Proposed IDA assisted ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP)

Equity Plan

1. Introduction

Equity refers to differences that are unnecessary or reducible and are unfair and unjust. The Constitution of India provides its citizens the *Fundamental Right to Equality*, which includes within it the principle of equity, allowing the state to make special provisions for the advancement of any socially and educationally backward classes of citizens or for scheduled cases and scheduled tribes. Translating this right into reality, the GoI has introduced various constitutional safeguards (*Box* 1) and development schemes for creating an environment of equal access and opportunity for socially and economically disadvantaged sections of society.

Box 1: Constitutional Safeguards

The Constitution of India guarantees protection from social injustice and all forms of exploitation (Art.46). It guarantees equality before law (Art. 14), and enjoins upon the State not to discriminate against any citizen on grounds of caste (Art. 15 (1)). Untouchability is abolished and its practice in any form is forbidden (Art. 17). The Constitution mandates that no citizen shall, on grounds only of caste or race, be subjected to any disability and restriction (Art. 15 (2)). It empowers the State to make provisions for reservation in educational institutions (Art. 15 (4) and (5)), and in appointments for posts in favour of SCs (Art. 16 (4), 16(4A), 16(4B) and Art. 335). Reservation of seats for SCs in the Lok Sabha is provided under Article 330, in the State Assemblies under Article 332 and in the Local Self-Governments bodies under Articles 243D and 340T. In addition to the above, the Parliament has enacted the Untouchability (Offences) Act, 1955, renamed as Protection of Civil Rights Act, in 1976. To check and deter atrocities against SCs, the Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989 has also been enacted.

Source: Eleventh Five Year Plan (Vol I): 2008, Planning Commission, Government of India

In its efforts to bring about the socio-economic development of disadvantaged sections, the GoI has adopted a multipronged approach, which includes social empowerment through educational development; economic empowerment through income and employment enhancing avenues; protection through effective implementation of protective legislations and eradication of occupations such as manual scavenging; and holistic development through earmarking of funds proportionate to the population (Scheduled Caste Sub-Plan (SCSP) and Tribal Sub-Plan (TSP)). This approach has seen the development of specific schemes like the Backward Regions Grant Fund (BRGF), the National Rural Employment Guarantee Scheme (NREGS) designed to redress imbalances in development and between sections of society.

The Eleventh Plan too emphasises this approach and highlights the concept of *inclusive growth,* advocating for inclusive development and planning by all sectors. Inclusive growth demands that all social groups have equal access to the services provided by the State and equal opportunity for upward economic and social mobility. It

also necessitates actions to ensure that there is no discrimination against any section of our society.

2. Recent efforts to promote equity in ICDS

Adopting the principles of inclusive development, the MWCD, through its flagship programme ICDS, provides child development services (supplementary nutrition, immunisation, nutrition and health education, health check-up, referral services and pre-school education) to the most vulnerable groups of population including children upto 6 years of age, pregnant women and nursing mothers especially those belonging to poorest of the poor families and living in disadvantaged areas including backward rural areas, tribal areas and urban slums.

Initially designed to target only BPL (*below poverty line*) families for supplementary nutrition, the scheme has now been universalised, to include all children (0-6 years) and PLW irrespective of their social and economic status. However, recognising the special needs of the disadvantaged and marginalised communities, the scheme makes a special effort to target these communities. It was for this purpose that the Ministry recently revised the population norms for setting up AWCs and Mini-AWCs. AWCs are now allowed to be established for a population of 400-800, enhancing ease of access for beneficiaries. For difficult areas (tribal, riverine, desert and hilly and other difficult areas) this population limit has been further reduced to 300-800 for an AWC and 150-300 for a mini-AWC, facilitating the inclusion of left-out hamlets. Further, there is also a provision of opening up 20,000 AWCs on demand by the States for such population e.g. migrant labourers, nomadic tribes where there are 40 children in the eligible group who are required to be covered under ICDS services. The GOI has time-to-time advised the States to ensure universal coverage in ICDS through GIS mapping. The monitoring formats that have been revised by the MWCD recently include indicators on key service deliveries in respect of supplementary nutrition and pre-school education disaggregated by SC, ST and minority beneficiaries.

