

Policy, Research, and External Affairs

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Public Sector Management
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Country Economics Department
The World Bank
August 1990
WPS 491

WPS 491

How Well Do India's Social Service Programs Serve the Poor?

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Reaching India's poor calls for greatly improved social service delivery systems, better targeting of the poor, more coordination between agencies, policies aimed at income generation, and more involvement of the poor and of nongovernmental organizations.

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This paper — a product of the Public Sector Management and Private Sector Development Division, Country Economics Department — is part of a larger effort in PRE to improve the management of poverty reduction programs. Copies are available free from the World Bank, 1818 H Street NW, Washington, DC 20433. Please contact Ernestina Madrona, room N9-061, extension 37483 (73 pages).

This literature review was initiated to fill the research gap on how well social service programs serve India's poor.

The authors found that India's social services were used relatively little by the poor — whether they were programs for the general public (such as education), programs targeted to the poor (welfare and social security), or programs meant especially to help the poor (nutrition).

The health and education of the poor has improved but not as much for the population as a whole. Children's nutritional status has changed little in the last 20 years. Legislation to protect the poor cannot be enforced.

The reasons that all social service programs did so little to alleviate poverty are similar:

- Physical access to education and health services has improved but inequalities exist because of biases in locating facilities. The access of the poor to housing, social security, and social welfare services has been limited partly because these services were inadequate relative to needs and partly because services leak to the nonpoor. Existing social service programs tend to maintain the status quo and sometimes even strengthen class differences.

- Social service policies are not comprehensive enough, reflect little understanding of demand, and ignore difficulties of implementation.

- The quality of services is low, their pattern not uniform. Issues common to the social sector delivery systems are weak management, ineffective targeting, and inflexible service delivery systems that result in a mismatch between perceived needs and services delivered. The bureaucracy is inadequate to reach the poor. Existing capacity and resources are inadequate, particularly for education and health.

Evidence from the government and NGO programs suggest that the poor can be reached effectively if:

- Policies focus on them and are linked more closely to income generation.

- An appropriate service delivery system is designed and implemented and efforts to alleviate poverty are integrated into it.

- Services of different agencies are coordinated.

- The poor and nongovernmental organizations (NGOs) are involved and given an appropriate role. NGOs' ability to serve the poor varies. Their coverage is 25 to 30 percent in education and health, but nearly 100 percent in welfare services. The government has been reluctant to involve NGOs in its housing program.

The review found no evidence to link social service inputs to labor productivity.

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CONTENTS

	<u>Page No.</u>
I. INTRODUCTION	1
II. PERFORMANCE IN RELATION TO THE POOR	6
Overall Performance	
Access to Social Services	
Utilization by the Poor	
Impact on the Poor	
The Kerala Experience	
NGO Experiences	
III. KEY ISSUES	21
Responsiveness of Policies	
Social Structure Impediments	
Reaching the Poor	
Meeting Needs of the Poor	
Limited Resources	
Contribution to Poverty Reduction	
IV. POLICY AND INSTITUTIONAL IMPLICATIONS	30
Focus on the Poor	
Design and Implementation of Delivery Systems	
Research Support for Policies and Programs	
ANNEX 1. An Overview of Social Service Programs	37
REFERENCES	52

* The authors are grateful to Samuel Paul and Arturo Israel for their comments on earlier drafts and to Ms. I. Menon for research assistance.

I. INTRODUCTION

It is well known that in the overall development of a country social overheads play an important role, perhaps more important than physical capital. Empirical studies based upon international cross sectional and time series data for different countries have clearly brought home the significance of human capital augmenting factors. The state in many countries has pioneered in the provision of various social services- education, health, nutrition, housing, social security and social welfare. As poverty alleviation is a major goal of development, social services are expected to enhance the quality of life, particularly of the poor. But more importantly they are expected to equip the poor to effectively participate in the development processes. In India the supply of social overheads has been handled by both government agencies as well as the private sector. However, the poor have not, in general, been able to afford the private social services offered on a commercial basis.

Need for Study: As part of its work on the management of poverty reduction, the Public Sector Management and Private Sector Development Division (CEPCS) of the World Bank decided to initiate a review of India's wide-ranging experience in this area. A great deal of attention has been given in India to the definition and measurement of poverty, and to the evaluation of public programs which aim to alleviate poverty. While it is recognized that the effective delivery of social services is essential to the enhancement of the quality of life of the poor, it is not known to what extent the poor are able to utilize these services, nor has the impact of such utilization, if any, on the well being of the poor been measured. Also research on how to integrate poverty issues into the design and implementation of public and private interventions in social service delivery is inadequate. Micro level studies throwing light on this issue exist in India. However, they are not widely published nor synthesized to yield macro perspectives useful for policy makers. In order to improve the general understanding of the state of knowledge in this field, a review of the relevant Indian studies of social service policies and programs, both published and unpublished, was undertaken to synthesize their findings, to gain insights into poverty related issues and to identify gaps in research.

The specific terms of reference for this study were to:

- (a) compile an inventory of all significant public and private interventions in India for the delivery of education, health, nutrition, housing, social security and social welfare services;
- (b) assess policy objectives and the extent to which poverty issues have been integrated into the design and implementation of these services;
- (c) analyze the access of the poor to these services and identify factors that determine access;
- (d) review the evidence on the impact of social services on the quality of life, productivity, and self-reliance of the poor;

(e) assess the effectiveness and efficacy of alternative institutional channels for the delivery of social services; and

(f) identify areas for further research, policy reform, and action to improve the access of the poor to social services.

Approach: As most of the literature is sector specific, the review was organized accordingly. Panchmukhi reviewed the literature on education; Satia and Murthy reviewed health and nutrition services respectively; and Hirway examined the literature on housing, social security and social welfare. The findings of these reviews were integrated to identify key issues and their policy and institutional implications.

The social services considered here pertain to the basic needs of the poor and are expected to ensure them a minimum quality of life, improve their productivity, make them self reliant and help them in improving their levels of living. It seems that the Government of India (GOI) has expanded the scope and content of these services over the years with the result that the present package includes a variety of social services for the poor (for details, see Annex 1).

Education: The importance of education as a major agent for human capital formation came to be clearly recognized in the 1960s. In fact, the National Education Commission 1964-65 (Kothari Commission) called its report the Report on Education and National Development. The recently declared Educational Policy (1985) and the subsequent document called The Program of Action also clearly recognize that education plays a pivotal role in the development of the nation.

Education policy and programmes in India have been directed towards expanding educational facilities at all levels and in all areas, improving the quality of education, and improving the skills of the people to increase their employability. Though the major part of the policy is addressed to the general population, some parts and some schemes focus on the poorer sections of society. A massive expansion of educational facilities in rural and urban areas, use of the regional language as the medium of instruction, schemes for skill formation for the poor, adult education, and pre primary schools are some of the efforts in this direction.

Health: Accepted as one of the important determinants of the quality of life of people by the planners, successive Five Year Plans have tried to achieve the objectives of raising the levels of health care. These plans emphasized expansion of the rural health infrastructure to take health services to the villages. Communicable disease control programs were strengthened to reduce morbidity and mortality in the population. In the last decade significant improvements have been recorded in health indicators. Between 1976-78 and 1983-85, the infant mortality rate decreased by 20 percent. The death rate also decreased by 22 percent between 1981 and 1985. Although the mortality has declined in all states and in both rural and urban population, the poor may not have benefited to the same extent.

Nutrition: The inadequacy of the nutritional status of the people in India can be summarized by three simple but telling statistics- over 30 per cent of children born have a low birth weight (less than 2500 gms), over 80 percent of the pregnant women suffer from severe anemia and about 70 percent pre-school children experience growth retardation and nutrition morbidity in varying degrees. The successive Five Year Plans have tried to address the issue of raising the levels of nutrition and public health in the country. In the first three Plans, nutrition was a part of the health program, and the problem was viewed as a deficiency which needed protein treatment. But as more and more studies revealed that in India, malnutrition was more a problem of calorie inadequacy than protein deficiency, the approach to the solution of this problem also changed. The major policy measures in this area have been (a) to increase in the country's food production and improvement in the per capita availability of foodgrains, (b) to set up fair price shops for distribution of foodgrains and (c) to undertake short-run measures of direct nutritional interventions like the mid-day meal scheme and integrated child development services for the disadvantaged groups. The schemes of the last category have grown in size and have become comprehensive through the inclusion of inputs like water supply, sanitation, health, education and nutrition as a package to reach the poor.

Housing: Shelter ranks next to food and clothing as a basic human need. Though it is essentially a place of dwelling, it fulfills the important social needs of a family and is intimately related to the improvement of the quality of life and to poverty alleviation. The term "housing" in the context of the poor in India includes both a shelter (that performs the basic functions of a house, i.e. gives protection against heat, cold, rain, insects etc. and provides minimum healthy conditions like fresh air and light) and minimum infrastructure (such as an approach road, drinking water and sanitation).

The housing problem in India is characterized by a severe shortage of houses, poor quality and by a lack of basic infrastructure¹. According to an estimate made by the National Building Organization on the basis of the 1981 census of population, the housing shortage in India in 1985 was of the size of 18.8 million in rural areas and 5.9 million in urban areas. In the case of urban areas, 25 to 45 percent of the population of metropolitan cities live in slums today; with the slums growing at the rate of 8 to 10 percent per year. In rural areas also it has been estimated that 94 percent of houses lack latrines, 97 percent lack separate bathrooms, and 68 percent of people depend on ordinary well-water. The houses of the poor usually lack minimum amenities like an approach road, drinking water, drainage, electricity and basic cleanliness.

Social Security: In the developed countries of the west, the term 'social security' is defined as a collective guarantee of income for the employed and for citizens in general, of substitute income and also a cover

¹ Housing shortage was defined by reference to the number of households that had no residential houses or that had houses with inadequate roofing and walls. Shortage was thus a measure of "need".

for particularly heavy expenses, such as children's education and ill health (ISSA 1987). In developing countries, however, the definition is slightly narrow and it includes measures like medical care; benefits for sickness, unemployment, old age, employment injury, maternity and invalidity, and survival benefits (ILO, 1984). When this narrow definition is interpreted in the context of India, it implies that: (a) social security has to mean ensuring minimum levels for about 40 percent of the people in India who live below the poverty line and have no income security to satisfy even their minimum needs; (b) lack of employment rather than its interruption is a major problem of the labor force and hence, according to some observers, the guarantee of work has to be an important component of social security; and (c) that 90 percent of the labor force is in the unorganized sector, where the majority of workers are temporary, earn lower wages/incomes than those in the organized sector and where the employer-employee nexus does not always exist. Covering them under social security calls for innovative ideas and intensive efforts. Unfortunately efforts in this area have been piecemeal and scattered, without any comprehensive policy framework.

Social Welfare: Social Welfare, which is a wider concept than social security, means the 'well-being of people'. In the context of India, it would include eradication of poverty, protection of the poor from exploitation, and improvement in the access of the poor to the fruits of development. Social welfare is not mere relief to the disadvantaged within the system, but a process of social development which aims at removing the constraints that prevent the poor from participating in the benefits of development. In other words, social welfare measures (a) attack the dependency of the poor. (b) protect the poor from being unfairly treated, (c) help the poor in the event of a crisis and (d) strengthen the position of the poor in general. In its broad interpretation, major social welfare measures should focus on legal protection to the poor from unfair treatment by others; public distribution system; general welfare measures for disadvantaged groups like poor children, women, the handicapped and the disabled; and organization of the poor. Government policies in this area have also been ad hoc and piecemeal in nature.

Our search for studies directly measuring the contribution of social services input to poverty removal was rather frustrating. Though a great deal of literature was available on poverty in India, and on poverty alleviation programs, very few studies dealing with the impact of social service programs on the poor could be found. This paucity of literature could be attributed to the ambivalence regarding the role of social services in poverty alleviation. Much of the literature on poverty alleviation in India is concerned with economic programs such as the Integrated Rural Development Programme and the National Rural Employment Programme. Social services are largely expected to serve as compensatory mechanisms to maintain a minimum quality of life. On the other hand, a view is emerging, albeit not well researched or well articulated, that the root causes of poverty are social rather than economic. If one accepts the premise that social and economic variables interact in a complex and not yet clearly understood manner, researchers need to pay more attention to social services in relation to the poor.

The social services selected for the purpose of this review differed in terms of their focus on the poor. At one end of the spectrum were educational programs meant to benefit both the poor and the non-poor. Even though some of the educational reforms were introduced specifically for the benefit of the poor, they could also benefit the non-poor. Therefore, the critical question in relation to these reforms was whether the non-poor were benefiting more from them than the poor, thereby widening the gap between the poor and the non-poor. At the other end of the spectrum were social welfare and social security programs specifically targeted to reach the poor. The questions raised in relation to these programs concerned the adequacy and appropriateness of the services they offered. In between these two were services like health and nutrition which were expected to be used more by the poor because they experienced a higher incidence of illness and malnutrition. The evaluation of these programs therefore rested on the question of whether proportionately the poor, more than the non-poor, were using and benefiting from these services.

Because of these differences, the issue of impact on the poor in these sectors has assumed different forms. In the education sector the issue is that of disparities in educational opportunities between the poor and the non-poor. In health and nutrition the impact of programs should be in terms of improved health and nutritional status of the poor, but most studies have been able only to measure the use of health and nutrition services by the poor. In the housing and social welfare sectors, evaluation studies have dealt mainly with the operational difficulties in reaching the poor. Studies assessing the contribution of these programs to reducing poverty are practically non-existent.

Despite these differences there are some remarkable similarities in the policy responses in these sectors. The factors responsible for the low utilization of services by the poor and the reasons why these programs have contributed little to poverty alleviation are similar. The major issues in these sectors are i) the difficulties of targeting the services to ensure better coverage of the poor, ii) obstruction of the benefits flowing to the poor by local power structures, and iii) the quality of services being sacrificed to achieve quantitative targets. The major questions which emerged, therefore, were the following:

- (a) Have India's social service policies and programs been responsive to the needs of the poor?;
- (b) To what extent are social services accessible to the poor?;
- (c) Have these services helped improve the quality of life and productivity of the poor?;
- (d) How does the efficacy of governmental and non-governmental channels of social services delivery compare?;
- (e) What are the key factors influencing the effectiveness of the delivery system?; and

(f) How can poverty issues be more effectively integrated into the design of policies and programs of social services?.

The social service programs performance in terms of access to, utilization by and impact on the poor is reviewed in Chapter II. Key issues emerging out of this review are presented in Chapter III. The paper concludes in Chapter IV with a discussion of the policy and institutional implications of the findings.

II. PERFORMANCE IN RELATION TO THE POOR

Our review shows that despite the massive expansion of physical facilities, incremental policy reforms and successive program improvements, the overall performance of the education, health and nutrition services in relation to poor is low. On the other hand, as we shall see later, housing, social security and social welfare activities covered only a small part of the need. The reasons for low impact could be a combination of a lack of physical access to and low utilization of available services. Because of several interacting factors, however, the Kerala experience is different and is discussed separately. Similarly, many nongovernmental organizations (NGOs) have been able to reach the poor but their coverage is limited.

