PROMOTING 'INCLUSIVENESS':
A FRAMEWORK FOR ASSESSING INDIA'S FLAGSHIP SOCIAL WELFARE PROGRAMMES

Kaveri Gill

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PROGRAMMES

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ABOUT THE AUTHOR

Kaveri Gill is a development economist and social scientist who lives and works in India. Currently, she is Senior Program Officer with IDRC's Think Tank Initiative in South Asia.

EXECUTIVE SUMMARY

This paper seeks to develop a conceptual understanding and analytical framework for assessing social exclusion, which is then applied to the central government's flagship programmes on sanitation, health and child welfare. It begins by contextualizing the current emphasis on inclusiveness in the policy sphere against the broad mandate of the Eleventh Plan. It then explores the concept of social exclusion and how it is transmitted in actuality, both at the macro institutional bias level and meso unruly practices level, which in turn impact flagship programmes in various ways. Based on an understanding of the aforesaid, a framework for assessing social exclusion – or its obverse, inclusiveness – in the flagship programmes is developed. The focus areas of the framework are flagship policy, delivery and implementation, and the beneficiary perspective, with various sub-strands emerging under each area. The paper goes on to use this framework to assess the flagship programmes (TSC, RCH / NRHM and ICDS) in relation to social exclusion. The data for this assessment are based on existing secondary literature. The final section presents findings, gaps in the literature and the way forward.

LIST OF IMPORTANT ABBREVIATIONS

APL	Above Poverty Line
ANM	Auxiliary Nurse and Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CLTS	Community-Led Total Sanitation
DDWS	Department of Drinking Water Supply
DLHS	District Level Household and Facility Survey
FOCUS	Focus on Children under Six (Report)
FP	Flagship Programme
GDP	Gross Domestic Product
GOI	Government of India
HDS	Hospital Development Society
IEC	Information, Education and Communication
ICDS	Integrated Child Development Services
IHHL	Individual Household Laterine
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IYCF	Infant and Young Child Feeding
JSY	Janani Suraksha Yojana
MCOCA	Maharashtra Control of Organised Crime Act
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MRD	Ministry of Rural Development
MWCD	Ministry of Women and Child Development
NFHS	National Family Health Survey
NGP	Nirmal Gram Puraskar
NIPCCD	National Institute of Public Cooperation and Child Development
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
OBC	Other Backward Castes
OCPMTAEFYP	Organising Committee of the People's Mid Term Appraisal of the Eleventh Five Year Plan
ODF	Open Defecation Free
PHC	Primary Health Centre
PIP	Project Implementation Plan
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PTG	Primitive Tribal Group
PUCL	People's Union of Civil Liberties
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RSM	Rural Sanitary Mart
RTF	Right to Food
SC	Scheduled Caste
SKA	Safai Karamchari Andolan
SNP	Supplementary Nutrition Programme
ST	Scheduled Tribe
TFR	Total Fertility Rate
TSC	Total Sanitation Campaign
UN	United Nations
UPA	United Progressive Alliance
UT	Union Territory
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

1.   Introduction[1]

This paper seeks to develop a conceptual understanding and analytical framework for assessing social exclusion, which is then applied to the central government's flagship programmes of the Total Sanitation Campaign (TSC), the Reproductive and Child Health (RCH) programme that comes under the umbrella of the National Rural Health Mission (NRHM) programme, and the Integrated Child Development Services (ICDS) programme. Section 2 contextualizes the current emphasis on inclusiveness in the policy sphere, including the flagship programmes, against the broad mandate of the Eleventh Plan. It then explores the concept of social exclusion and how it is transmitted in actuality, both at the macro institutional bias level and meso unruly practices level, which in turn impact

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flagship programmes in various ways. Based on an understanding of the aforesaid, a framework for assessing social exclusion – or its obverse, inclusiveness – in the flagship programmes is developed.

The framework's focus areas are: flagship policy, delivery and implementation and the beneficiary perspective. Further strands of interest emerge under each heading: on policy, the concerns are on its design, participation and coverage norms, budgetary resources and utilization, and monitoring and evaluation; on implementation, it looks at opportunities for discretionary delivery performance dependent on whether ongoing services through repeat delivery and interaction are required or not, shortfall in quantity and quality of services, provider discrimination, and accountability; and on the beneficiary perspective, it is concerned with access, (un) equal treatment and decentralized community involvement. Sections 3, 4 and 5 use this framework to assess the flagship programmes (TSC; RCH / NRHM; and ICDS) in relation to social exclusion. The data for this assessment are based on existing secondary literature. The final section presents findings, gaps in the literature and the way forward.

2. Flagship Programme Policy

1. Policy Context of 'Inclusive Growth', Eleventh Five Year Plan, Planning Commission

Titled, 'Inclusive Growth,' the Eleventh Five Year Plan of the Planning Commission, Government of India (GOI), begins its vision and strategy chapter with the explicit recognition that while the country recorded an average rate of growth of 7.7 per cent during the Tenth Plan period, a major shortcoming is that this growth is not perceived as being 'sufficiently inclusive for many groups, especially Scheduled Castes (SCs), Scheduled Tribes (STs), and minorities. Gender inequality also remains a pervasive problem…' (Planning Commission [GOI] 2008a, p. 1). Citing the National Sample Survey Organisation (NSSO) and other data evidence in support of this statement, it is argued that during the last decade and a half, the rate of decline in poverty has not been commensurate with the growth in Gross Domestic Product (GDP), and that the incidence of poverty amongst certain hitherto excluded groups, especially the Scheduled Tribes, has shown hardly any decrease at all (ibid.).

The Eleventh plan document argues that while in the short run access to basic facilities, such as health, education, clean drinking water, and sanitation impact welfare, in the long run they determine economic opportunity

The central vision of the Eleventh Five Year Plan is to 'trigger a development process which ensures broad-based improvement in the quality of life of the people, especially the poor, Scheduled Castes (SCs) and Scheduled Tribes (STs), Other Backward Castes (OBCs), minorities and women' (Planning Commission [GOI] 2008a, p. 2). Moreover, the target is 'inclusive growth, that is, a growth process which yields broad-based benefits and ensures equality of opportunity for all' (ibid., p. 2). For our purposes, amongst the interrelated components seen to further this vision and listed in the plan documents, the most relevant are access to services, social justice and empowerment, and governance.

On how access to services is conceived as a means to inclusive growth, the plan document argues that while in the short run access to basic facilities, such as health, education, clean drinking water, and sanitation impact welfare, in the long run they determine economic opportunity, and more importantly, equal opportunity. Since for the majority of the population, access to services depends not just on their income levels but also upon their delivery through public-funded systems, the Eleventh Plan envisages a major expansion in the supply of these services. These are to be funded, sustainably, through tax revenues generated from faster growth and funnelled towards increased plan expenditure.

The vision of the Eleventh Plan explicitly mentions social justice and empowerment of excluded groups as a means to inclusion. The latter is to be achieved through affirmative action for Scheduled Castes and Scheduled Tribes, Other Backward Castes, minorities and women, leading to equality of opportunity and possibilities for economic and social mobility. Empowerment is to be further facilitated through participation in the third established layer of democracy, that is, the Panchayati

Raj Institution (PRI) level, wrought through reservation for Scheduled Castes and Scheduled Tribes and women in these bodies. In particular, 'it is absolutely critical for the inclusiveness of our growth process that these large numbers of elected representatives in our PRIs are fully involved in planning, implementing and supervising the delivery of the essential public services' ((Planning Commission [GOI] 2008a, p. 23).

Finally, the vision for the Eleventh Plan acknowledges that government-funded social sector programmes have suffered from poor design, a lack of accountability, corruption and ineffective implementation. Accordingly, it cites the importance of improved governance by involving communities in the design and implementation of programmes, as also better scientific evaluation, which it is hoped will again feed back into their superior design and implementation.