3. Equity Issues in ICDS and in ISSNIP

ICDS programme has been universalized covering almost all villages/habitations/ hamlets across the country through a network of about 1.4 million Anganwadi Centres (AWCs). As per NFHS-3 (2005-05), the ICDS services have reached a higher percentage of tribal (49.9 percent) and scheduled caste children (36 percent) as compared to children belonging to other groups (28.3 percent) (*see* Table 1). However, the use of health services such as immunisation and diarrhoea management were found much lower in the lowest wealth quintile index groups as compared to the highest wealth index group. The lower coverage of health services in the lowest wealth index group also corresponds with almost three times the higher prevalence of severe underweight and stunting in the lowest wealth index as compared to the others (Table 1). It is interesting to note that the data on the percentage of low birth weight is almost the same in the various population groups.

Table 1: Nutritional status of children < 5 years according to caste and wealth index (NFHS-3: 2005-06)[1]

Indicators	Total	Caste				Wealth Index				
		SC	ST	OBC	Others	Lowest	Second	Middle	Fourth	Highest
Weight for age %										
Below 3 SD	15.8	18.5	24.9	15.7	11.1	24.9	19.4	14.1	9.5	4.9
Below 2 SD	42.5	47.9	54.5	43.2	33.7	56.6	49.2	41.4	33.6	19.7
Height for age %										
Below 3 SD	23.7	27.6	29.1	24.5	17.8	34.2	27.9	23.1	16.5	8.2
Below 2 SD	48.0	53.9	53.9	48.8	40.7	59.9	54.3	48.9	40.8	25.3
Children age 0-71 months receiving any service from AWC (%)	32.9	36.1	49.9	30.3	28.3	36.7	35.9	35.7	30.3	15.6
Children age 12-23 months who received all vaccinations (%)	43.5	39.7	31.3	40.7	53.8	24.4	33.2	46.9	55.3	71.0
Children (< 5 years) with diarrhoea taken to a health provider	59.8	60.7	54.3	57.5	64.9	50.5	56.7	60.3	65.0	73.6
Low birth weight (LBW) (%)	21.5	23.7	22.3	21.3	20.7	25.4	25.4	23.7	21.8	17.4

The equity ratio, presented for selected indicators in terms of economic situation and rural-urban ratio (Table 2) also reveal that the ratio is higher in case of services such as use of skilled birth attendant or antenatal care. Similarly, availability of safe water and sanitation services show a wide variation between rural and urban and a high equity ratio.

Furthermore, a social assessment study[2] undertaken by the MWCD in 2008-09, as part of the preparation of the ISSNIP, revealed caste based discrimination in the provision of ICDS services as well as *exclusion* from ICDS services by beneficiaries of these communities on their own choice. This was seen to be related to the differential attitudes of AWWs and Anganwadi helpers (AWHs) to different caste groups. Marginalized communities not only had poor physical access to the ICDS centre but were often also excluded from the home visits undertaken by AWW. In addition, lack of awareness of service entitlements adversely influenced the marginalized communities coming forward to take benefits of ICDS services such as supplementary nutrition.

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[1] *National Family Health Survey (NFHS)-3: 2005-06. International Institute of Population Sciences (IIPS), Mumbai.*

[2] *Social assessment for the IDA assisted ICDS-IV/Reform Project, 2008, PricewaterhouseCoopers Pvt Ltd and CARE India*