Overall Performance

The education and health status of the poor has improved, but to a lesser degree than that of the population as a whole. The nutrition status of the children has not changed significantly during the last 20 years. The housing programs continue to be inadequate compared to the growing need. A large number of programs were launched for social security and social welfare but each covered only a limited proportion of those in need to have a noticeable impact and the legislation to protect the poor could not be enforced effectively.

The constitutional commitment of universal elementary education by 1960 for children below 14 years of age still remains a promise. The shortfall largely affects children from the poor socio-economic group. For example, while the proportion of scheduled castes and tribes in the population was 24 percent in 1981, they accounted for only 15.4 percent of the total enrollment. The dropout and stagnation rates in this group were also found to be high. A case study in Gujarat (Vidyut Joshi 1982) showed that tribal literacy increased from 11.8 percent in 1961 to 14.1 percent in 1971. But this increase was much below the increase in the non SC/ST literacy rate (6.1 percent). In two districts, this low increase actually masked a near stagnation in tribal literacy. However, by 1975, 95 percent of the tribal villages in Gujarat with more than 500 persons had schools. The improvement in tribal literacy rate was due to residential schools and hostels. In addition to providing additional educational facilities, it would be necessary to overcome socio-economic and cultural hurdles if this problem is to be tackled successfully.

The Sample Registration Surveys have reported a continuing decline in death rates; from an estimated 15.0 to 11.7 per thousand population during the period 1976 to 1985. This decline is due to the reduction in infant mortality rate from 139 to 107 per 1000 live births, which has occurred in almost all states. But there is considerable interregional variation. The urban death rate was 7.6 as compared to a rural death rate of 12.9 per 1000 population in 1985. Similarly, infant mortality in urban and rural areas was 59 and 107 per 1000 live births respectively. During the period 1983-85, the death rate ranged from 16.5 in Uttar Pradesh to 6.5 per 1000 population in Kerala. While there are no significant differences in male and female life expectancies for the country as a whole, the situation varies considerably among the states. While in Kerala, female life expectancy was higher by 4.8 years in 1981, the situation was the reverse in Uttar Pradesh where male life expectancy was higher by 4.2 years. While incidence of certain diseases is reported to have declined, others seem to have risen. Unfortunately, since reliable data on morbidity is not available, it is difficult to comment on overall changes in health status.

Despite continuing economic growth and perceptible improvement in the availability of foodgrains over the last 25 years, the proportion of the population whose income is not sufficient to buy the recommended daily level of intake has remained constant at around 40 percent. Studies have shown that the benefits of increased agricultural productivity have not percolated to the poorest section of the population. Their income levels are too low to provide dietary adequacy at the prevailing levels of food prices. As a result, the extent of nutrition problems caused by poverty has not declined. A secondary analysis of the National Sample Survey (NSS) and National Nutrition Monitoring Bureau (NNMB) data carried out by the Nutrition Economics Group (Evenson 1986) showed that food consumption of the rural poor had remained roughly constant since 1950 while that of the urban poor had perhaps declined. During this period, food consumption in the higher income groups had declined which made the distribution of food consumption among income classes more equal. But there was no improvement in the position of the poorest 10 percent of the rural population while the diet of the urban poor had actually deteriorated. This hard core nutritional problem persists despite the various measures taken such as the distribution of food grains through the Public Distribution System, programs for nutrition education, supplementary feeding and public health which were expected to serve the health and nutrition needs of the poor, and the poverty alleviation programs to increase incomes of the poor.

Two major studies on the growth and development of Indian children carried out 20 years apart by the Indian Council of Medical Research (ICMR) in 1956-57 and by the National Nutrition Monitoring Bureau (NNMB) in 1974-79 have a significant story to tell. A comparison of these two data sets showed no change in growth retardation rates of the poor children over the 20 year period. The growth status of urban slum children appeared to be even worse than it was 20 years ago (Gopalan 1986). The nutrition surveillance data collected by the NNMB using the conventional Gomez's classification in 1969-75 estimated the percentage of severely malnourished children to be between 18 and 22. In 1976, NNMB adopted a lower standard of nutritional normalcy and got a much lower estimate of severely malnourished children (8.5 percent). In 1981, this percentage further declined to 4.4 percent. The Bureau claimed that

this reduction was due partly to the nutrition interventions and relief programs directed towards the severely malnourished children and also to the increase in calorie intake by the poor (NNMB report no.2). However, since there were many internal contradictions in the report these claims have not as yet been accepted as yet by researchers in the field (Ramchandran 1987). Thus the nutritional status of the poor, as measured by average height and weights by age, has not changed much over this period, though there has been some reduction in the levels of severe malnutrition.

The housing shortage in the country is gradually increasing, from 13.28 million in 1961 to 24.7 million in 1985 and an estimated 29.0 million in 1990. This indicates a general failure of the programs and an inability to keep up with population growth. The low priority given to the housing sector in the Five Year Plans is reflected in low allocations and in the gradual decline in the share of the housing sector in total planned investment. The overall picture which emerges is that, even after 40 years of planning, an important manifestation of poverty- poor housing and miserable surroundings- remains.

Performance in the area of unemployment, which is a major source of insecurity, has been dismal. The backlog of unemployment has been increasing over the Five Year Plans. For example, unemployment in the beginning of the Seventh Plan period was estimated at 13.89 million. During the plan period it is expected that 48.58 million will be added to the labor force. But the total employment to be generated is only about 40.35 million. This means that the size of unemployment will once again increase. Neither the National Rural Employment Program (NREP)/Rural Labor Employment Guarantee Program (RLEGP) nor any of the other special employment programs provide any guarantee of work to the poor (Hirway 86). Even the employment guarantee scheme provided work to only 3 percent of the unemployed in Tamil Nadu (Guhan 86). The Old Age Pension scheme which includes both the poor and the non-poor covers only 5 to 7 percent of the old; a detailed study in Tamil Nadu estimated it to be 6 percent. Group Insurance Schemes in the public sector have expanded rapidly, from a near negligible coverage in 1984-85 to an estimated 500,000 (Ministry of Welfare 1986). But even this coverage is far from adequate.

It is difficult to assess the overall impact of social welfare programs in India for want of data. The share of social welfare in the plan expenditure of the Government of India increased from 0.25 percent in 1975-84 to 0.56 percent in 1985-89. The absolute amounts involved, however, continue to be quite small. For instance the Central Social Welfare Board (CSWB), which is the main agency for carrying out social welfare programs, spent only Rs. 140 million in 1984-85. The funds created in the workers' welfare funds are also not very large. For instance in 1986-87, Rs. 14 million were provided for miners, Rs. 40 million for Beedi workers², while, Rs. 15.5 million were earmarked for Lime Stone and Dolomite workers. Although not evaluated systematically, a review indicates that these funds can provide adequate welfare only to a small proportion of the total workforce. Difficulties in the identification of workers and the time consuming nature of the delivery of

² Beedi is a cheap local variant of cigarettes.

welfare facilities further limits the number of beneficiaries. Women's welfare, in a wider sense, has received increasing attention at the central and state levels. In 1986, there were more than 200 Welfare Extension Projects and 7579 creches. Though these data indicate progressive trends, their achievements are far from adequate in meeting actual needs.

Almost all studies on the welfare of women, children and tribals indicate that the programs have not yet made much impact on the target groups, only a small part of the targeted groups benefited (Mulgaokar 84, Patra 79). This is because (a) the organizational network of welfare, including NGOs, did not cover backward and remote areas adequately, (b) the non-poor grabbed the benefits, (c) trained and committed staff were not available (Pathak 83, Gokhale 86, NIRO, 82), (d) extension work was poor, and (e) financial resources were inadequate.

The enforcement of protective labor laws has been observed to be highly unsatisfactory. A large number of studies have shown that these laws have virtually failed to provide any significant protection to the poor and they (say, the Minimum Wages Act) are enforced effectively mainly when the market forces have supported the enforcement. The main causes for this limited success are (a) lack of commitment on the part of the government to enforce the acts and the indifference of the staff (b) legal loopholes and small punishments which favor the erring employers, (c) inadequate staff, and (d) the power structure of the society and the vested interests of the rich which do not allow effective enforcement of the acts. In the case of the Bonded Labor Act, for example, it has been observed that the percentage of released laborers (which had been bonded to serve for a specified period to repay debts) to the total is extremely low (about 55 percent of the bonded laborers are identified and hardly 5 percent are released). The released laborers have not received adequate assistance for rehabilitation. In fact, it has been observed that many released laborers have gone back to bondage because they could not manage to survive otherwise (Dhagamvar 85). The total strength of child labor, has been increasing in India over the years³, although the number of child laborers as a proportion of relevant age group has declined. During the period 1973-83, the number of child laborers increased from 16.3 million to 17.4 million, in spite of government efforts. The policy of prohibiting child labor from hazardous occupations and regulating employment in other occupations has not been implemented satisfactorily.

The annual average government supply of foodgrains to the Public Distribution System (PDS) in India has increased from 4.64 million tones during 1984-86 to 14.09 million tones during 1984-86 (Hanumanth Rao et.al. 88). Though not many studies have been conducted on the Public Distribution System (PDS), available studies show that (a) the PDS has covered the entire population below the poverty line in Kerala, Gujarat (George 85) and Andhra Pradesh (b) the PDS has benefited the poor as revealed by the cost-benefit analysis of an all-India study (Scandizzo and Swamy 82) and a study in Kerala (George 85), (c) it has also shown a clear positive impact on nutrition

³ Child labor refers to children below 15 years of age and who work full-time or part-time for remuneration.

(George 85), and (d) in general, it has contributed to improving the levels of living of the poor. Gujarat has designed separate PDS schemes for different categories of the poor with positive results. More than 1.4 million families with an annual income of less than Rs. 5000 receive subsidized grains and 7 essential items. Special schemes cover tribals and old persons and fair price shops provide selected items at subsidized prices.

Access to Social Services

Physical access to education and health services has been improving over time, but considerable inequalities among districts and states persist because of biases in the location of the facilities. Tribal and geographically inaccessible areas suffer the most. Because these facilities tend to cluster in socio-economically advanced environments, inter-regional inequality in access contributes to inter-personal inequalities, in turn the inter-personal inequalities may further accentuate inter-regional inequalities. Although nutrition interventions are largely village based, caste considerations may deny access to them. Ineffective implementation, very low quantum of resources and some diversion of the available resources to more developed areas have resulted in poor access to housing, social security and social welfare measures.

Access to education for the poor is facilitated if the educational facilities are available in close proximity. The Fourth All India Educational Survey showed that most children have a primary school within one kilometer of their homes. However, nearly one-fifth of all habitations, including 16.4 percent of habitations with a population of less than 300, do not have a primary school. Forty percent of the primary schools have no permanent buildings, 39.7 percent have no blackboards and 49.5 percent have no drinking water facilities. Thirty five percent of schools have only a single teacher to teach 3 or 4 different classes. The incidence of these inadequacies is obviously higher for the socio-economically deprived sections of the population. Several exercises have been carried out for understanding inter-district inequalities (Education Commission 1964-66, Panchmukhi 1970, J.B. Tilak et al 1981, Panchmukhi 1983, Jain 1981). Generally Kerala, Tamil Nadu, Punjab, Himachal Pradesh and Maharashtra were found to be leading states in education and Bihar, West Bengal, Karnataka, Orissa and Madhya Pradesh were the most backward states during the period 1965-76. The economic base of a region exerts a strong influence on the spread of the literacy (Moonis Raja and Agarwal 1983) whereas areas with inhospitable physical conditions are characterized by poor accessibility to schools.

Rural urban differences are significant in terms of access to health facilities. Although only about 30 percent of the population reside in urban areas, they have 87 percent of all hospital beds. While the population norms in rural areas have been fixed taking into account the terrain characteristics and giving more facilities to the hilly and tribal areas, the locations of Primary Health Centers is still a problem. A study conducted in rural Haryana showed that while nearly 38 percent of the population resided within a 7 km distance from the Primary Health Centers, nearly 85 percent of the patients came from this area. The population served by a Primary Health Center varied between 10 to 17 percent of what it was expected to serve, largely due to its

unsuitable location from the point of view of ensuring equality in access to the services (Bose 1983). The tribal areas have been accorded special treatment in the health policy and in the tribal subplan. However, health services are still not readily available to the tribals. In a study of tribals living in three districts of Maharashtra, Gare (1983) found that one hospital and 167 subcenters were covering a population of 2.8 million. That was only one fourth of the infrastructure required. A study of a tribal district in Madhya Pradesh showed that a subcentre served about 7,000 population, covering an average area of 76 sq.km., against the norm of 3,000 population (AFC 1980).

In some cases, the poor may have been denied access to nutrition programs by local leaders due to caste reasons. One study in Andhra Pradesh reported a positive impact of mid-day meal scheme in terms of increased enrollment and reduction in dropouts among the children belonging to the poor sections of the community. In spite of this impact, the researcher reported that the scheme was discontinued at the instance of the local leaders probably because they did not approve of educational benefits going to low caste children (Haragopal G. et al 1985).

Studies show that the access of the poor to housing schemes has been limited (Singh 1986, Abraham 1985, Verhataiah 1986, Estimates Committee 1986). Frequently the non poor grab the benefits of the housing programs meant for the poor. In addition sites for the new housing schemes were frequently located either away from the main village or in low lying areas, basic infrastructural facilities were absent in most cases and the quality of houses were poor. Poverty, and consequently, low affordability also deny the poor access to housing. A World Bank study showed that 60 percent of all households in Ahmedabad and Madras were unable to afford the cheapest dwellings available on the city's commercial markets and lived in slums and unauthorized settlements. In the case of rural areas, the poorest sections were unable to pay the lowest monthly installments of the housing programs (Sharma 1985, Mathur 1986). Public participation was also low, and housing programs were frequently designed without consulting the client group. In an extreme case, the clients had stolen the building materials from the site where houses for them were being constructed under a government program.

Some studies show that a low level of resources, poor extension work and indifferent administration limit the access of the poor to the social security schemes. In addition, procedural delays, leakages to the non poor and uneven regional distribution of resources keep remote areas and the poorest of the poor almost outside the purview of these schemes (Shah 1987, Guhan 1986). For similar reasons, the unemployed in backward regions have also not benefitted much from the special employment programs (Hirway 1986, Dandekar 1985). In the case of social assistance programs like old age pension and assistance to widows, the identification of beneficiaries was difficult and was influenced by considerations other than poverty. Consequently the non poor benefitted more than the poor and old men got more benefits than old women (Mehta 1987, Arunachalam 1987, Guhan 1986).

Utilization by the Poor

Several hurdles come in the way of the poor in utilizing the education, health and nutrition services even when they are accessible. Those who need health services the most are not able to utilize them well; the utilization of health services is nearly twice in the southern states as compared to the northern states where mortality rates are higher. The use of educational services by scheduled castes and tribes differs significantly from the others. In the area of social security and social welfare, the low utilization of services by the poor was largely due to non access. In housing, low affordability in addition to non access resulted in poor utilization.

