billion days of employment each year with the likely participation of 30-40 percent of the potential beneficiaries. (World Bank, 1998)

Patterned on the Employment Guarantee Scheme of Maharashtra state the EAS was implemented in 1778 blocks in 261 districts in 1993. . The aim of the scheme was to provide 100 days of unskilled employment in a year to the rural poor above 18 years of age who sought such employment. The number of blocks covered under EAS had increased to 3197 in 1996 and further expanded to cover all the blocks in 1997-98. The District Collector or Deputy Commissioner is vested with the responsibility of allocating the funds and supervising the implementation. Other interventions targeting specific geographic areas included (i) Draught Prone Areas Program (DPAP), (ii) Desert Development Program, (iii) Integrated Wasteland Development Projects (IWDP).

Initially the scheme was demand driven, but from 1999 the allocation of resources was based on the incidence of poverty. The employment generated under this scheme has declined during the successive years and the objective of providing assured employment in areas of extreme poverty and chronic unemployment has not been achieved (Planning Commission, 2002). The Food for Work Programme, a component of EAS was started in 2001 in eight draught-affected states. Food grains were provided free of cost to the states, but the lifting of food grains from the godowns of the Food Corporation of India (FCI) has been tardy. In view of the complementarity of JGSY, EAS and the Food for Work Programme, these three wage employment schemes were merged and made a single scheme called Sampurna Gramin Rozgar Yojana (SGRY).

The National Rural Employment Guarantee Act (NREG Act) was introduced in 2005 to provide employment guarantee to the rural poor. Initially the scheme is being implemented in 200 districts in the first phase benefiting 17 million rural households, and is expected to cover 50 million rural households within a period of five years. Every eligible applicant will be provided employment within 15 days from the date of application, failing which he will be provided an unemployment allowance in cash. The scheme will focus upon water conservation and water harvesting, draught proofing through afforestation and tree planting, irrigation works, land development etc.

Poverty Alleviation Programs: An Evaluation

There have been numerous evaluations of the poverty alleviation programs in India by the government agencies, private scholars as well as the World Bank. These evaluations point out many deficiencies in these programs. The first major finding is that these programs are only partially successful in reaching their intended beneficiaries. There are three problems; (i) there is a leakage of resources towards the non-targeted groups. (ii) The targeted poor are not getting the benefits; (iii) The most vulnerable among the poor are not benefited; There is no doubt that the poor benefit more from the public works programs than the non-poor, but the non-poor continue to benefit significantly from the public works programs and others. (World Bank, 1998). The poorest quintile is most benefited by the public works programs, while the credit program (IRDP) takes the second place and the food distribution program (PDS) takes the third place. (World Bank, 1998). In the wage employment program (JRY), it was observed that 57 percent of the beneficiaries were above the poverty line, 35 percent near the poverty line and only 5 percent belonged to the poorest group. The IRDP has not enabled the "very very poor" and "very poor" to cross the poverty line, with around 22 percent of the assisted families in the periphery of the poverty line and 4 percent ineligible. (Thamarajakshi, 1998). At least 15 percent of those identified as poor and helped under IRDP did not belong to the category of poor and less than 5 percent of the rural poor were enabled to cross the poverty line. (Rath, 1985). In a study of four selected villages in Gujarat it was found that 55 to 75 percent of beneficiaries were non-poor, moreover, the scheme had benefited only the more developed villages (Hirway, 1984). Based on a study of two villages in Maharashtra where the EGS was in operation, Pellissery observed that local elites enjoyed informal ownership of the programme and were able to prevent some workers from participating in the programme by cajoling the supervisors and manufacturing muster rolls (Pellissery, 2006).