Table 2: Nutrition, Health, Water Sanitation Indicators (NFHS-3)– *Equity Ratio*

Indicators	*Percentage*		*Ratio*
Weight for Age			
Gender (M/F)	42	43	1.0
Urban / Rural	33	46	1.4
Poorest / Richest	57	20	2.2
Antenatal Care (1 ANC Contact)			
Urban / Rural	89	69	1.3
Poorest / Richest	82	99	1.8
Skilled Birth Attendants			
Urban / Rural	74	38	2.0
Poorest / Richest	19	89	4.6
Safe water source			
Urban / Rural	96	84	1.1
Poorest / Richest	79	96	1.2
Piped Water supply			
Urban / Rural	48	11	2.2

Taking these issues into consideration, the project proposes to undertake various activities that address equity issues during Phase 1 of the project (Table 4). These actions will contribute to strengthening the ICDS programme in achieving equity in outcomes with a key focus on gender, scheduled caste, scheduled tribes, minorities especially Muslims, the economically backward, geographically isolated, migrants, and other groups.

The project has already focused some attention on equity by selecting 'high burden' districts as the project area. It will operate in 162 districts in 8 states with the highest malnutrition in the country. In addition, all these states plus the NCR of Delhi will have pilots in urban areas to develop effective strategies to address urban malnutrition which is often higher than that in rural areas, particularly among slum and migrant children. Thus, the pilots will be designed *to address the most vulnerable urban dwellers.*

4. Consultations

During Phase 1, the project will hold consultations with various stakeholders to help develop a number of proposed interventions and strengthen their focus on vulnerable groups. Consultations on activities to be piloted will take place with key stakeholders during the design and implementation of the pilots (Table 3).

Table 3: Consultations planned during Phase 1

Topic	*Stakeholders*	*Timing*
1) ICDS Programme Guidelines; Decentralized Planning Guidelines	State and district officials of ICDS and other departments, NGOs, PRIs	By month 9
2) HR reforms and operational mechanisms	Officials and functionaries of ICDS (all levels)	By month 18
3) Supervision tools and mechanisms	State and district officials, Trainers, CDPOs, Supervisors and AWWs	By month 18
4) Training (some already held)	Trainers, State and district officials and functionaries of ICDS and health depts.	By month 24
5) Convergence with Health (guidelines, tools, models, etc.)	National and State officials of ICDS and Health depts; district level officials of these and other relevant depts.	By month 12
6) National BCC strategy and State BCC Plans	State and district officials of ICDS and other departments, NGOs, PRIs, CDPOs, Supervisors and AWWs, field functionaries of related depts such as Health, Water & Sanitation, Rural development	By month 12
7) Community mobilization and social audit mechanisms	Community members, CBOs/NGOs, PRIs, functionaries of ICDS at district level and below, other departments with community-mobilization experience	By month 12
8) Convergent Nutrition Action activities	Line departments in GOI and state governments; other stakeholders (to be decided)	By month 6 + on-going