Numerous studies on interpersonal disparities in education focus on access, preferences, performance and personality factors. Caste-based disparities continue to predominate at all levels of education (Naile 1965, Chitnis 1974, 1977, Shah and Patel 1977, Panchmukhi 1973). Scheduled caste girls are even more backward with respect to education and there are striking disparities within the scheduled caste population. The protective discriminatory increases in the form of concessions, hostel facilities and other privileges have not sufficed to fully integrate the SC children into the mainstream educational processes. Shah and Patel (1977) conclude that despite government measures in terms of literacy and enrollment in schools and colleges, STs occupy the lowest rung, the SCs are in the middle position and the non SC/ST population is at the top of the ladder. In terms of utilizing college scholarships in Gujarat, 23 of the 68 SCs did not have a single scholarship holder. Similarly 23 of the 67 STs did not have a scholarship holder while only 5 had 85 percent of all scholarships.

That performance in education is a positive function of the socio economic status of the student and his/her parents has been revealed by a number of empirical studies (George and Thara 1977, Panchmukhi 1981, Srivastava and Gupta 1980). Poor educational and economic background of the parents coupled with the lack of job opportunities were the major causes for dropping out or failing to utilize educational opportunities. Socio-economically disadvantaged students frequently show less interest in academic pursuits and less creative thinking (Vijayalakshmi 1980, Adisai 1978). Their incidence of failure in public examinations is also high (Directorate of Higher Education, Hyderabad 1965). It was found that 14 to 42 percent of socially disadvantaged students admitted to the various Indian Institutes of Technology could not perform well and had to be dismissed (Om Prakash 1985).

Female education is extremely underdeveloped and the ratio of male to female scholars varies from 5:1 to 8:1 among the SCs and from 3:1 to 8:1 among the STs. Residence in an urban area or in areas where facilities for higher education are fairly widespread increases the chances of a young person going to college, although, on the whole, SCs avail of these facilities to a greater extent than STs.

English as the medium of instruction or even as an additional language has been used by elites of the society to scuttle attempts to widen the access of the masses to education. For instance, attempts to abolish

English at the higher level of education before independence was opposed in West Bengal (Acharya 1982). Attempts to establish the regional language as the medium of instruction in Tamil Nadu have not been very successful: until 1983, only 12 percent of the college students had opted for Tamil as the medium. Since almost all scientific literature is produced in languages which are not Indian, supplying study material to the poor masses so that they have meaningful access to science education is a problem. There is a swing towards the English medium even at school levels. With inadequate facilities for special support courses to help the poor children learn English, the egalitarian and educational aspects of the switch over to English are highly doubtful.

A large number of studies have established a low utilization of health services in the northern states. Only about 20 percent of females and 30 to 40 percent of males had ever utilized government health services in Orissa (Srinivasan 1983), Rajasthan (Talwar and Bhatia 1985) and Uttar Pradesh (ICMR 1986, Satia 1984). In contrast, the proportion of users was nearly twice as large in southern states of Karnataka (Bhattacharjee and Gopal 1986) and Tamil Nadu (Srinivasan 1984). Unfortunately, the surveys do not show what proportion of the poor utilize these services. They do, however, reveal that fewer women utilize curative services than men and that maternal and child health services are utilized by a smaller segment of the population than curative services. Several descriptions of primary health centers and subcenters functioning in the northern states show that they are grossly deficient (Khan, Prasad and Quaiser 1983, IIMA 1985). Most people used the government's health services because they were 'free or cheap', whereas the reasons for non use were long distances, non-availability of medicines and improper behavior of the health staff (ICMR 1980). Micro level studies of health centers reveal vacant positions, low motivation, inappropriate training of doctors and workers, poor logistics support and lack of equipment and maintenance (IIMA 1985). Some studies have shown that although the health service delivery network is conceptually sound, it is underutilized mainly due to bureaucratic bottlenecks and mismanagement (Misra 1984, Takulia et al 1982).

In a tribal block in Gujarat, only 8 percent of the households utilized health center services whereas 56 percent sought treatment from private doctors (Masani 1977). The generally low utilization of health services by tribals was due to relatively high travel time and cost involved, a fear of mistreatment by staff (Tribal Research and Training Center, Andhra Pradesh, 1978), the relative isolation of tribal hamlets and an antipathy towards non-tribal medical practitioners (Mathews 1978). Thus, both demand and supply factors (para 3.16) seem to interact, leading to low utilization.

A few studies carried out in urban areas show that curative services are well utilized but preventive and specialist curative care are not. The very poor, who could not afford private health services were reported to be using free government out-patient services in Bombay. On the other hand, only one out of four slum areas surveyed in Delhi was found to have a good health infrastructure.

Several evaluation studies of the Integrated Child Development Services Schemes (ICDS) have compared ICDS and non-ICDS blocks. For example, a study showed that in two separate samples drawn from groups of the same socio-economic level, more children received immunization and nutrition services in areas which had been covered by ICDS for three years than in areas where ICDS did not operate. However, these studies have also shown that, by and large, there was no appreciable impact on the nutrition status although it is difficult to get accurate information on age and weight.

Have the real poor benefited from this program? According to a Program Evaluation Organization (PEO) Report (1982), the very poor families were reluctant to send their children to Anganwadis (village ICDS centers) because they did not have proper clothing. Also, it has been reported that in poor families, the pre-schoolers, especially the girls, are required to look after their younger siblings at home. Some Anganwadis overcome this problem by permitting them to bring along their younger brothers and sisters as well. Some case studies on the functioning of Anganwadis (IIMA 1985) describe instances where children of low castes were not allowed in the Anganwadi if the worker belonged to a higher caste. Also, it was found that severely malnourished children did not attend the Anganwadis because they were too weak to go to the center by themselves. Families living on outskirts of villages also have low access to Anganwadis. These and similar reported instances seem to point to the probability that the services are not reaching the poorest sections of the population. Why this is so? There are at least two possible explanations:

(a) ICDS provides too many diverse inputs. Therefore, it has not been possible to target it to specific segments of the population, consequently many non-poor benefit from the program. For instance, it is often argued that since ICDS is expected to provide non-formal education, whoever comes to the preschool has to be given supplementation, whether needed or not.

(b) While monitoring the program, no effort is made to find out if the poor are indeed participating. The program policy is to provide services to the poor. It is expected that around 40 to 60 children per village will fall in that category. If an Anganwadi reports this number of children as beneficiaries, it is assumed that the services are reaching the poor.

According to a study of the rice subsidy program in Kerala, rice from the Public Distribution System contributed only one-fifth of the calories and protein requirements of the low income household diets (Radhakrishna 1987). However, more ration rice was available to the middle income groups than the lowest income groups (Kumar 1979). This was because of the high price differentials between the ration and open market rice. The low income families sold some of their ration rice in open market, thus distorting the outcome of the distribution system. What this study showed is that the relationship between food availability and food intake is determined by the market and price variables. In the case of Kerala's food subsidy program, market price affected the food consumption adversely. In the case of a project in Gujarat,

which aimed at expanding production and marketing of milk, it was found that the nutritional status of low income households had improved, though they were not consuming more milk. The additional milk produced by these households was consumed by high income consumers and the income gains that accrued to the poor families were spent partially on consuming other foods. Thus, increase in income affected nutrition positively (Jul Mogens 1979).

It is observed that a number of legal problems prevent the participation of target groups in slum upgrading programs. These relate to land, rent control, building by-laws, housing standards and security (Mehta and Mehta 1987, Shah Kirtee 1986, Sharma and Raj 1985). Although these legal measures were well-intentioned, they hindered the participation of the poor. Limited availability of land, low resources, less-than-efficient administration, and legal hurdles accompanied by increasing size of urban population have widened the already enormous gap between the demand and supply of housing (Wadhwa 1988). Non-involvement of target groups, rigidity in approach, and the dominance of power groups have created obstacles in the implementation of housing programs. Several studies have also shown that environmental and infrastructural development around the houses of the poor is usually neglected.

Impact on the Poor

There has been very little research in India on the contribution of social services to the eradication of poverty. As observed in the previous section, a lower socio-economic status reduces the ability of a person to utilize social services. However, it could also be argued that non-utilization of social services would lead to a lower socio-economic status in the future. The two are thus inter-related and a simultaneous consideration of them may be needed to understand the nature and magnitude of the causality and, ultimately, the impact of the social services on the poor. But, by and large, studies have assumed that the government needs to provide these social services because the poor cannot avail of them through payment to the private sector. Therefore, these services are provided to ameliorate the effect of poverty rather than to eradicate it.

Datta (1985) showed that family background exercises an indirect influence on the economic status of the individual and in this, 'education acts as an important indirect means of transmitting socio-economic status from generation to generation.' In another study (Manohar Rao and Datta, 1985) the importance of hierarchic status as an intervening variable to channel the transmission effects of schooling and experience onto earnings was brought out, indicating that schooling alone plays a rather less effective role as an equalizer. The prevailing education and socio-economic system may be simply agents for the perpetuation of the status quo. Since educational standards are likely to be higher in private schools, where rich children study, than in government-run schools, education can perpetuate the socio-economic elitist pattern of the Indian society (Rao Ramoji 1977). This is true of both schools and higher education institutions.

Poverty is a major cause of, and sometimes a consequence of, poor health. It is often argued that improvement in living standards would lead to

better health status. Indeed, some researchers have argued that the reduction in mortality observed in the last 40 years was perhaps more due to improved nutrition, sanitation, water supply, income and education rather than due to medical services. While studies have documented the contribution of health services to life expectancy, their contribution to improved productivity and earnings of the poor has rarely been researched. The only evidence in this respect comes from a cost benefit study of the Malaria Program (Ramiah 1981), which concluded that reduction in malaria resulted in reducing productivity losses by saving man-days available. However, even here, the major benefit of the program was due to savings in treatment costs resulting from reduced mortality. By and large, the literature on poverty has not considered ill health as a factor leading to poverty. Careful studies at household levels of the poor are therefore needed to assess the consequences of diseases and how these can be mitigated.

The Kerala Experience

It has been suggested by numerous studies that even when programs of a similar nature are implemented, they tend to achieve higher success in Kerala compared to other states. Tremendous progress has been achieved in Kerala with respect to literacy. The inter-regional, inter-community and gender differentials connected with literacy levels are low despite a narrow economic base, stratified social structure and extreme caste disparities. For example, in Kerala literacy levels among SCs and STs were 55.29 and 31.57 percent respectively as compared to 21.4 and 16.4 percent for the country as a whole. For equitable progress in education, factors such as historical interest by the kings, requirements of the monetized economy in general and commercial agriculture in particular, a modernized administration and a limited degree of social modernization seem more important than others (Mathew 1987). Kerala not only spent a higher share of its state budget on education (37 percent), it spent much of the educational budget (80 percent) on primary and secondary education.

Of the various factors responsible for better delivery systems for the poor, the role of the private sector voluntary organizations, churches and other communal organizations cannot be overlooked. Each of these agencies took special care of the educational development of the deprived from among their respective communities. Notable among the educational reforms introduced in the state to reduce regional disparities are adjustment of school hours to suit the convenience of the people, changing the curriculum to serve the job needs of the school goers, appointment of trained teachers and the control of private agencies.

During the post-independence period higher education in the state has developed much more than school education, partly because school education was already well developed. However, the overriding role of private agencies in the spread of education has also had significant negative effects. Undue reliance on private organizations led to the indiscriminate expansion of low quality education, their emergence as communal pressure groups, commercialization of education with regard to admissions and appointments, and corruption. In the light of this experience, it may be preferable to adopt a cautious approach to, and qualify the role of private sector agencies in the

delivery system of education. In addition to regulation, positive action regarding the curriculum reforms and socio-economic reforms to aid the poor will be necessary.

Judged in terms of conventional health indices, Kerala's health status is better than that of most other states. But in terms of per capita income or health facility indices, Kerala stands lower than some other states (Panikar 1984). Panikar (1979) argued that better health status in Kerala was the result of measures like sanitation, hygiene, immunization, antenatal care and health education. The higher educational status of women contributed to a greater degree of health awareness and fuller utilization of available health care facilities. On the other hand Reddy (1980) has attributed Kerala's success to a more equitable distribution of income and improved access to health services because of its current unique settlement pattern and transportation. He shows that 83 percent of the population in Kerala live in settlements of 10,000 or more. Consequently, there is a subcenter in practically every village and a Primary Health Center (PHC) for every 8 to 10 villages. Because health facilities are readily accessible, it is easier for the people to utilize services and for medical and paramedical personnel to provide services in people's homes.

However, some scholars (Chatterji 1985) have hypothesized that, even in Kerala, the high rate of utilization of medical facilities is due to high morbidity caused by both diseases of poverty (infections, infestations and deficiency diseases) and other diseases (cardio-vascular, cancer) as well as accidents. In terms of nutritional status, between 1975 and 1979, about 38 percent of children in the pre-school age group were found to be moderately or severely malnourished (NNMB 1981). Significantly, percentages of 'normally' nourished children were no different in Kerala than in Uttar Pradesh. Thus the belief that low mortality implies low morbidity and an absence of malnutrition is belied by the nutrition and morbidity surveys. The surveys also suggest that while social development may be possible without concurrent economic development the consequences of low economic development on health may be obscured if only mortality data is analyzed.

NGO Experiences

Although the NGO's role in the delivery of social services in India is substantial, its impact on the poor seems to vary from sector to sector. In the education sector, the share of NGOs and the private sector was almost 50 percent. In the health sector, it was 25 to 30 percent while in the welfare services it was nearly 100 percent. The only exception was the housing sector in which government was generally reluctant to involve NGOs and the private sector in its programs.

Documented evidence relating to the NGOs' ability to reach the poor has been positive except, perhaps, in the area of education. The educational facilities provided in the NGO sector were usually of better quality but more expensive than the government run schools. Since the poor could not afford to attend private schools, they were deprived of better quality education. Thus, it could be argued that the NGOs' role in the formal education sector contributed to increasing the disparity between the poor and the non-poor.

However, it should be mentioned that it is the private sector agencies which have taken more effective interest rather than the government institutions in the 'non-formal methodology' at the school level as they have evolved suitable curricula, reading materials writing aids, etc. for the non-formal centers after considerable trial and error. The experiments of some of the voluntary agencies in this regard are highly innovative. It has been found that the non-formal methodology has been able to attract a large number of children who dropped out from the formal system (these students may be considered to have rejected the formal system). It has enabled their retention for a longer period in the educational process, and has aroused their interest in learning. The experiences that have been quoted by the voluntary agencies in this regard show that non-formal methodology has been a very effective tool for integrating poverty issues in the delivery of education.

NGOs are reportedly more successful in providing the poor with health care services that have greater impact. Perhaps the most famous of these programs was the Comprehensive Rural Health Project (CRHP) in Jamkhed, Maharashtra. The CRHP covered a population of 250,000. Health care delivery was effected through a three-tier system: a female village health worker at the community level, a mobile health team visiting each village once every fortnight; and health centers with facilities for diagnosis, treatment and indoor patient care. The project included other development activities like agriculture extension and the supply of safe drinking water. It was also successful in reducing the birth rate to 25 and the death rate to 8 per thousand population. To support these activities, the project relied on community contributions and funds generated through hospital charges.