A second major finding is the geographical variations in the performance in the different programs, the states that have performed well in one are not performing well in others. The poorest states have not achieved better results than the wealthier ones. (World Bank, 1998). In a poor state like Bihar poor as well as the not-so-poor households use the PDS. The PDS outlets invariably are located in the wealthier section of the village leading to a diversion of food subsidies by the non-poor. The TPDS suffers from the same problems as the PDS. While the poorest are expected to benefit, they may not receive the allowed quantity due to diversion of the supplies to others or due to inappropriate inclusion or exclusion. In another poor state, Uttar Pradesh the public works programs serve the poor more than the middle and upper classes, while the IRDP is benefiting the middle classes more than the poorer classes. In many cases, geographical targeting was not done properly with the result that many area development projects had ended in failure.

Thirdly, credit based programs with subsidy can result in corruption, miss-targeting, and poor cost recovery as observed by the author in the case of similar schemes in the Hyderabad Slum Improvement Project (Vaidyanathan, 1988b). Since the amount of funds available is limited the most influential in the community tend to jockey for these funds, while the most deserving ones tend to be sidelined. Moreover subsidized credit attracts the wrong kind of borrowers who have no interest in productive investment. Faced with a target for "lending" and pressure from the applicants, the bank managers are not unable to evaluate each proposal thoroughly before a loan approval, nor do they have sufficient staff to follow up the borrowers. Default of repayments is a common phenomenon since the "loan festivals" sponsored by political leaders has given the borrowers the impression that they need not return the loans (Vaidyanathan, 1988b).

The poverty alleviation programs in general are not gender sensitive, with the result that women constitute hardly 20 percent of the beneficiaries of the public works and credit programs. The number of women who benefited from IRDP was 3.43 million during the Second Five Year Plan (1987-88-1991-92) and 3.64 million during the Eighth Five Year Plan (1992-93 to 1996-97). As proportion of the total beneficiaries of IRDP, women were only 32 and 34 percent respectively. JRY had the target of 30 percent of the employment for women, but the actual achievement was only 24.2 percent. The DWCRA, the only program directed at women had enrolled 2.4 million women through 140000 self-help groups. However many of these groups became non-functional, once the initial enthusiasm faded. This program suffers from political and bureaucratic apathy, fund constraints, inadequate staff and lack of coordination. Very few DWCRA projects have taken into account factors like physical possibility, technical feasibility, financial viability, social acceptability and sustainability of growth (Prasad, 1995). The TRYSEM is linked to the IRDP program, and consequently fewer women benefit from TRYSEM. Moreover the content of TRYSEM did not include topics that are appropriate for women such as home management, family welfare or health care.

Although poor women are more disadvantaged than poor men in respect of health, nutrition, education and employment, none of these programs addressed these concerns of women. Poor women spend considerable energy and effort in collecting water and firewood from remote places, yet poverty alleviation did not address this problem. Although poor health aggravates poverty through financial burden of treatment, there is no attempt to integrate health programs with the poverty alleviation programs. Moreover there is nothing in these programs that can empower women or eradicate age-old taboos and cultural practices that limit the women's participation in society. There are no programs targeting the girl children and adolescent girls (5-19 years) of the poor communities in the poverty alleviation programs as well as the health and nutrition programs, although these are the future mothers, homemakers and leaders of the society.

IV. Lessons Learned and Factors for Success

Adequacy and stability of funding

The pattern of funding for the three projects differ greatly and this has made a difference in the outcome of the projects. The ICDS project had received ample funding from the central and state governments and from international sources, namely UNICEF and the World Bank. The contribution of central and state governments for this project had increased four-fold in a span of a decade. On the other hand The RCH project had funding from three sources- the Government of India, the pooled funding from DFID, the World Bank and the UNFPA and funding from other partners such as EC, USAID, UNICEF routed through a single nodal agency, namely National Institute of Health and Family Welfare. As part of the “sector-wide approach” introduced in 2005, all externally aided projects have been merged with RCH II. Although there has been no dearth of funds, the delays in the administrative sanctions together with the bureaucratic constraints of the state administrations result in delays in filling the posts and the supply of equipments at PHC and CHC levels. In the case of Poverty Alleviation Programmes, there is multiplicity of agencies involved and leakage of resources due to corruption, miss-targeting etc.