Looking back on the performance of India's economy under the Eleventh Plan on the eve of the Twelfth Plan, the Deputy Chairman of the Planning Commission notes that, 'It is more difficult to assess performance on inclusiveness than on growth for three reasons. First, inclusiveness is a multidimensional concept and progress therefore needs to be assessed in many different dimensions. Second, the data relating to various aspects of inclusiveness become available only after a considerable lag, and information for the Eleventh Plan period is often not available. Third, most policies aimed at inclusiveness have an impact only over a relatively long term, and this means that even when policies are moving in the right direction, the results may only be evident much later' (Ahluwalia 2011, p. 89). These are the challenges this paper seeks to address, albeit only in the limited domain of flagship programmes of the government.

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2. Social Exclusion and Flagship Programmes

As suggested above, and as envisaged under the Eleventh Plan, improved access to services is one of the lynchpins for achieving inclusive growth. Most flagship programmes address inclusion by building in regional equity components or targeted components, sub-plans or earmarked funds for traditionally excluded groups such as the Scheduled Castes or Scheduled Tribes. This is by design. Yet, others try and reach them through innovations in implementation on the ground. Before we assess the extent to which the three flagship programmes of our interest have been able to address exclusion, it is critical that we first understand the concept of social exclusion – what it means and what operational implications it can potentially have.

2.1. The Concept of Social Exclusion
Social exclusion has been defined as 'the process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live' (de Haan 1999, p. 6). Although often conflated with poverty, social exclusion is different in the sense that it focuses not just on poor outcomes (for example, low incomes, consumption, as seen in monetary definitions of poverty). Rather, it focuses on the institutional processes – in the economic, social or political sphere – that lead to poor outcomes (de Haan 1998). Its potential value addition to previous approaches, especially to monetary poverty, thus lies in the fact that it highlights the nature of disadvantage and deprivation as being multidimensional, relational, and processual and in doing so adds scope for temporal and causal analyses (ibid.).

Drawing out the analytical basis of the social exclusion approach in finer detail, Kabeer posits that different forms of disadvantage stretch along a spectrum, with economic injustice ('what you have') at one end, cultural injustice ('what you are') at the other, and hybrid forms lying somewhere in between (Kabeer 2000). The latter give rise to 'bivalent collectivities', that is, social groups for whom economic disadvantage is bound up with cultural-valuational disadvantage (ibid., p. 85). A key example of such bivalent collectivities is gender and, in the context of South Asia in particular, caste or, more precisely, Scheduled Castes and ethnicity, which alludes in this instance to Scheduled Tribes.

Gender, caste or ethnic disadvantage translates into social exclusion when the 'institutional mechanisms through which resources are allocated and values assigned operate in such a way as to **systematically** deny particular groups of people the resources and recognition which would allow them to participate fully in the life of that society' (Kabeer 2000, p. 86, emphasis added). The key ideas emphasized by this definition are those of the processes of disentitlement, 'given' group characteristics (as opposed to chosen ones), and faulty (or a lack of) access for them, which are reinforced across multiple domains.

Systematic exclusion has been documented in several studies in India. Among the most notable of them is the longitudinal study by Drèze et al. that documents economic development and societal change over five decades in Palanpur village of Uttar Pradesh. The authors found that a scheduled caste identity, as a 'predetermined characteristic' or 'given group', engendered radically different endowments and opportunities in various spheres, which resulted in a systemic poverty trap for them. Moreover, entire

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generations of Scheduled Caste families were unable to move out of poverty suggesting intergenerational transmission of inequalities (Drèze et al. 1998).

2.2. Applying a Social Exclusion Lens to Flagship Programmes
In terms of actual practices through which social exclusion is transmitted, two are especially relevant to the subject of this paper. First, at the macro-policy level, is the mobilization of institutional bias, that is, a predominant set of values, beliefs, rituals and institutional procedures or rules of the game that operate systematically and consistently to the benefit of certain persons and groups at the expense of others (Kabeer 2000, p. 91). These are insidious in that they can operate to exclude those who threaten the status quo without conscious decisions or awareness by status quo representatives. Second, at the meso-level are unruly practices, that is, gaps between rules and their implementation which occur in all institutional domains (ibid., p. 92). They are especially relevant to the flagship programmes, where unofficial norms are likely to shape actual (non) provision and mediate people's (in) ability to gain access to goods to which they are technically entitled.

In sum, and as is appropriate for the limited remit of the present paper, which is to apply the concept of social exclusion to flagship programmes, the following points emerge. First, we are to focus on the 'bivalent collectivities' of gender and excluded categories (for example, Scheduled Castes and Scheduled Tribes) that are explicitly named as priority beneficiaries in each of the central government's flagship programmes. Second, we are to recognize and explore the extent to which – for these 'given groups' – social exclusion is possibly reinforced across multiple sectors, which leads to poverty traps and intergenerational transfer of inequality.

Third, our analysis should look for evidence, if any, of a 'macro institutional bias' operating against these groups, and which is sought to be compensated for by explicitly naming them as priority categories in terms of the macro-vision, design and budget allocation of flagship programmes. Finally, we need to focus also on 'meso unruly practices', if we find any in the implementation of flagship programmes, which result in outcomes other than those intended (here, outcomes may even allude to access to inputs promised by the programme, not necessarily the final development outcomes).

Keeping these factors in mind, exclusion in flagship programmes can be studied in terms of (1) policy; (2) delivery system and implementation; and (3) what target group representatives themselves have to say about exclusion in these programmes, that is, a beneficiary perspective. Annexe 1.1 summarizes this analytical framework in tabular form, including the sub-strands falling under each of the above categories that need scrutiny.

Four issues arise at the policymaking stage itself: (1) design and strategies; (2) guidelines for participation and coverage norms; (3) budgetary resources and utilization; and (4) monitoring, evaluation and assessment documents. A look at the programme-specific policy documents can throw considerable light on whether it is indeed inclusive by design, for example, does it target scheduled caste and scheduled tribe populations in its objectives? Do the programme guidelines have coverage norms for excluded groups? Are adequate resources allocated for covering them? Is there a provision for gathering disaggregated data on services and inputs reaching these groups?

When it comes to actual delivery or implementation, this paper will assess findings on the following social

Exclusion in flagship programmes can be studied in terms of policy; delivery system and implementation; and what target group representatives themselves have to say about exclusion in these programmes, that is, a beneficiary perspective.

exclusion strands identified: (1) opportunities for variable performance dependent on whether the flagship programme provides for one-off or on-going delivery; (2) shortfall in quantity and quality of services and physical infrastructure and other resources available to provide these services; (3) provider discrimination; and (4) checks and balances for accountability, in terms of supervision and punishment for malfeasance in delivery.

In terms of assessing the beneficiary perspective, issues of exclusion can be broken up in the following manner: (1) access, especially to components of the flagships programmes that are meant for certain 'given' groups, such as Janani Suraksha Yojana (JSY) for women under the NRHM; (2) (un)equal treatment and opportunity; and (3) knowledge, participation, agency, voice and empowerment in specific PRIs, for example, Rogi Kalyan Samitis (RKSs), and Village Health and Sanitation Committees (VHSCs).

The rest of this paper uses existing secondary material on flagship programmes to review exclusion through these three aspects, that is, policy, implementation and beneficiary perspective. The secondary material encompasses government documents, external evaluations of the chosen flagships (by practitioners, academics and Comptroller Auditor General [CAG] accountability authorities), civil society and activist-group documentation, and United Nations (UN) and international body studies. The aim is not to undertake an impact evaluation of outcomes and how they differ for different groups. Rather it is to assess how flagship programmes of the TSC, RCH/ NRHM and ICDS are faring on the goals they have defined for themselves, viz., reaching out to excluded groups through inputs and service delivery.

