Whose Public Action?
Analysing Inter-sectoral Collaboration for Service Delivery

Identification of Programmes for Study in India

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ACRONYMS

ANMs	Auxilary Nursing Midwives
APL	Above Poverty Line
BMC	Bombay Municipal Corporation
BPL	Below Poverty Line
CAPE	Comprehensive Access to Primary Education Project
CBO	Community Based Organsiations
CDO	Community Development Officer
CHC	Community Health Centres
CLHI	Community-led Health Initiative
CRSP	Central Rural Sanitation Programme
DIET	District Institutes of Education and Training
DSS	Door Step school
DPEP	District Primary Education Programme
DRU	District Resource Unit.
EGS & AIE	Education Guarantee Scheme and Alternative and Innovative Education
ESIS	Employees' State Insurance Scheme
FNGO	Field NGOs
IEC	Information, Education and Communication
IED	Integrated Education for the Disabled
ISRO	Indian Space Research Organisations
IWSD	International Water and Sanitation Decade
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
LJP	Lok Jumbish Project
MNGO	Mother NGO
MoU	Memorandum of Understanding
MPW	Multi Purpose Worker
NCERT	National Council for Educational Research and Training
NFE:	Non-Formal Education
NGPA	Non Government Public Action
NPE	National Policy on Education
NRHM	National Rural Health Mission
PHC	Primary Health Centres
PHU	Primary health units
PoA	Plan of Action
PPC	Public-Private Partnership Cell
PRI	Panchayati Raj Institutions
SCOVA	State Standing Committee on Voluntary Action
SKP	Sashiksha Karmi Project
SSA	Sarva Shiksah Abhiyan
TSC	Total Sanitation Campaign
UEE	Universal Elementary Education
ULB	Urban Local Bodies
VAMBY	Valmiki Ambedkar Awas Yojana
VGKK	Vivekananda Girijan Kalyan Kendra
VHC	Village Health Centres

Identification of Programmes for Study in India: Initial Notes

This note provides an analytical overview of specific programmes within the three sectors of the NGPA research study: primary education (non- formal education), primary health (primary health care centres) and water and sanitation (urban sanitation). The purposes are to trace the emergence of the non-governmental sector in the specific programme and to provide a base for the in-depth case studies.

The note is based on several rounds of discussions with experts, relevant government officials at the policy and programme management level, and heads and senior management teams of NGOs in Delhi, Bombay, Pune and Bangalore. The note will also refer to several research reports (published and unpublished), government documents as well as the previous work of the team on non-state service providers (Nair 2004).

Section 1: Non-Formal Education

1. The state and non-formal education

1.2 Definition of NFE in the Indian context

The term Non-Formal Education (NFE) in the Indian context applies to education of out-of-school children and is described as an organised activity that takes place outside the traditional framework of formal education system. As such, it is said to be flexible in terms of organisation, teaching methods and contents, target group of learners, evaluation procedures, etc., all of which is expected to enable it to reach out to the hardest-to-reach group of children, in both rural and urban areas. In this sense the definition has come to include all children who are drop-outs from the formal system of education because of economic and cultural compulsions, or who have stayed out of the system, again for socio- economic reasons or because they do not find primary schooling attractive or meaningful. It brings within its scope a range of children including those who assist in domestic chores and attend to siblings, or lend a helping hand in contributing to the family income. It also includes children from scattered habitations with population below the permissible school norms, drop outs and over-age children. NFE has, thus, been coceptualised as an alternative to formal education for these children in order to achieve universalisation of elementary education.

'Formal education' on the other hand is the structured system of the country, stretching form the pre-primary to the higher university levels; it also includes technical and professional education. In spite of its 'formality', this system is also characterised by a lack of uniformity in both learning materials and methods. Somewhat similar to the non-formal system, there are sub-regional variations in the formal education system across the country, largely dependent on the socio-political characteristics of specific regions[1].

[1] Private schools are mostly English-medium and opt for the CISCE Board common across the country, while all central government run schools as well as some private schools students write the all-India CBSE exam. The various state government and aided schools within states on the other hand are affiliated to the

Thus, currently there are over 28 Examination Boards at the elementary school level operating in India. This unequal formal system has been the focus of many policies and civil society movements since 1964, and efforts have been made - with out much success so far - to set up, what has been termed a Common School System, guaranteeing equity in education and equal opportunities.

1. 3. Evolution of the NFE concept as a State supported programme

Pre 2000: emergence of a State initiated NFE programme

The need for a non-formal type of elementary education was articulated as far back as the mid-1940s as part-time education for those who could not avail the benefits of full-time schooling. The issue was brought into the forefront of debates again during the mid-sixties, by the Education Commission (1964-66), which recommended the adoption of a flexible programme of part-time education at the elementary stage for all children in the age-group 11-14 who could not complete the lower primary level or were not attending school. Interestingly the Commission also suggested that the content of the NFE course should be determined according to the needs and capacities of the learners and that part-time education for a period of one year should be made compulsory. However, in spite of strong recommendations no such programme emerged until some large-scale pilot initiatives were undertaken during the 1970s. These seem to have influenced the State to acknowledge the need for creating a non-formal school system, in order to ensure universal elementary education.

The first efforts of significance were made by the National Council for Educational Research and Training (NCERT) which developed an early model of NFE in Bhumiadar, integrating education with the environment. NCERT, followed this by setting up a large number of NFE centres in different parts of the country through a network of Regional Colleges of Education and Field Officers. During the same period the 'Madhya Pradesh Model' of part-time education for children in the age-group 9-14 was developed in Madhya Pradesh. This adopted a condensed version of the course followed in the formal primary schools and was to be completed in two years instead of five. This scheme is said to have received the full support of the state bureaucracy and to have been effectively implemented by the state government.

These early State initiated experiments culminated in the development of a centrally sponsored NFE scheme in 1978-79 (just prior to the start of the Sixth Plan) on a large scale (after an initial pilot phase) in the educationally backward states of Andhra Pradesh, Assam, Bihar, Jammu and Kashmir, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. It was eventually extended to the educationally backward pockets of the remaining states. Known as the '*Experimental Projects for Non-Formal Education for Children of 9-14 Age-group for Universalisation of Elementary Education'*, the scheme focused on ensuring participation of all `out of school' children including those living in small, unserved habitations and others including working children, migrating children, street children, adolescent girls etc who were out of school. It also advocated the adoption of the Madhya Pradesh Model for NFE. Almost at the same time, another nation-wide project known as the `Comprehensive Access to Primary Education (CAPE) Project' was launched by the central government for the large scale production of local-specific and problem-centred learning materials. Although, subsequent evaluations indicated that the sheer scale of the project, over-ambitious

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State Examination Boards.

targets and the dependence on the bureaucracy for implementation did not allow it to deliver as effectively as envisaged, the project itself was unique in terms of it its non-formal and decentralised approach to curriculum development for the NFE centres.

The State promoted NFE programme continued and expanded in scope, with no major changes but with periodic revision in norms, for a period of 22 years (until 2000). In 1986, the National Policy on Education (NPE) was formulated, which reiterated the role of NFE as a critical component in the overall strategy for achieving UEE in India. The focus was on equal access to elementary education in small and inaccessible habitations; and NFE was to mainstream children in these locations. The scheme was revised in 1988 and extended to include urban slums, hilly, tribal and desert areas, and projects for working children in other states and union territories. Subsequently, in 1992, six year after the formulation of the NPE, when the Programme of Action (PoA) was developed, it clearly outlined strategies to strengthen and consolidate the scheme. This included micro-planning for opening NFE centres and community participation in the identification and supervision of the centres. Besides, it recommended that different models of NFE be developed for different categories of children, while at the same time establishing linkages with mainstream schools to facilitate the lateral entry of students from NFE centres. Therefore the level of learners' achievement in the informal schools had to be the same as that for formal schools.

The programme was thereafter expanded and consolidated in the subsequent Plans to cover all the states and union territories and continued to be implemented until the year 2000 when major revisions were made. By the year 2000 more than 303,800 NFE centres were being run across the country by state governments and their agencies in 25 states and by 826 NGOs. Of these, 7,800 were reported to be upper primary level NFE centres, run by the state governments and NGOs, and 58,000 were primary level NFE centres run by NGOs alone. Besides, 41 experimental and innovative projects were also being implemented by NGOs. Together they catered to the needs of over 7,400,000 children in the country.

Structure of the NFE programme

Under the programme NFE centres were set up in rural areas and urban slums. Centres were also set up exclusively for girls. Local instructors with modest academic qualifications were hired on a small honorarium while the community was expected to provide space for the centres. The centres were run at locally convenient times for a couple of hours a day and six days of the week. Teaching-learning materials and stationery were provided free of charge, while provision for testing of children to facilitate entry into formal schools was also made. A supervisory structure was developed consisting of a supervisor, project officer and district and state level functionaries. Provision for testing and certification of children of NFE centres to facilitate their entry into formal schools was also made. Instructors were provided with training by District Resource Units (DRU) in District Institutes of Education and Training (DIETs). The voluntary sector was encouraged to participate and, while states were given a 60 percent grant, the NGOs were provided with 100% assistance directly from the central government. Some marginal changes to funding norms have been effected over the years, and the minimum age lowered to cover all children in the age group 6 to 14 years of age; however, by and large the structure remains the same.

1.4 NFE in State and donor aided initiatives

The concept of NFE was also adopted outside the centrally sponsored programme in various states and urban centres and was mostly externally funded. During the 1980s and 90s the following major initiatives were undertaken with a strong NFE component:

Shiksha Karmi Project (SKP) in Rajasthan was launched in 1987 (SIDA supported) to improve and ensure access to primary education in the remote, inaccessible and backward villages of Rajasthan where formal schools were non-existent or were not functioning. Day schools, Prehar Pathshalas (schools of convenient timing) and Aangan Pathashalas (Courtyard Schools) were opened. They provided non-formal education to out-of-school children in the age group 6-14 years who were unable to attend day school due to socio-economic and cultural constraints. An evaluation in 2001 found that the project catered to 2700 day schools, 4335 Prehar Pathshals and 97 Angan Pathshalas. It sought to combine the flexibility of NGOs with the legitimacy of the official government system and to demonstrate the effectiveness of NGO-government partnership by bringing the strengths of each into the programme. The evaluation concluded that the project could be seen as a strategy for non-formalising a formal and hierarchically run system with the partnership of various stakeholders. The project has now been adopted as an approach by the state.

The *District Primary Education Programme* (DPEP) was launched in the early 1990s. It was assisted by the World Bank and European Union, and aimed to operationalise the strategies for achieving UPE/UEE through district plans. It opened 10,000 new formal schools and over 56,000 alternative schools covering 2,000,000 children besides conducting 20,000 bridge courses

Lok Jumbish Project (LJP) in Rajasthan, again with a focus on UEE through a community-based and decentralised approach, was launched in 1992 (supported by SIDA, GOI & GOR) and an NFE component was introduced in 1993. At its peak the programme covered about 20,000 children through approximately 1500 NFE centres and the model is considered as a feasible design for providing primary education to out-of-school children who are working or have crossed the school admission age. Its strengths were considered to be the fact that the model stresses parity with the formal system and quality education, that centres were opened on the basis of community-based school mapping and micro-planning exercises, and that experienced and innovative NGOs were involved.

Janshala Programme, in collaboration with the Government of India and five UN agencies – UNDP, UNICEF, UNESCO, ILO and UNFPA – was created to provide programme support to the efforts towards achieving UEE in urban areas. It was a community-based primary education programme, aiming to make primary education more accessible and effective, especially for girls and children in deprived communities, marginalised groups, scheduled caste and scheduled tribe minorities, working children and children with special needs.

The Education Guarantee Scheme (EGS) in Madhya Pradesh was launched in 1994 and built on the concept of community demand and participation. Initially designed specifically to address the issue of access, it adopted a fast track approach and evolved into evolved into a programme that guaranteed quality education. The strategy was to

empower the communities to demand quality education, while simultaneously linking up the process with local self-government institutions. It went to scale within a short period of its start and by the year 2000 over 26,550 EGS Schools were created (42% tribal given the huge tribal population in Madhya Pradesh), run by local resource persons (*guruji*) trained and positioned for this purpose. An evaluation (Ramachandran, 2004) concluded that the programme had a number of elements to its credit, including the fact that it was completely state government inspired, owned and implemented and not linked to grants from Government of India or external donors. It is stated to be an unique example of effective social sector planning, based on community demand and management by the PRIs. However, Ramachandran (2004) notes that the EGS experience indicates that to sustain structural reforms in one sector, reforms in governance (local self-government in this case) must follow.

1. 5. Post 2000: Education Guarantee Scheme & Alternative and Innovative Education (EGS & AIE)

NFE went through a major revision in the year 2000, the primary reasons for this being:

- Rigidity of the existing approach as well as norms for NFE which led to a lack of flexibility in the organisational procedure followed across states;
- Low coverage of out-of-school children in the age group 6-14 (less than 10 %);
- Low investments, problems in release of funds, etc;
- Lack of involvement of the community and the PRIs;
- Weak linkage between the formal schools and the NFE centres that inhibited lateral entry to formal schools and a low transition rate from NFE centres to formal schools;
- Above all, poor quality of the teaching-learning process in the NFE centres as a result of which the children from these centres could not compete with those in mainstream schools.