Streehitkarani, a women's organization working in the slums of Bombay provides maternal and child health, and family planning services to about 100,000 slum dwellers. The local women function as community health workers, each looking after 2000 persons. Its health activities include home visits, supplementary feeding of under-fives, well baby clinics and family planning, female education and some income generation programs. A survey showed better antenatal care and higher immunization rates in this project area as compared to the control area. Fertility had also declined as 72 percent of the couples were practicing family planning.

The Rural Unit for Health and Social Affairs (RUSHA) provides health services to a very backward block in Tamil Nadu. A total development approach was adopted for the poorest of the poor. This included providing both economic and health inputs. The main economic development activity is to arrange loans from government programs for income generating activities. The Project has recorded a significant economic and social impact on the area in terms of employment and quality of life. The infant mortality rate declined from 116 to 70 per thousand live births, the birth rate from 36 to 24 and the death rate from 15 to 8 per thousand population.

Another group called Action for Social Welfare and Awakening in Rural Environment (AWARE) operates in the least developed areas of Andhra Pradesh. Their approach is to generate awareness about the existing services and organizing women's groups to undertake income and employment generation

programs. This health program began with curative services. However, they found that most of the health complaints were due to unsafe water. Therefore, AWARE persuaded the government to provide safe drinking water and drainage to the whole Primary Health Center area. AWARE has formed 1,500 village associations covering a population of more than 500,000.

A rural health project operating in Padhar, located in the forest area of Madhya Pradesh and inhabited mainly by tribals covered an area within a 10 km. radius around the mission hospital. It focused on making safe drinking water available in every village in the project area with tubewells and handpumps. Malnutrition, the second major cause of ill-health, was tackled by extensive agricultural education and a nutrition program. Immunization coverage was substantially improved. As a result, the infant mortality rate was reduced from 150 to 76 per thousand live births and the birth rate declined from 57 to 25 per thousand population. Malnutrition in under-fives declined from 42 percent to 10 percent and the incidence of diarrhoea declined by 90 percent.

These and other NGO experiences indicate that they were able to achieve a considerable improvement in health status at the current level of socio-economic development. Factors contributing to their success seem to be women health workers at the village level, accessible medical facilities, a high level of community participation and integration with other developmental activities. NGO programs also reported better utilization and higher impact on health indicators than government programs without using more resources than what the government uses in its programs. A study of NGOs in rural health care in Maharashtra (Jesani et al 1986) reported that 12 organizations for whom financial data were available, spent less than Rs.5 per capita for their outreach services, approximately the same amount that government spends on outreach activities of primary health care.

Successful voluntary agency programs have been designed on the premise that durable improvement in the nutritional status of poor people can be brought about only through a multi-pronged integrated attack on all its major attributes. The program of Child in Need Institute (CINI) and the Integrated Health Program in Jamkhed have been selected as just two examples of what seems like a successful approach to deal with nutritional problems on a durable basis. In both these projects the health and nutrition impacts have been found to be substantial, sustained and less dependent on outside help.

The Child in Need Institute (CINI) in Calcutta was started in response to overwhelming malnutrition among children in the slum areas adjacent to the Behala Balanada Hospital, and in the nearby villages. The beneficiaries of this project belonged to landless families, unskilled laborers and urban construction workers. Some of the men were rickshaw pullers and worked as casual laborers in transport and haulage trades. Initially, the objective of the project was to provide nutrition supplementation to malnourished children below 6 years of age. But gradually basic health care services like immunization, treatment of minor ailments, and health education were included in the services package. In 1977, functional literacy and other socio-economic programs were introduced as well. CINI's program activities were as multifaceted as were the needs of its target population. Though

nutrition supplementation was a major activity undertaken to deal with malnutrition among the children, food inputs were used as a focal point for the general development of the poor. CINI felt that income generating activities for mothers were important since it was found that the benefits from the mother's income percolated to the child more than the benefits from the father's income. Also, it was felt that if mothers could earn by working at home they would not have to leave their severely malnourished children unattended at home. Activities like sewing, embroidery, and making paper bags were therefore started to provide the mothers with some gainful employment at home.

The Jamkhed Project emphasized community participation in helping its children get better food. The comprehensive Rural Health Project in Jamkhed offered comprehensive health care through a three tier delivery system which consisted of a village health worker, a mobile health team and a fully equipped health center for diagnosis and treatment. However, right from the beginning, more emphasis was laid on rural development rather than medical care. The project supported activities such as agricultural extension, drinking water, social forestry, growing fruit, and promoting young farmers' and women's associations at the village level. With this level of input in village development and with the support of a network of local community organizations like young farmers clubs, a system was worked out in which each land-owning farmer contributed at the time of harvest a bag or two of food grains for children, nursing mothers and ailing people, who needed more food but could not afford it.

The role of NGOs in implementing housing programs has been extremely limited. Major instances of NGO housing are ASAG (Ahmedabad Study Action Group's Scheme in south Gujarat), Kerala's housing schemes involving NGOs, Housing programs of UNNAYAN (a Calcutta-based NGO) and BSC's (Behavioral Science Center, Ahmedabad) Golana Village housing scheme in Gujarat. In addition to these, some urban-based NGOs have also worked successfully in cities. It was reported both by the NGOs and the government authorities that NGOs were not encouraged by the government to take up housing projects (Bhatt 86). Some of the constraints of NGO participation were that they found the governmental approach too rigid to permit flexibility in their operations. Government targets were defined precisely in terms of number, cost, area and design of houses, and the time allotted for completion. NGOs, on the other hand wanted to establish rapport with the client groups, and involve them in the design and environmental plans. This required time, more money and some scope for experimentation. It has also been suggested that since housing programs involve a lot of money, there is a certain amount of apprehension in the government regarding the NGOs' capacity to utilize these funds judiciously.

It was not easy to compare the costs of housing in the government and NGO programs because of differences in the quality of the housing. However, available estimates revealed a mixed picture. The cost of housing under the ASAG program was higher than the cost of housing under government programs (Bhatt, 1986); on the other hand, the cost of the Golana housing was much less (Shah, 1986). The high cost of ASAG program was due high overheads in setting up organizations for developing participatory housing programs; and

the low cost of Golana housing was because of the innovative technology used in their building and people's active participation in the construction work.

Extremely limited information is available about the role of NGOs in social security. The only available micro studies are Arunachalam's study in Kerala, Mehta's study in Gujarat and SEWA's study in Ahmedabad (Gujarat). As these studies are not very systematic, it is difficult to generalize on the basis of their findings. These studies found that the involvement of NGOs helped in reaching the target group, but that NGOs found it difficult to implement government social security programs because of the red-tape and procedural delays involved. In the case of maternity benefits, for example, SEWA observed that sometimes the benefits reached a mother only when the baby was 8 months old.

Though the involvement of NGOs in social welfare programs has its own advantages, it creates certain problems. First of all, locational distribution of NGOs may not be adequate, which may result in the neglect of remote and backward areas. And secondly, priorities of NGOs may not match the priorities of the planners, which may lead to over-spending on some programs and neglecting others.

III. KEY ISSUES

The review of the access and utilization of social services in Chapter III suggests that the ability of the poor to utilize these services and benefit from them is impeded by several factors. However, the policies and programs in these sectors cannot simply wait until a socio-economic transformation with an egalitarian structure is fully brought about. We have discussed how policies and program reforms have responded to needs of the poor. We also have several examples in both the government and NGO sector where these services have been able to reach the poor. Our review of these programs raises several key issues in relation to social services and the poor in the Indian context, which are discussed below.

Responsiveness of Policies

Our review indicates that generally, policies have been responsive to needs of the poor. In education and health, the policy response was to expand the facilities to reach each and every village. Also, specific measures for reform were introduced in education over the decades. The health policy, announced in 1982, explicitly recognized the problem of regional imbalances in availability of the health services and gave priority to the hilly and tribal areas. In order to take the nutrition and social welfare services to the poor, the policy was to locate project sites in the tribal and backward areas. By and large this policy succeeded in its intent. Though the policy package in providing social security to the poor is not very satisfactory, a beginning has certainly been made. There is more awareness about the need for covering the weaker sections under various insurance schemes. One important aspect of the welfare policy in India is that it shows a clear evolution from pure

welfare (of the post-independence days) to a wider concept of welfare which incorporates protection of the poor, improvement in their access to development, and their organization. In other words, the government has now adopted a multi-pronged approach towards welfare, which aims at taking care of various aspects of deprivation of the poor and helping them to participate in the mainstream of development. Also, new organizations have been set up for these programs, more staff has been engaged, more funds have been spared and wider geographical coverage has been achieved over the years.

While being responsive, the policies did not go far enough to meet needs of the poor, partly because they ignored demand considerations, were not comprehensive and did not take implementation difficulties into account. For instance, in the Indian society, where large inequalities exist, the Constitution provided for the weaker sections by adopting the principle of protective discrimination. But, though constitutional provisions have been made, there are limitations to these provisions in that they are primarily enforceable only against state actions, (Shivrammayya, 1983). It has also been pointed out that in a country where illiteracy and poverty exist in gigantic proportions, access to courts presents a formidable problem in the enforcement of rights. In fact, in some cases, courts of law have pointed out that social and educational backwardness is 'ultimately and primarily due to poverty'. (Justice Gajendradakar in Balaji vs. State of Mysore case. A.I.R. 1963 S.C. 649). There is also growing evidence of a confrontation between persons who have received the benefits of compensatory discrimination in the form of reservation and those who have not. Similar problems have arisen in nutrition and social welfare services where the selection criteria covered only the poor and the needy. But these have not always worked leading to low coverage of intended beneficiaries.

It is possible to classify reforms in education into two broad categories- those meant for specific classes and those meant for the masses. For example, universal primary education, protective discrimination, mother tongue as the medium of instruction, mid-day meals for school children, adult education programs, science education for the masses, basic education, special institutions for girls and so on are mass based reforms. On the other hand, regional colleges for professional and technical education, regional universities, institution of external degrees and mass media for higher education can be considered class based reforms. By and large, mass oriented reforms in education are less successful than the class oriented ones. Because of the elitist character of Indian society, a few privileged groups corner the benefits that accrue from expansion of facilities. The masses on the other hand, who are mostly first generation learners, are not conscious of the long-term benefits of education and are mainly concerned with the immediate objective of getting two square meals. This economic compulsion has led to a lower degree of interest and involvement in the education process. Wherever mass-based reforms have proved successful, they have taken longer to succeed than class-based reforms.

One striking feature of the housing policy/programs in India is that it is a demand-based policy in that government, by and large, does not provide houses to the poor. In the days of Slum Clearance and Rehabilitation during the 1950s, government followed a need-based policy and took upon itself the

task of constructing houses for the poor. However, when it was realized that there was a wide gap between the demand and the need for housing, and that most of the poor could not afford to spend on housing, government decided to follow a demand based policy (Wadhwa, 1988). Except for the RLEGP/NREP housing for the rural poor, all housing programs in India are demand-based. In other words, (a) the government does not recognize the right of the poor to housing, and (b) it helps housing activities only when there is demand for it. Government has, however, attempted to bridge the gap between need and demand by means of housing subsidies, reducing housing costs (through innovative measures and lowering the standards/norms of housing), providing credit for housing and through price control (i.e. rent control). The relevant question in this context is whether the demand-based approach will meet the housing needs of the poor.

It is argued by some experts that the demand-based approach will not meet the needs of the poor because (a) such an approach will favor builders, land developers and contractors who will not bother about the housing needs of the poor (Jai Sen, 1977), (b) the affordability of the poor is so low that they will not demand houses, that is, they will not be able to pay for it, in spite of loans, subsidies and low housing norms, (c) lowering of housing norms to such a level that the houses will not be much better than the ones in which they are living, and (d) the infrastructural facilities created for the poor will cost a lot if the poor really make use of them, for instance, if they want to have electricity and water in their homes. It therefore appears that if one wants to follow the demand-based approach, one will have to raise the income levels or affordability of the poor by providing them income/employment generating activities (which will take a long time) and increase the levels of subsidies. When the government housing policy is viewed from this angle, it becomes clear that its efforts are isolated, scattered and far from meeting the needs of the poor. With the exception of setting up the National Housing Bank which may strengthen the financial support to housing, the newly declared National Housing Policy does not appear to be overcoming any of the limitations listed above. It neither ensures that it will meet the needs of the poor, nor does it guarantee housing which is socio-economically viable for the poor.

There is no comprehensive approach towards social security emerging from the schemes. That is, no attempt has been made to design an overall policy or a broad package of social security for the country. The present schemes are scattered and piecemeal in character, conceived for different groups of workers in different states on an ad hoc basis (Guhan 1986, Economic Administration Reforms Committee, 1984). There is no concept of a critical minimum effort either in terms of coverage or in terms of assistance. Small amounts given to a small number of beneficiaries in limited areas do not make the required impact on the poor. Some of the weakest sections like migrant workers, contract workers, bonded workers, and construction workers are completely left out or are poorly covered by these measures. Lastly, unemployment and under-employment, which are the greatest sources of insecurity among the poor have not been addressed by any scheme at an all-India level. Security against unemployment can be ensured either by providing the poor with a guarantee of work or by unemployment insurance and unemployment assistance schemes. More emphasis should be laid on the former,

since it will strengthen (and not weaken) the links between growth and social security. Though it is clearly the more expensive alternative, guarantee of work, however, could be regarded as a basic social security measure.

Although there is gradual broadening of its approach, social welfare is still largely treated as 'pure welfare'. That is, welfare programs still focus more on relief measures (for women, children, SC/ST population, tribals) within the system and less on strengthening the capacity of the poor. A comprehensive policy towards social welfare has not evolved in the sense that specific components of social welfare for the poor have not been identified and prioritized in an integrated fashion to formulate a policy. Questions regarding reducing the dependency of the poor or identifying specific steps for protecting them from exploitation still remain unresolved. The programs which have been undertaken for the purpose, therefore, do not really meet the essential requirements. To illustrate, a number of studies show that the poor get exploited when they have to borrow from moneylenders/large farmers/local traders for seeds, for foodgrains in the lean season, for sickness in the family or for celebrating social functions like marriages, deaths, etc. A strategy which protects the poor, specially the poorest, from this exploitation has not yet been formulated.

The Health Policy Document (1982) mentioned the interlocking nature of poverty and diseases but did not examine its implications fully (Bose 1982, Banerjee 1985). It was assumed that the goal of 'Health for All' could be met only if the services reached the poor. And because the services are free, they will mostly be utilized by the poor. However, lack of demand because of lack of knowledge and low felt need for these services resulted in the underutilization of health facilities.

We have discussed the attempts to deal with the supply aspect of the policies and programs which has generally predominated most of the social services. However, comprehensive policies in housing, social security and social welfare are still needed. Although receiving more attention now, they have generally been neglected. This neglect is reflected in the low priority given to them in the Five Year Plans (low allocations and their poor utilization), in scattered and haphazard programs, in the delay in formulating the policies and inadequacy of the policies to meet the needs in general. In education, health and nutrition, the policies did not pay adequate attention to the special needs of the poor.