3. Exclusion in Policy

1. Policy: Total Sanitation Campaign[2]

Launched in 1999, the TSC is a comprehensive programme aimed at: ensuring adequate sanitation facilities (toilets) in rural areas, with the specific objective of accelerating coverage to ensure access for all by 2012; to increase coverage of institutional toilets in schools and anganwadi centres (AWCs), giving preference to girls in the former; and mobilizing communities and PRIs to promote sustainable, cost-effective and ecologically safe sanitation facilities through awareness and education. It replaces the Central Rural Sanitation programme introduced in 1986 that was based on a full subsidy principle but was discontinued because of a lack of community participation and the realization that top-down approaches to sanitation fail – simply providing a latrine to people does not ensure its use (Mehta and Movik 2011). For this reason, the TSC takes particular

2. TSC falls under the Department of Drinking Water Supply (DDWS), Ministry of Rural Development (MRD), GOI. This section is based on 'TSC Guidelines' (2004; revised 2007) and other programme documentation obtained from the official website of the DDWS, MRD, GOI: <http://ddws.nic.in/tsc_index.htm> (last accessed on 11 June 2010).

The TSC conducts information, education and communication (IEC) campaigns for community groups, in order to bring cultural, attitudinal and behavioural change by creating awareness about the importance of sanitation to health, hygiene and general well-being.

pride in modelling itself as a Community-Led Total Sanitation (CLTS) approach (ibid.).

On a principle of 'low to no subsidy', a financial incentive is given to below poverty line (BPL) rural households for construction of a toilet (that is, an individual household latrine [IHHL]), an endeavour that they undertake themselves and for which they are paid after the construction of the toilet. Alongside, the TSC conducts information, education and communication (IEC) campaigns for community groups, in order to bring cultural, attitudinal and behavioural change by creating awareness about the importance of sanitation to health, hygiene and general well-being. This in turn generates demand to choose an option that is appropriate to individual and community needs, economic circumstances and hydrological conditions from a set of alternative delivery mechanisms and options. These are to be provided by Rural Sanitary Marts (RSMs).

In order to provide added impetus for fully sanitized (100 per cent sanitation coverage for individual households and schools) and open defecation free (ODF) villages, blocks and districts, the Nirmal Gram Puraskar (NGP) was introduced by the GOI in 2003. Under this, eligible gram panchayats, as well as individuals and organizations that have been instrumental in the drive for full coverage, are given recognition and a monetary award.

1.1. Does TSC Policy Take Account of Social Exclusion?

The TSC policy framework makes no attempt at articulating a cohesive plan to tackle social exclusion, with the consequence that even at the state level, there has been no conscious attempt to tackle the issue in a comprehensive manner

(Organising Committee of the People's Mid Term Appraisal of the Eleventh Five Year Plan [OCPMTAEFYP] 2010a). From the perspective of the various strands identified for assessing social exclusion, it can safely be said that on design and guidelines for participation, the TSC documents are not explicitly sensitive to the problem of social exclusion. Since TSC incentives are aimed at rural BPL households, and since certain groups, that is, Scheduled Castes and Scheduled Tribes, are over-represented amongst this target group, needs of the Scheduled Castes and Scheduled Tribes are taken account of only in this tangential way.

To some extent, the 'macro institutional bias' against the 'given groups' of scheduled castes and scheduled tribes is implicitly recognized, and it is sought to be ameliorated by budgetary allocations for the TSC. The government does so by naming the aforesaid groups as priority categories within the flagship programme, so that out of the total incentives earmarked for construction of household latrines, a minimum of 25 per cent is to be provided to Scheduled Caste/Scheduled Tribe households (DDWS, Eleventh Plan submission note to the Planning Commission, as reported by the OCPMTAEFYP 2010a). State governments have also recently been instructed to accord special attention to 71, 406 villages where the population of Scheduled Castes/Scheduled Tribes is more than 40 per cent as per Census 2001 (ibid.).

As for actual budgetary allocation and expenditure under TSC, a budget brief posits that the GOI allocation for rural water supply and sanitation stood at 0.15 per cent of GDP in the fiscal year 2009–2010 (Accountability Initiative 2010a). It clocks a vast improvement in the utilization of TSC funds released by the GOI, which went up from 48 per cent in the fiscal year 2005–2006 to 86 per cent in fiscal year 2008–2009. However, it notes a

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wide variability in individual state capacities to utilize released funds (including contribution by the centre, the state and the beneficiary). Some states show an improvement over time (Rajasthan and Jharkhand are able to spend 94 and 52 per cent respectively of total releases in the fiscal year 2008–2009, as opposed to only 30 and 25 per cent in the fiscal year 2005–2006), while others show a worsening (Uttar Pradesh and Uttarakhand are only able to spend 63 and 73 per cent respectively of total releases in the fiscal year 2008–2009, as opposed to 70 and 83 per cent in the fiscal year 2005–2006) (ibid., p. 4).

Finally, there is some disaggregated monitoring (see the government's online progress monitoring system for the TSC[3]), albeit only at the level of geographies inhabited by these groups. The website allows for special reports on the physical tracking of the TSC at the state and district level, with a further option of choosing districts that are, 'Scheduled Caste or Scheduled Tribe dominated / Minority concentrated / Naxal affected or Backward Region Grant Fund'. For example, if one chooses Andhra Pradesh and Scheduled Tribe dominated districts, one gets a report on the physical progress (actual against objectives) of IHHLs (BPL and APL), sanitary complexes, school and anganwadi toilets for the eight districts of Adilabad, East Godavari, Khammam, Srikakulam, Visakhapatnam, Vizianagaram, Warangal and West Godavari. Or if one picks Chhattisgarh and Naxal-affected districts, one gets a report on similar physical progress for the five districts of Bastar, Dantewada, Kanker, Rajnangaon and Surguja. An analysis of this monitoring data on physical coverage of the TSC would allow for an assessment of progress

3. <http://ddws.gov.in/crspnet/Report/Special%20Report/RptPhysicalSpecial.aspx> (last accessed on 17 June 2010).

amongst socially excluded 'given groups', although only for some limited categories.

Looking at exclusion from the perspective of those who provide the service, we find that scheduled caste groups, such as the Bhangis, have been traditionally engaged in the offensive and ritually unclean task of manual scavenging. However, the government has banned the practice even before the TSC came into place (Planning Commission 1991–1992). The TSC has taken this further by aiming to convert all dry latrines to pour flush latrines wherever the former are in existence in rural areas (Alok 2010).

Other excluded 'given groups', for example, women, differently-abled and the elderly, however, are overlooked by the TSC policy documents. Civil society groups seem particularly irked that women's specific needs are not articulated and written into programme guidelines, despite the fact that this group makes up 50 per cent of the target population and suffers disproportionately – owing to safety, privacy and productivity considerations – from a lack of sanitation facilities at home (OCPMTAEFYP 2010a). Moreover, the guidelines do not take into account menstrual hygiene requirements, which are critical to the health of women for a large part of their lives (WaterAid 2008). Where this issue has been taken up at the behest of individual state initiatives, for example, Haryana, it has received an overwhelmingly positive response from women's groups (ibid.).

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2. Policy: Reproductive and Child Health, National Rural Health Mission[4]

Reproductive and Child Health (RCH II) is a comprehensive sector-wide programme that comes under the umbrella of the GOI's flagship programme, the National Rural Health Mission (NRHM). Launched in 2005, the primary objective of the RCH II is to bring about improvements in the three critical health indicators, that is, total fertility rate (TFR), infant mortality rate (IMR) and maternal mortality rate (MMR), by reducing social and geographical disparities in access to and utilization of quality reproductive and child health services.

Marked points of departure from RCH I are: a greater and more explicit pro-poor focus; a concern with outcomes, as opposed to inputs; using an evidence-base to prioritize interventions and shift resources to where health outcomes are the worst and need is the greatest; encouraging innovative approaches, including public-private partnerships (PPPs), to improve reproductive and child health among Scheduled Castes/Scheduled Tribes; and monitoring of the programme by multiple internal and external organizations to track equitable access by and outreach to excluded groups.

The United Progressive Alliance (UPA) government launched NRHM in 2005, undertaking an 'architectural correction' – decentralization and communitization, in institutional terms – of the public health system to provide access to affordable and accountable primary health care services to poor households in remote parts of rural India.

