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

Scoping Study of Relationships between the State and the Non-Governmental Sector in India

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<tr>
<td>ANM</td>
<td>Auxiliary Nursing Midwife</td>
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<td>ARWSP</td>
<td>Accelerated Rural Water Supply Programme</td>
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<td>ASHA</td>
<td>Female health activist</td>
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<td>AUWSP</td>
<td>Accelerated Urban water Supply Programme</td>
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<td>BOT</td>
<td>Build Operate Transfer</td>
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<td>CART</td>
<td>Council for Advancement of Rural Technology</td>
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<td>CAPART</td>
<td>Council for Advancement of People’s Action and Rural Technology</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CHC</td>
<td>Community Health Centre</td>
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<td>CRSP</td>
<td>Centrally Sponsored Rural Sanitation Programme</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>CSWB</td>
<td>Central Social Welfare Board</td>
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<td>DPEP</td>
<td>District Primary Education Programme</td>
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<td>EBB</td>
<td>Educationally Backward Block</td>
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<td>EFA</td>
<td>Education For All</td>
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<td>EGS</td>
<td>Education Guarantee Scheme</td>
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<td>EGS&amp;AIE</td>
<td>Education Guarantee Scheme and Alternative Innovative Education</td>
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<td>ESA</td>
<td>External Support Agency</td>
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<td>ESIS</td>
<td>Employees’ State Insurance Scheme</td>
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<td>ESSE</td>
<td>Early Childhood Care and Education</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>Government of India</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HDR</td>
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<td>ICDS</td>
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<td>IMA</td>
<td>Indian Medical Association</td>
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<td>ISM&amp;H</td>
<td>Indian System of Medicines and Health</td>
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<td>ISP</td>
<td>Intensive Sanitation Programme</td>
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<td>JNNURM</td>
<td>Jawharlal Nehru National Urban Renewal Mission</td>
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<td>KVIC</td>
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<td>MCH</td>
<td>Maternal and Child Health programmes</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MJP</td>
<td>Maharashtra Jeevan Pradhikaran</td>
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<td>MLL</td>
<td>Minimum Level of Learning</td>
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<td>MPW</td>
<td>Multi Purpose Worker</td>
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<td>NDWM</td>
<td>National Drinking Water Mission</td>
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<td>NFE</td>
<td>Non-Formal Education</td>
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<td>NHDR</td>
<td>National Human Development Report</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>NLM</td>
<td>National Literacy Mission</td>
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<td>NPE</td>
<td>National Policy on Education</td>
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<td>NPEGEL</td>
<td>National Programme for Girls at Elementary Level</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>NPO</td>
<td>Non-Profit Organisation</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>NSP</td>
<td>Non State Providers</td>
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<td>OBC</td>
<td>Other Backward Castes</td>
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<td>PADI</td>
<td>People’s Action for Development in India</td>
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<td>PHC</td>
<td>Primary Health Centre</td>
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<td>PHED</td>
<td>Public Health Engineering Department</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>PRIs</td>
<td>Panchayat Raj Institutions</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RGNDWSM</td>
<td>Rajiv Gandhi National Drinking Water and Sanitation Mission</td>
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<td>RMP</td>
<td>Rural Medical Practitioners</td>
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<td>SC</td>
<td>Schedule Caste</td>
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<td>SD</td>
<td>Swajal Dhara</td>
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<td>SRP</td>
<td>Sector Reform Programme</td>
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<td>SSA</td>
<td>Sarva Shiksha Abhiyan</td>
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<td>TSC</td>
<td>Total Sanitation Campaign</td>
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<td>U5</td>
<td>Under 5 Mortality Rate</td>
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<td>UEE</td>
<td>Universal Elementary Education</td>
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<td>ULB</td>
<td>Urban Local Body</td>
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<td>VHAI</td>
<td>Voluntary Health Association of India</td>
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<td>VO</td>
<td>Voluntary Organisation</td>
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<td>ZP</td>
<td>Zilla Parishad</td>
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SCOPING STUDY: INDIA

1. INTRODUCTION

1.1. About the study on ‘Whose Public Action?’
The research study is being undertaken by the International Development Department, School of Public Policy, and University of Birmingham in collaboration with the Centre for International Education, University of Sussex, WEDC at the University of Loughborough, and the London School of Hygiene and Tropical Medicine.