Social Structure Impediments

Another indictment against the existing social service programs is that they tend to maintain the status quo and even strengthen the class differences. For example, the mere provision of facilities, like a school or a health center, is not sufficient to ensure that the poor will benefit from them. There were other obstacles the poor had to overcome. As passing an examination was a major hurdle for children from a poor background, reforms were introduced to make examinations easier for them. While the poor children did benefit from this reform, the non-poor benefited even more, making the gap between the poor and the non-poor wider. Better quality and more lucrative education in science and technology subjects is attained by children from the

higher castes, despite the reservation quota for backward castes. Not all social security measures are directed towards the poor. Measures such as crop and cattle insurance are likely to favor the better off sections of the population (Shah 1987, Dandekar 1986).

Often local leaders and the elite do not support a program which benefits the poor. Also, the elite seem to have a vested interest, as some studies reviewed earlier have showed, in discouraging the poor from taking up education, which is the source of social status and potential economic power. Some Social Security and Welfare programs even create avenues for exploitation of the poor. Efforts to overcome these class and caste barriers have not succeeded except in cases where the beneficiaries could organize themselves. In addition, such efforts have been too few to make any impact.

Reaching the Poor

Besides social structure impediments, diverse factors limited the ability of the different social services delivery systems for reaching the poor. Both physical and social distances discouraged the poor from using health and nutrition services. They could not afford the housing provided and the national level organizational network was too far removed to reach them effectively. Lack of information also prevented the poor from utilizing social security and social welfare services. In addition, these programs, though utilized only by the poor, were too small in resources and scope to make any impact. For example, the Employment Guarantee Scheme, in which only the poor participated, reached barely 5 percent of the unemployed.

In the health sector, the policy of rapid expansion of facilities in the backward and tribal areas was pursued but not fully implemented. The health facilities were, therefore, grossly inadequate in these areas. It has been well documented that the primary health centers cater to the people living within a 5 km radius. The outlying areas which are not covered are usually inhabited by the poor. Another factor which determines utilization of health services is the social distance between the health care providers and the client groups. Studies have reported that the very poor and the tribals hesitated to come to the health centers for fear of being insulted by the health staff. Recognizing the need to reduce this distance, the Community Health Volunteer scheme (CHV) was introduced (para 3.6). In this scheme, village level volunteers were trained to provide primary level health care to the people. By and large, the poor found the CHVs more approachable, though the quality and level of care they could provide was limited. In the nutrition programs, the poor reportedly did not participate either because their children did not have proper clothing or because they had no information about the scheme.

In housing programs, even the cheapest houses were found to be too expensive for the poor, unless they could be engaged in economic activities in the area. Not only are there gaps in housing technology, there is also a need to consolidate research and development efforts of both the governments and the private sector for use in various housing programs. The consolidation of these efforts and their proper extension will go a long way in helping the poor. Technological efforts made by some NGOs for housing in flood/cyclone

prone areas are important (UNNAYAN 1979, 1980) but their internalization in housing programs has not been achieved. NBO, which is doing good work in housing technology, extension, demonstration and training and whose potential in easing the housing problem is therefore quite high, is only advisory in nature. Its work is therefore not properly utilized by government and semi-government organizations in their housing programs.

Providing for the housing needs of the poor is a long process, however, government has not been able to provide adequate organizational network to support housing programs. Firstly, the existing network is unable to reach the poor (at the block or village level) and provide them with new technology, supplies of building materials and finances. Also the number of these organizations is too small to cover all areas. Secondly, facilities in the area of financing are highly inadequate. The present financial institutions like LIC, GIC, HUDCO, HDFC and government subsidy are not enough to meet the huge financial needs of housing (the new National Housing Bank will perhaps change this situation). Also, there is need to introduce innovative financial techniques so that the poor, who do not always get regular or cash incomes, are able to take advantage of financial help.

It was observed by the Economic Administrative Reforms Commission that poor extension efforts and the consequent lack of information about the different social security measures was one important reason for the limited access of the poor to these measures. The task of covering the labor force in the unorganized sector under appropriate social security measures calls for innovative ideas in the designing of the scheme as well as in the field of finance and administration. The government of India has introduced a useful concept of Welfare Funds in this context. However, the program reviews found that the low level of funds and problems of identification have hindered the achievement of desired results. It seems that a determined approach and more efforts are needed to effectively cover the unorganized sector under the social security program.

Meeting the Needs of the Poor

The government has not understood the nature of the demand for social services. For instance, even information about the nature and extent of housing needs of the poor is not available with the government (Hirway, 1987). Government has devised schemes to provide free house sites and construction assistance to the poor in rural areas as it is felt that (a) all landless (without agricultural land) and the poor do not own the land on which their huts stand, and (b) all the poor need a new house. Both points are incorrect. Various studies have shown that many landless laborers do own the hut and the land on which it stands (Wadhwa, 1987), and that where some of the huts may need dismantling, others only need improvements or repairs or additional facilities. The faulty diagnosis of the problem makes the housing programs too costly on the one hand and unacceptable to many of the poor on the other. In the case of urban areas, also, the housing support programs focus more on environmental improvement, infrastructural facilities and on development of sites and services, but neglect the issues of land credit and material support. In fact, government has very scanty information about the types of recycled material used in slums and their sources of supply. Consequently, the

programs do not really meet the demand for housing (Mehta and Mehta, 1987, Shah Kirtee, 1986).

In the process of the rapid expansion of facilities, little attention was paid to the quality aspect of the services. Poor quality, both actual and perceived, has been a serious drawback of the social services programs. For example, it is felt that many of the educational reforms which were meant for making education accessible to the poor provide inferior quality education. English medium colleges are considered superior to the regional language colleges; formal school education is considered better than non-formal education and vocational training. Because of these preferences even the poor want an English medium, formal education despite its higher cost. It is also well known that because of their poor quality care, the health centers are being underutilized even though the need for health care far exceeds the facilities being created. The situation in housing programs is similar. In trying to keep the construction cost low, the quality of the houses is lowered to such an extent that the poor find the houses inhabitable. In the absence of carefully designed needs assessment studies in all these sectors, it is not possible to decide on the trade-off between the quality and quantity of services to be provided for maximum effectiveness. It is for this reason that the recommendation for needs assessment studies has emerged from diverse sector reviews.

Social services follow a uniform pattern ignoring the diverse needs of the poor. For instance, the government seems to be interested in constructing large-scale, prototype houses for the poor without paying attention to the needs of individual families at the micro level. A family's housing needs would depend on the size, age distribution, life cycle, occupation and socio-cultural background on the one hand, and on the condition and ownership of the present housing on the other. There is thus a need to design a program which is flexible enough to take care of individual preferences.

A major criticism against the social service programs is the bureaucratic functioning of the implementing agencies. While the government recognizes the limitations of its bureaucratic style, it can find no alternative method for dealing with large scale program delivery. NGOs cannot substitute for the government as a delivery channel for social services because their number is too small and not all NGOs are equally capable or committed. Implementing programs through the local governments is another possibility. Unfortunately, social service programs rank lower on the state and local governments' priority lists. Also, many of the welfare schemes are centrally designed, often to the minutest detail with little scope for local modification and adaptation. Decentralized program design and implementation, therefore, still remains a concept yet to be seriously attempted. In fact, an experimental approach to implementing these programs needs to be fostered, perhaps by providing earmarked funds for trying out new ideas.

Limited Resources

Paucity of resources has been a serious limitation on social service programs, particularly for housing, social security and social welfare. For

instance, in 1986 the total per capita public expenditure on education and health was only Rs. 116 and Rs. 41.7 respectively. The expenditure on housing, social security and social welfare was even less, together amounting to a per capita expenditure of Rs. 21.9. It has been argued that a developing economy like India cannot afford to spend on these sectors not only because they require enormous resources, but also because it will have an adverse effect on the rate of investment for growth and hence on growth itself. Further, in trying to meet the various needs of the poor, the programs have become too small and fragmented. This has resulted in thinly spread resources which cannot make any impact. The problem is compounded by the lack of evidence regarding the impact of social services on the productivity of the poor. The inadequacy of resources is closely linked with the priority of planners and the search for alternative ways of financing. Not much work has been done on either issue.

Privatization or commercialization of social services to the non-poor, for example, can be one way of financing services for the poor. Charging the non poor for education above the primary level is already under consideration in Andhra Pradesh. Mobilization of people's savings for social security is another way. Many social insurance schemes, which are designed for different groups of workers can be financed, at least partly, by the workers themselves. The concept of welfare funds, which are created primarily through employers contribution, is another source. Therefore, devising innovative schemes for social security is a major need in this area.

Several mechanisms for financing health care have been considered, such as user charges for government health services, community financing and insurance. But experience with these is limited and so far somewhat unsatisfactory. Although the rate structure for government hospitals stipulates that fees be varied according to income groups and only the poor be given free treatment, it has not been possible to enforce this in practice. Even the limited revenue so generated is credited to the general revenue of the government, robbing the institutions of any incentive to collect such fees. Recently the State Government of Andhra Pradesh began charging fees in outpatient departments but the experience has not been evaluated. A few experiments in community financing have also been carried out. Attempts to introduce insurance mechanisms (Sevagram, Wardha, PRIA 1986) or collect payments for village health guides have not been successful. The poor do not have the resources to regularly contribute towards health insurance services and any illness seems to require resources beyond their reach. Finally, the insurance mechanisms (Employee State Insurance Scheme, Central Government Health Services and General Insurance Corporation Medicare) seem to reach a limited non-poor group. Thus although there is a need for innovative ways of obtaining health financing for curative care, the poor may not be able to contribute significantly towards primary health care. Perhaps if the non-poor are asked to pay for their health care, public resources could be directed towards health care for the poor.

Our review suggests that while additional resources need to be generated for social service sectors, improving the efficiency and effectiveness of existing resources is more important, particularly for education, health and nutrition. To illustrate, there is considerable scope

for reducing costs in government hospitals. Unplanned expansion of hospital facilities results in their poor utilization (IIMA, 1987). Rational plans for health facilities in government as well as in the private sector need to be developed after a careful epidemiological and locational analysis. Similarly, expansion of tertiary care and use of sophisticated medical technology needs to be carefully planned. Cost reduction in relation to purchase and use of medicines is yet another important measure. It is generally believed that prescriptions are often wasteful and excessive in relation to the medical problem. Development of inappropriate health manpower can add to health care costs. There is also considerable scope for reorienting the intra-sectoral allocation of the government in the health sector to maximize health care at minimum cost.

However, to achieve any of these policy or program reforms in social services, better data at household, institutional and overall levels through a comprehensive program of research is necessary. Such a program should have three components: household and facility surveys to collect reliable data; costing studies to estimate unit costs of different services; review of the technical effectiveness of these services; and finally experimentation with financing mechanisms to assess their feasibility, viability and likely consequences.

Contribution to Poverty Reduction

One reason for providing social service inputs was that they help to increase the productivity of the poor and help them cross the poverty line. We could not find any empirical evidence that linked social service inputs to productivity. The impact of health and nutrition measures on poverty alleviation has not been studied while the social security and welfare programs are viewed more as distress-relieving rather than as poverty-alleviation measures. Ironically, poverty is identified as one of the reasons why the poor do not benefit from these measures and poverty alleviation programs have a long time horizon. It is therefore suggested that for better impact, social services should be provided in conjunction with the poverty alleviation programs.

Social security measures are an essential component of anti-poverty programs as (a) the poverty of the bottom-most decile, which is mainly due to destitution, can be eased only by appropriate social assistance schemes, (b) the poverty of the un/underemployed also can be eradicated by guarantee of work, and (c) the poor can be supported in vulnerable situations (i.e. in old age, sickness, death) and protected from exploiters through appropriate social security measures. It can also be said that security of minimum incomes to the labor force enhances their productivity and thereby their remuneration. These measures, however, can contribute to poverty alleviation only if the measures are designed well, provide enough benefits and are accessible to all sections of the poor.

There are also some conceptual difficulties in trying to establish such linkage. For instance J. B.G. Tilak (1980) found from a sample study of Andhra Pradesh's West Godavari district that rates of return from education for backward castes were higher than those for others, indicating that

education can act as a significant redistributive agent. on the other hand, Jaswant Singh (1978) conducted a sample study of 450 fathers and 1300 sons from 450 families of Chandigarh. By using different scales of socio-economic status, occupational prestige, job satisfaction, etc., the author came to the conclusion that 79 percent of the population had an upward, inter-generational social mobility though additional education beyond a certain level was less effective as an agent for social mobility. This is natural, because, rates of return for higher educational level are found to be lower than those for lower educational levels. But vocational training, for example, was expected to increase the job potential of the poor. However, studies have shown that though the training was useful in developing skills, it was not helpful in getting jobs. In the job market, those who opted for vocational training were valued less than those who had formal education. Thus, even with equitable educational access, utilization and performance, education may not emerge as an equalizing agent unless rewards from education are also 'equitably' distributed

The impact of social service inputs, however, also depends on the performance of other sectors. For example, the relationship between education and job availability depends on the job market and the infrastructure development in the region. Similarly, the impact of health and nutrition programs is interrelated and also depends on other inputs such as drinking water, agricultural production, public distribution system and education. Not all of these inputs can be provided as a package, but with increased inter-sectoral coordination, their impact can be improved. At present, very little evidence of intersectoral coordination is found at the program level. Though one appreciates that perfect coordination is neither possible nor necessary, formal and informal linkages between related departments are essential. Efforts should be made to bring about these minimum linkages by setting up coordinating mechanisms.

IV. POLICY AND INSTITUTIONAL IMPLICATIONS

In India, the utilization of social services is greater in the relatively more developed regions and by the better-off sections of the population. Does this mean that economic growth will take care of social services? If the poor are given higher employment and income, will they feel the need, and pay for these services (Lakdawala 1985, Muthayya 1983, NIRD 1983, Mathur et al. 1982)? Is faster growth a better solution than expenditure on social services at this stage? As the rate of growth in India has been low and uneven across regions and across sections of the population, it is widely agreed that a policy of providing social services to the poor has an important place in the country.

Our review shows that, while the policies in the social sectors were generally responsive, they did not go far enough in terms of meeting the needs of the poor because they ignored demand considerations and did not adequately take into account implementation difficulties. The programs found it difficult to reach the poor, and their overall utilization was low. Poverty itself is

one of the reasons why the poor cannot participate. Evidence both from the government and NGO programs suggests that the poor can be reached effectively if the policies focus on them and an appropriate service delivery system is designed and implemented. Both of these would need to be supported by ongoing research.

Policy Reforms: Focus on the Poor

A policy focus on the poor implies linking these services more closely with income generation, inter-agency coordination among various services, seeking the involvement of the poor and providing a suitable role for NGOs.

1. Closer Linkages with Income Generation

The poor will perceive a need for the social services if these services contribute towards increasing their income. Thus education needs to be linked more closely with employment opportunities. Health services should also be directed towards reducing adult morbidity and thereby increase productivity. The present housing policy has adopted a demand based approach which can only work if housing is seen as an economic activity and the poor are encouraged to participate in housing construction. Finally, social security should preferably take the form of employment guarantee (which the government is considering), rather than of social assistance or social insurance.

2. Inter-agency Coordination

Usually, several factors need to interact if optimal benefits from social services are to be realized. For instance, the nutritional status of children is affected by infectious diseases, feeding practices and food taboos which require health and educational interventions. Unless the importance of these factors is taken into account, the impact of nutritional interventions, especially on the poor, will not be substantial. Since comprehensive integrated programs are difficult to implement, specific mechanisms are needed to effect better inter-agency coordination in areas where the poor reside.