Some new strategies under NRHM include the creation and upgradation of health centres; using

4. RCH and NRHM fall under the Ministry of Health and Family Welfare (MoHFW), GOI. This section is based on MoHFW 2005 as well as RCH II and NRHM programme documentation obtained from the official website of the MoHFW, GOI:< http://mohfw.nic.in/NRHM/RCH/index.htm> (last accessed on 21 June 2010).

untied, flexi-pool grant and maintenance funding; Janani Suraksha Yojana (JSY), which provides cash incentives to BPL women for institutional delivery; introduction of Accredited Social Health Activists (ASHAs) – a female interface between the health system and the community; Village Health and Nutrition Days (VHNDs) to educate and mobilize the community; Hospital Development Societies (HDSs) or Rogi Kalyan Samitis (RKSs) and Village Health and Sanitation Committees (VHSCs), all of which encourage the involvement of the community at decentralized levels; and District Health Plans (DHPs), which converge health, nutrition, water, sanitation and hygiene activities.

2.1. Does RCH (NRHM) Policy Take Account of Social Exclusion?

Taking the issues of design and coverage norms together, we find that while the NRHM policy framework is targeted at the BPL rural households in general, with universal access for women and children as a particular goal, there is no explicit mention of groups, such as the Scheduled Castes and Scheduled Tribes. On the contrary, RCH II formulates a comprehensive and well-articulated plan to tackle social inclusion (MoHFW 2004).

In a document titled, 'Project Implementation Plan for Vulnerable Groups under RCH II' (MoHFW 2004), 'vulnerable communities' are identified as those groups that are 'underserved due to problems of geographical access (even in better off states), and those who suffer social and economic disadvantages, such as Scheduled Castes / Scheduled Tribes and the urban poor' (ibid., p. 3). Interestingly, the RCH II is the only policy document that not only acknowledges differential outcomes for certain groups, but also identifies various causal pathways

> Interestingly, the RCH II is the only policy document that not only acknowledges differential outcomes for certain groups, but also identifies various causal pathways that result in exclusion.

that result in exclusion. Accordingly, it states, 'marginalisation results in poorer indicators for these groups, including maternal and child health indicators. This can be as much a result of service provider behaviour, as of health seeking behaviour and capabilities' (ibid., p. 3). Other identified causal factors include: poor connectivity to health centres because of distance, topography, and a lack of public transport; social and cultural barriers, especially for women; lack of flexibility and reduced responsiveness to local diversity and needs; scarcity of funds for non-salary expenditure, including innovative activities; lack of an appropriate human resource (HR) policy to encourage and motivate service providers to work in understaffed remote and tribal areas; and weak monitoring and supervision systems (MoHFW 2004, p. 4).

It is argued that RCH II 'seeks to address the above issues systematically' (MoHFW, p. 4) and that the Vulnerable Communities Health Plan 'adds value by acting as a "conscience" within the Department of Family Welfare to ensure that RCH II is progressively more focused on reaching those least served, and by earmarking a separate pool of resources that will enable innovative solutions to be implemented – in monitoring systems; behavioural change communication; service delivery; PPPs; demand-side financing, such as insurance and voucher programmes; training and supervision of professional, auxiliary and administrative staff; research on tribal systems of medicine, planning capacities, disseminating good practice etc.' (ibid., p. 4).

In terms of actual strategy, the document puts the onus on states to identify the vulnerable groups and include in their Project Implementation Plans (PIPs), a

strategy to prioritize them, that is, what will be done to improve their health status and how it will be done. Moreover, state PIPs are mandated to reflect this strategy in an appropriate monitoring and evaluation (M&E) mechanism; capacity development; behaviour change communication; flexible state and district plans; converging health activities with those of ICDS, as well as water and sanitation; and weighting of resource allocations towards vulnerable groups. Lastly, RCH II has a performance fund that gives additional funds to states and districts that provide evidence of 'significant improved performance,' where the majority of indicators for success are based on quality and convergence of services for the vulnerable (MoHFW 2004, p. 5).

For scheduled tribes in particular, state and district plans are to include a special health plan in accordance with the PIP for Tribal Health (Annexure I of MoHFW 2004). The Tribal Health Annexure reads like any other PIP, except for the following:
1. Under strategies – to promote and encourage a tribal system of medicine;
2. Under human resources – to give additional incentives to health service providers who are working in tribal areas and to provide Auxiliary Nurse and Midwife (ANM) training to tribal girls by relaxing educational standards;
3. Under coverage – to implement the programme in a phased manner, eventually covering all 600 Tribal Blocks, with initial priority to blocks having Primitive Tribal Groups (PTGs).

Turning to NRHM budget allocations under the flagship privilege heavily populated, poorer 'focus' states by allocating centre plan funds to individual states according to a weighting system dependent on the population and category of state (whether a focus

NRHM budget allocations under the flagship privilege heavily populated, poorer 'focus' states by allocating centre plan funds to individual states according to a weighting system dependent on the population and category of state.

or a northeastern state). Under RCH II, a sum of Rs 115 crores has been earmarked for the Tribal Health Program (over and above the budget for taking up activities covered under other programmes of RCH II in tribal areas). Additional funds are also available out of the 10 per cent of the budget earmarked especially for northeastern states, for taking up said activities in areas covered by this programme. On the basis of an average cost of Rs 40 lakh per block per year, and coverage of all 600 Tribal Blocks over a period of five years, the total proposed allocation is estimated at Rs 688 crores (MoHFW 2004, p. 18).

As for actual allocation, release and expenditure, an evaluation report suggests that despite the privileges accorded to poorer focus states while making budgetary provisions, allocations in fact have not been in line with the proposed weighting system (CAG 2009–2010). Instead, a vicious cycle appears to be in place where a lack of capacity inhibits acceptable levels of expenditure in focus states, which in turn fail to attract release of funds as they are entitled to under the weighting system. On the other hand, non-focus states, such as Andhra Pradesh, Gujarat, Kerala and Tamil Nadu, obtained larger grant releases than warranted on the basis of better prior utilization records. Furthermore, in 2007–2008, only four states (Andhra Pradesh, Bihar, Gujarat and West Bengal) made their financial contribution of 15 per cent as per the MOU between the centre and states (ibid.). Low expenditure levels in general and in focus states in particular are a finding that is borne out by numerous other assessments of NRHM: both internal (MoHFW 2009a) and external (Gill 2009). But for our purposes, neither the mid-term review of the RCH II (MoHFW 2009a) nor the joint review mission of NRHM / RCH II (MoHFW 2009b) makes any mention of actual budgetary allocation, release or utilization for

the vulnerable communities in general or the Tribal Health Plan in particular.

Finally, on monitoring and evaluation, it remains the case that such tracking, if it is occurring routinely, remains unavailable in the public domain. For example, neither the MoHFW website nor the NRHM / RCH II pages leads to any documents. Although there are links to state PIPs and to the M&E Framework for RCH II – monthly, quarterly and annual reporting formats – they lead to blank pages. Consequently, despite many promises of enumerating excluded communities in State and District Health Plans and of undertaking subsequent, regular, sensitive M&E in the programme documentation of RCH II, including the call for such exercises to gather disaggregated data on the utilization of services and outcomes by Scheduled Castes and Scheduled Tribes and other excluded communities (MoHFW 2004, pp. 6, 7), it thus far remains an unfulfilled claim.

3.   Policy: Integrated Child Development Services[5]

Launched in 1975, the Integrated Child Development Services (ICDS) programme is one of the older flagships programmes of the GOI, seeking to comprehensively address the nutrition, health and pre-school needs of children under 6 years of age. Its objectives include the following: to improve the nutritional and health status of children under six;

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to reduce the incidence of mortality, morbidity, malnutrition and school drop-out rates amongst this cohort; to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper health and nutrition education; to achieve effective coordination of policy and implementation among various departments to promote child development; and to lay the foundation for the proper psychological, physical and social development of the child.