These limitation were more glaring when viewed against experiences like Lok Jhumbish, Shiksha Karmi, EGS, DPEP and other innovative schemes implemented by NGOs, wherein flexible strategies of alternative schooling showed that these programmes could be implemented with reasonable quality. One of the key lessons that seemed to have influenced the subsequent revision of NFE was the fact that the quality aspects of NFE needed to be addressed. This would include appropriate teaching-learning materials and pedagogy for the multi-grade and multi-age situation in NFEs; improved capacities of teachers; increased teaching hours; and effective and sustained academic support and monitoring.

The revised NFE programme - the ***Education Guarantee Scheme and Alternative and Innovative Education (EGS & AIE)*** - became a critical component of the Sarva Shiksah Abhiyan (SSA), the Indian version of Education For All.[2]

The objectives of SSA was to ensure that all children were in regular schools or EGS Centres, Alternate Schools, or Back to School camps by 2003 and all children who went to these centers would complete five years of primary schooling by 2007 and eight years of schooling by 2010. The EGS & AIE in turn provides for opening EGS schools in unserved habitations (no schools within a radius of 1 km.). A point of departure from the

[2] The SSA also subsumed all existing programmes, including externally aided programmes. The World Bank and DFID pool in resources at the Central Government level.

earlier approach to NFE is the focus on adopting diversified strategies for out-of-school children, including bridge courses, back to school camps, seasonal hostels, summer camps, residential camps, sugar schools for children of migrant workers, multi-grade learning centres, drop-in centres for children in difficult circumstances, mobile and remedial coaching and support to *Maktabs/Madrasas.* Besides, with the SSA's emphasis on improving the quality of education, EGS/AIE aims to improve classroom processes and management so as to raise the quality of non-formal education to the level of the formal education system. However, as in the earlier NFE, it continues to have three components i.e. (i) state-run EGS centres, alternate schools and back-to-school camps; (ii) learning centres or alternative schools run by voluntary agencies, including NGOs; and (iii) experimental projects for innovative pedagogical strategies implemented by the voluntary agencies.

The funding for the EGS and AIE scheme is shared on a 75:25 basis between the central and state governments (from the overall SSA budget) for all the state-run EGS centres/schools, AIE centres and other interventions for alternative schooling. As earlier, it provides 100 percent funds to voluntary agencies or NGOs running alternative education centres/schools and for implementing experimental and innovative projects. Annual investment per child was raised from Rs. 375 to Rs. 845 at the primary level and from Rs. 580 to Rs. 1,200 at the upper primary level.

The new approach was adopted in the Tenth Five Year Plan.[3] Some of the recommendations of the Steering Committee on Elementary and Adult Education (2001) in the Tenth Plan, relating to the urban areas and NGOs are significant in this regard. These include:

- Convergence between government departments of education, social welfare, health, police, railways, labour, urban development, and the municipal corporation;
- Opening of new schools and EGS centres based on the need of the area in cities; initiating bridge courses, transition classes, camp schools etc., with the help of private sector educational institutions and NGOs working in the area;
- Evolution of a mechanism to set up seasonal schools at the site of work of migrants such as sugar schools, brick kiln schools etc.,
- Continuing profile of the Scheme of Support to NGOs wherein NGOs would provide resource support to literacy programmes through resource centres and actual implementation of programmes in areas which are not covered otherwise under the schemes. NGOs are also expected to take up more innovative projects, which would serve as examples for making policy changes.

Some of the state specific Alternative Schools that have emerged are: the Education Guarantee Scheme in Madhya Pradesh, Orissa, Uttar Pradesh, the Maavadi in Andhra Pradesh, Multi- Grade Learning Centres in Kerala, Shishu Shiksha Karamsuchi Kendras in West Bengal, Contract Schools in Maharashtra, and Rajiv Gandhi Swaran Jayanti Patshalas in Rajasthan.

[3] A total of Rs. 522,800 million has been budgeted for elementary education, including NFE under the Tenth Plan

2. NGOs in non-formal education

2.1 Types of State-NGO collaboration

As a broad policy, in India the State enters into partnership with NGOs within the education sector with the aim of achieving participatory development and taking some of the burden off implementation from the State and its administrative departments. The nature of the State is thus found to have played a critical role in shaping the relations between the State and NGOs. The State was positioned to influence the development agenda and hence not only set the framework for development but also defined the NGOs' role within this framework (Sen 1999). The previous study on non-state provisions (Nair 2004) observed that three types of government-NGO collaborations emerged in the process.

The first model is collaboration between a 'high-profile' NGO and government wherein the State initiates the collaboration, with the established credibility of the NGO giving the latter greater clout as well as autonomy in the relationship. Besides, such NGOs are also financially independent of the government. The relationship generally graduates from an informal arrangement in the early days when the NGO is piloting approaches in a small way to a collaboration based on a formal contract or agreement. Such NGOs also are often able to make a significant impact at the macro or policy level. Often support provided by an individual in the State Department and a 'proactive' relationship between the NGO (again generally an individual) and the department facilitates the relationship. Some examples are:

- *Eklavya,* in Madhya Pradesh initially collaborated to upgrade science teaching in 16 government middle schools in the rural areas of the state and subsequently expanded to a 1000 government schools in 15 districts, until the collaboration came to an abrupt end in early 2000, due to differences. Its activities ranged from writing text books to developing a science teaching method.
- *MV Foundation* in Andhra Pradesh started activities in three villages in Andhra Pradesh and expanded to cover 500 villages. Its influence on the state government in matters relating to child labour and elementary education is considerable.
- *Bodh Shiksha Samiti*, working in the slums of Jaipur, developed a model for quality primary education and negotiated with the government to start pilot programmes in ten municipal schools of Jaipur. The model is now replicated in all urban areas of the state under a joint UN agencies initiative, with Bodh providing training and resource support.
- *Pratham* in Mumbai was started on the initiative of the Municipal Corporation of Greater Mumbai, UNICEF, slum dwellers and some concerned citizens. It subsequently emerged as an independent NGO with considerable resources generated from the corporate sector and individual donors. It has now extended its activities to several states and to both the urban and rural areas. Pratham's support in the initial years came from UNICEF and currently the ICICI Development Bank provides parenting support.

As indicated in Nair (2004) report and as verified during initial interactions with NGOs in Mumbai and Pune, the NGOs' contribution is in the nature of curriculum development,

pedagogy, teachers' training, improved management, assessment systems and also facilities and resource persons within the school system. The state provides funds (now as prescribed under SSA and its EGS & AIE component) and allows the NGOs to use the existing infrastructure, appropriate teacher time, etc. NGOs also often intervene in existing government schools rather than setting up parallel structures or systems. Tensions within these partnerships exist generally because of a lack of commitment of the bureaucracy, the differing ideology of the NGOs, inefficient administration and flow of funds.

The second model is that of a State-created and registered NGO (generally also termed as a special purpose vehicle). Conceptually an NGO it, however, continues to be managed by bureaucrats and officials on deputation from the government together with contracted consultants. The Baljyothi Project in Andhra Pradesh is a case in point. While this kind of arrangement brings in some flexibility of approach and procedures relative to the purely government structure, it falls short of adopting the NGO spirit of innovation and proactive community participation.

In the third kind of model, diverse kinds of smaller NGOs are coordinated through an autonomous body created within a government project as in the case of SSA. Within this model itself two categories of NGOs are present. The first category consists of NGOs that are hired to run non-formal or alternative centres. While these NGOs are often small with a limited local base, and work within the guidelines and tight funds prescribed, there are some that have moved on to relatively higher levels, both in terms of coverage and influence. Akshara Foundation and Doorsteps, both having a base in Mumbai and Pune, are two cases in point. The second category within this model consists of those that are exclusively involved in developing teaching-learning materials and modules and undertake training. They are well funded (generally by external and corporate donors) and have relatively good capacities. Such NGOs have flexibility to innovate and a relatively better managed contract because the outputs are more tangible in terms of modules, learning materials etc. Nalanda in Lucknow is one such a case.

The initial scoping also revealed that the categories are not exclusive and that NGO-State relationships move along a continuum, based on several factors. Besides, there are others who refuse to be defined by these categories. These are NGOs (smaller in number) that largely work outside the government system, have different goals, learning methodologies and apparently do not specifically aim to get children into mainstream schools. Katha and Room To Read in Delhi were reported to be two such NGOs.

Katha, established in 1988, primarily works in the areas of language, culture and translation, as well as poverty alleviation. They have creatively used stories and storytelling as powerful tools to bring about change in all their areas of work including classroom practices. Story-telling is the pedagogy they use. They work with more than 60 communities and their children in the age group of 0-17 (0 to 17?) in Delhi through their School on Wheels. The uniqueness of their approach is the efforts to involve parents and the whole community and the creative use of newspapers, magazines, books, etc, instead of the regular curriculum and learning materials. Hence every lesson is a new one. Similarly, *Room to Read India*, an international NGO, established in India in 2003, focuses on establishing Reading Rooms (libraries)[4], in Delhi and in the rural

[4] Other programmes include establishing computer rooms, publishing reading material in local languages and funding girls education through scholarships

areas and urban slum communities of the states of Rajasthan, Uttaranchal, Madhya Pradesh, and Himachal Pradesh, in collaboration with local partners. However, a closer look at the Katha reveals that it is not completely outside the State system because it receives resource support from the Delhi Government, the Government of India, besides the European Union and other international NGOs and corporate entities, while most of Room to Read centres are located in government schools.

2.2 NGOs in Education in Mumbai

NGO work in education in Mumbai appears to have started in 1970 when the College of Social Work started to work with some municipal schools in parts of south Bombay with funds from other NGO funding agencies. Subsequently in 1979, fifteen other centres were opened at the behest of the Municipal Commissioner and funds from the Municipal Corporation, appropriated from the Corporation's budget for 'remedial education'. Together the fifteen centres are reported to have covered 80, 000 children. In 1985, the Education Department of the then Municipal Corporation of Greater Bombay took over responsibility for the project and set the stage for large-scale collaboration in the future. The NFE centres and the appointment of Community Development Officer(CDO) have all been credited to these initial projects.

Although studies indicate that Bombay traditionally has seen the emergence of a large number of NGOs, NGOs working exclusively on education are very few. In most cases educational activities are part of broader initiatives for slum and street children, most of which emerged in the mid-1980s. Some of these are:

- *Amchi Kholi* set up in 1989 by the Women's Committee of the railways primarily for runaways and street children. Recreational activities and NFE are some of its interventions.
- *Rotary Club* of Bombay initiated a Project Mainstream with 70 other small NGOs to reach out to 11000 street children with non-formal education together with some income generating activities.
- *Sneh Sadan* a rehabilitation centre run by Christian Missionaries with funds from the corporate sector. NFE is part of several other activities.
- *YUVA,* set up in 1984 and working with slum communities for overall empowerment, tenure rights, etc. It also runs homes for street children and conducts NFE classes.
- *Akanksha Foundation,* started in 1991 and currently running 51 Akanksah centres in Bombay and Pune through its school projects. The centres use underutilised spaces to conduct classes (2.5 hours a day) for children using non-formal and innovative methods. Subsequently they integrate children into formal schools. It has a large cadre of trained teachers assisted by volunteers. Its other porgrammes include the Mentor Programme (which pairs each Akhansha child with a corporate mentor) and the Social Leadership Programme. It also has a School Project, within the formal school system (Municipal Schools in Bombay and Pune) primarily to improve the quality of education. Started with voluntary efforts, it is now a professional organisation that boasts of corporate sponsors and funding.
- *Save The Children India* (STCI) established in 1988 and working with both children and women in the area of health nutrition, education and vocational training. Its Balwadi Programme seeks to provide quality elementary education

through 125 centres in Bombay and to mainstream children into formal schools. 60 Study Centres impart remedial classes for students from class 1 to 7 studying in the formal system.

Two other NGOs, also based in Mumbai and shortlisted for the study, are Door Step School and Pratham.

Door Step school (DSS)

Door Step was established in 1988 by a group of academicians (a teacher and her students) and professionals working in the social development sector. It largely works with slum communities to address the issue of their children's inability to attend schools. The founders' experience in the public school system and the slums of Mumbai led them to set up a voluntary organisation exclusively devoted to the cause of education with the goals to 'eradicate illiteracy' and 'improve the quality of learning at the primary level'. The target group were children between the age of 3 and 18 years. In 1993 DSS extended its activities to the slums and poor communities of the fast growing city of Pune in Maharashtra.

The objectives of the organisation are to address the problems of non-enrolment and low quality of learning in the public school systems; provide alternate educational facilities to out-of-school children; provide facilities for improving literacy skills for children, falling both in the school going and non-school going categories; and to provide services at flexible timings and at suitable locations (in slums/pavements/streets). Hence it focuses on three major needs of (i) school enrolment, (ii) education for those not in school and (iii) retention, through its Balwadi (pre-school) Programme, Study Classes for children enrolled in municipal schools, Non Formal Education, and Adopt a School Project.

Pratham Mumbai Education Initiative

Pratham was set up as a Public Charitable Trust for universal primary education in Mumbai in 1994. Pratham's mandate was to generate a societal mission to achieve universal primary education. The uniqueness of the organisation is that it was initiated by the Municipal Corporation of Bombay and was supported by UNICEF for the first three years. A Public Charitable Trust was formed by the Commissioner of the Municipal Corporation of Greater Mumbai together with the association of several prominent citizens of the city. The Municipal Commissioner remained its ex-officio chair and was active during the early years. Subsequently, the 'parental' role of Pratham was taken over by the ICICI Bank. From the slums of Bombay, Pratham quickly moved outside the city into other parts of the country by the year 2000, and is now poised to go almost nation-wide. At present it is active in about 14 states. While Pratham Bombay is the parent and founding organisation, Prathams elsewhere are set up as autonomous organisations working within the broad framework and mandate of Pratham.