3. Involvement of Poor

Community participation is often looked upon as an answer to all difficult problems. But more often than not, local leadership remains indifferent and is sometimes even hostile to programs designed to benefit the poor. A mid-day meal scheme in Andhra Pradesh was discontinued because educating the poor was construed as disturbing the social hierarchy. Antia (FRCH 1981) reported that in his project, local leaders stopped cooperating when they realized that the nutrition benefits were meant for the lower socio-economic group. Organization of the poor is a must if they are to get their due share in the gains of development. Though this organization ultimately comes from the poor themselves, government can do a lot by supporting upcoming organizations and protecting them from undue harassment.

4. Role of NGOs

NGOs can play many significant roles. One would be for them to develop replicable models which can be used by the government. In the past, these models have not been replicable mainly because government agencies could not emulate the NGOs' flexible approach. Recognizing the need for a flexible approach in social service sectors the government has been keen on increasingly involving them in these programs. But this solution also has problems. Many voluntary agencies are located in urban or town areas and tend to work around these areas. Therefore, the resources allotted to them get used up in the urban areas, while the rural areas get a smaller share of the welfare resources. More systematic work with NGOs could remove these limitations. Though the involvement of NGOs creates certain limitations (as seen above), they can provide a link between the poor and the government by representing the interests of the poor before the latter and educating the people about government's programs and policies. However a more important role of NGOs should be to create a movement to mobilize public awareness and opinion, and to participate in policy making so as to tilt it in favor of the poor. The government needs to accept and respect the role of NGO as a movement or as a pressure group in its policy formulation process.

Design and Implementation of Delivery Systems

Several factors including implementation difficulties have resulted in the low utilization of social services by the poor. The issues common to the delivery systems in these sectors were ineffective targeting of services, inflexible service delivery system resulting in a mismatch between the perceived needs and services provided, and weak management. On the other hand, successful programs were (a) started after assessing the needs of the community, (b) involved beneficiaries in design, (c) were flexible and accommodated changes to suit local conditions, (e) integrated the relevant services, and (f) were systematically and regularly monitored.

1. Targeting

In general, global approaches have not achieved the desired level of access to social services for the poor, mainly on account of a highly stratified social structure, inadequate resources and a lukewarm attitude to poverty issues in implementation. It has been repeatedly shown that social services can reach the poor only through proper beneficiary selection. This is not being done for many reasons. The education and health programs cannot be targeted to the poor because they are meant for universal application. In these programs, the only way to reach the poor is to ensure that the services reach everyone. However, socio-economic and occupational groupwise differentiated delivery systems in education may be more effective. NGOs have been able to target health services to the poor by conscious choice of personnel from backward communities and lower levels of comfort in their health facilities that would not satisfy those who can afford to pay for private sector services (CRHP 1975).

In other social service programs, the problem lies more with the program's inability to adhere to the selection criteria either because of lack of data or because of local political pressures which are not always in favor of the poor. The experience with nutrition services in Tamil Nadu indicates that the only alternative to careful targeting is complete coverage; anything in between is not effective. Tamil Nadu Integrated Nutrition Project (TINP 1980) was a well-focused program concentrating exclusively on children below 3 years of age and pregnant women. Supplementary feeding was provided to those children whose growth was faltering and to pregnant mothers at risk. These activities were supported by intensive communication efforts and community level participation. Evaluation after two years showed that the incidence of severe malnutrition among children had declined by 30 to 50 percent (World Bank 1982, Berg 1987). In the ICDS blocks in the same state the decline was between 10 to 20 percent. In contrast to TINP, the Noon-Meal Program provides all children between 2 and 14 years of age one wholesome meal per day on all days of the year. Although it is basically an anti-poverty program, some studies have reported significant nutrition gain. But this is achieved by a high level of political commitment and a considerable expenditure of resources.

Also, since targeting can be achieved only by the increased cost of monitoring and supervision, this approach is administratively unattractive. For these services to be effective, there must be a comprehensive and objective information system which can be used to properly select the beneficiaries, respond to their specific needs and monitor their progress, all of which come at a high administrative cost. Questions have always been raised as to whether the amount spent on beneficiary level targeting could not be better utilized in expanding the services. Benefit-cost tradeoffs of targeting need to be carefully worked out. If beneficiary level targeting is very difficult to implement, area level targeting may be utilized. For instance, programs located in areas where SC/ST predominate have been able to reach them. Similarly, programs specifically planned for urban slums are more likely to deliver results.

2. Improving Management

Increasing the efficiency and effectiveness of the government's social services has been a major concern of researchers and administrators alike. Although not well documented, experiences in the health sector show that issues of management improvement do not lend themselves to easy answers. Mutually reinforcing actions are likely to be more effective than a single isolated intervention. The largest of such efforts in health was the area projects which covered 42 districts in 12 states and were funded by a large number of donor agencies including the World Bank, USAID and the United Nations Fund for Population Activities (UNFPA). Evaluations showed that although services improved, the results were not commensurate with the expenditure involved. Maru et al (1987) describe the experiences in the early projects where management information systems and training programs were designed and implemented. But these by themselves did not improve program performance. Rather, these should be regarded as tools which successful administration can use, as shown by the Maharashtra experience during the period 1981-84 (Murthy and Satia 1984). Several steps were taken to remove

slackness in the functioning of the health system- improving monitoring, strengthening the field level supervisory structure, increasing staff motivation, selective and rapid expansion of field infrastructure- which resulted in more than doubling the performance of the various health programs.

Learning from previous researches and the experiences of NGOs in the health sector suggests that several lacunae must be corrected if management improvement efforts are to be effective. First, service delivery has to be accessible and appropriate for local needs. Successful NGOs were also able to develop commitment among staff through committed leadership. Finally, all NGOs secured some form of community level participation though the kind and degree of participation, varied (Bhatt 1984). Thus issues of service delivery structure, leadership and community linkages need to be addressed along with management improvements for increasing the efficiency and effectiveness of the government programs.

Research Support for Policies and Programs

The problem of unequal share of the poor in the social service inputs has received considerable attention of both the policy makers and researchers. Despite this awareness and the existence of several studies examining the causes and consequences of this inequity, the problem still persists. In fact, newer and subtler aspects of inequities affecting the poor are emerging out of policy and program interventions themselves. A closer linkage, therefore, is necessary between policy and program formulation and research. To deal with this complex phenomenon a comprehensive approach involving economic, political and managerial perspectives will be necessary.

1. Policy Research

Ideally, policy making and research endeavors should reinforce one another. But the reality in India is far from this ideal. This is because researchers have not clearly recognized their role in strengthening policy formulation and policy makers have not adequately recognized the usefulness of such research. In view of this shortcoming of the research-policy nexus, there is a need to promote studies which have significant implications for policy to overcome the problem of inequalities and to raise the effectiveness of social services as agents for social mobility. How can the goals of equality and efficiency be reconciled? What other inputs from sectors like employment and income are needed to realize equality and social justice? What is the role of public, private and voluntary action interventions in achieving these goals? These are some of the questions which need further probing.

Policy research can be broadly defined as research that relates to determining the costs or benefits of alternative public policies. The major components of policy research in the area of social services would be the development of a sound conceptual framework for social services, formation of comprehensive policies, understanding the problem of service delivery to the poor and feedback for reformulation of policies. Social services need to be defined carefully. For instance, social welfare should incorporate overall social development rather than only 'relief' and social security should include 'guarantee of work'.

In the field of inequalities of social services, future researchers need to meaningfully marry the quantitative, qualitative and conceptual approaches. Research has been largely descriptive in nature, without careful measurements. Even when inequality is measured, quality aspects are generally neglected. For instance, in the area of education, access, facilities, attendance and results have received more attention than the quality of educational services. The qualitative aspects of social services thus need to be quantified. There is also a need to examine the micro level processes which work behind the limited access of the poor to social services.

2. Research for Design of Interventions

In addition to policy research, it is also necessary to ensure that the nature and the quality of intervention is appropriate to the problem. For instance, the central plank of practically all ongoing nutrition programs is supplementary feeding which, as results show, does not bring about durable improvements in the nutritional status of the poor as it does not address the basic causes of under-nutrition (Gepalan 1982, 1987). Malnutrition is caused by both low nutrition intake and high energy losses, but the latter is often neglected. Among women, energy losses are the result of closely spaced frequent births and prolonged breast-feeding. Among children, energy losses are caused by repeated diarrhea, fever and infections. Mid-day meals programs are in great demand because they are highly visible but they have not been cost-effective in either improving nutritional status or in increasing enrollment levels.

Understanding the needs of the poor is crucial if social services are to meet them effectively, as is illustrated by the housing and nutrition services. For example, the rural housing program's assumption that all the landless (without agricultural land) do not possess land for a house and that all the SC/ST population need new houses is found to be false. Information on how many poor want new house-sites, how many want new houses and how many want additions/repairs/improvements and of what nature is essential as a basis for designing housing schemes. Micro studies should also provide information about financing patterns and sources of housing material supply. In order to increase the effectiveness of nutrition programs, the program inputs must match the needs of the people in terms of timing and place of service.

Many evaluation studies which have attempted to relate the input of social services with its impact, such as education with income and food distribution with nutritional status, without exploring the nature of the causal linkages between the two, risk reaching erroneous conclusions. For example, expanding milk production improved the nutritional status of low income households not because of additional milk consumption but the consequent increase in income spent on other foods. Similarly, studies have reported that there was no association between education and upward social mobility beyond a certain level because of lack of infrastructural development. Thus the role of intermediate variables like market mechanisms, social structures and infrastructure development needs to be more clearly understood.

Action research can play an important role in supporting the formulation of appropriate policies and programs. However, very little action research has been undertaken so far. There is a need to define and distinguish action research from activism. There must also be a conscious endeavour to develop linkages between among action and basic and empirical research. It is a pity that the funding organizations in India have not taken adequate interest in action.

3. Integration with Poverty Eradication

Before we conclude, we would once again like to emphasize the need for integrating social services and anti-poverty programs. Anti-poverty programs focus on employment and income generation. Although they often include a component of social development, it tends to get neglected because the emphasis is on employment of unskilled workers in programs such as road building. Some of the items in the government's 20-point program, which reflects priorities, do mention housing, labor laws, primary schools, drinking water and health services, but they are more like items on a list and less like components of a comprehensive social service policy for the poor. For social services to serve as a direct intervention for poverty eradication, vocational education, adult health and adult nutrition also need to be emphasized together with primary education, child health and child nutrition which are likely to have only a delayed impact on poverty. It seems that despite a recognition of the need to integrate the poverty issues involved in the delivery of social services, and the role of social services in anti-poverty programs, not enough has been achieved in this direction.

Annex 1. An Overview of Social Service Programs

Education: Policies and Programs

Educational activities are carried out both by government agencies and the private sector. Within government, until quite recently, state governments were responsible for these activities. With the new Education Policy (1987), however, the central government intervention has increased. Even though education can be considered a major instrument for upward socio-economic mobility, poverty eradication objectives are not well integrated with it. Nevertheless, there is an awareness of the need for such an integration and as a result, several measures have been taken. In a country of continental size, with education being on the state list till recently and with the private sector also taking major initiatives, it is difficult to list all of these measures. However, a few major policies which have attempted to integrate poverty issues in the delivery of education are discussed below.

Massive Expansion of Educational Facilities: The primary objective of the massive expansion of facilities in the post-independence period (especially after the Education Commission Report) was the elimination of the educational disparity between different individuals, both male and female. The main logic behind this expansion of all types of education facilities is that the poor are not in a position to move up in the socio-economic ladder because of the lack of these facilities. A number of rural educational institutions were also set up, based on the recommendations of the University Education Commission (1948) and a Committee on Higher Education in Rural Areas. These institutions were mainly residential with coeducational facilities and provided instruction for a diploma in rural services and teaching and certificate courses for overseers, health workers and agricultural workers. Rural institutes at higher levels of education with feeder institutions at lower educational levels located in the rural areas were also set up, primarily for the eradication of the rural-urban inequality in educational access and for improving the employment levels of the educated in rural areas. To facilitate the easy access of the poor rural people and first generation learners, the medium of instruction in these institutes is either the regional language or the mother tongue of the people concerned.

Hostels for the Scheduled Caste and Scheduled Tribe Students: These students normally come from low income groups and hence need residential facilities close to the educational institutions. The government and some of the private charities have therefore set up hostels specially meant for them. The government has also established ashram (residential) schools for the education of tribals, who are nomadic and generally very poor.

Mid-day Meals Program for school Children: The major constraint working against education of the poor people is that their opportunity cost of time for attending school is very high; it may even come in the way of earning their daily livelihood. To overcome this, some states have introduced a Mid-

Day Meals program for school children. The pioneering experience of the state of Tamil Nadu is fairly encouraging so far as the integration of poverty issues in the delivery of education through mid-day meals is concerned. The merit-cum-means scholarships and the book loan program also reduce the cost of education. Many states have also introduced schemes for providing free uniforms, free text books, and special allowances for sending female children to school.

Mother tongue or Regional Language as the Medium of Instruction:

The mother tongue as the medium of instruction may facilitate a higher enrollment rate and help people continue their education without dropping out from the system. The progress of this reform, however, has been adversely affected by the mushroom growth of English medium schools which, though not always financially supported by the government, are status symbols and considered to be superior to other schools. These schools have created a dualism in the field of education, widening the disparities between the poor and the better off as far as access to and utilization of educational opportunities are concerned.

Vocationalization of Education: The majority of children from poorer classes are interested in functional education which would provide them skills for earning their livelihood. Vocationalization of school education, diversification of courses at the secondary and higher secondary school stage, and setting up technical education centers in the rural areas represent some attempts in this direction. However, as of 1984, only 1900 institutions in 10 states and 5 union territories offered vocational courses at the two year post-secondary stage. Significantly most of the states with a larger percentage of population below the poverty line and a higher proportion of scheduled castes and tribes population had not implemented this reform. These courses were also not adequately supported by the development of skills in entrepreneurship, marketing and finance.

Examination Reforms: With a view to facilitating poor learners and learners from poor socio-economic backgrounds, children are tested through objective types of questions in the new system of examinations. The first generation learners have found this reform very useful in crossing the examination hurdle and in getting the necessary certification which would enable them to aspire for competitive positions in the job market.

Non-formal Methodology of Education: The most important method of integrating poverty issues in the delivery of education is the non-formal methodology. Students are allowed to learn at their own pace, during a period which is convenient to them, a course which is of interest to them and through a method which is most effective from their point of view. The major schemes of non-formal education are the centrally sponsored program of non-formal education, state level schemes like the 'Earn While You Learn' scheme of Madhya Pradesh, action research project on Universal Primary Education of the Indian Institute of Education and the UNICEF-assisted projects on non-formal education centers. In the Seventh Five Year Plan (1985-90), 39 million children are expected to be covered by the non-formal scheme as compared to 25 million children under the formal system. The non-formal scheme is much less expensive; the annual cost of educating a child in a formal school has been

estimated at Rs 853 as compared to about Rs 24 in a non-formal education center. However, non-formal education is poor in quality and is generally not recognized in the job market. Despite all the misgivings and reservations about non-formal methodology, future educational policy may have to heavily depend upon it in view of resource constraints. Several non-formal strategies tailored to the divergent needs of different occupational and socio-economic groups will be needed for the government intervention to succeed.