ICDS offers a package of six services:
(1) Supplementary nutrition (SNP) to a target group of children younger than 6 years (excluding children younger than 6 months) and to pregnant women and lactating mothers; (2) pre-school education of a non-formal kind to a target group of children 3–6 years; (3) nutrition and health education to a target group of adolescents and women, 15–45 years; (4) immunization; (5) growth monitoring and health check-ups; and (6) referral services. Services (4), (5) and (6) are provided to a target group of children younger than 6 years, pregnant women and lactating mothers. In common with other centrally sponsored programmes, it is actually the state governments that are responsible for the implementation of ICDS. Institutionally, it is the AWC that is the fulcrum of the programme, and it is the anganwadi worker (AWW), along with her helper where one exists, who is the key frontline provider of this programme.

3.1. Does ICDS Policy Take Account of Social Exclusion?
Assessing ICDS on design and guidelines for coverage norms, we find that the 'macro institutional bias' against 'given' groups of Scheduled Castes and Scheduled Tribes is implicitly recognized by the government in

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5. ICDS falls under the Ministry of Women and Child Development (MWCD), GOI. This section is based on ICDS programme documentation obtained from the official website of the MWCD, GOI: <http://wcd.nic.in>(last accessed on 30 June 2010).

naming them as priority categories for the ICDS programme (for example, the ICDS policy states that there should be one AWC per 1000 population; but the population norm is lower in tribal areas – one AWC per 700 population).

In reality, however, until the involvement of the Supreme Court[6] and subsequent pressure by academics and activists of the National Advisory Council for 'universalisation of ICDS' as a core commitment of the National Common Minimum Programme of the UPA, the programme remained badly targeted – the poorest states and those states with the highest levels of undernutrition tended perversely to have the lowest coverage by ICDS activities (Gragnolati et al. 2006). This fact that access to ICDS was the worst in states with the gravest malnourishment indicators remained true regardless of the indicators of ICDS coverage, such as, the percentage of villages with an AWC centre; the number of ICDS beneficiaries enrolled; or public expenditure in ICDS per malnourished child (ibid.).

In recognition of the above unsatisfactory and inequitable delivery of inputs under ICDS, pressure was mounted for 'universalisation with quality and equity' (Drèze 2006; FOCUS 2006). This demands that not only should every settlement have a functional AWC and all Indian children have access to ICDS services, but the quality of these services should be radically improved, and priority should be given to

In recognition of the unsatisfactory and inequitable delivery of inputs under ICDS, pressure was mounted for 'universalisation with quality and equity'.

excluded groups, especially residents of Scheduled Castes and Scheduled Tribes hamlets and urban slums. The equity argument is emphasized in order to stem the intergenerational transmission of social inequality by providing a level playing field of opportunity for growth and development in the early years (FOCUS 2006). The socialization role of the ICDS as a tool with the potential to encourage social integration, such as communal eating and interaction irrespective of caste, class and gender, and thus as inhibiting the formation of deeply entrenched, divisive social norms from childhood itself is seen as especially valuable in preventing the internalization of inequitable practices in the first place (ibid.).

Abiding by the Supreme Court order, the GOI sanctioned a total of 13.8 lakh AWCs, of which about 10.7 lakh AWCs were actually operational at the end of 2009 (OCPMTAEFYP 2010a). An alternative source reports these figures for sanctioned and operational AWCs as 13.56 lakhs and 11.42 lakhs, respectively (Planning Commission 2010). This period has seen a marked increase in the coverage of children from 6 months–6 years under the SNP, a leap from under four crores to over eight crores (OCPMTAEFYP 2010a).

Still, caution is warranted as 'these are official statistics and it is well known that they are overestimates' (OCPMTAEFYP 2010a, p. 21). The figures in NHFS3 reflecting the status in 2005–2006 on real and effective coverage in terms of actual receipt of various ICDS services are less than cause for celebration. Moreover, no large-scale independent evaluations are available since the commencement of the Eleventh Plan period (ibid.). This is a very important point related to monitoring

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6. People's Union of Civil Liberties (PUCL) vs Union of India and Others, Writ Petition (civil) 196 of 2001, arguing for the right to food. The website for the Right to Food Campaign provides the most up-to-date and comprehensive coverage of secondary literature pertaining to all facets of ICDS, including its implementation: <http://www.righttofoodindia.org> (last accessed 2 July 2010).

and evaluation documents on ICDS and its social exclusion aspects, in particular. In the light of the Gragnolati findings (Gragnolati et al. 2006) using NFHS2 data, which alleged that poorer states with the worst malnourishment indicators tended to have the least access to ICDS services, we have no way of undertaking a systematic countrywide comparison on how things have changed since then, for better or worse, until NFHS4 findings are made available.

As for monitoring, the MWCD website uploads state-level consolidated 'status reports' on the ICDS programme on a yearly basis, which allows for on-line monitoring of quantitative numbers of projects, frontline providers and enrolled beneficiaries. However, they wrongly focus on inputs – such as number of AWCs – than on outcomes (for example, changes in infant-feeding behaviour). Also, there is very little information about real and effective delivery of these inputs as well as their quality, let alone the proportion of excluded groups benefiting as a disaggregated subset within each state.

The National Institute of Public Cooperation and Child Development (NIPCCD) brings together recent research on the ICDS into a single, comprehensive volume, including evaluations (NIPCCD 2009, pp. 75–148) and studies focusing on malnutrition outcomes (pp. 209–230). The key shortcoming of these studies is that most are limited to a single state, or a single or a few districts within a state, which do not render generalizable conclusions across the country or even systematic comparisons across states. The handful of studies that include Scheduled Tribes or other excluded groups, as a separate sample for research, covers only single-service delivery aspects of the ICDS.

In order to facilitate a restructuring and universalization of the new, improved programme, allocation for the ICDS jumped from Rs 12,147 crores in the Tenth Plan to Rs 44,400 crores in the Eleventh Plan, a large increase of 266 per cent

We now turn to the last strand of social exclusion as it applies to flagship programme policy, that is, budgetary resources and utilization. In order to facilitate a restructuring and universalization of the new, improved programme, allocation for the ICDS jumped from Rs 12,147 crores in the Tenth Plan to Rs 44,400 crores in the Eleventh Plan, a large increase of 266 per cent (Planning Commission 2010). Critics gripe that the new amount is still not sufficient for 'universalization with quality', and that although a Gross Budgetary Support of Rs 44,400 crores in the Eleventh Plan translates into an annual budget of Rs 8,880 crores, in actuality, annual budgetary allocations have been lower at Rs 5,293 (2007–2008), Rs 6,300 (2008–2009) and Rs 6,705 (2009–2010) crores, respectively (OCPMTAEFYP 2010a). Quite apart from low and inadequate budgetary allocations is the problem of underutilization of allocated or released funds, which is attributed to a lack of capacity by some and governance problems by others. As things stand, no publicly available data allows one to reliably track budgetary allocation, release and expenditure, especially on excluded groups.

4. Exclusion in Implementation and Delivery

Much has been written on implementation and delivery performance – or the lacunae and inadequacy thereof – of the flagship programmes of the government. These will not be discussed, since to do so would actually overwhelm and detract from the focus of this section, which is to unearth and shed light on the 'meso unruly practices' affecting implementation of flagship programmes and resulting in unintended outcomes for excluded groups. No doubt, general implementation and governance failures – especially as vast and intractable as they appear to be in the context of many flagship programmes – do in turn negatively impact outcomes for groups such as Scheduled Castes and Scheduled Tribes, and indeed it would be hard to separate out the causation, but they shall not be explored in any detail here.

1. TSC Implementation and Delivery Performance: A Social Exclusion Lens

What of the implementation and delivery of sanitation services from a social exclusion perspective? The

secondary literature is more or less silent on this aspect, which is accorded three pages in one report (WaterAid 2008, pp. 37–39) and one page in another report, which draws almost entirely on the WaterAid paper (OCPMTAEFYP 2010a, p. 49). It merely proposes that for women and Scheduled Tribes, 'involving them as active participants and change agents in the development process, as also in service provision, requires special efforts, which have been largely missing from implementation plans and strategies of most of the states and districts'(WaterAid 2008, p. 37).