The objectives of Pratham are based on certain guiding principles, namely universalisation of elementary education, an organisational methodology based on a mission mode, partnership with government, raising resources from the city as far as possible, low costs, sustaining change and the ability to replicate. It aims to fulfil its objectives through a number of programmes, including *Balwadi Pre-School Program; Balsakhi Remedial Education Program* designed to help children who are identified as lagging behind academically; *Bridge Course Program* designed to "bridge" the gap to help prepare and support out-of-school children; *Pratham Education Center* set up in areas where there no schools or where the schools are over-crowded; *Outreach*

Program for child labourers, street children, pavement dwellers and children in conflict with the law; *Computer Assisted Learning* for children in municipal schools who have no access to computers; and now its most widely known *Reading Programme to* help children to master the basic art of reading in Marathi and other local languages.

The organisation is based on a triangular partnership: the government, the corporate sector and citizens. Apparently, in each city of its operations, corporate leaders have taken the lead, the government has responded by opening its schools and sharing its facilities. Funding comes from various sources: Friends of Pratham have started Pratham chapters in the USA, UK and the Middle East. Funds also come from agencies such as the NOVIB and America India Foundation. Pratham's funding relations with the State appear to be limited to support for research, etc. (this needs to be clarified)

2.3 NGO Network in Mumbai

The above NGOs in Bombay have long years of working with slum communities and many of them are part of city level or even inter city networks-formal or otherwise address areas of common interest. In 2005 an NGO Council, a collective of Mumbai-based NGOs, was formed with the aim of providing a platform for individuals and organisations to engage constructively with the government and others in areas of mutual interest as identified by its member organisations. Bombay Municipal Corporation (BMC) and the NGO Council signed an MoU in December 2005 for Good City Governance, recognising the need for an institutionalised partnership between Municipal Corporations and NGOs. This MoU provides for a more effective and sustained working mechanism with BMC.

Recently NGOs working in the area of elementary education came together as a representative body in the Public Participation Cell of the BMC. The initiative to form the NGO forum – the Focus Group on Municipal Schools was led by SCFI. The Focus Group is expected to function as part of the NGO Council. The formation of the Focus Group was a response to a move by the Municipal Commissioner to decentralise NGO-BMC collaborations and address issues of administrative lapses and corruption. Thus the Public-Private Partnership Cell (PPC) for Municipal Schools was set up by the Municipal Corporation of Greater Mumbai towards the end of 2006 and is headed by a Deputy Municipal Commissioner. It has been conceptualized as a one-window mechanism for interested and concerned civil society organisations to engage with the BMC Education Department. The stated objective of the PPC is to provide NGOs easier access to civic schools. However, from interviews with the Deputy Commissioner it also appears to be a way to keep a check on the often unwelcome interventions of the NGOs in the schools.

3. Role of the Municipal Corporation of Mumbai

The Municipal Corporation of Greater Mumbai, through its Department of Education, is responsible for primary schools in Mumbai. It currently runs around 1200 municipal schools teaching eight local languages in response to the multi-lingual population. Primary education has been the responsibility of the Corporation since 1884. It also provides aid to some private schools. The Bombay Primary Education Act of 1947 is the governing act and defines the relationship of cost sharing between the state government and the corporation. The Act also allows the corporation to provide for free education at

the primary stage. The corporation also provides free text-books and slates, and also has a school feeding programme in place.

Bombay city is divided into 23 wards and six administrative zones with a Deputy Commissioner for each Zone. While forming policies is the responsibility of its elected council and its various committees, implementation is entrusted to the Commissioner. This structure is also the basis for administration of primary education. Thus, policies are formulated by the Education Committee while an administrative structure under the Commissioner, assisted by the Deputy Municipal Commissioner, takes care of actual implementation. The Commissioner functions through the Education Department of the Corporation headed by an Education Officer (usually on deputation from the state). This department has an Administrative and an Academic wing with a full staff being provided right down to the school level through a network of superintendents and beat officers. More specifically on the academic side this includes superintendents, research officers, assistant research officers, junior supervisors, physical education trainers and inspectors. On the administrative side, there are administrative officers for schools and for office functions, office superintendents, head clerks and other administrative staff from different categories. A Community Development Office, headed by a Community Development Officer, was also set up in 1985 to foster the Department's links with community. The CDO, until recently, was also the critical link with NGOs.

Apart from these municipal schools the corporation also provides grants-in-aid to a number of private primary schools, runs community development centres to provide additional support to poor children through balwadis and study classes, runs a school feeding programme, provides training to teachers, etc. The corporation is also responsible for the maintenance and repair of municipal school buildings. Interventions under the SSA include teachers' training, distribution of free text books to all pupils from scheduled castes and tribes and to girl students in municipal schools, Integrated Education for the Disabled (IED), Mahatma Phule Education Guarantee Scheme, training of community leaders, and Jagar Community mobilisation, etc.

Funds for the education schemes are largely generated by the corporation itself from municipal taxes and fees, and a small percentage is received from the state government from its SSA funds. The budget for 2005-2006 was reported to be of the order of Rs.6450 million.

4. Emerging issues for the NGPA research

The preceding discussion on the evolution of the NFE programme in the country and the role of the State and the NGOs within the programme raises issues pertinent to the NGPA research.

An issue of relevance is that in India non-formal education has been actively initiated and promoted by the State, and hence also shaped by it. We need to examine the reasons behind the State's attempts to establish an NFE programme and also the State's interpretation of the concept. This would facilitate a better understanding of the State-NGO relationships and the roles that the State has demarcated for the latter.

Going back to the 1940s, the primary reason for NFE emerging as a state concern is reported to have been the large number of children who were deprived of formal education. NFE appears to have emerged as a transitional alternative. The debate on

the State's responsibility to provide free and compulsory education raged over decades, until the passing of the Free and Compulsory Education Act in 2005. The debate continues but is now focused on the provisions of the Act itself. The efforts of the State, until recently, have almost exclusively centred on issues of 'access' and increasing the number of non-formal centres to get more children into schools. Even the new Act (2005) emphasises the objective of setting up transitional schools for those children who do not have access to fee charging, approved or regular government schools.

Therefore, while the State itself set up NFE centres of the EGS kind, it also encouraged the NGOs to do the same with resource support leading to the emergence of two kinds of NFE centres within the State programme: the State-run (EGS) and the NGO managed but State-supported centres. Within the NGO category itself, a genre of NGOs, such as Door Steps School, Save The Children India, Akhansha, etc., have emerged which have been trying to shape the concept of NFE on their own terms. They generate their own funds but for apparently strategic reasons, they have also opted to access State resources, even though these are only a miniscule addition to their other resource. Questions that this research will need to probe are: What is the relationship between these relatively independent NGOs and the State and is it different from that of the wholly State dependent NGOs? Why have they opted to engage with the State?

The State's envisaged role for NGOs however, is largely limited to the latter providing resource support to literacy programmes through resource centres, and managing centres in uncovered areas. While the State tends to look to NGOs as a provider of resources in reality the NGOs appear to have been turned into an extension service of the State under the NFE programme with little scope for innovations. Even where the NGOs have been visualised as developing innovative projects (41 'innovative projects' so far) that would serve as examples for making policy changes, there is no evidence of an adequate mechanism for translating learning into practice. Tensions between the State and the NGOs are bound to exist because of possible variance in the State's envisaged role for the NGOs as against the NGOs' perception of their own role within the context of the NFE programme. Indeed, discussions with NGOs and experts in the initial stages of this research indicate that partnership strategies and State-NGO relationships vary with the different perceptions, commitment, resource position, of the NGOs. A well resourced with clout and credibility is able to engage more proactively with the State. Further, the relationship of an NGO with the State may also undergo changes over a period of time.

Our preliminary explorations show that organisations like Pratham, that was itself initiated by Bombay Municipal Corporation, appears to have carved out an independent position of influence within a period of a little over a decade. It has moved away from a vertical or client-patron relationship to one of co-production and subsequently in recent years appears to have little formal engagement with the BMC. By comparison, a large number of NGOs, which have been in existence for at least the same number of years and which appear to have been equally effective at the project and community level, have remained relatively small in their scope of work and influence and have chosen to remain within a vertical, patron-client relationship for various reasons. An analysis of the different kinds of position NGOs have adopted within a State-supported programme will enhance our understanding of the State-NGO relationship.

The research will need to look into the dynamics of the State-NGO relationship and study the processes by which NGOs have attempted to negotiate for space in which to

be proactive and to rise above the label of an ‘extension wing’ of the State. The response of the NGO fraternity in Bombay to the Deputy Commissioner’s policy of setting up a single window system to facilitate partnership between the NGOs and the corporation in running the 1200 municipal schools is evidence of the existence of a process for negotiation. During the next stage of the research, we will follow the process with the NGO Forum that initiated the negotiations and with the Deputy Commissioner’s office.

The State sought to partner with NGOs both to fill resource gaps and to bring in innovations and flexibility. Over the years, with the concept of community participation and decentralisation gaining ground, ‘partnership’ has been extended to cover the local bodies as well as the communities. However, the dominant role of the State appears to have generally led to the setting up of a hierarchical partnership. Within this, most of the State-run centres, except in the case of specific donor-supported programmes like Lok Jumbish and Shiksha Karmi of Rajasthan or individual State-initiated ones like the EGS in Madhaya Pradesh, which were managed by special purpose units with a lot of autonomy, are reported to have suffered from all the ills of the regular government-run schools: teacher absenteeism, poor infrastructure, poor quality of education, etc. These were compounded by inadequate mechanisms for monitoring and evaluation. Many of the NGO-run centres also appear to suffer from the same ills, perhaps due to the inadequacy of resources. What is the response of the State when NGOs fail to deliver?

State policy and programme documents define NFE as an ‘alternative’ form of education for children who have been kept ‘out-of-school’ for various reasons. Additionally, though the programme has been designed ‘outside’ the formal education system, it is itself ‘organised’ in terms of very defined activities and rigid budgetary norms within a given time-frame. Thus, a dichotomy between intention and action is visible in the way the NFE programmes have been implemented by the State. Successive policy documents explicitly indicate that the State is aware of this lack of flexibility and bureaucratisation of the NFE programme, yet a solution does not seem to have been found. This needs to be further explored so as to better understand the State-NGO relationship. The issue for the research would then be to understand the struggles of the NGOs to work within this framework and mechanisms adopted for resolving problems and conflicts.

The State’s priority for increasing the <u>number</u> of children in the centres has often been at variance with the NGOs’ perceptions about the equal, if not more, greater importance of the <u>quality</u> of inputs to the centres. In fact, the priority given to ‘access’ at the cost of ‘quality’ has been the subject of criticism from educationists as well as the development sector since the 1960s. Ironically successive State-commissioned committees and programme evaluations have voiced the same concerns. In the early days, before large-scale pilots were initiated in the 1980s and 1990s, a number of State policy-makers and decision-makers argued that the priority of the State was to educate the ‘willing’ with efforts to educate the unwilling coming later! Leading from this belief, the next logical thought appears to have been that it was more important to get the ‘unwilling’ or out of school children into school - quality education could come later. It is this approach of the State that has prompted authors like Ramphal (2005) to question whether the policy of the State is “Schools for the ‘Willing’, ‘Alternatives’ for others?”. The question for this study would be to try and understand the perceptions of the State and the NGOs regarding quality and the process, if any, adopted to negotiate and strike an informed balance between the two.

Interestingly, in the last few years, the State, at least in its policy and programme documents has started to acknowledge these gaps and failures, spurred on by several evidence-based independent studies. It has therefore begun to emphasise the critical role of the NGOs to improving pedagogy and curricula. One reason for this apparent change in focus may be the State's claim to have largely achieved the goal of 'access' so that it was now time to focus on 'quality' - a claim contested by a number of educationists and researchers. However, discussions with educationists and several NGOs (Bombay and Pune) during Stage 1 and 2 of the research as well as reports and documents of the State and independent authors reveal that poor quality (together with access) continues to be a major concern. Given this, a significant question that arises is related to the nature of the tensions that exist between an NGO that is concerned about quality of education in NFE centres and a State that does not appear to have gone beyond tokenism in translating its avowedly similar concern into action.

Lastly, a related issue is that of resources and the emergence of the corporate sector, both as a source of substantial funds and as an implementing agency in its own right. While generous funds contributed to some NGOs appears to have given the latter substantial autonomy and strength to engage on a more 'equal' level with the State, the corporate organisations' increasing tendency to float their own non-profit centres may lead to a change in the relationship between the State, NGOs and the corporate sector.

Section 2: Primary Health Care

1. Evolution of primary health care delivery services

After Independence, the GoI envisaged a national health system in which the State would take the lead in determining and managing priorities and providing primary health services in both the urban and rural areas. Thus, the first three decades saw the commissioning of a number of committees, all of which focused on strengthening the health care delivery structure, and more specifically primary health care services.

The health policy, until the beginning of the 1980s was based on the principles of equality and universal access and the predominant role of the State. The first step was taken by the Health Planning and Development Committee Report in 1946 (Bhore, 1946). This emphasised the key role of the State and recommended a health care system based on the needs of the people, especially the poor and the marginalised. The Committee recommended that a strong basic health service delivery structure at the primary level should be developed with referral linkages. Integration of preventive and curative functions in a single state agency was also thought to be necessary. Thus, the concept of Primary Health Centres (PHCs) and its referral structure and services was introduced in the country and given shape.