It is primarily concerned with the relationship between government and non-governmental actors in realising public action for the delivery of basic services (primary health and education, water and sanitation), especially to poor people. The research is based on the argument that the relationship is an area of contention between the state and Non-State Providers (NSP) as they have structurally and ideologically different perspectives on both means and ends of public action, but who nevertheless enter into a relationship.

1.2. Scoping Study
1.2.1 Purpose
The purpose of this scoping exercise is, firstly, to assess the relevance of the research questions in the context of India and to allow for its further development. Secondly, the paper aims to facilitate the location of case studies on the basis of some common and agreed parameters.

1.2.2 Framework
The framework of analysis is developed to construct the overall status of the three sectors under study, in terms of its development and relevant policies and programmes on one hand and on the other to understand the prevailing notions and concepts on the NSP-state relationship in general and within the sectors under study in particular. Thus, the framework includes a description of the status of the basic service sectors, role of the state and service delivery mechanisms; sectoral policies and programmes; trends in non state provision of services; and evolution of the relationship between the state and non state providers

2. OVERVIEW OF INDIA’S BASIC SERVICE SECTOR

While profiling the basic services, which have a critical impact on the reduction of poverty, one needs to refer to the three macro indicators that have dominated the development debate in India since the early 1990s: the steadily growing Gross Domestic Product (GDP), the gradually reducing - and of late much contested - poverty ratio and the Human Development Index (HDI) which, although showing an overall improvement, has only marginally moved up in the global ranking. It also needs to be kept in mind that since the beginning of the 1990s the country has initiated a process of structural and economic reforms, which have had bearings on subsequent development activities, including basic service delivery sectors.
2.1 Growth and Poverty in India

India is at present ranked the fourth largest economy in the world (based on comparisons of GDP measured in purchasing power parity terms), with an annual growth that is close to 8 percent. The growth in per capita GDP, although falling short of the 10 percent threshold necessary to reduce mass poverty by the end of the current decade, is one of the fastest growing in the world. The relatively sustained economic growth has reduced the poverty ratio significantly and, although it has registered yearly fluctuations, the long-term declining trend in the poverty ratio has continued throughout the 1990s and well into the early years of the current decade\(^1\). The decline in the 1990s was faster than in the previous decades due to a combination of factors, including pro-poor policies and several targeted poverty reduction programmes.

In India, poverty reduction has largely been driven by economic growth (Ravallion and Datt, 1996) and the poverty profile is very different from what it was until the 1970s, both in terms of the spatial focus as well as the social base. Even so, 260 million people in the country live below the poverty line, with more than 74 percent residing in rural areas, with poverty being increasingly concentrated in selected regions and states of the country and amongst certain social groups (Radhakrishnan and Ray, 2005; Panda, 2005). On the one hand, poverty reduction has been faster in states like Gujarat, Karnataka, Punjab, Haryana and Rajasthan where economic growth during the last decade (1990s) has also been relatively reasonable. Even states like Tamil Nadu and West Bengal, which had more than 50 percent of the population living below the poverty line in 1983, were able to reduce the poverty ratio by more than half by the year 2000. On the other hand, states like Orissa, Assam, Madhya Pradesh, Uttar Pradesh and Bihar have been lagging behind both in terms of economic growth as well reduction in poverty levels. Overall, while the poorest states are Orissa (47.15%), Bihar (42.6%), Madhya Pradesh (37.43%), Assam (36.9%) and UP (31.5%); the Punjab and Haryana (6.16 and 8.74% respectively), Kerala (12.74%), Gujarat (14.0%), Rajasthan (15.28%), Andhra Pradesh (15.7%), Karnataka (20.04%), Maharashtra (25.02%), and West Bengal (27.02%) fall in the relatively better off category.