Correspondence Courses and Use of Mass Media: Even though a comprehensive national evaluation of the correspondence courses and the use of mass media for education is not available, they have been able to spread education amongst the poor. However, the recruitment processes tend to screen out persons educated through correspondence courses, sometimes for fictitious reasons.

Adult Education: Adult education is another channel through which the poor, who could not undergo regular formal education, can get introduced to the world of written words and ideas.

Health: Policies and Programs

Although difficult to estimate precisely, a significant proportion of all curative care in India is provided by the private sector practicing western medicine. In addition, there are a large number of practitioners of indigenous and other systems of medicine. Thus a large proportion of the poor pay directly for the curative services. However, since much of the research in terms of integrating poverty issues in health care delivery has been in the context of the government's preventive and promotive health care services, our review focuses on them. But it should be noted that there is a serious gap here in research; for illness care rather than preventive and promotive health care is the priority need as felt by the poor.

Government Primary Health Care Services

The report of the Health Survey and Development Committee (popularly known as the Bhore Committee) had stressed in as early as 1946 the role of suitable housing, sanitation and safe drinking water as preconditions for good health. Health was not to be equated with either health services or with illness care, and the committee suggested the development of a hierarchy of health care units at the primary, secondary and tertiary levels, emphasizing people's involvement in Primary Health Care. Although the Bhore committee recommendations were later found to be too ambitious they served as a framework for health services development (Giridhar et al, 1985).

The first two Five Year Plans concentrated on creating health facilities and training medical and para-medical personnel. In the Third Plan (1961-65), efforts were directed towards improving the coverage and quality of health services, by removing deficiencies in building facilities, equipment and personnel. In the Fourth Plan (1969-74), a series of disease-specific programs launched earlier, such as malaria and small-pox, were merged with the

general health services by converting unipurpose workers of these programs into multipurpose workers with reduced areas of operation. The Fifth Plan (1974-79) devoted considerable attention to increasing the accessibility of health services and correcting regional imbalances. The Minimum Needs Program was the main instrument through which health infrastructure in the rural areas was expanded to ensure primary health care to the rural population through a network of rural health centers.

Despite the extensive network of Primary Health Centers and subcenters, a large gap existed between the need and provision of services at the village level. The Srivastava Committee (1975) provided some guidelines to develop a viable and economic model of health services at village level, using health workers from the community to provide simple promotive, preventive and curative health services. Accordingly, the government launched a Community Health Worker scheme (later called Village Health Guide) in 1977. Under this scheme, every village or community with a population of 1000 selected a health volunteer. This volunteer was trained in necessary skills, paid Rs 50 as honorarium and given medicines worth Rs 50 per month (\$1 = Rs 16.5). With the exception of Jammu and Kashmir, Kerala, Tamil Nadu and Andhra Pradesh, which made alternative arrangements, all states implemented this scheme. A program for training dais (traditional birth attendants), another major avenue for reaching the poor with maternity services, is also being implemented.

The need to integrate practitioners of traditional medicine into primary health care has been well recognized. It is estimated that there are about 500,000 practitioners of traditional medicine in India. But although the national health policy (1982) indicated the need for a meaningful and phased integration of the indigenous and modern systems, it did not indicate specific actions for this purpose.

In the early 1980s, the urban slums began to attract the attention of the policy makers as a disadvantaged group. Consequently in 1982, the Urban Community Development, Small and Medium Town Development, and the Low Cost Sanitation Projects were brought under a single umbrella called Urban Basic Services (UBS) which became a national program. The UBS program aimed at children and women who were most vulnerable to diseases and death and other dangers in slum conditions (Bhatnagar 1986). A health infrastructure, similar to that of rural health services, is being developed in the urban slums.

After the Government of India signed the Alma Ata Declaration on "Health for All" by the year 2000, considerable significance was attached to improving the quantity and quality of health care to the rural poor (ICMR - ICSSR 1979, ICSSR - ICMR 1981, Ministry of Health and Family Welfare 1981). The National Health Policy statement (1982) sought to provide universal comprehensive primary health care relevant to the national needs and priorities of the community at an affordable cost. It emphasized community participation and sought the involvement of voluntary organizations. In this, priority was to be given to people living in tribal, hill and backward areas and to populations affected by endemic diseases. The policy laid out specific goals to be achieved by the year 2000 - a reduction of infant mortality from 125 to 60 per thousand live births, an increase in life expectancy at birth to

64 years, and a decline in the crude birth rate from 35 to 21 per thousand population.

Disease Specific Programs

Communicable diseases were responsible for a significant proportion of morbidity and mortality at the time of independence. Some of the disease control programs expected to contribute significantly to the health and productivity of the poor were (Banerjee 1985): (a) Malaria Control: In 1947, 75 million cases of malaria were reported. The National Malaria Eradication Program, was therefore started in 1953. (b) Tuberculosis: Until about 1960, surveys showed that 1.8 percent of the population suffered from radiologically active tuberculosis and hence the National Tuberculosis Program (NTP) was launched. But NTP did not receive special attention until it was included in the 20-Point Program in 1982. (c) Leprosy: It was estimated that there were about 2.5 million cases of leprosy in 1982 and there has been no subsequent evidence to indicate any major change in the incidence. The leprosy program consists of case detection and treatment through urban leprosy centers and district leprosy offices. It is now included in the 20-Point Program and accorded high priority. (d) Immunization Programs: An expanded program of immunization was launched in 1976. In the Sixth Plan (1980-84), the program of immunization was strengthened to protect mothers from tetanus and children from diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis. In the Seventh Plan (1985-90), universal immunization by 1990 became the objective. Integrated immunization services under one roof, training of manpower, investment in cold chain and equipment, development of a surveillance system and production of vaccines are emphasized. Recently immunization has been included as one of the five technology missions (National Immunization Mission 1988) to provide a more coordinated approach.

Another category of disease specific programs attempt to remedy nutrition or environment related deficiencies to reduce morbidity. Some of the important programs in this respect are: (a) Blindness Prevention Program - In the early stages trachoma was believed to be the major cause of blindness and large scale antibiotic treatment and improvements in eye hygiene were attempted. Later nutritional blindness was sought to be prevented through the administration of large doses of vitamin A; (b) A Goitre Control Program was launched in 1962 to control goitre which arises from environmental iodine deficiency. The program strategy was to supply iodized salt to endemic areas estimated to have a population of 120 million; and (c) Diarrheal Management Program: It has been estimated that about 250 million episodes occur every year in children below 5 years of age. The recently launched National Diarrheal Management Program consists of educating mothers in Oral Rehydration and involves private practitioners. However, even when taken together, these programs are small and do not receive priority attention from top administrators, although unlike communicable diseases, the poor are more likely to suffer from the ailments listed above. These programs are also more difficult to implement for they involve altering environmental conditions and the behavior of people.

During the last decade, considerable emphasis has been placed on reducing mortality, particularly of infants. However, reduction of morbidity,

particularly of adults, has not received corresponding attention. This may be a high priority for the poor because adult morbidity reduces the ability to earn.

Nutrition Interventions

Since nutritional deficiency is a multifaceted problem closely associated with poverty, illiteracy, lack of environmental sanitation, large family size and lack of safe drinking water, its solution also requires that multiple inputs such as food, drinking water, health care, and education be provided simultaneously to make the desired impact.

Though the problem of malnutrition was recognized at the inception of the Plans, the first three Plans treated nutrition as a component of the health sector rather than as a separate program. It was only in the Fourth Plan that an Applied Nutrition Program was introduced (1960). By 1973, it was extended to all the states. This program aimed at spreading among the poor the concept of balanced diet, production and consumption of protective foods and proper techniques of cooking. It was the first major, direct nutrition intervention that tried to raise the nutritional status of the poor by encouraging the local production of foods.

In successive plans, newer and better schemes were implemented with more inputs in the form of food supplements, health care and nutrition education, to improve the nutritional status of the vulnerable groups. The Mid-Day Meal Program (MDM) was one such scheme; started in the tribal and other economically backward areas of the country, it aimed at supplementing the diet of primary school children. First launched in Tamil Nadu state in 1956, the MDM, unlike the ANP, was a substantial scheme providing free meals with a view to increasing the enrollment of poor children in schools. In 1962-63, MDM became a centrally sponsored program with the objective of improving the nutritional status of school-going children while encouraging their regular attendance at school. A daily ration of food providing 300 calories and 14 grams of protein was distributed to all school children on all school days. In the Fifth Plan, the scheme became part of the Minimum Needs Program under the state sector. However, the other two components of the program, namely health care and nutrition education, were never implemented.

The Special Nutrition Program (SNP) which was designed to take care of pre-school children and pregnant women was initiated in 1970 with a parliamentary sanction of Rs 4,000 millions for providing supplementary food to children under the age of three. Later, the program was extended to cover all children under the age of 6 as well as pregnant and nursing mothers. By 1980, the scheme had more than 6 million beneficiaries in the country, primarily from the tribal and backward blocks and from urban slums.

The Integrated Child Development Services (ICDS) program, which came in place of the SNP, is perhaps the most important and comprehensive nutritional intervention currently in operation. Initiated in 1975-76 on an experimental basis in 33 rural, tribal and urban blocks, it now covers more than one-third of the community development blocks. While selecting these blocks preference is given to tribal and economically backward areas to ensure

that these inputs reach the poor on a priority basis. The ICDS provides a comprehensive set of the inputs needed for the all round development of a child. The major program objectives are to:

- (a) reduce morbidity and mortality among children in the age group 0-6 years;
- (b) improve their health and nutritional status;
- (c) provide the environmental conditions necessary for their psychological, social and physical development; and
- (d) enhance the ability of mothers to provide proper care to their children.

To achieve the above goals a package of services comprising supplementary feeding, immunization, health check ups, referral services, and nutrition education was introduced. As it was felt that along with nutrition and health inputs, the children should also be provided with an environment conducive for their psychological and social development, ICDS provides non-formal education. At present ICDS is the largest direct nutrition intervention scheme in the country.

In addition to these direct interventions, some state governments have introduced food subsidy schemes like the subsidized rice schemes of Andhra Pradesh and Kerala to benefit the poor in those states. Since poverty levels are very sensitive to variations in food production and food prices, direct subsidy on the staple grains should result in increased grain consumption by the poor. There is a strong justification to consider food subsidy programs as nutrition interventions, but empirical evidence to show the extent to which these subsidies contribute to increased food consumption is very limited.

In 1984-85, the government of Andhra Pradesh introduced the two-rupees-a-kilo rice scheme to reach the families with an annual income of less than Rs. 6000. The scheme provided 5 kgs of subsidized rice per month per person to these families subject to a ceiling of 25 kgs per month per family. This was done through a network of 232 thousand fair price shops covering over 27 thousand villages and towns. Nearly 10 million households, comprising 70 per cent of the total households, were receiving rice at two-rupees-a-kilo.

Housing: Policies and Programs

Until recently, the Government of India had no declared national housing policy. Different schemes and programs were undertaken in an ad hoc fashion as and when the need was felt. The first housing program for rural areas, the Village Housing Scheme, was introduced as part of the total rural reconstruction program and was very small in proportion to the needs. With the introduction of special programs for the poor in the Fourth Plan, a crash scheme for providing free-of-cost house sites to landless agricultural laborers was introduced in the central sector of the Plan. In the Fifth Plan, the scheme was transferred to the state sector and was extended to cover rural

artisans as well. It included provision for extending construction assistance to the beneficiaries. The scheme was a part of the Minimum Needs Program and later of the 20-point program.

The Sixth Five Year Plan (1980-85) declared that by 1990 all the landless workers would get complete housing assistance, i.e. free house site as well as construction assistance along with the minimum infrastructure like water and approach road. The target was to provide free house sites to all the landless and construction assistance to 25 percent of the landless laborers. About 90 percent of the estimated landless families were declared to have been given house sites and 52 percent were sanctioned construction assistance. The Seventh Plan therefore decided to provide free house site to all landless workers by the end of the Plan. Rs.360 million will be spent on this. In addition, Rs.5.71 billion will be spent on providing housing assistance to 2.71 million households, and Rs.2.89 billion will be spent on other supportive programs.

The major housing schemes for the rural poor at the all India level today are the house site-cum-construction assistance scheme for landless workers, the housing scheme for scheduled castes (SC) and scheduled tribes (ST), and the housing scheme of the Ministry of Agriculture which is implemented as a part of the RLEGP (Rural Landless Employment Guarantee Programme) and the NREP (National Rural Employment Programme). In addition to these schemes, efforts have been made to improve the environment in rural areas. Construction of approach roads, arrangements for drinking water, construction of latrines, sanitation and hygiene facilities, and the provision of separate bathrooms and smokeless stoves in the houses of the poor are some of the schemes taken up for this purpose.

In the case of urban areas, one finds a trial-and-error approach towards housing. In 1956, the government introduced a Slum Clearance and Rehabilitation Program under which slum dwellers were to be shifted to the outskirts of urban centers in newly constructed houses. This program was found to be expensive as well as unacceptable to the poor. In the late 1960s and 1970s, therefore, the Environment Improvement Scheme (EIS) and the Slum Upgradation Scheme (SUS) were introduced, and later on, a Sites and Services (S and S) scheme was also introduced. The objectives of these schemes were to provide the slums with minimum infrastructural facilities such as water, sanitation, and roads, and to support housing activities of the poor by providing them credit (with subsidy), technology and materials through appropriate organizational support. Special Housing Schemes for lower income groups were formulated, building by-laws were relaxed, ceilings on urban land holdings were fixed (to provide surplus land for the poor) and rent control acts were enacted. In short, the programs and schemes in urban areas aimed at encouraging informal sector housing for slum dwellers. The role of the government was mainly promotional in nature.

Organizational Support

Government of India (GOI) has set up an organizational network to support the housing programs in rural and urban areas. The Ministry of Works, Housing and Urban Development is the apex body in charge of housing activities

in the country. The Ministry, in consultation with state governments, formulates Plans and Programs for meeting the housing needs of the country. The National Building Organization (NBO) was set up (1954) in the Ministry of Works and Housing at the center with the primary objective of transferring technology from research labs to the construction sector for low cost housing for the rural and urban weaker sections. The Central Building Research Institute (CBRI) is a research organization which provides research and development inputs to the NBO. Another important organization set up in this field is the Housing and Urban Development Corporation (HUDCO) through which the major chunk of public sector investment in housing under the central plan is to be channelled. HUDCO helps rural (since 1976) as well as urban housing activities.

Financial support for housing comes mainly from the Life Insurance Corporation (LIC), the Provident Fund Department, HDFC (Housing Development Finance Corporation), Housing Boards and, marginally, from commercial banks. Most of the support is for the non-poor sections of the population. Considering the need for an institution to address the financial requirements of the poor, the government of India has announced the setting up of the National Housing Bank (NHB). The main objective of this bank will be to mobilize resources for the housing sector, to promote housing finance institutions both at local and regional levels, and to regulate the working of housing finance institutions at all levels.