The first two Five Year Plans focused on developing the basic infrastructure and manpower as visualised by the Bhore Committee and, in the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. However, while most of the core elements of primary health care (provision of water supply and sanitation; preventive health care of the rural population through health units and mobile units; health services for mothers and children; training and health education) were addressed, the impact was less then desired for several reasons. The concept of vertical programmes was introduced early in the First Plan (for malaria control and others), which not only appropriated the time of the primary health care workers but also failed to create an integrated system. Similarly, in the Third Plan, family planning became a focus and took away manpower resources. During the Fifth Plan (1974-79), primary health care appeared to receive an impetus when the Minimum Needs Programme was initiated. This again proposed an integrated approach together with the strengthening of health infrastructure in the rural areas and the integration of the peripheral staff of vertical programmes into the structure. However, intentions were derailed when a period of 'Emergency' (1975-77) was declared and the much criticised population control programme of that time took away most of the primary health care workers and facilities. Moreover, although health care was accorded priority, investment levels in the sector were very low throughout the early Plans. These concerns were reflected in the reports of several committees set up during the period. All of these recommended that the health services infrastructure and the health cadre at the primary level should be developed and strengthened urgently, radical changes needed to be brought about at the primary level, investment in the health sector had to be increased, and health cadres at the primary level had to be effectively distributed and deployed.[5]

[5] Health Survey and Planning Committee (Mudaliar Committee 1962), Chaddha Committee (1963), the Kartar Singh Committee on Multipurpose Workers (1974), the Srivastava Committee on Medical Education and Support Manpower (1975).

The beginning of the 1980s saw a change in the sector when the Government of India became a signatory to the Alma Ata Primary Health Care Declaration (1978), and also commissioned a comprehensive review of the health sector. The focus from then until 2000 appeared to be based on the principle of encouraging the private sector in service delivery, while expanding access to publicly funded primary health care. The recommendations of the Report ('Health for All by 2000', ICMR/ICSSR Report, 1980) led to the formulation of the first National Health Policy in 1983. Provision of universal, comprehensive primary health services was the goal and a decentralised system of health care was to be developed. The Policy also outlined the State's intentions to mobilise the support of private and voluntary organisations into a system of integrated health services. However, verticality was re- introduced and a selective approach to health care was adopted as a result of doubts raised on the financial repercussions of the primary health care approach. Programme-driven health policies again became the focus until subsequent Plans (the Seventh onwards) emphasised restructuring and developing health infrastructure, especially at the primary level.

The Seventh Plan (1985-90) restated that the three-tier health services system needed to be strengthened, and the Eighth Plan (1992-97) attempted to encourage private initiatives, including hospitals and clinics. The National Commission on Macroeconomics and Health (Nundy,2005) points out that the Plans focused on building health services infrastructure, especially with reference to primary health care, but remained limited to primary level care which too was not effectively implemented. As a result, by 2000 India had not achieved most of the goals laid down in the first National Health Policy (1983) and, between 1986-96, there was a decrease in the utilisation of public facilities for outpatient care from 26% to 19% (utilisation of the capacity) a decrease in access to free care from 19% to 10% and an increase in the number of persons not accessing care due to poverty. The Commission, hence, questioned the framework, design and approach within which the policies over the years had been planned.

A second National Health Policy was formulated in 2002 with the objective of integrating vertical programmes, and strengthening the infrastructure for providing universal health services. The Policy proposes the decentralisation of the health care delivery system through Panchayati Raj Institutions (PRIs) in the rural areas and also the regulation of private health care by PRIs, while providing space for the private sector in the first referral and tertiary health services. Public investment in health was to be increased from the then current level of 0.9% of GDP to 2%-3% and utilisation of primary care facilities from less than 19% to over 75%, by 2010. Since 2000, in fact there has been a perceptible move towards utilisation of private sector resources for addressing public health goals. The State's role is also being redefined from that of a provider to a financier of health services (NCMH 2005).

2. Profile of primary health care service in India

The health care system in India consists of a public sector and, what is broadly termed the private sector. The latter includes an informal network of health care providers who largely operate within an unregulated environment, besides the for-profit and not-for-profit organised sector.

2.1 Public Primary Health Care delivery structure

Public primary health care services in India are delivered through a network of primary, secondary and tertiary facilities and a range of government professionals and para-professionals, designed on the basis of population, density and geographical location of settlements.

In the rural areas the network consists of:
Village Health Centres (VHC) at the village level. VHCs or their equivalent are run by the *anganwadi* workers, MPW (multi purpose workers) or volunteers from their homes in the village. They are expected to provide first aid medicines and other relevant family planning and nutritional requirements/supplies and also to maintain health records.

Sub-Centres exist at the next level catering to a small cluster of villages at the Gram Panchayat level, supervised by field health workers or ANMs. Although they are expected to have their own building, surveys have indicated that a large number of them operate from rented premises. As no qualified doctor is available at the sub-centre level, difficult cases are referred to PHC/CHC.

Primary Health Centres (PHC) are at the next highest level. It is here that the first formal and professional medical and health facilities are made available to the rural population generally at the block level. The earlier Scoping Study (Nair 2006) noted that the PHC is the first contact point between the village community and the medical officer and primarily provides primary outpatient care, with minimal arrangements for inpatient care and hospitalisation. It is, thus, responsible for promotive, preventive, curative and rehabilitative care and has been envisaged to offer a wide range of services, such as health education, nutrition promotion, basic sanitation, mother and child family welfare services, immunisation, disease control, and appropriate treatment for illness and injury. PHCs are generally provided with the necessary medical staff who are provided with residential facility. In practice however, the doctors generally commute from nearby urban locations.

Community Health Centres (CHC) are at the highest level of referral serices and hence are generally expected to be better equipped with testing, diagnostic and curative facilities as well as specialist doctors. However, the required pathological and clinical facilities at CHC are either of poor quality or suffer from lack of trained staff to operate them.

District Hospitals are the upper end of public health care facilities for the rural population and are located at the district headquarters, usually an urban centre.

Overall the primary health care system in the country has an elaborate staff structure consisting of the Chief Medical Officer at one end of the spectrum at the district level to ANMs, male and female workers etc. at the lower or village level

As noted in the Scoping Study, presently the rural primary health care network consists of 1,600,000 sub-centres, 22975 PHCs and 2935 CHCs. The CHC is expected to provide secondary facilities and specialists inpatient beds. The network is supported by dispensaries and hospitals providing services under the Indian System of Medicine and Health care(ISM&H) and Aganwadis providing nutrition and psycho-social care for children and mothers under an early child care programme. Over 500,000 trained doctors and a village level work force of over 700,000 ANMs, Multi Purpose Workers and

Aganwadis staff the network. In Karnataka as in other states, primary health care revolves around the PHCs. Karnataka currently has 1,685 PHCs, 583 primary health units (PHUs) and 249 CHCs. Some PHCs also have smaller PHUs attached to them, some of which have now been phased out or upgraded as per the recommendations of the Karnataka Task Force on Health and Family Welfare (2001). In comparison to other states, Karnataka matches or does slightly better than the national average, but health facilities in Karnataka are more concentrated at the higher levels with more CHCs per PHC and fewer sub-centres per PHC.

The urban primary health care network in the country on the other hand is less elaborate and consists of municipal hospitals, state government-run hospitals set up as part of the Employees' State Insurance Scheme (ESIS) and Urban Health and Family Welfare Centres run by the municipal corporations.[6]

In 1995, after the 73rd constitutional amendment when the process of decentralisation was effected, the PHCs and government dispensaries were transferred to the village panchayats; block PHCs, CHCs, block hospitals and government hospitals to block panchayats; and CHCs, block headquarter hospitals and government hospitals in corporation and municipal areas to corporation and municipal councils. However, although the staff came under the direct supervision of the local government agencies, their salaries continued to be paid by the state

2.2 Gaps in public primary health care services

The Scoping Study (Nair 2006) noted that the primary health care network, especially in the rural areas faced severe 'facility gaps, supply gaps and staffing gaps' and had been falling far short of its objectives and goals. A World Bank study (Radwan 2005) indicates that this state of affairs arose because of 'weak stewardship' of the sector. The study identified the following factors:

(i) A bureaucratic approach to health care provision that has multiple repercussions:

- A rigid PHC structure that does not respond to local needs.
- Political interference in the location of health facilities resulting in skewed distribution of PHCs and sub-centres, prolonged vacancies in PHCs or an excess of manpower.[7]
- Bureaucratic rigidity also forces health officials and departments to focus more on inputs than outputs and outcomes leading to a supply driven approach.
- Low public health management capacities at this level.

(ii) A lack of accountability resulting in:

- Doctors being frequently absent. Even where doctors are present their lack of concern for the poor discourages the latter. The poor facilities in rural areas in the country are the key factor that leads to medical professionals opting to live in

[6] The Scoping Study notes that the primary health care infrastructure in the urban areas had been established through schemes like the All India Hospital Post-partum Programme, the Urban Family Welfare Centres, the Urban Revamping Scheme (Health Posts in slums) and Sterilisation Beds Schemes.

[7] Radwan (2005) also observed that, on average, 25 percent of sanctioned PHC posts in Karnataka were unfilled and questioned whether this was a deliberate strategy to reduce the budgetary burden or just a case of administrative inefficiencies.

nearby urban areas from where commuting is difficult. Doctors and other medical personnel also cite lack of basic infrastructure like electricity, water, road network and transport facilities as some of the reasons for their inability to perform better in the PHCs.

- Lack of accountability is also reflected in the poor response from ANMs. The ANMs again are not readily available and pregnant mothers often resort to local *dais* (traditional birth attendants) at the time of deliveries. The World Bank study reported that in Karnataka dais attend to as many births as ANMs.
- The PHCs function for a limited number of hours a day and the timings are never convenient to a working rural population.
- Although the PHC is supposed to provide services free of charge most PHCs require a fee – generally an informal payment. This charge, when added to the cost of transportation and medicines that also generally have to be purchased, is said to make the cost of public sector health care more expensive than a relatively low-cost private provider who is also open to deferred payments.

(iii) Finally lack of resources together with the failure to make efficient investments contributes to the poor performance of PHCs. This often leads to a lack of medicines in stock, poor salaries and hence recruitment of less qualified doctors or else doctors indulging in private practice at the cost of the public health care system, and finally poor infrastructure in the PHCs.

The recently initiated National Rural Health Mission (NRHM) is expected to address a number of these issues and take measures to correct the anomalies. The National Rural Health Mission (2005-12) seeks to provide effective health care to the rural population throughout the country, but with special focus on states with poor public health indicators and infrastructure. The Mission also articulates the commitment of the government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. Amongst other goals, the Mission aims to improve access to primary health care and make it equitable, affordable and accountable, especially to the poor and marginalised. Access to integrated comprehensive primary healthcare is a primary goal. The key components of the Mission therefore are:

- Provision of a female health activist in each village (ASHA)
- A village health plan prepared and managed by the health and sanitation committee of each panchayat;
- Strengthening of rural hospitals for effective curative care and making their performance measurable and accountable to the community; and
- Provision of adequate funds for optimal utilisation of infrastructure and strengthening delivery of primary healthcare.

At the core of the strategy are strengthening of sub-centres through an untied fund to enable local planning and action; provision of additional Multi-Purpose Workers (MPWs), strengthening existing PHCs and CHCs; technical support to national, state and district health missions for public health management; formulation of transparent policies for deployment and career development of staff; and promoting the non-profit sector particularly in under-served areas.

2.4 Status of Primary Health Care in Karnataka

Documents of the Government of Karnataka indicate that the health in the state has improved over the years in terms of the critical indicators of life expectancy, infant mortality, birth and fertility rates. Besides, Karnataka has also managed to eradicate, or at least drastically reduce, the incidence of some diseases like leprosy and malaria. The state government also claims to have improved the provision of infrastructure in terms of sub-centres, PHCs, PHUs and hospitals, and to have increased the number of hospital beds and human resource. The combined impact has placed Karnataka above the national average in health status.

However, gaps remain in terms of rural-urban differences, inter-district and inter-regional disparities (Bidar, Koppal, Gulbarg, Raichur, Bellary, Bijapur and Bagalkhot are the worst served districts), poor nutrition amongst the under-5s and anaemia in women, etc. Mental and disability care, especially of women, is still poor, and preventable health problems continue amongst specific population or in specific geographical areas. A Task Force on Health and Family Welfare (2001), constituted by the state government, identified the following as the key deterrents to the better functioning of the health sector in the state:

- Corruption - manifested in monetary considerations for appointments, promotions and transfers, and also in un-warranted monetary demands for use of government facilities - has distorted the "access and utilisation of health care services at different levels."
- Neglect of public health with regard to sanitation, housing, a lack of emphasis on preventive, promotive and rehabilitative care, and failure to strengthen and nurture public health cadres, have led to poor performance and outcomes.
- Large distortions in primary health care exist and are reflected in inadequate community participation, increased 'verticalisation' of programmes, neglect of the PRIs, inadequate integration of other systems of medicine, lack of appropriate technology, inadequate efforts to upgrade technology at the primary health care level, and little interaction with the voluntary agencies. This has led to the concept of primary health care being diluted almost to the point of non-existence.
- Inequalities between sub-regions in the state and between various communities within society have widened. The inequities include differences between urban and rural areas and between districts, gender discrimination and neglect of the scheduled castes and tribes and other groups like the elderly, disabled and street children. Inadequate monitoring of these issues has further complicated the situation.
- A widening gap between policy intent and action is perceptible. The gap is a result of multiple factors including a lack of political will, poor planning, implementation and supervision, overall lack of vision, lack of leadership, promotion of individual agendas based on caste politics, failure to fill critical vacancies for prolonged periods, bureaucratic red-tapism and a lack of accountability.
- Neglect of planning and policy for human resource development, ranging from clarity on skill and capacity requirements to the absence of a human resource development policy and social accountability have led to ineffective schemes.