A similar trend is also visible in the HDI, which encompasses the broader concept of human poverty. The 2005 HDR (UNDP) ranks India at 127 (out of 177 countries) in terms of the composite HDI (Government of India, 2005-006). Although there have been significant improvements in human development in the last two decades, the overall performance has been mixed with some critical indicators still being below the envisaged target and wide disparities across states, though to a lesser extent than income disparities.

2.2 Indicators of basic services

The delivery of basic services, including elementary education, primary health care, safe drinking water and sanitation are some of the critical constituents of the HDI, and any shortcomings in these are reflected in the composite index. In this section we take a closer look at the profile of the basic service constituents - in terms of key

\(^1\)The proportion of those estimated to live in poverty has declined from 51 percent in 1977-78 to 44 percent in 1984 and stood at 26 percent in 1999-2000.
indicators, state variations, accessibility of the poor, constitutional provisions and policies and programmes.

### 2.2.1 Macro indicators

India has made considerable progress in the education sector since independence (1947). Overall, as the National Human Development Report for 2001 (GoI, 2002) points out, there has been a considerable reduction in inequalities in educational attainment in terms of gender, caste, income levels and rural-urban divide. However, while progress on one hand reflects extraordinary success, on the other it underlines glaring gaps, attributed to the flawed nature of policy focus and public interventions of services.

As a result, while there has been a remarkable increase in overall literacy levels\(^2\) from a low 18.3 percent in 1951 to 65.2 percent in 2001, and in enrolment in elementary education from 2.2 crore in 1950 to 16.9 crore in 2002-03 (Tilak, 2006), about 300 million persons (1/3 of the population) in the age group of 7 years and above still remain illiterate. Further, although the average enrolment of children in the age group of 6-14 years is above 82 percent, the bigger challenge facing service providers is dropout of children from the schools. For instance, in 2002-03, although the enrolment ratio of children at primary level was above 95 percent there was an almost 35 percent dropout at that level.

On the other hand during the 1990s, for the first time since 1951, the number of illiterates in absolute terms declined by a significant 32 million. The rural-urban disaggregated figures also reflect a positive trend in terms of an increase in literacy in rural areas (36% in 1981 to 59% in 2001) and urban areas (67% in 1981 and 80% in 2001), also resulting in a decrease in the rural-urban gap from 31 to 21 percentage points. The decrease in the gender gap in literacy however, has been less impressive (decreased from 26.6 percentage points in 1981 to 21.7 percentage points in 2001).

The key health indicators tell a somewhat similar story - one of some successes and some glaring and puzzling failures: While life expectancy at birth has more than doubled in the last fifty years (above 60 years), it is less than most other developing countries in East Asia and Latin America. The infant mortality rate declined from 115 per thousand live births in 1981 to 63 in 2002, but this has been much slower than expected. At the same time, the maternal mortality rate stood at a worrisome 408 per thousand live births in 1997. Morbidity due to common communicable diseases is also high enough to cause concern, and there seems to be an apparent shift from communicable to non-communicable diseases (Mishra, 2005). Even so, India has had some remarkable success in almost eliminating such killer diseases as Smallpox, Guinea Worm and substantially reducing the incidence of the Plague, Cholera, Measles and Polio.