Political Commitment and Leadership

The variation in performance of different states of India is an indication of the variations in the extent of political commitment and leadership of the states. In general the Southern states have performed better than the northern states, and there is a North-South divide in the pace of economic development which is reflected in almost every programme. The commitment and participation of individuals and the community is far greater in the ICDS and RCH programmes than in the PA programme.

Institutional Development

Institutional development is important for determining the kind of programme and delivery mechanism. In the case of ICDS and RCH, the institutions of anganwadi, primary health centre and sub centres have been established over a period of time, and their reach and capabilities have also expanded over the years. In the case of poverty alleviation programmes, such institutions do not exist at the grass roots level and the panchayati raj institutions are not capable of implementing such programmes. Consequently, the infrastructure projects under the EGS are designed and executed by government engineers under the supervision of the tehsildar, the administrator of the taluk or sub district. The tehsildar is again responsible for providing subsidized credit under IRDP and he depends upon the local elites in the implementation of these programmes, resulting in rampant corruption.

Improved Targeting Especially Of Vulnerable Groups

Proper targeting is essential for the success of such programmes. In the Integrated Child Development Services (ICDS) many poor are not covered while one in five of those helped are non-poor. In the public distribution system (PDS), only three out of five intended beneficiaries were benefited while the TPDS covers hardly 10 percent of the needs of the people below poverty line. In the case of ICDS and RCH, the targets are children and women in the reproductive age groups and they are more easily identifiable than the poor and vulnerable for the employment generation programmes. According to Prof Nilakant Rath, 15 percent of beneficiaries of PA programmes are non-poor and the programme has helped less than 5 percent of the rural poor to cross the poverty line. All the programmes will be more effective if the persons of low economic status and scheduled castes and scheduled tribes could be targeted. In addition the ICDS needs to focus attention on younger children under three years of age and the RCH programme on adolescent girls. Targeting can be improved if a partnership between civic leaders, NGOs and government can be established at the community level.

Selection and Training of Grass Roots Workers

In the three programmes performance is constrained by the quality of grass roots level staff recruited and the training and skills imparted. The anganwadi workers and anganwadi helpers in ICDS are recruited from the local area and mostly of primary level education. In the case of RCH, the ANMs are usually matriculates and they also receive training of a longer duration covering aspects of home care, clinical care and community level care. In either case the health workers are not adequately trained in community mobilization skills and to effectively perform their duties in the midst or pressures from the crowd milling around them. In the case of PA programmes the panchayat and revenue department officials are not equipped to evaluate schemes and are susceptible to pressures of the local elites to give employment to their supporters.

Collaboration with Other Projects

Closer collaboration in planning, implementation and monitoring between different programmes at the grass roots level could create greater synergy and effectiveness in the implementation of all programmes. For example, the collaboration between the anganwadi worker of ICDS and ANMs of RCH could result in better immunization coverage, identification of sick children and pregnant women and their referral to PHCs and CHCs for treatment. Such collaboration could greatly facilitate the achievement of the objectives of the ICDS and RCH programmes.

Community Participation

There is little participation of panchayat raj institutions in the ICDS and RCH programmes, and community ownership is minimal. The gram sabhas (village councils) play only a ceremonial role and they do not have the powers or technical or financial resources to participate in the implementation or monitoring of programmes. The anganwadi workers of ICDS and ANMs of RCH are directly recruited and paid by the state government and they are not accountable to the community they serve. On the other hand the local government institutions have a role in identifying the beneficiaries of the PA programmes, and regrettably they are the ones contributing to the corruption and miss-targeting taking place in these programmes. Stricter application of rules and regulations and greater involvement of civil society and NGOs could help to minimize these tendencies.