- The existence of several systems of medicines, from the traditional to the modern, and varying perceptions of the systems have led to the dominance of one system of health care over others.
- A compartmentalised attitude has led to the neglect of other sectors and failure to establish effective synergies.

The Task Force therefore recommended several short and long term measures to improve the situation, including the strengthening of partnerships with the 'voluntary sector' in order to augment resources - human, material and financial - and to build on the NGOs' ability to establish rapport with the community. Besides, the Task Force observed that the NGOs were considered to be "flexible, less formal and more effective in providing health care service" and to "usually execute programs at less cost (greater efficiency)". It therefore proposed the setting up of an NGO cell under the Commissioner/DGHS (Task Force, 2001). [8]

3. NGOs in primary health care

In India, NGOs' presence in the health sector is relatively limited, especially in primary health care. Although, since the early 1990s, health NGOs are supposed to have grown in numbers they still account for only a little over 1 percent of the total health delivery sector. The spread of NGOs is also stated to be quite varied across states. While Uttaranchal (43%) has a substantial number of NGOs operating in the health sector, followed by Punjab (15%), states such as Bihar, Goa, Jharkand and Karnataka have a negligible presence accounting for less than 1% of the total health establishments in these States. (MoHFW, GoI, 2005)

Although, heterogeneous in size as well as the issues they cater to, wherever they are present the NGOs are believed to provide good-quality care and require limited regulation or oversight from the State. More importantly they are generally observed to the needs of the poor by charging lower rates. Until the mid-1960s, the NGOs in the health sector (most of which were religious based) were mainly involved in hospital activities. Subsequently, community health also began to receive attention. As in the case of other development issues, the failure of the State to deliver, together with structural adjustment policies and international and external donor influence saw the growth, although slow, of the NGO sector in health care delivery during the 1980s and subsequent decades. They are now generally involved in vertical disease control programmes - particularly in the areas of community mobilisation and awareness creation (running TB, HIV/AIDS counselling and testing centres, or adopting PHCs). However, most NGO activities in the health sector are isolated events, ad hoc and highly susceptible to funding. Thus, such partnership models so far have not been sustained in the long run and are also difficult to scale-up. Because of their smaller coverage few have had any great influence.

The State for its part, from the Sixth Five Year Plan onwards has been trying to facilitate the involvement of NGOs by offering subsidies and grants under various National Health Programmes (TB, Leprosy, and Family Planning). While, with the involvement of NGOs, community participation began to gain ground, NGO activities were broadly centred on

[8] NGOs in the context of this study are primarily the not-for-profit organisations, including Faith Based Organisations working within the development sector.

awareness building and health education, advocacy and research, actual provision of services to some extent, and a fast growing presence in disease control and vertical programmes. The State also tried to set up consultative groups of the voluntary sector in some states, but not with much success. However, the State's efforts to involve the NGOs appear to have increased with successive Plans. Hence, while in the Eighth Plan NGOs were provided with grant-in-aid for experimental projects, largely focusing on family planning and mother and child care, in the Ninth Plan some PHCs were for the first time handed over to NGOs. As Nundy (2005) states, the object of the State's interest in encouraging the participation of NGOs appears to have been to incorporate NGOs' effective approaches into governmental programme, and to make use of NGOs to improve programme outputs and outcomes. These sentiments of the State have also been reflected in National Health Policy documents. While the NHP of 1982 clearly encouraged the increased involvement of NGOs in establishing curative centres in order to reduce government expenditure, 20 years later the NHP of 2002 also recommended facilitating civil society organisations in implementing public health programmes.

Some of the few significant cases of State-NGO collaboration in primary health care are:

***The contracting out of 192 urban health centres (UHCs)* in Andhra Pradesh in 2000**. The UHCs were contracted out to NGOs based on a package that included delivery services to households, mobilising the community, and engaging in behaviour-change communication to encourage greater use of services. Each UHC covered a population of 15,000 to 20,000. Outputs were pre-determined by the State (UHC advisory committee and the district health officer in this case), quarterly reviews were undertaken and even benchmarks established. While the UHCs were provided with less than a quarter of the PHC budget, they were allowed to levy a fee of Rs.2 per patient. The PHCs were allowed to recruit ANMs and other staff on a contract basis at half the government rate. At the end of the first three years of operation, the contracts of four NGOs that did not manage to meet expected minimum standards were not renewed, while the others continued to function. However, although largely considered to be successful, the model was not scaled-up.

In 1980, SEWA Rural started its activity in Jhagadia block of Rajasthan by acquiring a maternity home converted to a 30 bedded small hospitals providing health services for the village community. An integrated development approach through a community outreach programme was initiated in consultation with Surat Medical College. In 1982 SEWA Rural took over the control of village level functionaries like Anganwadi workers, traditional birth attendants, community health volunteers (CHV) and engaged them in community motivation. Eventually they were absorbed into SEWA Rural, with the consent of the state government. In 1984, USAID in collaboration with the state government supported SEWA Rural in taking over the health activities of 39 villages, and all male and female workers and supervisors were transferred to the NGO. The NGO was also given autonomy to recruit staff and prepare the budget as well as to plan and execute outreach activities, while the staff cost was covered by State Government. In 1989 after completing five years of partnership the government formally handed over the management of the PHC at Jhagadia block to SEWA Rural.

The Karuna Trust *is* part of the Vivekananda Girijan Kalyan Kendra (VGKK) founded in 1981 and set up to work with the Soliba tribal population of BR Hills in Karnataka. It later extended its area of operation to other areas. Karuna Trust itself was subsequently founded (i.e. registered as a charity) in 1987 as an organisation dedicated to rural

development and rural health. It now operates 25 PHCs across the state. The PHCs focus on community-oriented preventive medicine. Although the Trust is involved in other health-related activities, its management of the PHCs in 23 districts is the most talked about. The PHCs are now also operating as Village Resource Centres and in collaboration with the Indian Space Research Organisations (ISRO) are providing various services to the community including tele-medicine and tele-agriculture, wasteland and watershed mapping..

The Karuna Trust's management of PHC was started as an initiative in public private partnership in 1996 when the Trust took over the running of the Gumballi PHC in Yellandur Block. Subsequently the government handed over 25 PHCs in 23 districts of Karnataka. A community health insurance scheme has also been launched. The Trust has appointed new staff and replaced all the government staff who were previously employed. The PHCs' performance is monitored by the district health officer. The model, thus, focuses on partnering with the state government. Karuna Trust enters into an MoU with the government after obtaining clearance from the local leaders and the zilla panchayat. The government pays 75% of the running cost and the rest is to be mobilised by the NGO. Other funds come in the form of fees and philanthropy and funds from the local and federal level Members of the Legislative Assembly and Parliament. Recently the Government of Arunachal Pradesh has signed an MoU with the Trust for the management of nine PHCs in that state.

Mother NGOs (MNGOs): The Mother NGO (MNGO) concept was developed by the Department of Family Welfare, GoI. MNGOs receive grant-in-aid from GoI through a State Standing Committee on Voluntary Action (SCOVA) and provide funds to ground level NGOs called Field NGOs (FNGOs) in their allocated districts. The underlying philosophy of the MNGO scheme is one of nurturing and capacity building, which includes:

- Assessing the gaps in information on Reproductive and Child Health Services (RCH) services in the project area.
- Building strong institutional capacity at the state, district, and field levels.
- Advocacy and awareness generation.
- Facilitating service delivery in the underserved and unserved areas.

The concept evolved during the 7th and 8th Plans when the government realised that NGOs were not alternatives to working through the government system but actually complementary in nature. Being seen as flexible in procedures and having a better rapport and credibility with the local population, they were viewed as better placed to try localised innovations which the government system was not in a position to attempt. With the 9th Plan, the GoI began to give more importance to local NGOs, essentially in innovative programmes and processes for conferring a large degree of autonomy to the NGO sector.

At the village, panchayat and block levels, small NGOs are involved in advocacy of Reproductive and Child Health Services and family welfare practices and in counselling. As these small NGOs have limited resources, Mother NGOs were identified to assist them, with one MNGO for every eight to 10 districts. These are NGOs with substantial resources and proven competence, and are given grants by the department directly. The MNGOs are required to screen the credentials of the applicant small NGOs, obtain proposals from them, consider them for sanction, release money, monitor their work and

obtain utilisation certificates from the small NGOs. The MNGOs are also required to provide training to the staff of the small NGOs in management of the NGO and of the programme itself. While every state has a set of MNGOs at the state level, a few of them have also been identified as MNGOs at the national level. These include the Family Planning Association of India, the Voluntary Health Association of India, and the Society for Services to Voluntary Associations which also have state chapters and receive funds through state governments as MNGOs at state level. The GoI's stated objective is to promote a true partnership for innovation between the NGOs and also to encourage NGOs' participation in areas where the presence of the government has been traditionally weak.

Currently, 215 MNGOs are working in 324 districts of the country. The focus of services of MNGOs is primarily Reproductive and Child Health Services.

4. Conclusions

It is clear from the above description that the existing status of the primary health care system in India leaves much to be desired. Although the State of Karnataka has been able to raise itself above the national average in terms of both health status and health care delivery, the gaps that continue to exist in the system have implications for State-NGOs partnerships.

A rigid vertical structure has put the burden of health care delivery on to the Primary Health Care Centres. The Village Health Centres and Sub-Centres (at levels lower than the PHC) are almost non-functional, whereas the Community Health Centres and district hospitals are difficult to access, because of their geographical location as well as their inherent shortcomings. The PHC therefore has become the critical unit of primary care at the community level and the State has (in all probability by default) focused on the PHCs to bring about improvements and innovations, with partnerships being one of the key strategies. However, the poor structure and profile of the PHCs themselves are a challenge for any partnership initiatives. The fact that State allocations for infrastructure and facilities are less then adequate, and allocations for PHCs' upkeep and maintenance even less so, is an issue that State-NGO partnership in primary health care have to address upfront. It is here that the ability of the NGO will be tested - its capacity to raise additional resources for improved infrastructure and facilities and for their maintenance. Critical determinants are the space and scope for negotiations within the partnership, and the NGO's ability to leverage existing government funds and facilities.

A related issue is what strategy can make the PHCs viable within the meagre government grants. How does the partnership raise additional resources, adequate to sustain improved service levels? Does it levy user charges, depend on the PRIs to raise funds, or depend on the often uncertain contributions of philanthropists? And at the same time, how does it ensure that equity of access to services – a stated government requirement - is maintained?

Besides, the partnership will have to work within a larger system of health care planning, management and administration that appears to be burdened by bureaucratic delays, poor quality of supplies (drugs and instruments), inadequate data bases and information systems, etc. The effectiveness of the partnership may hence depend on the strategies that it evolves to make the State system more proactive and responsive.

The presence of alternative and traditional forms of medicine and traditional healers and practitioners within the community is a critical part of the existing health care system in India. While the State has begun to recognise the role played by the traditional system of medicines, the effectiveness of the partnership may also be influenced by how well NGOs understand and respond to this factor and by the way they strike a balance between the traditional and the modern forms of care and treatment.

Issues of integration with vertical disease control programmes, which over the years have been a burden on the structure and staff-time of the PHCs, may be a determining factor in the success of partnerships. An area to be probed in the context of the present research will be the definition and scope of primary health care within the partnership.

The partnership will necessarily need to address the issue of human resource in its entirety: its low capacities, non-availability, credibility, and corruption and rent-seeking tendencies, etc. How it does this depends on the freedom and flexibility that the NGO has to bring about innovations, the sensitivity with which it handles and evolves improved system of staffing and recruitment, its skills in building the capacities of existing or new staff, etc. How effectively the NGO uses the large body of community health workers (consisting of the male and female health workers, the ANMs and also the Anganwadi workers) may be a key factor in ensuring the effectiveness of the partnership. It may also depend on the political will of the State as well as the attitude of the State administration at various levels, especially at the sub-regional levels of the district and block.

Years of neglect and poor performance of the PHCs has led to a low level of confidence of the community in the PHCs' ability to deliver. Any partnership may therefore need to simultaneously develop an effective community outreach programme to establish credibility in the system and ensure participation. The fact that the State itself is now in the process of decentralisation of health services, through the institutions of the panchayati raj institutions (PRIs) in the rural areas, would mean that the partnership additionally also may need to engage with the PRIs, bringing another dimension to the relationship. Adding to the challenges of State-NGO partnerships is the weak capacities of the PRIs. In spite of stated intentions, most state governments have failed effectively to transfer responsibilities and resources to them or to establish a system of transparency and accountability.

Section 3: Urban Sanitation

1. Introduction and context

1.1 Overview of sanitation in India

In India, sanitation was brought into the public arena for the first time by Mahatma Gandhi. However, Gandhi's interests were more focused on the social consequence[9] of the practice of delegating the cleaning of toilets exclusively to communities in the lowest rungs of the Hindu caste system, rather than on ensuring hygienic habits. On the other hand, for India's British rulers of the pre-independence period, open defecation and poor sanitation was more a public nuisance to be checked where it posed a threat (health hazard) to its own citizens in the country, than a case for provision of amenities and services. Therefore, facilities for the common man were minimal during the period.