Table 4: Equity Action Plan for Phase 1

<table>
<tr><th>Project Actions</th><th>Equity Measures</th><th>Monitoring Indicator(s)</th><th>Responsibility & Timeframe</th></tr>
<tr><td colspan="4">Component 1: Institutional and Systems Strengthening of ICDS</td></tr>
<tr><td colspan="4"><u>1a. Equity Issues/Challenges</u>:
• Understanding of ‘equity’ among policymakers, professionals and programme managers and how to bring it about in day-to-day actions, is a challenge in any such programme of this magnitude (viz. ICDS), where it is extensive and touching the last service points in habitations/villages and more so vulnerable sections of the society;
• The sense of equity gets diluted when it comes to actual application of delivery of benefits in ICDS and more so when the society is heterogeneous in composition and iniquitous having large segment of population in the underprivileged group;
• ICDS functionaries do not always have sufficient motivation to serve disadvantaged areas or people and have limited sensitivity towards delivery of services to such groups;</td></tr>
<tr><td colspan="4">Equity Vision:
• Policymakers, programme planners, managers and professionals are made aware of the principles of equity and its adoption both in planning and its actual implementation;
• Measures such as district planning, social mapping of village/urban slums are undertaken to identify left-out areas/groups;
• Framework/guidelines for HR reforms and new approaches (e.g., PPPs) proposed in the project would address the need to reduce disparities and carry out relevant pilots.</td></tr>
<tr><td>i. Review and refinement of <u>policies, guidelines and procedures</u>; preparation of consolidated and harmonized guidelines</td><td>Ensure that policies, guidelines and procedures have clear mandates and adequate instructions (‘how to’) for ICDS to provide quality services to socially, economically and geographically most-disadvantaged groups</td><td>Inclusion of appropriate contents in all relevant documents</td><td>CPMU and SPMUs (where applicable) – by month 18 of project</td></tr>
<tr><td>ii. <u>Human Resource</u> reforms</td><td>Promote system of differential incentives (and TA-DA norms) for functionaries in the highest burden/remotest/ poorest areas</td><td>Guidelines issued for such incentives/norms</td><td>CPMU and SPMUs – by month 24</td></tr>
<tr><td>iii. Preparation of <u>decentralized planning</u> (DP) guidelines</td><td>Ensure DP guidelines focus attention on the worst affected areas and people in the district, and describe how to plan for them based on local data collection and contexts</td><td>DP guidelines include appropriate contents; District plans address needs of disadvantaged groups</td><td>CPMU and SPMUs - Guidelines by month 12; plans by month 30</td></tr>
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Project Actions	Equity Measures	Monitoring Indicator(s)	Responsibility & Timeframe
iv. Guidelines for CSO engagement in community mobilization, BCC, service delivery and monitoring	Consider special incentives for work (or rewards for achievements) in the remotest areas and among the most disadvantaged groups. Carry out pilots specifically for these areas and groups.	Guidelines for CSO engagement include appropriate contents;	CPMU - Guidelines by month 12;
1b. Equity Challenge: • *In ICDS training content, the subject of equity planning is limited to working with tribal populations.* • *Limited attention is directed to changing the attitudes of ICDS workers to deal with minorities /ST/ SC/other disadvantaged groups with sensitivity.*			
Equity Vision: *ICDS workers are trained to deal compassionately not only with SC/STs but also with other disadvantaged groups/minorities. Training plans of ICDS programme managers and frontline workers include issues pertaining to gender, social exclusion, migration, disability and geographical exclusion.*			
i. Strengthened training system	Training for all levels (including trainers and programme managers) to include a module on the need to focus on the most vulnerable, who they are, and *how* they can be served (i.e., 'equity planning and implementation,' particularly for AWWs, ASHAs, ANMS, etc. to provide services to at risk and excluded households); The training needs assessment (TNA) includes study of Knowledge, Attitude and Practice (KAP) of functionaries on social exclusion.	Completion of: TNA with equity related questions and analysis; review of training contents; training modules with appropriate contents	CPMU with training institutions; TNA by month 12; review of training contents by month 15; modules prepared by month 24
ii. Strengthened convergence with health	Convergence guidelines and tools at the village level to focus on excluded groups and households and those most at risk, and cover all key ICDS and health services	Inclusion of appropriate contents in convergence guidelines and tools	CPMU with MOHFW – by month 12
iii. Innovations and pilots	Support pilots in most disadvantaged areas such as dispersed villages, SC/ST hamlets, very large villages in arid zones, urban slums	Relevant pilots designed and implemented	CPMU/ SPMUs; pilots started by month 12; completed by month 36