Proper Monitoring and Use of Information

Mechanisms for gathering information at the grassroots level and for monitoring are in place in the three programmes but they are not effective. . The author found out to his surprise that lot more information is collected in ICDS than are used, and the quality of information is also poor. The training imparted to the anganwadi worker and ANMs are oriented to service delivery and does not give importance to the collection of information or their use in service delivery. . The data are mostly of a quantitative nature, and there is little information on the quality of service provided. In the PA programme the rosters of workers are often fudged, and the employment generated by these programmes inflated, resulting in wastage of resources. Relying on the outcome indicators of employment generated can be misleading. There is a case for replacing outcome evaluations by process evaluations in measuring the success of these programmes. Alongside measures to improve data quality efforts are called for to integrate data collection and analysis into programme operations and in decision making.

V. Larger Policy Issues

Differentials in Performance between States and Regions

Some states are performing poorly compared to others in the implementation of programmes, and within each state some districts are not performing as well as others. This is often attributable to constraints such as low educational levels, lack of infrastructure, socio- cultural obstacles, lack of material and manpower resources etc. Policy should address such differentials by providing additional inputs and incentives to the laggard states and regions to encourage them to catch up with the rest of the nation. In the RCH there is an attempt to identify “poor-performance” areas and to initiate special remedial measures. The Empowered Action Group (EAG) constituted by the Department of Family Welfare reviews the performance of health

system and health indices for such areas and recommends steps to improve access to health care. A similar approach is needed in other programmes as well.

Role of NGOs and CSOs

It has been recognized that linkages with the private sector including NGOs and CSOs can optimize the use of resources and contribute to extending the reach of the programmes to underserved and disadvantaged populations. National NGOs are able to develop new approaches to health care delivery and complement the services provided by official agencies. International NGOs serve as conduit for securing material and technical resources, raise awareness, conduct research, disseminate information etc. The MOFW has recently taken steps to enlist the participation of NGOs in the RCH programme. Women's self help groups have been active in providing employment opportunities for women. Participation of women's groups in the ICDS and RCH programmes can increase women's access to services and at the same time make the programmes sensitive to women's needs. There is also scope for utilizing them as change agents within the community. The participation of private sector in financing and service delivery needs to be encouraged and at the same time ensuring that their performance meets the required standards.

Gender Perspective

Discrimination and neglect of female infants in India is well documented, and the ICDS programme has not succeeded in overcoming this. The high maternal mortality ratio in India (500 maternal deaths per 100000 live births) is a reflection of lack of access to health care, especially maternity care, contraceptives and safe delivery services. The training of female health providers, timely detection of obstetric emergencies and ensuring emergency care, prevention of violence against women, community outreach and education can help to bridge the gender gap. The gender perspective is missing in the PA programmes, where less than 20 percent of the beneficiaries are women. This is unfortunate since women represent a disproportionate share of the poor and vulnerable and the PA programmes are meant to address their needs.

Cost Recovery

No attempt is made in these programmes to recover at least partially the costs incurred. While the services cannot be denied to the non-poor, consideration may be given to charging "user fees" to the non-poor who avail the services, or for services provided outside the standard package of services. Charging of moderate user fees could contribute to improvement of the services to the poor apart from raising the quality of services. If user fees are charged, there must be a mechanism for exempting the poor from the payment of such fees. The introduction of statutory minimum wages in the Maharashtra EGS programmes resulted in many non-poor rushing for wage employment under the EGS. Apart from increasing the costs, this has led to the genuine poor being sidelined from the programme. Such labour market distortions could be avoided if the programme wages are kept close to the prevailing market wages for unskilled workers. In the IRDP where loans are provided for purchase of animals, the price of animals shot up making the effective rate of interest higher by 20-25 percent.

Role of Panchayati Raj Institutions (Local Administrations)

Although panchayati raj institutions (local administrations) exist in almost all states, their participation in development programmes varies. In Kerala where there has been devolution of

powers and finances to PRIs, they are involved in decentralized planning and monitoring of programmes. In Andhra Pradesh, Rajasthan and Haryana PRIs are involved in the implementation of the programmes in the health sector. In Maharashtra EGS they are involved in the identification of beneficiaries, and their role has not been a positive one. There is a need to examine the modalities of participation of PRIs in social protection programmes. Apart from political empowerment of PRIs issues of competency, transparency and accountability need to be addressed. Decentralization must be accompanied by capacity building and proper monitoring and evaluation.