The situation did not change much for years after independence because of various factors including a lack of political will, cultural practices of communities and its being an overall lack of priority for both the State and households. Although water supply and sanitation were recognised as sectors in the First Five Year Plan (1951-54), they have always been linked conceptually to each other: sanitation has always been an add-on to the water supply sector. Subsequent to the declaration of the International Water and Sanitation Decade (IWSD 1980-90), the Delhi Declaration formed the basis of water and sanitation policy in India. Since then, Five Year Plans have, in principle, focused on protection of the environment and safeguarding health through better and integrated management of water resources and liquid and solid waste, sound financial practices and use of appropriate technology, organisational and institutional reforms, and community management and devolution of responsibilities to local bodies. Capacities of the community and local institutions were to be strengthened to manage and sustain resources and services. However, most of these principles were primarily applied to the rural water supply sector alone.

1.1.1 Focus on rural sanitation

In the early eighties, as a result of the IWSD, and the alarming sanitation coverage figures (1 % in rural and 27% in urban) the Government of India initiated, in collaboration with UN and other external support agencies, efforts to improve sanitation in the country. These efforts crystallised into India's first nationwide exclusively focused programme for sanitation: the Central Rural Sanitation Programme (CRSP) which was launched in 1986 under the Ministry of Rural Development continued as the major programme until almost the end of 1999.

CRSP's vision however was limited. The approach adopted was to increase coverage using large-scale subsidies to mobilise socially and economically marginalised households, with little concern for changing practices. Although some bilateral donor programmes in selected states in the 1990s were able to demonstrate relative sustainability, both in terms of quality of facilities and use through community participation and with the active involvement of a few NGOs, the lessons from these

[9] The practice of 'untouchability' of those who were traditionally called the *Sudaras* and were renamed by Gandhi as '*Harijans*' or children of God

were not seriously reviewed or their findings adopted. The overall result was poorly constructed, often semi-finished toilets scattered across rural settlements, which quickly fell into disrepair or were used as storage rooms, while the communities by and large continued to defecate in the open. Thus, although the rural areas saw an increase in terms of coverage between 1990 and 2000, the pace of progress in coverage was very slow and was estimated to range between 15 to 22 percent (WaterAid 2005, Census of India 2001, Department of Drinking Water and Sanitation, GoI).

In fact, sanitation has never been high on the State's agenda, until a few years back when again rural sanitation was accorded the status of a campaign and launched across the country under the banner of the TSC or the Total Sanitation Campaign (1999). TSC has brought about some changes in the rural areas both in terms of approach and coverage (which was estimated to be around 36 percent at the end of 2006 as per the Department of Drinking Water and Sanitation's online data). Designed on the Midnapore Model of a West Bengal-based NGO, TSC has adopted a reform mode and is based on demand-driven and community-led principles, wherein collective community action based on information and education (IEC) is expected to lead to behaviour change at household and community levels. Subsidy levels have thus, in principle, been reduced, although many states continue to use TSC as the key instrument for increasing coverage[10].

There have been continuous attempts to develop TSC in terms of institutional structures and implementation processes. Thus, while in some states the responsibility for TSC continues to be vested in the traditionally responsible water and sanitation utility departments of the state, in others it has been shifted to the panchayati raj departments (rural local bodies) in line with the call for greater community participation and ownership. To meet the sudden spurt in demand for pans and traps, private sector participation and local community-based entrepreneurs have been encouraged by the states. A large number of local and national NGOs are also being contracted, primarily for community mobilisation and overseeing overall construction and implementation activities. Hence, with TSC not only has there been a sudden spurt of NGOs in the (rural) sanitation sector since the beginning of 2000, but NGOs have also entered into the field of actual construction of toilets in the rural areas in a number of states, while in others the *Gram Panchayats* are responsible.

Rural sanitation and TSC has also attracted donor interest and funds. The World Bank supports selected states like Maharashtra, Karnataka, Uttaranchal, etc. UNICEF is providing capacity building and institutional support to 14 states (including Maharashtra and Karnataka) for efficient and effective opertionalisation of TSC. As a result, TSC as a programme has now gained momentum. In some states, including Maharashtra, state specific commitments, particularly for the eradication of open defecation and elimination of manual scavenging, have shown encouraging results. In other states, activity is slowly picking up. Incentives, instituted at national and local level[11] have given a fillip to TSC, increasing access to sanitary toilets at household level.

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[10] Sanitation is a state subject and as such while the GoI provides guidelines and funds, decisions regarding subsidies are influenced by state priorities.

[11] Nirmal Gram Puraskar (national), Sant Gagdge Baba Puraskar (Maharashtra)

The programme however, still has large operational gaps[12]. While coverage has increased, usage remains low due to poor construction, water scarcity and above all the ineffective hygiene education strategy. A WaterAid study (2005) concludes that resistance from households cannot be attributed to behavioural preferences alone. In fact in the rural areas of India, it is also due to a variety of factors related to poverty, structural aspects of livelihood and increasing migration into urban areas.

What is, however, significant is that rural unlike urban sanitation has now been clearly placed on the list of national and state government priorities. In fact, the rural water supply and sanitation sector generally appears to have received greater attention in terms of the reform agenda. There has been a paradigm shift in approach and strategy, adopting a mission mode and instituting Special Purpose Vehicles (national, state and district level missions), etc., something which still needs to be introduced in the urban sector. Urban sanitation has not been accorded the same status and, in comparison to interventions in the rural areas, the focus is grossly inadequate and intermittent. While a programme approach has been defined for TSC in the rural areas, and some states like West Bengal are also in the process of drafting rural sanitation policies, the urban areas lack any such direction.

The see-sawing priority given to urban sanitation is also reflected in the fact that, while overall the first Five Plan periods were characterised by relatively negligible investments in water supply and sanitation, investments in the urban sector were relatively higher. In fact Central Plan outlays for the rural water supply sector far exceed the outlays for urban water supply or rural and urban sanitation. However, with the beginning of the 1980s (the Water and Sanitation Decade), budget commitments to the water supply and sanitation sector were substantially increased and so was the focus on rural sanitation. With the current Tenth Plan (2002-2007), this gap has been relatively narrowed.

1.2 Urbanisation and urban sanitation

1.2.1 Urbanisation

Urban sanitation in India has to be looked at against the trends in urbanisation. It is estimated that the urban population has grown from 210 million in 1992 to 290 million in 2001 and is expected to reach the 400 million mark by 2015. The urban areas accounted for almost 25% of the total population (850 million) in 1992, increased to a little more than 28% (of 1030 million) in 2001 and are expected to be over 32 percent of the total population by 2015. The National Capital Territory of Delhi (92%) has the highest percentage of urban population followed by Tamil Nadu (43.9%), Maharashtra (42.4%) and Gujarat (37.4%). Maharashtra, with a population of 41 percent accounts for 14% of India's total urban population.

1.2.2 Slum population

What is of greater concern is that within this scenario there has been a rapid growth of slum population in the country with, according to a recent World Bank study (World Bank, 2006), 41 million people living in slums in 607 urban centres (out of a total of 5161 centres). Historical trends indicate that the slum population is expected to increase at an

[12] The sustainability of change is seriously questioned by the continued focus on construction targets reflected in the subsidy pattern , inadequate focus on changing hygiene behaviour, inadequate budgetary allocations together with low levels of funding by states, poor supervision and hence the poor quality of toilets constructed, all of which seriously questions the sustainability of change

average growth rate of 3.5% during the next fifteen years to reach about 69 million by 2017. But the figures are considered to be under-reported across cities, as there is no appropriate means of enumeration of the various kinds of poor settlements, especially those located on encroached government or private land and no count of squatter settlements. Estimates generally place the average slum population in the cities to be around 40 to 50 percent.

Studies indicate that while a large number of poor households live in slums that are conclusively illegal, many of them are located on a continuum of categories, making provision of any services difficult. As per the 58th round of the NS (National Sample Survey)), while 65 percent of slum households are located in notified slums[13], 35 percent live in non- notified slums. While secure tenureship may imply better facilities, some diametrically opposite cases have been thrown up by studies that show that mere security of tenure does not ensure access to basic services and facilities; there are other social and structural factors that intervene. Generally, however, slums are the most poorly serviced settlements in any urban area in the country.

1.2.3 Access to toilets

The 2001 census estimated that 62 percent of urban households had access to toilets, an increase of almost 20 percent from 1991. An assessment commissioned by the Planning Commission (2002) attributes much of this increase to private household initiatives rather than to any public action and overall sanitation beyond households is of great concern. Interestingly, data generated by various national and international agencies (Planning Commission, WHO, UNICEF) indicate that, in spite of the rapid increase in urban population, India is on the way to meet the MDG targets. Between 1990 and 2000, on average an additional 7.7 million people per year gained access to toilets, and only about 18 percent of the population remained without toilets of any kind.

However, this optimism is an issue of debate as the coverage data is fuzzy about enumeration of the slum population as well as pavement dwellers and does not discount for unsafe and poorly maintained systems.[14] A majority of the households have septic tanks and service latrines also continue to exist (despite government claims to the contrary). Besides, access to sewerage is much lower; estimates range from 22.5 percent (Zerah, 2006) to 28 percent (World Bank, 2006) being connected to sewerage facilities. While states like Maharashtra (47%) and Gujarat (36%) are in a relatively better position, sewerage systems are almost non-existent in the urban areas of states like Bihar, Madhya Pradesh, Orissa, etc. Even where sewerage systems exist, treatment facilities are inadequate.[15] In fact the septic tank is the most commonly used technology in the urban areas with 35% of the urban population depending on them.

Large state variations in access to toilets across states exist. A World Bank study (2006a) estimates sanitation coverage figures to be in the range of 46% to 71%, with Gujarat accounting for the highest coverage (71%) followed by Maharashtra (49%). Access in larger, more populated and poorer states is reported to be even lower than the

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[13] Notified by the urban local bodies or development authorities

[14] There is no mechanism for generation of urban sanitation coverage data by the state or the central government agencies. WSP-South Asia is currently supporting the Government of Maharashtra in generating data related to sanitation in the larger urban areas of the state and to develop a system for this

[15] Out of a total of 300 urban centres with sewerage systems, only 70 are reported to have treatment facilities. (Zerah, 2006)

national average. The study also states that in spite of a higher proportion of slum areas, mega-cities like Bombay (56%), Delhi (52%) and Hyderabad (90%) have a better access rate to toilets.

1.2.4 Slum sanitation

Although almost 70 percent of slums in urban areas do not have access to sanitation facilities, the disaggregated data indicate, however, that the situation in notified slums appears to have improved over the years as per the NSS data. In 1993, while 54 percent of the slum population had no access to any kind of latrine facilities, the 58th round of NSS reported that in 2002 only 17 percent of the population in notified slums was without latrine facilities. However, in non-notified sums over 50 percent of the population continued to lack facilities of any kind. During the same period 30 percent of the population in notified slums and 15 percent in non-notified slums were able to gain access to the sewerage system. The poor conditions of the non-notified slums brings to the fore the issue of urban land tenure and the reluctance of the State and its urban agencies to provide basic services to people living on encroached land. Access to services thus varies according to the type of land the slum is located on. Inter-state variations in improvement in services to the slums continue to be glaring, with no slum in states like Orissa reported to have access to latrines of any kind, while in a state like Gujarat 83 percent of slum households have gained access to latrines connected to the underground sewerage system, largely as a result of innovative initiatives led by the municipal corporations together with NGOs and CBOs.

2. Response to urban sanitation needs

The Government of India's response over the years have been piecemeal and project-oriented. Chaplin (999) attributes this to three factors that she broadly terms as the 'politics of urban sanitation': the lack of pressure from the middle and upper class for sanitary reforms (they monopolise government facilities and due to advances in community health and medicines are somewhat protected from the health risks of unsanitary conditions), the lack of threat from the poor communities who are not organised to demand services, and the lack of capacity of the urban local bodies that are the primary service providers.

In the absence of a defined urban sanitation policy, discussions and budget outlays have largely focused on better sewerage facilities and capital intensive investments. These have been mostly limited to the larger metro cities and to low cost sanitation both as a separate programme and as part of slum improvement and upgradation schemes.

In fact urban and slum sanitation has been part and parcel of slum upgradation and environmental improvement programmes in India, ever since the centrally sponsored Bustee Improvement Plan in Kolkata and the nation-wide Environmental Improvement of Slums launched in the early 1970s. These projects introduced the concept of *in situ* development of slums, wherein improved facilities and services, including low cost sanitation, were to be provided. However, being more target oriented and supply driven, the projects failed to involve communities and to assess their needs and facilities, and therefore were not sustained. The Task Force on Shelter for the Urban Poor and Slum Improvement (Planning Commission) set up by the GoI in 1983, pointed out the need to set realistic norms for budget allocations, to ensure the active involvement of urban local bodies, to ensure that improvement programmes were linked with security of tenure, and, above all, to ensure the full involvement of the community, voluntary agencies and

community organisations. It also advocated the institution of a pattern for cost recovery (at least in part) and functional arrangements for maintenance of assets and services. However, apart from marginally raising the expenditure norms the GoI chose to ignore most of these recommendations. As a result, low cost sanitation has been the major approach and has focused on both individuals and communities to pay and use toilets.

The urban local bodies, on the other hand, have performed better in terms of experimenting with innovative approaches and structures for improving the sanitation status of cities, and especially of the slums within the cities. Water and sanitation in India is a state subject, although substantial funds (which influence policies) come from the central government. Some states have used this autonomy to experiment with innovative models to improve the sanitation services.