On the other hand, the provision of safe drinking water - a determinant of health and the quality of life - appears to be on track to meet the MDG target of 2015. According to official estimates (GoI, 2005-2006), an impressive 96 percent of the rural habitations - i.e. an estimated 720 million people - in the country have been fully covered with drinking water sources in 2005. This is a significant increase in coverage

\(^2\) Proportion of literates to total population in age group 7 and above as defined by Census of India
from 65 percent in 1990. However, studies indicate that in reality the coverage may be much less than projected as data estimation has certain integral problems largely related to the issue of ‘use’ and ‘accessibility’ (WaterAid, 2005). The Central Government itself admits to a modest 15 percent ‘slippage’ due to problems related to seasonality, functionality and water quality. In the case of urban areas, 90 percent of the population, i.e. about 250 million people, were provided with ‘safe’ water sources by 2001. What is of concern to planners and policy makers however, is the fact that only 74 percent of the urban population has been provided with a piped water source. Moreover, in the case of both rural and urban water supply, reliability in terms of quality and quantity of services, environmental sustainability, financial sustainability, especially to cover the operation and management costs and affordability, especially for poor households are critical concerns. (World Bank, 2006).

The sanitation status of the country is alarming, to say the least. Serious efforts to address the issue of almost non-existent coverage only began in the early 1990s. However, concerted efforts over the last decade have at least given some momentum to the sector and the rural coverage rose from an abysmally low 5 percent in 1990 to 20 percent in 2001. The urban areas have been better off, and the coverage rose from an initial 43 percent in 1991 to 61.5 percent in 2001.

2.2.2 State variations in indicators
When we look at the state-wise HDI, it is observed that most of the income-poor states in the country also have a relatively lower HDI. The links between the State Domestic Product and HDI, although weak, is seen to be positive. Radhakrishnan and Rao (2006) for instance point out that while higher income states like Punjab, Maharashtra and Tamil Nadu performed well on the HDI (all recorded a value between 0.523 and 0.537), Kerala, a middle income state, did far better (0.638). Studies attribute Kerala’s high HDI to the quality of health and educational facilities and the efficiency with which they are used and overall well-directed state interventions, public participation and social movements. (Radhakrishnan and Ray, 2005; Dev and Mooji, 2005)

When we further unpack the HDI and look at the education, health, water and sanitation indicators separately, a trend is visible to some extent:

- Wide variations exist in IMR, under 5(U5) death rates and MMR. The National Family Health Survey (1998-99) data shows that U5 mortality rate ranges from a minimum of a little less than 19 per thousand live births in Kerala to a maximum of 137.6 in Madhya Pradesh. Seven states, including Bihar, Madhay Pradesh, Rajasthan and Uttar Pradesh have a U5 rate that is way above the national average of 94.9. In the case of IMR, while Kerala again has the lowest rate at 16.3, Meghalaya with an IMR of 89 has the highest and significantly above the national average of 67.7. Uttar Pradesh and Madhya Pradesh closely follow Meghalay at 86.7 and 86.1 respectively. On the other hand a number of states like Tamil Nadu, Andhra Pradesh and Haryana have brought down their IMR from a high of 90 in 1981 to below 50 in 1991. In 1997, the MMR was 408 at the national level with state ratios varying from 707 in Uttar Pradesh to 29 in Gujarat. (National HDR, 2001) Tamil Nadu, Punjab and Kerala also have a relatively lower MMR. Uttar Pradesh, Madhya Pradesh, Orissa, Gujarat, Rajathan and Bihar on the other
hand have high MMR. Kerela, Maharastra and Tamil Nadu have fared better in terms of health transition\(^3\), while Bihar, MP, UP, Orissa, West Bengal and Rajasthan are still in the early stages of transition.