Sustainability

None of these programmes are self-sustaining. Improvements arising from the ICDS and RCH programmes in a given period (month, quarter or year) do not result in a permanent improvement, and the inputs under the programme will have to be continued if the improvements are to be sustained. Similarly the employment generated under the IRDP and JRY programmes does not sustain from one year to the next year. The employment generated in a given season/year terminates and there is a continuing necessity for generating employment in the following season/year. The question therefore arises whether the country should spend such huge sums of money in programmes that are not self-sustaining, and whether the funds could be better spent in developing infrastructure like roads, irrigation works, water supply and drainage schemes, schools etc.

VI. Concluding Remarks

This paper presents three examples of social protection interventions in India aimed at children (ICDS), women (RCH) and families (Poverty alleviation programme). Although these programmes are well conceived and well funded, they have failed to achieve their objectives due to weaknesses in implementation. Some of the factors are poor targeting, administrative and financial lapses, leakage of resources, corruption etc. More often the poorer and vulnerable sections of the population are not benefiting, and it is the non-poor, and more influential sections are taking advantage of these programmes. The performances of the different states in these programmes also reflect the quality of governance in these states. . Among the three the ICDS has emerged as a more cost effective intervention and the Poverty Alleviation programmes are the least effective. The paper has identified a few operational and policy issues that need to be addressed in such programmes.

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Table 1
Activities and Institutional Arrangements for Social Protection Measures in India

Department of Women and Child Development

- Support to Training and Employment Programme (STEP)
- Swalamban –Setting up Employment and Income Generating Training and Production Units for Women
- Construction and Expansion of hostel Buildings for Working women with day care centres
- Balika Samridhi Yojana
- Kishori Shakti Yojana- National Programme for Adolescent Girls
- National Crèche Fund Scheme
- Grant-in-Aid for Voluntary Organizations in the field of Women and Child Development
- Integrated Child Development Services (ICDS)
- Swa-Shakthi Project- Scheme for Rural Women's' Development and Empowerment
- Swayamsiddha- Integrated Scheme for Women's Empowerment
- Swisher- Scheme for Women in difficult circumstances
- Ashtray Manila Koch- Credit Scheme for Women
- Distance Education for Women's Development and Empowerment

Central Social Welfare Board

- Grant-in-Aid for Voluntary Organizations in the field of Women and Child Development
- Awareness Generation Programme
- Condensed Courses for Women
- Crèches/Day Care Centres for Children of Working /Ailing mothers
- Family Counseling Centres
- Mahila Mandal programme (Women's associations)
- Short stay homes for Women and Girls
- Socioeconomic Programme for women
- Working Women's Hostels

Department of Education, Ministry of Human Resource Development

- Alternative Women's Education Programme
- Sarva Siksha Abhyan- Education for ALL Programme
- Strengthening the boarding and lodging facilities for students of secondary and higher secondary schools
- Free Education for the Single Girl Child
- Mahila Samakhya- Education for Women's Equality
- Assistance to voluntary agencies under National Literacy Mission

Ministry of Rural Development

- Swarna Jayanthi Gram Swarozgar Yojana (SJGSY)-Rural Self employment
- Sampurna Grameen Rozgar Yojana(SGRY)
- National Social Assistance Programme (NSAP)
- Jawahar Gram Samridhi Yojana (JGSY)
- Indira Awas Yojana (IAY)
- Maternity Benefit Scheme (MBS)
- National Food for Work Programme

Ministry of Urban Employment and Poverty Alleviation

- The Swarna Jayanthi Shahari Rozgar Yojana (SJSRY)- Urban Self Employment

Ministry of Social Justice and Empowerment

- Child-line Services
- National Initiative for Child Protection
- Integrated Programme for Street Children
- Establishing hostels for boys and girls belonging to Scheduled castes and other backward classes
- Assistance to voluntary organizations to provide social defense services