2.1 National policy and programmes

2.1.1 Low cost urban sanitation

Low cost urban sanitation has been in focus since the beginning of the 1980s. This includes provision of free, often collective, toilets for the urban poor as well as pay-and-use toilets. However, a supply-driven targeted approach led to poor quality of construction and poor maintenance and to the failure of most of the schemes. This failure includes the pay and use schemes such as that run under the NGO banner of Sulabh Sauchalaya. Surveys indicate high use-costs and untrained caretakers as the major cause for the ineffectiveness of the Sulabh schemes. Thus, most of these schemes have only resulted in large financial transfers for facilities that are eventually not used, building a strong case for a participatory demand-driven approach.

The major programme so far has been the Urban Low Cost Sanitation for Liberation of the Scavengers initiated in 1980-81 and continued into the current Tenth Plan as a centrally sponsored scheme. The objective is to convert dry latrines into low cost pour-flush latrines and provide alternative employment to the 'liberated' scavengers. The scheme is taken up on a whole town basis. While the Urban Development Department is responsible for conversion of latrines, the rehabilitation of scavengers is the responsibility of the Ministry of Social Justice and Empowerment. While initially the concept of low-cost sanitation was perceived as a solution for eliminating the practice of carrying night-soil, it also came to be seen as an appropriate solution where resources did not permit the provision of underground sewerage or septic tanks. The scheme now covers all the households which have dry latrines and households having no sanitation facilities including those in slums and squatter colonies.

It is technically a demand-driven scheme and hence no targets or state allocations are fixed. Under the scheme, both subsidies from the central government and loans from the Housing and Urban Development Corporation (HUDCO) are available simultaneously. While subsidy is given according to the economic status of households (45 % EWS, 25 % for LIG, no subsidy for MIG and HIG)[16] loans ranging from 50 per cent to 75 per cent of the cost can be availed at 10 per cent interest repayable over 15 years. The beneficiary contribution has been pegged at 5%, 15% and 25% for EWS, LIG and MIG/HIG households respectively. Loans are also given for construction of community latrines on the pay-and-use principle and for shared latrines in slums. While subsidy is

[16] EWS: Economically Weaker Section; LIG: Lower Income Group; MIG: Middle Income Group; HIG: Higher Income Group

limited to the cost of the sub-structure, the loan can be availed for the construction of the super-structure also. The loan component, however, requires the state government's guarantee.

The Low Cost Sanitation programme also includes community toilets and has now been merged with the new scheme of Valmiki Ambedkar Awas Yojana (VAMBAY). These toilets cater to the needs of slum and pavement dwellers, rickshaw pullers and the floating population. The maintenance of these units is generally handed over to NGOs or a community-based organisation, with the users paying a small fixed monthly amount towards maintenance.

Progress, however, has been slow and by the end of March 2002 only a little over 1.45 million were converted or new ones constructed (out of a 1989 estimated total of 5.4 million dry latrines) and 3000 community toilets constructed, while 387 towns were declared scavenger-free and almost 37500 scavengers were 'liberated'. Weak project management, low subsidies and loans, the poor state of municipal finances, and therefore the inability of states to stand guarantee and consequently for HUDCO to extend loans have been cited as the reason for the poor performance of the scheme. Besides, lack of awareness, poor quality of construction, lack of maintenance, etc, were the other major deterrents to the poor performance of urban sanitation interventions. Besides, there is no dedicated organisational structure at the state level with a capacity to propagate urban sanitation programmes and supervise their implementation. As a result, no efforts have been made to develop locally relevant technological options responsive to user needs by using suitable and cost-effective locally available materials and through user education. Besides, delays have also been due to bureaucratic inability and road blocks.

2.1.2 Other centrally sponsored schemes

Urban and slum sanitation has also been a component of other centrally sponsored schemes like:

- Integrated Development of Small and Medium Towns scheme, launched in 1979 with the objective of development of infrastructure, including water and sanitation in towns that serve as intermediaries for rural-urban migration.
- Urban Basic Services for The Poor, an integrated community based programme that attempted to facilitate and empower community based women's groups to access existing government services and programmes.
- Mega City Scheme (1993), launched in the mega-cities of Mumbai, Calcutta, Chennai, Bangalore, and Hyderabad, creating a revolving fund to finance urban infrastructure in particular in slums.
- National Slum Development Programme that sponsors infrastructure development, including water and sanitation facilities and environmental improvement.
- Valmiki Ambedkar Malin Basti Awas Yojana (2001) again targeting slum dwellers and earmarking 25% of its total funds for water supply and sanitation.

2.1.3 Corrective measures in the Tenth Five Year Plan

The Tenth Five Year Plan (2002-2007), attempting to correct the existing anomalies in the urban sanitation sector vis à vis the low cost sanitation approach, advocated:

- Propagation of the concept of low cost sanitation as a package that includes maintenance of environmental health, i.e. water supply, protection of the

environment and preservation of environmental cleanliness, etc. It would adopt an integrated approach wherein a coordinated programme would cover sanitation in schools, individual households, and public places with special emphasis on the sanitation needs of the urban poor and slum-dwellers and pavement dwellers.

- Setting up high level State Sanitation Councils consisting of experts, NGOs, representatives of PRIs and urban local bodies (ULBs), HUDCO, and other institutions in the fields of environmental sanitation, health, etc. The council are expected to promote the concept of sanitary latrines while mobilising communities to eliminate open defecation as well as manual scavenging.
- Adequate provision for Information, Education and Communication(IEC), project management and NGO involvement.
- Subsidies based on the cost of the basic twin-pit pour-flush model for a small household to be extended to cover the super-structure and sub-structure and design options would also be provided.
- While HUDCO should provide technical and organisational back-up, the ULBs should be strengthened to undertake the recovery of loan instalments.
- Finally, the programme is to be extended to all the states as the focus is shifted to prevention of open defecation rather than only elimination of manual scavenging.

Thus, a gradual shift towards a concerted strategy in line with the rural sanitation programme is visible. Together with TSC in the rural areas, the GoI is aiming to achieve Open Defecation Free Status by 2012. However, so far little seems to have changed as indicated by the updated (July 2006) figures for low-cost sanitation released by the GoI, and as yet no comprehensive urban sanitation policy has emerged.[17]

2.1.4 JNNURM and the sub-mission on Basic Services to the Urban Poor

Towards the end of 2005, GoI launched a large urban renewal and development programme known as the Jawaharlal Nehru National Urban Renewal Mission (JNNURM). The JNNURM would appear to offer renewed opportunities to improve the urban sanitation situation, especially with a focus on the slums and the poor settlements. Moreover, it places the onus of service delivery largely on the ULBs as well as attempts to operationalise decentralisation as has been laid down by the 74th Amendment to the Constitution.

With two separate sub-missions (Urban Infrastructure and Governance, and Urban Basic Services to the Poor), JNNURM is the GoI's response to the massive problems that have emerged as a result of rapid urban growth, and is a first attempt at a comprehensive strategy. The GoI has drawn up an urban strategy to implement projects in a mission mode and take forward the reform agenda indicated in the Tenth Plan. The overall strategy focuses on reforms driven by the planned development of identified cities wherein community participation and accountability of urban local bodies towards citizens are key features. Planned urban perspective frameworks for a period of 20-25 years (with five yearly updates) indicating policies, programmes and strategies for meeting fund requirements have been prepared by 63 identified cities, including Mumbai and Pune, to be followed by detailed project designs. Private sector participation for development, management and financing of infrastructure is also being encouraged. The

[17] 2.13 million converted/new units; 52829 scavengers liberated. Data released by Ministry of Housing and Urban Poverty Allocation, GoI

sub-mission on Basic Services to the Urban Poor specifically focuses on integrated development of slums through projects for providing shelter, basic services and other related civic amenities including water supply, sewerage, drainage, community toilets, baths, etc., while ensuring security of tenure and houses at affordable costs.

2.2 Initiatives at the State and ULB levels

Since the late early 1990s, innovative city specific comprehensive slum improvement and upgradation projects have been undertaken, primarily in collaboration with international and bilateral agencies. Many of these, like the one being implemented in Kolkata (covering 38 municipalities and three corporations of Kolkata Metropolitan Region), have several components, have gone through multiple phases, and have received support from multiple donors. Others like the WaterAid supported urban sanitation project have been less ambitious covering about 25-30 slums and have exclusively focused on slum sanitation and provision of toilet facilities. While all of them have been in partnership with NGOs and CBOs, in several of the projects NGOs were involved in actual construction activities and maintenance of services thereafter. Interestingly, many of the projects graduated from initial pilots to a city wide approach with the NGOs in partnership with the urban local bodies (ULBs).

Some of the state and ULB initiated projects are:

- The WaterAid supported Integrated Slum Sanitation Project (1999) was implemented in partnership with Tiruchirapalli Municipal Corporation, with local NGOs like Gramalya, SCOPE, SEVAI and WAVE a community based federation. This is for construction of pay and use toilet blocks in 25 selected and 'approved' slums of the Tiruchirapalli urban area. A range of options from conversion of dry latrines to construction of new individual as well as community blocks based on demand, space and tenure status were offered by the project. The NGOs were involved in planning implementing and monitoring the construction activities besides community mobilisation. The project was scaled up by the Municipal Corporation to cover the remaining 75 slums, wherein construction was handed over to contractors but community inputs continued to be provided by the NGOs. These slums have now been declared 'open defecation free' and the toilet blocks are well maintained by women Self Help Groups (SHGs) formed and trained for the purpose. In fact all 300 toilet blocks have been handed over to the SHGs for maintenance. The partnership has to its credit the development of low cost technological innovations catering to the special needs of children and a model of pay and use toilets.

- A similar programme - the Integrated Sanitation Programme, a part of the Tamil Nadu Urban Development Programme in 102 municipalities and five municipal corporations - targets the population living below the poverty line. This too adopts a demand-driven approach involving communities and is in partnership with CBOs, NGOs and ULBs. Here again the community complexes have been handed over to the SHGs for maintenance.

- DFID's integrated projects in several cities also included improvement of services, including household, community and environmental sanitation, slum improvement, solid waste management sewerage and drainage as key components. All the projects were implemented in partnership with municipal

corporations and other urban development agencies and NGOs were involved in community mobilisation and in some cases in the construction of toilets. Some of the key projects include:

- Indore Habitat and Slum Networking project in Indore (Madhya Pradesh) in the early 1990s;
- City wide projects in Cochin, Vishakhapatnam, Hyderabad and Cuttack;
- Gomti Pollution Control project in Lucknow where, while the focus was on the cleaning up of the river, key components in partnership with NGOs were improvement of sanitation along the banks, including provision of toilets to slum communities;
- A series of slum improvement programme in Kolkata, including three phases of the Calcutta Slum Improvement Project and the current Kolkata Urban Services for the Poor and Kolkata Environmental Improvement Project in partnership with ADB;
- An integrated programme in Madhya Pradesh covering five cities where while ADB is funding the major infrastructural activities, DFID is supporting community development and institutional reforms (ULBs).

- The Slum Networking project in Ahmedabad was in partnership with NGOs, Ahmedabad Municipal Corporation, the private sector, the community and initially the corporate sector. Improvements in household sanitation and slum level upgradation were key elements. The programme had some successes and some failures, the key one evolving out of the withdrawal of the corporate sector from the alliance. There were conflicts within the alliance, mainly involving the private sector and a primary reason for this was attributed to the hurried formation of the alliance. Some of the alliance members in retrospect conceded that safeguards needed to be built as common goals alone would not ensure effective partnership between organisations with different values, approaches and structures.

- The Slum Sanitation Project (SSP) in Mumbai was implemented by the state with funds form the World Bank-financed Bombay Sewage Disposal Project (BSDP). The BSDP itself was started in 1995 and aims to improve the health and environmental conditions of about one million slum dwellers of Greater Mumbai, constituting about 20 per cent of the total slum population in the city. The project was limited to slums located on municipal land. The SSP was based on a demand-led, participatory approach with cost recovery as a key feature. It led to an innovative partnership arrangement between the Corporation, NGOs, private contractors and CBOs. Various arrangements for partnership were initially mooted until finally a unique arrangement wherein an NGO and a contractor together took responsibility for the full cycle of planning, implementation and handover of toilet construction was arrived at. What eventually emerged was one NGO (SPARC) led consortium (in a joint venture with a contractor) and two contractor-led consortia (in joint venture with NGOs) being contracted by the Corporation for the full cycle of project activities. In fact the success of the project appears to have heavily depended on the contract system for the construction of toilets devolved to NGOs and private contractors with tight quality norms, involvement of beneficiaries in the design of the toilets as also in their operation

and maintenance. By the end of February 2005, 253 toilet blocks were completed and handed over to CBOs to manage.[18]

- A city wide slum sanitation programme was launched at the initiative of Pune Municipal Corporation (PMC) in 1999. The objective was to change the approach from government-centred provision and management of services to community-centred and managed. The project was implemented in four phases. While reconstruction of old toilets was undertaken in the first two phases of the project, the subsequent two phases focused on construction of new toilet blocks. The success of the project is attributed to the unique partnership established between PMC and the NGOs (SPARC, Shelter Associates and five other NGOs) as well as the participation of the communities, a process again facilitated by the NGOs. The NGOs were invited by the municipal corporation to both construct and maintain toilet blocks in all the slums, including those located on encroached land. The PMC took the lead in making the partnership effective by simplifying implementation procedures (issuing work orders, release of payments, etc) and through regular interactions with the NGOs, etc. While the NGOs had to cover the cost of community mobilisation activities, the PMC facilitated the provision of infrastructure such as water supply and electricity. On the other hand, the PMC disbursed the capital expenditure incurred without cutting any project or appropriating funds, and mobilised the elected representatives to support the project. The NGOs have been requested to take over maintenance on a long term basis (30 years) and have appointed caretakers for the purpose. In some cases maintenance appears to be the responsibility of CBOs formed by the NGOs. The fact that both SPARC and Shelter Associates had a previous and long-term presence in these slums is attributed as a reason for their relative success. 418 toilet blocks have been constructed so far, covering 80 percent of the slum settlements against a target of 20,000 toilet seats to cover over 500 slum pockets. The 'Pune model' is now quoted as an example of an effective NGO-ULB partnership and is being propagated by the Government of India in its aim to achieve universal sanitation.