Project Actions	Equity Measures	Monitoring Indicator(s)	Responsibility & Timeframe
1c. Equity challenge: *Data are not disaggregated or analyzed for differences between social groups for use in planning, implementation and monitoring.*			
Equity vision: *Disaggregated data are used at the local level to ensure coverage of disadvantaged households, and collated upwards as needed for planning and programme management. Both MIS (programme) data and surveys/studies provide robust information on differences between groups and changes over time.*			
i. Strengthened and expanded monitoring system	Pilot mechanisms to facilitate universe coverage of target groups, such as joint mapping by ICDS and health functionaries at the SC level, GIS mapping etc, The MIS to capture data for all households with PLW and 0-6 children, disaggregated by socio-religious groups, location, etc. Baseline/end-line surveys to include all related socio-economic variables and additionally other information on mothers education, income level, occupation etc that have proven evidence on the nutritional status of children. *(as part of project M & E)*	Disaggregated data (DD) registers, formats and reports (prototypes) available and pretested; training materials prepared for DD collection and reporting. BLS, ELS include specific social & economic variables and full analysis.	CPMU (with SPMUs, training and evaluation consultants) – formats etc. by month 12; training by mo. 18 BLS, ELS as planned
Component 2. Community Mobilization and Behaviour Change Communication			
2a. Equity challenge: • *Communication strategies and plans are often based on KAP studies of the general population. Understanding of the needs, KA, or receptivity of SC/ST/ minority/other disadvantaged groups and formative research with them is limited.* • *Community mobilization has been limited by poor understanding of the constraints faced by these groups in participating in ICDS activities, adopting positive nutrition and child development practices at home, etc.*			
Equity Vision: *Formative research, KAP and communications studies are done with appropriate SC, ST, minority, poor groups. Their unique social, cultural and environmental issues are taken into consideration in the development of the community mobilization and BCC strategy and plans of action, covering both home-based and anganwadi activities.*			

Project Actions	Equity Measures	Monitoring Indicator(s)	Responsibility & Timeframe
i. BCC strategy and plans	Ensure formative research studies socially and economically disadvantaged groups in different contexts specifically, and appropriate messaging and understandable media (including language, pictures, etc.) for the excluded groups;	Formative research covering excluded groups completed; BCC strategy and plans based on the research and include appropriate contents	CPMU and SPMUs + consultants; strategy by 12 months; BCC materials by 24 months
ii. Community mobilization to participate in programme activities	Ensure community mobilization covers the excluded and vulnerable groups; focus home visits (HV) on the 'unreached,' most disadvantaged households, biologically most vulnerable	Community mobilization and home visit guidelines describe clearly how to reach and serve these groups; at least 1 pilots done to test their effectiveness	CPMU and SPMUs + consultants; CM and HV guidelines by month 9; pilot completed by month 36
iii. Social audits and Social agreements	Pilot mechanisms that ensure involvement of excluded groups in social audits and social agreements at village level	At least 1 pilot completed for social audits and 1 for social agreements	CPMU and SPMUs + consultants; pilot begun by month 12 and completed by month 30
Component 3. Convergent Nutrition Actions			
3a. Equity challenge: *Households most at risk of under-nutrition require many inputs simultaneously to address poverty, health, nutrition, sanitation etc.*			
Equity vision: *The available relevant public sector interventions and schemes (supplemented by private initiatives where necessary and feasible) focus on the most needy villages and households, individually and together (in convergence) where applicable.*			
Convergent Nutrition actions	The framework and pilots of the convergent nutrition plans will ensure that interventions by other line departments focus on the disadvantaged groups/areas. Ensure collection/use of disaggregated data, proper planning and good impact evaluation to show results by categories of beneficiaries.	Impact evaluations of convergent nutrition actions to cover social/ economic variables.	CPMU and SPMUs; Completed by month 36
Component 4. Project Management			

Project Actions	Equity Measures	Monitoring Indicator(s)	Responsibility & Timeframe
Staffing	CPMU and SPMUs to include Technical Consultant having Social Development background to ensure equity focus of project activities, monitoring them and providing reports, working with all 'component' specialists, and interacting regularly with lower levels (C→S, S→D) to keep them focused on this issue	Staff in position at CPMU and SPMUs	CPMU – by Effectiveness; SPMUs – by month 9
Grievance redressal (GR)	Excluded groups to receive information about services they could receive, and know where to go to resolve grievances	Messages and media identified and piloted, along with a system for GR	CPMU and SPMU – by month 24

CPMU: Central Project Management Unit; SPMU: State Project Management Unit