Ministry of Health and Family Welfare

- Child Survival and Safe Motherhood Programme
- Reproductive and Child Health Programme
- Gramodaya Yojana for Primary Health Care
- Universal Immunization Programme
- Pulse Polio Immunization Programme
- Prophylaxis programme to Prevent Blindness due to Vitamin A deficiency
- Prophylaxis Programme to Prevent Anaemia due to Vitamin A deficiency
- Prophylaxis Programme to prevent Iron Deficiency
- Prophylaxis programme to Prevent Iodine Deficiency Disorder Syndrome
- National Rural Health Mission (NRHM)
- National Maternity Benefit Scheme

Ministry of Labour

- Vocational Training Programmes for women
- Establishing Regional Vocational Training institutes for Women
- Providing grants-in-aid for Industrial Training Institutes (ITIs) for women.

Ministry of Tribal Affairs

- Vocational Training in Tribal Areas
- Educational programmes and scholarships for Tribal students
- Establishment of Ashram schools
- Establishment of hostels for tribal boys and girls
- Providing grants-in-aid for voluntary organizations promoting welfare of tribal populations.

Source: National Institute of Public Cooperation and Child Development (NIPCCD), New Delhi, *Fact Sheet on Women in India, 2005*, pp 4-7

Table 2
Direct Interventions for Poverty Alleviation in India

Programs	State or NGO	Target Group	Mode of Assistance
1. Credit Based Programs for Rural Areas			
Integrated Rural Development Program (IRDP)	Countrywide, monitored by the Central & State Govts. implemented by the block machinery under guidance of the District Rural Development Agency.	Small & Marginal farmers, agricultural laborers and rural artisans below the poverty line, assisted families are drawn from SC/ST communities (50%), women (40%) and the handicapped (3%).	Subsidy and bank credit, the rate of subsidy varying with the deprivation of different socio-economic groups.
Development of Women & Children in Rural Areas (DWCRA)	Countrywide	Groups of women of the identified rural poor families.	One-time grants given as a revolving fund.
2. Credit Based Programs for Urban Areas			
Prime Minister's Rozgar Yojana (PMRY)	Government operated with the association of NGOs.	Educated unemployed youth of poor families in rural and urban areas.	Micro-enterprise development subsidy of up to 15% of the stipulated investment/individual with a margin money of 5% of the total project cost.
Scheme of Urban Micro-Enterprises (SUMU) under the Nehru Rozgar Yojana (NRY)	State	Unemployed and underemployed youth from poor families (30% should be women).	Has 3 components: a) Loan Subsidy with 25% from a bank; b) Training Component; c) Infrastructure facilities such as common facility centres, technology upgradation, design centres, marketing, job centres.
3. Wage Employment Programs for Rural Areas			
Jawahar Rozgar Yojana (JRY)	State/Central funds directly reach grass roots through the Village Panchayats, who are responsible for planning and execution of work.	Self Targeting	Employment in works for wages at notified min. wage levels - maybe paid partly in cash and partly in kind. Works are linked to durable asset build-up for facilitating implementation of other poverty alleviation programs.
Employment Assurance Program (EAS)	State in operation in 3197 blocks in the country.	Self-Targeting needy workers can get themselves registered.	Provides assured employment of 100 days of manual unskilled work during the lean agricultural season for a max. of 2 adults/family.