Where women have been actively enlisted as community sanitation activists, for example in Haryana, positive benefits have accrued.

Where women have been actively enlisted as community sanitation activists, for example in Haryana, positive benefits have accrued. The TSC makes no conscious attempt to engage with Scheduled Tribes, merely assuming they will be included in the community involvement approach, which may or may not take place depending on the local context – they fare well in Chhattisgarh, in particular Sarguja district, and not so well in Tripura, for example, Dhalai district. Dalits in Vaishali and Nalanda districts of Bihar had no knowledge of the sanitation programme in the village and, consequently, never used the community toilet complex they were provided with (WaterAid 2008). They were also put off by the low quality of the toilets, which they found disgusting (ibid.).

Whether implementation of the TSC has improved inclusion for Scheduled Castes who have traditionally been providers of sanitation through manual scavenging of dry latrines, the affirmative answer can be ascribed almost entirely to the awareness and activist efforts of the Safai Karamchari Andolan (SKA), a national movement spearheaded by a dynamic leader who is committed to the total

eradication of the practice of manual scavenging. Using 1,400 volunteers across the country, SKA has engaged in an ongoing sample survey to document the continued existence of this practice[7] and has lobbied the government incessantly to use various means to put a stop to this denigrating practice. In inclusion terms, the outcomes are nuanced in that while the SKA's efforts have gone a long way in taking Scheduled Castes out of this work, there have been variable successes in terms of getting them alternative means of livelihood and rehabilitating them.

In sum, and in terms of the four strands identified, we can conclude that the TSC is a one-off delivery rather than an ongoing delivery. We can also conjecture that on the demand side for sanitation, excluded communities probably suffer from both quantity and quality shortage (as Mehta and Movik [2011] point out, even with CLTS, it is a challenge to include the poorest), though the precise nature and scale is a subject for further enquiry. Whether such communities are subject to provider discrimination and can hold accountable these providers for malfeasance in delivery are questions that must be addressed by primary research.

2. RCH (NRHM) Implementation and Delivery Performance through a Social Exclusion Lens

As a key social sector, implementation and delivery performance under the flagship programmes for health – NRHM and, by extension, RCH II – have

7. < http://safaikarmachariandolan.org/survey.html> (last accessed July 2010).

While there is considerable evidence on the performance of ASHAs across the country, there is little or no research on their social identity background, and whether that has facilitated or detracted from serving sections otherwise excluded, such as Scheduled Castes and Scheduled Tribes.

been the subject of a number of external academic assessments. However, few have adopted an explicit social exclusion lens in their analysis. For instance, while there is considerable evidence on the performance of ASHAs across the country, there is little or no research on their social identity background, and whether that has facilitated or detracted from serving sections otherwise excluded, such as Scheduled Castes and Scheduled Tribes.

The scarcity of human resources – both medical and paramedical, and in the context of RCH services, female doctors and adequately trained obstetricians and gynaecologists, in particular – in rural primary public health care is found to be a complicated and key driver of less than ideal implementation of NRHM (Gill 2009). We know that health care in general involves the most repeat delivery and intensive interaction between provider and beneficiary compared with other programmes. Thus it is unique in being especially prone to asymmetry in information and hence to principal agent problems, such as moral hazard.

A recent innovative project in Chhattisgarh looks at the human resources issue in detail. It flips the usual absent and absconding question to ask instead why some qualified health workers continue to remain and work in otherwise underserved rural and remote areas of Chhattisgarh, with its significant tribal population of poor economic status (IIPHD, PHFI, NHSRC and SHRC Chhattisgarh 2010). The answer for a subset of the total respondents (N=37), of whom (n=5/37) share ethnic (tribal) affiliations, and of whom (n=14/37) were brought up in the same district or region of their present habitation and duty, was articulated as being these very factors, that is, shared identity and belonging, which fuels greater duty and obligation, and which helps to inhibit moral hazard in frontline provider behaviour.

Borooah (2010) explores whether there is a social gradient to certain health outcomes in India, of which I mention the two that have a direct health care focus, that is, after controlling for several non-group factors that affect health outcomes, what is the likelihood that treatment for the ailing elderly and pre- and post-natal care for women are significantly influenced by their social group identity? Using the Morbidity and Health Care Survey (M&HC Survey) for January–June 2004, conducted across the country by the NSSO, Borooah found that living in a forward state (compared with living in a backward state), affluence, household-living conditions and education significantly improved the probability of receiving treatment and care. Even controlling for all these factors, however, the social group to which people belonged had a significant impact, with Adivasis, Scheduled Tribes, Christians, Dalits, Other Backward Caste Muslims and non-Muslim Other Backward Castes faring worse than their Hindu counterparts in the likelihood of their elderly taking treatment, and Scheduled Tribe Christian, Other Backward Caste Muslim and non-Other Backward Caste Muslim women faring worse than their Hindu counterparts in receiving pre-natal care. Study limitations notwithstanding, he shows group identity is the main cause of health inequity (that is, the part of inequality generated by factors beyond a person's control).

Excluded communities probably suffer to a greater degree from both quantity and quality shortage under NRHM and RCH II than the rural poor in general (and Borooah's study does not directly speak of public service delivery under these programmes, though tangentially it does, alluding even to better outcomes in forward states). The poor as a whole suffer enough of a degree of lack on both accounts to make a separation of general implementation and

The precise nature and scale of the lack of excluded communities vis-à-vis service delivery under the flagship programmes, therefore, are still a subject for further enquiry.

governance failure from particular social exclusion rather difficult, though it is important to be able to do so. A study that uses secondary NFHS data to record the poorer access to public maternal and child health care services of Scheduled Castes and Scheduled Tribes as compared with 'Others', with Scheduled Tribes faring the worst, is that of Baraik and Kulkarni (2006). However, it pre-dates the rolling out of NRHM and overlaps with the first year of RCH II. The precise nature and scale of the lack of excluded communities vis-à-vis service delivery under the flagship programmes, therefore, are still a subject for further enquiry.

As for provider discrimination, Acharya (2010) records the prevalence of discriminatory behaviour by dominant castes and resultant beneficiary experiences of unequal and unsatisfactory delivery of health care to Scheduled Caste children in 12 villages of Gujarat and Rajasthan. Such a study, which attempts to measure discrimination and construct an index for an essentially behavioural and subjective phenomenon, remains to be replicated on a much wider scale and also to be applied to communities other than the Scheduled Castes.

Finally, as regards accountability, community monitoring as a means of engendering accountability is negligible or less than effective at the moment (Comptroller and Auditor General of India 2009–2010). It is argued that 'monitoring mechanisms in the NRHM should include systems and processes… so as to involve community-based representatives, including women and those from marginalised groups. This is extremely critical because these systems and processes will have to move beyond existing power dynamics in the community to ensure that…[all] their health needs are met' (OCPMTAEFYP

2010a, p.13).

The MoHFW names the following priority actions for the annual plans of 2010–2011:

1. 'Clear Action Plan for Backward Districts as part of the PIP – the state must identify the backward areas for greater attention (difficult, left wing affected, minority, tribal, Scheduled Caste/ Scheduled Tribe, gender etc.). Special incentives to medicos and para-medicos for performing duties in difficult areas, which was part of 100 days agenda of this Ministry, may be made part of the State PIPs for the year 2010-11' (MoHFW 2010, p. 29).

2. Constitution of District Planning Teams and ranking of Backward Districts for planning – 235 high-focus districts identified on the basis of ranking of 13 indicators from DHLS III, districts with 35 per cent or more Scheduled Caste/ Scheduled Tribe population, and 33 left-wing, extremists-affected districts. District Planning Teams constituted for visiting the high-focus districts to observe and ensure adequate attention to these districts in the planning process. The entire process has been coordinated by NHSRC (MoHFW 2010, p. 30).

Since this is a plan yet to be carried out, judging its successfulness is for the future.