- Community Led Sangli Toilet Project (CLSTP) in Sangli, Maharashtra, being implemented by the Sangli Miraj Kupwad Corporation (SMKC) since 2001. The SMKC is implementing a CLTSP covering all slums in the city in four phases. The project is being implemented by SMKC in partnership with an NGO (Shelter Associates) and a CBO (Baandhani). USAID under its Indo-US FIRE Project (Community Water and Sanitation Facility), has been supporting the Corporation and Shelter Associates through all the phases. In Phases 2 and 4 Shelter Associate has been supported by IOG (Canada) and Cities Alliance, respectively. While the first phase focused on a detailed survey and analysis of the situation, the second phase saw the successful construction of two toilet blocks and the

[18] During the course of the preliminary investigations, I also came across a reference to a project that was implemented in 1992 by CORO (Community of Resource Organisations) in Bombay in partnership with the Department of Science and Technology, GoI (the major funder), CMC limited, a public sector corporation (construction), National Literacy Mission (provider of funds for libraries), community organisers (mobilisation) and slum residents. CORO took over the management of 21 toilet blocks built by the Municipal Corporation and integrated the sanitation component with their literacy programme. The toilets were managed by the community on a cooperative basis and in some cases funds were generated from sponsors.

setting up of a community based system for their maintenance on a pilot basis. The third and the fourth (current) phase involve city wide scaling-up of the project. The second phase was significant because it also saw the creation of a Forum consisting of representative of the government, media, and civil society for planning and supervision. The Forum was set up as part of an action research work of the South Asia Media and Governance Network Programme (MAGNET) managed by the Institute on Governance (IOG), Canada. The IOG linked with SKMC to bring local government, civil society (NGOs and CBOs) and the media together to ensure the delivery of basic services to the poor. Although there is no maintenance contract drawn up between the NGO/CBOs and the Corporation, maintenance of the pilot blocks constructed in phase 2 is reported to be satisfactory. The success of the pilot phase and subsequent developments is largely attributed to the processes initiated by the Forum,[19] leading to a transparent process, fewer bureaucratic hurdles and effective monitoring.

It is to be noted here that CLTS as a concept was only recently introduced in the India. In fact it was first piloted in Maharashtra in 2002 in the rural areas of the districts of Ahmednagar and Nanded, which led to 'open defecation free' (ODF) villages. Now it is being adopted by almost all the districts in the state and is slowly spreading to other states in the country, including Haryana, Rajasthan, Chhattisgarh, Orissa, Gujarat, Karnataka and Andhra Pradesh. It is less known in the urban areas. In fact a recent report by Kar and Bongartz (April 2006) states that the only known case is in the Municipality of Kalyani near Kolkata, State of West Bengal, where it was piloted under a Community-led Health Initiative (CLHI), of Kolkata Urban Services for the Poor (KUSP). They conclude that, except for the rural areas of Maharashtra, CLTS has not been very successful in India primarily because of the low profile accorded to the sanitation sector, the 'narrow focus' on targeting the Below Poverty Line (BPL), without a concrete approach to involving the Above Poverty Line(APL) and the continuing high subsidies.

3. Urban institutional framework for delivery of sanitation services

A plethora of agencies exist for the provision of water and sanitation facilities in the country. The most critical one is the Public Health Engineering Department in each state which is responsible for the execution of all water supply capital works in both the urban and rural areas. Maintenance activities are thereafter transferred to separate agencies, mainly urban local bodies and PRIs. Sanitation, however, is by and large the responsibility of the PRIs in the rural areas and the ULBs in the urban.

3.1 NGOs in urban sanitation

Until recently NGOs working in the sanitation sector were very few. While their numbers have increased since the operationalisation of TSC in the rural areas, they remain peripheral players in the urban areas. WaterAid, the international NGO is one of the biggest and oldest in the sector. Apart from WaterAid, SAATH and SEWA in Ahmedabad and SAPRC and Shelter Associates in Maharashtra, are the other few well-known NGOs. Sualbh International, perhaps the only exclusively sanitation focused NGO (besides WaterAid with its water and sanitation focus) and with a country wide presence,

[19] The Forum was earlier initiated in Pune under the slum sanitation project, but had to be abandoned and shifted to Sangli for reasons primarily related to a lack of adequate engagement with the PMC

falls conceptually into a different category. Interestingly, for NGOs like SAATH, SEWA, Shelter Associates and SPARC, sanitation is part of a larger agenda of tenurial rights and adequate housing. A brief description of some of these NGOs follows:

The ***Sulabh International Social Service Organisation*** was established in 1970 to improve sanitation facilities particularly among the poor and in low-income settlements. The organisation is founded on the belief that partnership between the government, local authorities and NGOs backed by community participation can make a substantial impact in improving the environment. Sulabh operates in more than 20 states, covering 1200 towns having its offices in the respective states, zonal areas and local areas. It enters into a contractual arrangement for provision of sanitation facilities with public agencies and most of its interventions and activities are collaborations with municipalities/municipal corporations and other public agencies.

It undertakes three types of direct provision of sanitation facilities: construction of two pit pour-flush toilets for individual households, construction and maintenance of community toilets on a pay and use basis, and construction and maintenance of community toilets in slums and squatter settlements. It does this with the support of block grants from the corporations. By 2000 it is reported to have constructed one million low cost toilets in slum areas and 4000 pay and use community complexes catering to the poor and low-income sections.

WaterAid started its work in India towards the end of the 1980s with a few small projects primarily in the southern states of the country and has extended its operations to cover the poorer states in the north. It now works on water and sanitation in 10 states in partnership with local NGOs and government departments in both the urban and rural areas. Community sustained improvements in water and sanitation have been the approach adopted. The projects have a strong component of partnering with state governments. As indicated earlier, it was a pioneer in urban sanitation in the country.

The Society for the Promotion of Area Resource Centres (SPARC) was established in 1984 to work with the slum and marginalised population of Mumbai with a focus on pavement dwellers. Their work philosophy revolves around the concept that anything that works for the poor can be scaled up to cover the entire city. In the course of its work and as a critical strategy it created and empowered two community-based organisations: the National Slum Dwellers Federation (NSDF) and Mahila Milan, together known as the 'Alliance'.

The NSDF (initiated in 1986) is a national organisation of community groups and leaders who live in slums and informal settlements. Its objective is to mobilise and organise the urban poor to articulate their concerns and together find solutions to their problems of tenure, housing, livelihood, etc, in the urban areas. Currently the NSDF has a membership of over half a million households in the country. Mahila Milan on the other hand is an exclusive federation of women. It is a decentralised network of poor women's collectives that manage credit and savings activities in their communities. It also provides space for women to undertake decision making roles in the community. Initiated in 1986, with a group of 500 women living on the pavements in Bombay to protect their right to shelter, MM now has a large membership and has also become a significant savings and credit federation. Although the Alliance members work closely together, their roles are clearly defined. A critical component of their approach is to work closely with the government at all levels. SPARC and its alliance work are now spread

across 70 cities in the country. It also has networks in about 20 other countries although its major initiatives continue to be focused in Mumbai and other cities of Maharashtra. The Alliance is a key partner in the Mumbai slum sanitation programme as well as the Pune project and as such has managed a large programme of community-designed, built and managed toilet blocks in both the cities.

Shelter Associates is a Pune-based NGO launched by a group of architects, social workers, and community workers, who work with the urban poor, particularly women in informal settlements. They facilitate, and provide technical support for community-managed housing (slum rehabilitation) and infrastructure projects. Like SPARC it has formed a community-based network (Baandhani - 'building together' in Marathi), a collective of poor men and women from informal settlements in the urban areas of Maharashtra. It works in close partnership to promote community participation in housing and infrastructure projects for the poor and to support the formation of savings and credit groups which work for poor women, amongst other activities. In the early years of its existence Shelter Associates worked in close collaboration with SPARC and continued to do so for a period of six years. Shelter Associates are a major player in the Pune and Sangli Slum sanitation programme and work in close corporation with both the municipal corporations.

4. Conclusions

Clearly there is a need for major interventions and on a large scale to improve the situation of urban sanitation in the country. However, the above description of sanitation in India in general and urban sanitation in particular raises issues that are critical to the core questions of the NGPA research framework. What is significant is that in almost all the major initiatives described, the NGOs and CBOs have been key players. While the roles of the CBOs have ranged from actual construction of facilities to its maintenance, NGOs have been central to the entire gamut of activities, including construction - a relatively new addition to an urban NGO's profile. The municipal corporation on the other hand appears to have been responsible for contracting, monitoring and oversight, and for ensuring the flow of funds. This is an ideal situation conceptually, but a deeper exploration of the way that the roles and responsibilities have been discharged should reveal the complexities of this triangular partnership, the extent of autonomy and independence that each of the partners could negotiate, and most importantly the sustainability of the partnership.[20]

A crucial issue is the lack of a national sanitation policy, in the absence of which, interventions so far have been generally small, pilot in nature, usually propelled by donor-funded programmes and often in response to crisis situations. This together with a lack of political will, as in many other instances of social development, has resulted in project-based interventions with a short term perspective at the cost of ignoring the need to put in place an institutional system for service delivery. The lack of a clear policy perspective has also led to ignoring the problems of the existence of multiple state

[20] Besides, a programme like the Bombay SSP has introduced another dimension and hence another area of potential conflict and concern, by promoting the concept of an NGO-contractor consortium. What actually appears to have happened is that while a better organised NGO with inroads into the community set up a CBO-based construction unit, contractors quickly put together an 'NGO' or tied up with an existing and obscure one.

agencies whose actions have an impact on any sanitation programme. For instance, in the urban areas, although the Urban Local Bodies (ULBs) are primarily responsible, land and development clearance has often to be obtained by the Urban Development Authority, electricity from the Electricity Board, etc. In a partnership situation, the more stakeholders that have to be consulted the more the conflicts and tension that are bound to arise.

The 74th Constitutional Amendment and the transfer of responsibilities of services, including sanitation, to the ULBs provided scope for creating a sustainable institutional system. However, it also brought into question an added dimension – that of the capacity of the ULBs to perform. Urban sanitation has now become ULB-dependent: dependent on the ULBs' vision, policies, financial capacities, perspective on community participation, involvement of NGOs and above all the presence of a champion within the institution. For these reasons not only is one ULB different in profile, performance and outcome from the other, but the same ULB can also be seen to reflect different profiles and different levels of performance over a period of time. Hence the relationship of an NGO may differ from ULB to ULB and also from one period to the other. Discussions with Shelter Associates indicate that their experience in implementing an urban sanitation programme in Pune is vastly different from that of urban sanitation in the Municipal Corporation of Sangli-Miraj Kupwada Corporation. Moreover, within the Municipal Corporation of Pune itself, Shelter Associates' relationship with the Corporation appears to have changed from being effective and fruitful to a position of mistrust leading to an almost complete halt of the partnership following a change in leadership in the ULB. Although the change in leadership may not have been responsible alone for the change in the status of the partnership, that it did have a significant impact is obvious from preliminary discussions with both the NGO and the Corporation. The attitude and opinions of the top management may also percolate and be reflected in the actions of the staff team at the implementation level.

Initial discussions also indicate the possibilities of the relationship between the NGO and the municipal corporation also being a function of the vision and capacities of the NGO. Where NGOs have the strength of clear goals, technical skills, rapport with the community, and is not solely dependent on funds from the municipal corporation, the dynamics of the relationship appear to become more complex. The NGO consistently seeks space to negotiate its own agenda and may be in a position to use multiple strategies to achieve its goal. The greater status and clout of the NGO may on the one hand lead to its being displaced by less threatening or more compliant partners (viz the case of Shelter in Pune) or allow it to assume a position of supremacy or monopoly (SPARC in Bombay).

The ambiguity of the legal status of poor urban settlements and slums is another factor that has an influence on the provision of urban sanitation. Land in urban areas, besides being a scarce commodity, is also highly susceptible to vested interests. The issue of slum tenure is a subject of interest not only to NGOs and civil society organisations working for the rights of the poor but is also a valuable platform to negotiate for political votes and patronage. Lack of space for community toilet blocks in crowded settlements is therefore an area of possible negotiations and contention between the ULB, NGO and CBOs. Again it may also involve negotiations and engagements with one or the other of the multiplicity of agencies responsible for infrastructure and services in the urban areas.

Finally, there is the issue of operation and maintenance of the community facilities and the extent of their sustainability. Who is responsible: the community or the CBO that represents it, the NGO which may or may not have a maintenance agreement with the municipal corporation, or the corporation itself? These questions are loaded with assumptions: that the community is sufficiently aware, informed and well organised to maintain the toilet blocks (an assumption that will be coloured by factors such as the heterogeneity of urban slum communities, high rates of migration, etc.); that the NGO has a long term vision and objectives to sustain its engagement in the project and also has the financial capacity to do so; that the MC is consistent in its policies and intent, irrespective of changes in its executive or elected wings.

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