Programs	State or NGO	Target Group	Mode of Assistance
4. Wage Employment Programs for Urban Areas			
Scheme of Urban Wage Employment (SUWE) under the Nehru Rozgar Yojana (NRY)	Departmentally executed.	Urban poor i.e., unskilled laborers, laborers in towns with population below 0.1 million.	Statutory min. wages to unskilled laborers and market wages to skilled workers.
5. Area Level Interventions for Rural Areas			
Drought Prone Areas Program (DPAP)	Central and State Governments.	Covers 946 blocks in 149 districts and 13 states.	Core activities include land development, soil conservation, water resource development, afforestation and pasture development. Since 1995-96 a watershed approach adopted using the Panchayat Raj institutions, user groups, Self-Help Groups and Voluntary Agencies.
Desert Development Program (DDP)	Central and State Governments.	Covers 227 blocks in 36 districts and 7 states.	
6. Area Level Interventions for Urban Areas			
Prime Minister's Integrated Urban Poverty Eradication Program (PMUEP)	Central and State Governments and NGOs.	Covers 345 urban agglomerates with a population of 50,000 - 100,000.	Conveyance of services under various ongoing poverty alleviation programs in smaller towns.
7. Training Programs			
Training for Rural Youth for Self-Employment (TRYSEM)	Implemented by DRDA.	Rural youth in the age group 18-35 years from families below the poverty line.	Need-based training given in formal institutions and non-formal modes. Trainees receive stipend and toolkits free of cost. Honorarium given to training institutions.

Source: Thamarajakshi, ILO SAAT, *Alleviating Poverty in Asia*, New Delhi, 1997, pp 108-116.

Table 3
Performance under Poverty Alleviation Programmes IRDP / SGSY, JRY/ JGSY & EAS (Year wise Under The Eighth and Ninth Plans)

SI	Years	IRDP / SGSY		JRY / JGSY		EAS	
		Total Expenditure	Families Svvarozgaries	Total Expenditure	Employment Man days	Total Expenditure	Employment Man days
		Rs. in millions	In '000s	Rs. in millions	In '000s	Rs. in millions	In '000s
Eighth Plan							
1	1992-93	6938.8	2069	27095.9	782102	-	
2	1993-94	9566.5	2539	38787.1	1025840	1837.5	49474
3	1994-95	10083.1	2215	42683.3	951707	12354.5	272956
4	1995-96	10771.6	2089	44669.1	895825	17206.1	346527
5	1996-97	11316.8	1924	21639.8	400632	21604.1	403002
Total		48676.8	10836	174875.2	4056106	53002.2	1071960
Ninth Plan							
1	1997-98	11095.4	1707	24393.8	395589	29049.7	471774
2	1998-99	11622.8	1677	25254.8	376641	28821.8	427936
3	1999-2000	9598.6	934	20324.5	268308	21826.1	278617
4	2000-2001	11162.7	1030	19292.3	268317	18611.1	218392
5	2001-2002	5551.5	625	6990.7	86079	5309.2	66627
Total		47161.7	5692	96256.1	1394934	103617.9	1463350

Note :2001-02 - SGSY - up to January, 2002
2001-02 - JGSY - up to October, 2001
2001-02 - EAS - up to September, 2001

Source: Government of India, Ministry of Rural Development

List of Acronyms in the Paper

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
AWW	Anganwadi Worker
AWH	Anganwadi Helper
CDPO	Child Development Project Officer
CHC	Community Health Centre
CNAA	Community Needs Assessment Approach
CSO	Civil Society Organization
CSSM	Child Survival and Safe Motherhood
DWCRA	Development of Women and Children in Rural Areas
EAS	Employment Assurance Scheme
EGS	Employment Guarantee Scheme
ICDS	Integrated Child Development Service
ICPD	International Conference on Population and Development
JGSY	Jawahar Gram Swarozgar Yojana
IIPS	International Institute for Population Sciences
IRDP	Integrated Rural Development Programme
MHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
NFHS	National Family Health Survey
NCAER	National Council for Applied Economic Research
NGO	Non Governmental Organization
NPP	National Population Policy
NREP	National Rural Employment Programme
NRHM	National Rural Health Mission
PA	Poverty Alleviation
PDS	Public Distribution System
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RLEGP	Rural Landless Employment Guarantee Programme
RTI	Reproductive Track Infection
SC	Scheduled Castes
SGSY	Swarnjayanthi Gram Swarozgar Yojana
SITRA	Supply of Improved Tool Kits for Rural Areas
ST	Scheduled Tribes
TFA	Target Free Approach
TINP	Tamilnadu Integrated Nutrition Project
TPDS	Targeted Public Distribution System
TRYSEM	Training of Rural Youth for Self Employment