3.   ICDS Implementation and Delivery Performance through a Social Exclusion Lens

The ICDS programme involves repeat delivery and intensive interaction between multiple frontline providers, although, primarily, it is between the overburdened AWW and the beneficiary. On the

Simple examination of ICDS registers was found to be least helpful as a tool of research to unearth social exclusion for the simple reason that it does not include families who did not enrol, and, therefore, their social demographics and their reasons for not doing so are omitted.

quantity versus quality shortfall, despite the drive for 'universalisation with quality and equity', there is enough evidence to suggest that quantity – primarily, in terms of setting up sufficient AWCs / Anganwadi-on-demand in Scheduled Caste/ Scheduled Tribe hamlets – and quality – in terms of ensuring a sufficient standard of individual services promised by ICDS – are still far from what they ought to be (FOCUS 2006; Mander and Kumaran 2006; Thorat and Sadana 2009).

All these three studies conclude that a lack of AWCs in Scheduled Caste and Scheduled Tribe and Muslim habitations and hence harder physical accessibility compared with the 'Other' group is the first exclusionary feature of delivery under ICDS (see FOCUS 2006, p. 48). More strongly, 'in none of the surveyed mixed-caste villages was the ICDS centre located in the Scheduled Castes or Scheduled Tribes hamlet,' which suggests that 'seemingly "neutral" factors for explaining denial from ICDS services, such as geographical distance, or the ceiling on numbers who can be enrolled or receive services and SNP in every village, frequently disguise factors that are more akin to social exclusion' (Mander and Kumaran 2006, p. 3).

Pinpointing social exclusion from ordinary survey data is hard as is further illustrated in the social composition of children enrolled in ICDS, where FOCUS (2006) finds that the share of Scheduled Castes/ Scheduled Tribes among children enrolled in sample AWCs is 40 per cent, much higher than their population share in sample districts of 27 per cent (FOCUS 2006, p. 49). Also, a simple examination of ICDS registers was found to be least helpful as a tool of research to unearth social exclusion for the simple reason that it does not include

families who did not enrol, and, therefore, their social demographics and their reasons for not doing so are omitted (Mander and Kumaran 2006). Similarly, the use of AWCs and the receipt of some services as recorded by NFHS III is actually higher for Scheduled Castes/ Scheduled Tribes, perhaps because of their inability to afford private services, for example, private nurseries for their children in this instance (Thorat and Sadana 2009).

On provider discrimination, FOCUS (2006) finds limited evidence of active exclusion, such as, Scheduled Caste children being made to sit separately from other children while eating, or their being served from different utensils, or instances of objection from upper-caste parents to a Scheduled Caste cook preparing food for their children or giving them water. For the most part, it is hidden exclusion that is all pervasive. For example, an AWW may say she skips home visits to Scheduled Caste hamlets not because they are Scheduled Caste hamlets, but because they are physically at a distance. Again, Mander and Kumaran (2006) found that, initially, parents of children from lower castes would often put a lack of their participation in ICDS down to their own failures, or those of their children, or because of neutral factors like distance. It was only after persistent efforts at building trust and a rapport with the interviewers that they opened up about their experiences of subtle forms of discrimination. The interviewers also found that other groups, that is, disabled children and children of daily-wage workers and migrant workers were more conspicuous by their sheer absence in registration for the programme, leave alone differential access to ICDS services.
FOCUS (2006) finds more neutral provider behaviour where the AWW and her helper are themselves

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Scheduled Caste or Scheduled Tribe, thus calling for a drive to actively recruit women from Scheduled Caste and Scheduled Tribe communities as AWWs, ANMs and ASHAs in order to overcome social exclusion in the delivery of services. On the other hand, Mander and Kumaran encountered a few low-caste AWC functionaries and frontline providers, but upper-caste parents resisted sending their children to the centres where they worked and complained incessantly about their performance. Moreover, these frontline providers were often appointed under the patronage of dominant caste groups and appeared to exercise limited agency and freedom in their work (ibid). Consequently, on incentivizing and fostering accountability in delivery, it is suggested that ICDS and health frontline providers should receive performance-related rewards for reaching underserved Scheduled Caste and Scheduled Tribe communities (Thorat and Sadana 2009). Additionally, M&E systems at the district and facility level need to be disaggregated by social group, capacity must be built to undertake the technical analysis of underserved groups, and systemic bottlenecks that are hampering the delivery of services to them need to be identified so that retrospective and effective management action can be taken (ibid.). Moreover, the authors suggest, such data must be open to public scrutiny.

5. Exclusion from the Perspective of Beneficiaries

The phenomenon of social exclusion has a large experiential dimension, where the positionality and identity of the individuals in the 'given' groups are key to their reflexive perception of differential and unequal treatment meted out to them. Where certain individuals fall in multiple 'given groups' experiencing discrimination, for example, being scheduled caste and a woman, one would expect that this cumulative identity would influence the degree of disadvantage they face and make it more extreme. This certainly appeared to be the case on listening firsthand to the testimonies of Muslim women's groups, such as Awaaz-e-Niswan. The women were living in deprived and congested slum neighbourhoods in Mumbai, such as Cheetah Camp and Dharavi, and they recounted their experiences of service delivery in education and health .

Muslim women recalled how they routinely faced highly derogatory stereotypes in perceptions about their community when they went to public health facilities, for example, doctors and frontline health providers who told pregnant women that they opted

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to have 'too many children and ultra-large families' or that certain commonplace stomach and other ailments were due to their 'unclean habits and meat-eating ways'. Similarly, in the sphere of education, they would be confronted with questions from government schoolteachers about whether they 'did not prefer to send their children to madrassas'. In cases of domestic violence, they were so afraid of their men being booked and taken away under the draconian Maharashtra Control of Organised Crime Act (MCOCA) that they would hesitate to report such cases to the police (demonstrably privileging their minority identity over their gender rights concerns, so wary were they of a disproportionately harsh response to the menfolk of their community by the state law and order machinery).

From such accounts, it would appear that the beneficiary perspective is especially important in trying to assess how social exclusion affects service delivery under the flagship programmes, and in accordance with the structure of this paper, it would be the final aspect in seeking to do so. Participant perspectives on their experiences of exclusion could serve to triangulate the evidence-based data gathered from previous exercises, too. Two such excellent studies look at the experience of dalit children in schools (Nambissan 2010) and in the government's flagship programmes of mid-day meal schemes, and at the public distribution system (Thorat and Lee 2010).

Taking in turn our flagship programmes of interest, there appears to be very little or no secondary literature that explores the beneficiary perspective, in particular that of excluded groups. It is worth pointing out that the TSC, with its one-off delivery structure, would in all likelihood afford a different

and less extreme opportunity for social exclusion than would flagship programmes that involve ongoing delivery of services with intensive, repeat interaction between the frontline provider and the beneficiary, such as RCH, NRHM and ICDS. Conjecturally, RSMs may give Scheduled Caste households a worse deal, or Scheduled Caste households in villages may not in actual fact be allowed to use community sanitary complexes.

Anecdotal evidence of lesser treatment meted out by public health providers to groups such as women, Scheduled Castes and Scheduled Tribes does exist (Gill 2009, PHFI, NHSRC and SHRC Chhattisgarh 2010). A detailed analysis of the beneficiary perspective on the discrimination faced, however, is at present restricted to a study looking at the experience of Scheduled Caste children in a few villages of Gujarat and Rajasthan (Acharya 2010). It is particularly important to unearth social exclusion in the delivery of health services, because the latter is not a routine commodity, but one that ethics dictate is a universal right from a social justice perspective. Moreover, its delivery often involves actual physical contact, which in the face of caste discrimination might mean that Scheduled Caste beneficiaries face acute disparity in service delivery from dominant-caste providers in this sphere.