Some state governments have also set up special housing organizations, and introduced housing schemes for weaker sections of the population. Andhra Pradesh, Kerala, Tamil Nadu, Uttar Pradesh, Gujarat, Maharashtra, Karnataka, Haryana and several others have set up State Housing Boards and some have set up special housing boards for the weaker sections. The special housing schemes introduced by some state governments are: (a) Rehabilitation and Subsidized Self-help Housing Scheme (b) Village Housing Project Scheme, Own Your House Scheme and Save a Rupee a Day scheme of Tamil Nadu; (c) Housing Scheme for the Scheduled Castes of Uttar Pradesh; (d) the Rural Site and Service Program, the Rural Semi-permanent Housing Program and the Cyclone-prone Area Housing Program of Andhra Pradesh, and (e) Housing Schemes for the poor of Gujarat, Punjab and Haryana.

The National Housing Policy (NHP) was announced only in May 1988. It states that the main objectives of the policy are: (a) to help every family to own an affordable shelter by the year 2001 AD, (b) to encourage people to build and improve their own house, (c) to promote repairs, renovation, expansion and upgradation of the existing housing stock, and (d) to preserve India's rich and ancient heritage in the field of human settlement planning and architecture. The means of achieving these objectives, according to the NHP, are legislation (by making suitable amendments in the Urban Land Ceiling Act, the Rent Control Act, the Tenancy Act and Building By-laws), making land available for housing for the poor, providing financial and technical support, ensuring supplies of cheap building materials, discouraging luxury housing, and linking up employment programs with housing activities. The policy emphasizes the use of local materials, local skills and local technology and encourages informal sector housing. It also encourages community participation

in housing through cooperative housing or through the involvement of voluntary organizations.

Social Security

Article 41 of the Constitution provides that "the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in case of unemployment, old age, sickness and disablement, and in other cases of undeserved want."

The social security measures for the workers of the organized sector are (a) The Workman's Compensation Act 1923, (b) The Employees State Insurance Act, 1948, (c) The Employees Provident Fund and Miscellaneous Provisions Act 1952, and the schemes linked to it (such as Employees Family Pension Scheme 1971, Employees' Deposit-linked Insurance Scheme 1976, etc.), (d) The Maternity Benefit Act, 1961, and (e) The Payment of Gratuity Act, 1972. Except for the Workman Compensation Act, the measures do not cover the unorganized sector in which most of the poor work.

Social security schemes for the unorganized sector which employs about 90 percent of the labor force, have been of relatively recent origin, and one observes a spur in the schemes mainly during the last 10 years or so. These schemes have been introduced by the central and state governments for specific groups and specific areas. Their nature, coverage and administration differ from state to state. To provide social security to the poor, four types of schemes are in operation, namely employment schemes, social assistance schemes, social insurance schemes and welfare funds.

Employment Schemes: Employment generation is a measure that remedies the source of distress of the poor. A number of special employment programs, special self-employment programs, special wage employment programs, and employment schemes for the educated unemployed have been introduced. However, except for the Employment Guarantee Scheme of Maharashtra no other scheme provides a guarantee of work and therefore does not ensure minimum income security to the poor.

Social Assistance Schemes: These schemes provide security to the various categories of destitute such as the old, the handicapped, widows and others. Most of them are formulated and implemented at the state level.

Social Insurance Schemes: Life Insurance Corporation of India (LIC), General Insurance Corporation of India (GIC), and New India Insurance Company (NII) have introduced a few social insurance schemes in collaboration with the government of India or other State Governments. These schemes are for individual life insurance, group life insurance, life insurance-cum-pension, crop insurance and cattle insurance.

Welfare Funds for Social Security: Welfare funds have been created by the levy of cess on production or export of materials produced in those industries which are seasonal in nature and where production units are small and scattered. These funds provide welfare measures like health, education,

housing, recreation etc. as well as social security for old age and sickness. So far these funds have been created for (a) Mica Mines, (b) Limestone and Dolomite, (c) Iron ore, Manganese ore, and Chrome ore mines, (d) beedi workers and (e) cine workers.

Social Security Schemes at the State Level: Social security being a state subject, state governments have also formulated their own schemes. However, since information about these schemes was not available at any one place, the data presented here may not be complete. The most common social assistance schemes introduced by the states are Old Age Pension Scheme and Allowance to Destitute like widows and the disabled. The latter includes stipends for training and loans to rehabilitate them. Also West Bengal, Punjab, Maharashtra, Kerala, Tamil Nadu, Assam, Bihar, and Gujarat have also introduced unemployment assistance schemes for educated and/or uneducated unemployed youth for limited periods of time.

Among the Social Insurance Schemes implemented at the state level, the most common is the life insurance scheme and group insurance scheme for landless workers, small and marginal farmers and village artisans. The premium rates of these schemes are low and are partly or fully paid by state governments. In addition to this, a number of innovative group insurance schemes have also been introduced by several state governments, the major ones among them being Tamil Nadu's Insurance-cum-Retirement Benefit Special Scheme for the workers in the unorganized sector, Madhya Pradesh's Krishak Samoh Bima Yojana (Farmers' Group Insurance Scheme), Gujarat's Group Insurance Scheme for Employees of Small Shops and Establishments, Low-paid Employees Group Insurance Scheme of Uttar Pradesh, Punjab and Maharashtra, Forest Laborers' Scheme of Gujarat, Handloom Weavers' Scheme of Maharashtra, Grape Garden Workers Scheme of Andhra Pradesh, Beedi Workers Group Insurance Scheme of Maharashtra, Building Workers Scheme of Kerala, and the Construction Workers' Group Insurance Scheme of Andhra Pradesh.

Gujarat, Kerala and Karnataka have introduced maternity benefit schemes for poor, rural women which cover landless women workers under its purview and provides minimum wages for six weeks before and after delivery, free medical check-ups, free medicines to the mother and medical assistance to the child or cash benefits.

Social Welfare Programmes

Historically, social welfare activities started in India as voluntary action. In the immediate post-independence period, these were limited to the welfare of women, children, the old, and the handicapped. In the First Five Year Plan, a National Advisory Committee was set up by the planning commission to make recommendations for public cooperation and public participation in social welfare activities. Bharat Sevak Samaj, a non-governmental organization which is no longer active, was set up as per the recommendations of this committee. The Samaj was to provide a link between the people and planning.

In 1953, the Central Social Welfare Board (CSWB) was set up to coordinate assistance to voluntary welfare organizations and promote such

organizations where they do not exist. The CSWB is still an active organization, involved in social welfare activities for women, children, the old etc., and about 6,000 NGOs are working with it (1984).

The limited concept of social welfare gradually expanded with the realization that it also has to incorporate the concept of social development. Social welfare in the traditional sense was covered under "social defence" (the activities for women in distress, widows, orphans, the handicapped, the old, and the mentally retarded etc.); and other social welfare activities were taken up under the Ministry of Labor, Ministry of Human Resource Development, Ministry of Rural Development, Ministry of Civil Supply and even Ministry of Finance. These activities pertain to labor laws, distribution of essential goods, special development efforts for tribals, women, scheduled castes, and welfare funds for the workers of the unorganized sector.

Social Welfare Programmes for Disadvantaged Groups:

These programs are mainly for women, children, the old, scheduled castes/tribes, and the poor, including workers of the unorganized sector. It is important to note that these social welfare programs for specific groups of weaker sections do not limit their activities to social defence activities only. They also include activities meant for the development of these disadvantaged groups.

Welfare for Women:

Major government welfare programs for women include (a) programs for widows, old women, disabled women, female beggars and women in distress, such as service homes and widow homes etc.; (b) skill-training programs, condensed courses for skill formation and hostels for working women; (c) programs for the organization of women, such as Mahila Mandals (women's clubs), training camps for public cooperation, adult education and functional literacy camps; (d) programs pertaining to creches, day care centers, child care and child development, (e) family welfare program which is a comprehensive program covering mothers' health, child welfare and family planning, (f) DWCRA (Development of Women and Children in Rural Areas), a comprehensive program which generates employment for groups of women and also provides supportive measures such as reduction in drudgery, creches, child care and child welfare; and (g) the program of assistance to voluntary organizations working for women's welfare. These programs are run by the Ministry of Welfare (CSWB), Ministry of Human Resource Development and the Ministry of Rural Development of the Government of India. A special department for women's welfare has been created in the Ministry of Welfare, and a women's cell has been created in the Ministry of Labor. The Ministry of Human Resource Department has recently set up a National Commission on Self-employed Women. It is important to note that the report of the National Commission on self employed women and women in the informal sector has recently come out with detailed recommendations for improving the conditions of women workers in the unorganized sector, and a National Perspective Plan for women has been prepared by the Ministry of Human Resource Development (government of India) for the period 1988-2000 A.D.

Many state governments have introduced additional programs for women's welfare, and set up women's Economic Development Corporations with a view to expanding employment opportunities for them and providing related assistance in training, organization, credit, marketing and so on. Rajasthan government's innovative Women's Development Programme (WDP), which employs organizers for promoting and activating development activities for women, is worth noting in this context.

Children's Welfare: Major welfare programs for children, like the ICDS and related programs like ANP and SNP, are centered around health, nutrition, immunization, literacy and general welfare. In addition to these, there are (a) programs for disabled and handicapped children, foster care homes, orphanages, remand homes, and homes for beggars and destitute children; (b) programs for the recreation of poor children, such as holiday camps, games and sports etc., (c) creches for workers in mines, plantations, factories and also for rural children in a limited way and (d) welfare programs and rehabilitation programs for child labor. These programs are implemented through the Ministries of welfare, Human Resource Development, and Rural Development.

Welfare for ST/SC/Backward Classes: Special welfare programs for the scheduled castes, scheduled tribes and for socio-economically backward castes are designed both at the all-India level and at State levels. The component plan (for the scheduled castes), the Tribal Sub-plan and programs for tribal welfare (for the scheduled tribes), and programs for backward castes are the major programs in this context. A number of State Governments have set up special corporations like the SC Corporation, the ST Corporation, the Minority Board, and the SEBC (Socially and Economically Backward class Corporation) for specific backward communities. Major welfare activities for these backward sections of the population pertain to education (freeships, free uniform, mid-day meal, free books, subsidized/free residential schools and reservation of seats in higher education), health (free medical check ups, public dispensaries and hospitals, health education, nutritional guidance and assistance, and family planning), training and employment, and supportive assistance.

In addition to these corporations a state labor welfare board has been set up in each State for carrying out welfare activities for workers in the areas of health, education, training, recreation, etc. Gujarat has set up a separate Rural Workers Welfare Board for rural workers.

Labor laws for Protection of Workers: Government of India has enacted some important labor laws to prevent exploitation of specific categories of workers, mainly in the unorganised sector. These include the Minimum Wages Act, 1948; the Inter-State Migrant workers Act, 1979; the Bonded Labor Act; the Contract Labor Act; the Payment of Wages Act and the Equal Remuneration Act. Under the Minimum Wages Act there is a provision for declaring minimum payable wages to the workers of those employments in which they are paid very low wages. The Inter-State Migrant Workers Act ensures minimum facilities of work and wages to workers who migrate from one State to another. The Contract Labor Act controls the system of employing contract

workers by ensuring the minimum terms of their employment and minimum wages. The Bonded Labor Act aims at the abolition of the bonded system of work, releases the laborers from bondage and provides them support for rehabilitation.

The Child Labor (Prohibition and Regulation) Act, 1986 has prohibited child labor (about 5.2 percent of the work force of the country consists of child labor) in about 11 hazardous industries and industrial processes. Government of India, in collaboration with the ILO, has also taken up 10 comprehensive projects for the eradication of child labor from 10 hazardous industrial centers in the country.

Ministries of Labor at the center and at the state levels are responsible for enforcing these labor laws. As some of these laws are included in the 20-point program of the government, the enforcement situation is reviewed periodically. It is worth noting that Bihar and Gujarat have set up Rural Labor Commissionerates to enforce these laws in rural areas.

The Public Distribution System:

The Public Distribution System (PDS) is recognized as a strategy to control prices, reduce fluctuations in supply and achieve an equitable distribution of essential goods. By ensuring minimum consumption of essential goods to the poor, the scheme plugs an important point of exploitation of the poor who now no longer have to buy or borrow essential goods at high prices from village money-lenders, traders and rich farmers. The scheme has been included in the 20 point program of the Government. The main advantage of the PDS is that it enables the poor to consume essential goods at minimum/subsidized prices. Initially the scheme was implemented in urban areas, but since the 1970s rural areas have also been covered. Kerala was the first state to extend it to rural areas. Later on, Gujarat, Tamil Nadu, Andhra Pradesh, and Karnataka introduced the PDS in rural areas on a regular basis.

The central government has confined its responsibility to seven commodities, namely, wheat, rice, sugar, edible oil, kerosene, soft coke (for cooking) and controlled cloth. These seven commodities constitute the core of the PDS. The various policies and programs that help the PDS are (a) price support for agricultural commodities, and (b) procurement, buffer stocks and supplies of the essential products through the Food Corporation of India, the Union Ministry of Oil and Petroleum, the Department of Coal, the Central Agency for Soft Coke, and the central Public Sector Corporations for oil, oilseeds and controlled cloth.

The PDS is implemented through the departments of civil supplies at the central and state levels. At the Center there is also an Advisory Council which reviews the working of the PDS from time to time. All the states have set up Consumers' Advisory Committees at the State and district levels in some form or another for the supervision of the scheme. A full network of fair price shops has been set up in the country to support the scheme along with mobile shops in unserved regions.

Some state governments have made extra efforts to expand the scheme. Andhra Pradesh's schemes of (a) Mini Super Bazaars in urban and semi-urban areas (b) the rupees two a kg rice scheme and (c) a green card system for the poor to enable them to buy a number of essential goods at cheap rates; Kerala's full coverage of rural areas and elaborated PDS; Assam's Gram Panchayat Level Societies (GPL Societies); the Unnati Vitaran Scheme (a pilot scheme that covers 100 per cent population) of Punjab; and Gujarat's two-tier scheme for the poor and for the very poor are the important state level schemes of public distribution.

Government of India has a special approach for stabilizing consumption during droughts, which occur frequently in many parts of the country. This approach consists of (a) drought relief works or employment works for creating employment on a continuous basis on public assets, (b) special public distribution programs to provide food grains to drought workers, and (c) efforts for providing drinking water, and other essential inputs. Special resources are allotted by the government for drought relief on an emergency basis.

Organization of the Poor: Since the non-percolation of gains of development to the poor is often blamed on the absence of organization of the poor, a central scheme of appointing Honorary Rural Organizers was introduced in 1980 on an experimental basis. The functions of the honorary organizers are to educate rural workers about their rights and duties, and to motivate them to organize themselves as a trade union or a cooperative. Such organizers were expected to undertake employment/income generating activities, and activities in the areas of health, education, labor laws and family welfare. Initially the scheme was introduced in 415 blocks in 8 states. It was later extended to 1000 blocks in 14 states and union territories. Though the reviews conducted by the Central Labor Ministry do not show satisfactory performance of this scheme, so far the scheme has neither been modified nor terminated.

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