Finally, excluded groups recount differential behaviour at the hands of the frontline providers of ICDS (FOCUS 2006; Mander and Kumaran 2006). Again, since the programme requires repeat and intensive interaction, as well as some amount of physical contact in the sphere of food and nutrition delivery, between children, pregnant women and lactating mothers and the frontline provider or the AWW, the scope for exclusionary practices and

There is enough evidence, however, in the specific Indian contexts of caste and minority identity of how prevalent identity-based discrimination is and how deeply damaging experiences of exclusion can be even in the public policy sphere.

discriminatory behaviour is often more extreme. It is easy to see why scholars have shied away from seeking to capture in detail the elements of social exclusion as experienced by members of 'given groups' in the delivery of public services. Other than anthropologists or sociologists, social scientists have in general been wary of systematically studying an ideologically charged phenomenon such as discrimination. There is enough evidence, however, in the specific Indian contexts of caste and minority identity of how prevalent identity-based discrimination is and how deeply damaging experiences of exclusion can be even in the public policy sphere. There is little excuse, therefore, to refrain from undertaking such studies, though they should be done using sound qualitative methods as very meaningful supplementary data to rigorous quantitative studies.

6.   Conclusion

There is widespread agreement amongst academics, practitioners and policymakers in India today that available data categorically shows that development outcomes across sectors are consistently differential and disproportionately worse for certain groups, that is, Scheduled Castes and Scheduled Tribes, women, and minority community when compared with the mainstream. This may be ascribed in part to the phenomenon of social exclusion, which may operate in any or many spheres (World Bank 2011). Systematic and sustained inter-group inequalities based on identity are problematic not just because they have interrelation effects and intergenerational consequences (Thorat and Newman 2010), but because if it is established that it is indeed discrimination (rather than neutral factors such as a skill gap, etc.) causing disparities between groups, then there are very strong policy implications, such as reservation for the socially excluded (Deshpande 2011).

Given the government's recent emphasis on inclusive growth and on service delivery through flagship programmes as a key channel to bring about more broad-based development, it is surprising that in fact there is little substantive research and there are few in-depth studies on the phenomenon of social

Given the government's recent emphasis on inclusive growth it is surprising that in fact there is little substantive research and there are few in-depth studies on the phenomenon of social exclusion in the flagship programmes.

exclusion in the flagship programmes. Civil society and activist-group literature, to the extent that it is available in this broad area, is focused more on the general shortcomings of centrally sponsored government programmes – their faulty design, inadequate funding, limited scope, approach of targeting as opposed to universalization, lackadaisical implementation, failures in capacity, governance and accountability – than on social exclusion, perhaps because they see a focus on the latter as detracting from their larger and more pressing cause.

But what does available secondary literature – howsoever limited in its remit on the exclusionary aspects of flagship programmes – tell us? In terms of the 'macro institutional bias' against 'given' groups, we can conclude that there appear to be two routes prevalent in flagship programme policy. The first is that of explicitly recognizing groups, such as the Scheduled Castes and Scheduled Tribes, and naming them as priority beneficiaries for the programmes (RCH II, ICDS). The second is of targeting rural BPL households, and, since certain marginalized groups, such as the Scheduled Castes and Scheduled Tribes, are over-represented amongst this target group, assuming that social exclusion concerns are thus tangentially addressed (TSC, NRHM). The macro bias also emerges at the level of utilization. Very few budget analyses are able to disentangle the reasons for underutilization of budgetary allocations for centrally sponsored flagship programmes, especially in poorer focus states. That is, they are unable to separate the capacity constraints and governance failures leading to such an outcome from specific social exclusion factors. There is no disaggregated tracking of budgetary allocation, release and expenditure for groups such as the Scheduled Castes and Scheduled Tribes. Further, there is a tendency to

judge performance based on counting of physical inputs (number of beds, mobile units, doctors), even though theory tells us these might only have a tangential bearing on outcomes. Here too, there is no disaggregated data on service delivery to specific social groups (with the exception perhaps of some DLHS3 data on health) and how this relates to their outcomes.

In terms of the 'meso unruly practices', one can conclude that general governance and other failures in implementation and delivery, both in quantity and quality, are significant across flagship programmes. It is therefore imperative, but very difficult, to distinguish the effects of these from specific social exclusion factors that negatively influence implementation and service delivery. That is to say, lack of proper implementation and delivery of flagship programmes is a generalized malaise in poorer focus states and is not restricted to the experience of Scheduled Castes and Scheduled Tribes and women. So how do we segregate and assess the contribution of general factors versus causation owing to social exclusion factors? Secondly, it is hard to unearth and pick out exclusionary behaviour from ordinary survey data, a simple reading of which might even lead to misleading and perverse conclusions. Conversely, robust studies and indicators designed to capture subjective phenomenon, such as discriminatory behaviour, are difficult to find.

Clearly, evidence on exclusion per se is lacking. In undertaking future research on social exclusion in the flagship programmes, two challenges must be overcome.

First, groups suffering from social exclusion are many in the Indian context – Scheduled Castes and

Groups suffering from social exclusion are many in the Indian context – Scheduled Castes, Scheduled Tribes, women, minority groups, and less often considered but equally valid groups, such as differently-abled people, the aged and migrant workers.

Scheduled Tribes, women, minority groups, and less often considered but equally valid groups, such as differently-abled people, the aged and migrant workers. Government policy in general and flagship programmes in particular focus on some of these groups, for example, Scheduled Castes and Scheduled Tribes, far more than others. When gender is taken into account, it complicates the picture, because in many instances, there might be cumulative identity problems, that is, being a poor dalit woman might intensify one's negative experience of service delivery in the public health system. Good research must be able to separate out the effects of each. Also, the historical trajectory of social exclusion faced by Scheduled Castes is very different in nature and causation to that faced by Scheduled Tribes, and again it is variable for sub-groups within these broad categories. Research on exclusion must therefore be sensitive to and reflect the nuanced contexts of disaggregated groups.

Secondly, in undertaking future research on social exclusion in flagship programmes, there is a need for interdisciplinary collaboration. Recently, the publication of two books marked the beginning of the field-building task of developing an interface between economics and the broader social sciences in order to better understand and capture the phenomenon of discrimination, as well as foreground research on it and get greater attention from policymakers (Thorat and Newman 2010; Deshpande 2011). It is a great start, but much remains to be done, for there is little in either volume on the government's flagship schemes and discrimination therein – whether it exists, its nature and extent, and the institutional processes which explain, at least in part, how and why development outcomes for certain groups continue to be consistently dire.

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TSC, ICDS, RCH	Focus on, in recognition of	Strands	Constraints, Caution and Challenges
Flagship programme policy	•Women, scheduled castes, scheduled tribes •Macro 'institutional bias' against 'given' groups implicitly recognized by govt. in naming above priority categories in FP	•Design and strategies •Guidelines for participation, coverage norms •Budgetary resources and utilization •Monitoring and evaluation / assessment	•Constraint: Availability of authenticated official secondary data on budgetary allocation and utilization, M&E for social exclusion strands in particular
Implementation / delivery system	•Women, scheduled castes, scheduled tribes •'Meso unruly practices' in implementation of FP so that outcome other than intended	• Actual one-off (TSC) and on-going (ICDS, RCH) delivery • Quantity vs quality shortfall • Provider discrimination, types of exclusion (active / passive etc.) practised • Checks and balances for accountability, in terms of supervision and punishment for malfeasance in delivery	•Caution: how to separate general implementation and governance failures from specific exclusion ones, i.e., lack of proper delivery not restricted to scheduled castes, scheduled tribes, women, etc., rather is a generalized malaise in poorer focus states •Challenge: To capture provider discrimination and accountability, which are intangible, in quantitative, objective indicators design for field instruments, both qual-quant, i.e. ,including interviews and questionnaires
Beneficiary perspective	•Women, scheduled castes, scheduled tribes •Participant perspective on experiences of exclusion, triangulate previous evidence-based data	•Access (esp. on strands of FP weighted towards certain 'given groups', for e.g., JSY for women) •(Un) equal treatment and opportunity •Knowledge, participation, agency, voice and empowerment in specific PRIs	•Caution: Not much out there •Challenge: To capture perceptions and subjective phenomena, such as agency and voice, in quantitative, objective indicators design for field instruments, both qual-quant, including exit interviews / questionnaires