- The NHDR observes that there are large inter-state variations in the literacy rate in the country, although the regional variations have declined since 1981. In 2001, while Kerala, with 90 percent and Bihar with 50 percent stood at two ends of the scale, 10 states had a literacy rate below the national average. Although, it is encouraging to note that while in 1991 there were several states with less than 50 percent literacy and by 2001 only Bihar remained in this category, large states like Orissa, MP, AP, UP and Rajasthan continue to be relatively poor in all four dimensions of literacy, i.e. total literacy, relative deprivation in literacy, improvement in literacy and gender disparities. Enrolment rates on the other hand have improved in Kerala, Maharastra and Himachal Pradesh (Census 1991) as compared to Bihar, Rajasthan and Uttar Pradesh. Similarly the dropout rate has been quite high in Bihar, Rajasthan, UP, West Bengal, and Orissa. It has been stated that Rajasthan, Madhya Pradesh and Andhra Pradesh, followed by Orissa and Uttar Pradesh have made great improvements in their enrolment rates during the 1990s. But there are contentions that, in order to suggest that they have overcome the problem of out of school children, states like Orissa and UP (and Bihar) have given incorrect figures (Jhingran, 2004).

- Overall 16 states in the country had more than 78 percent of the population (above the national average) covered with safe drinking water by the year 2001. However, while Punjab topped the list of best performers with more than 97 percent coverage, Tamil Nadu, Karnataka, AP, Maharastra, Gujarat, West Bengal and even states like Bihar and Uttar Pradesh seem to have significantly improved their positions over the last three decades (Economic Survey of India 2005-2006). On the other hand in MP, Orissa and Rajasthan more than 30 percent of the population still do not have access to safe water sources. Interestingly, Kerala’s otherwise impressive profile falters on this score with less than 24 percent of the population having been provided safe water sources. Zerah (2006) attributes the very poor performance of Kerala to the presence of the large number of open wells. In addition, Kerala, Bihar, Assam, UP and Orissa have been able to provide tap water to less than 50 percent of their urban population, whereas states like Maharastra, Gujarat and AP, together with six smaller states have done much better with almost 90 percent of the urban population receiving tap water. These states have also been able to improve their delivery modes as well as service standards. Karnataka, Rajasthan and Tamil Nadu come in the next category of performers who have been able to provide over 80 percent of their urban population with tap water.

- Only 9 states are above the already poor national average for sanitation coverage. And even out of these, with the exception of Assam (60 percent) and Kerala (80 percent), the rest have less than 40 percent coverage. Even

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\(^3\) Health transition has three components: demographic (low mortality and fertility rates, aging population), epidemiological (change in pattern of diseases from communicable to non-communicable diseases), and social (ability to self-manage health, better knowledge and expectations from the health system. Bajpai, et al 2005)
Karnataka, Tamil Nadu, AP and Maharashtra, although showing marginal improvements, have a long way to go. Orissa and MP are again almost at the bottom of the list closely followed by Bihar, Tamil Nadu and Rajasthan. Similarly, sanitation coverage is the worst in the urban areas of states like MP and Bihar with more than 45 percent of the population having no access to any type of toilets. Although Punjab, Maharashtra, Gujarat and Tamil Nadu appear to fare better the percentage of population covered is still below 50 percent. (Zerah, 2006).

2.3 Role of the State in provision of basic services

2.3.1 Constitutional provisions

The Constitution of India under its ‘Fundamental Rights and Directive Principles of State Policies’ provides the foundation for delivery of basic services. It directs the State to ensure the provision of ‘free and compulsory education for children’ and asserts that it is the ‘duty of the State to raise the level of nutrition and the standard of living, and to improve public health’ as well as protecting ‘life and personal liberty’. And herein lays the genesis of education, health care and water and sanitation as a human right.

Although, education was not a fundamental right at the time when the Constitution was adopted, several Articles in the Constitution underline its importance. Thus, the State is directed to: provide for free and compulsory education to all children until the age of 14 to be achieved in a period of ten years of the commencement of the Constitution (Article 45); promote the educational interests of historically disadvantaged sections of the society (Article 46); and protect the interests and rights of minorities to establish and administer educational institutions (Articles 29 and 30).

In the last decade education has moved into the realm of human rights and with the passing of the landmark Right to Education Bill in 2005 (insertion of Article 21A through the 86 Amendments to the Constitution) elementary education has become a fundamental right in India. The Indian Constitution now guarantees eight years of elementary education to each and every child in the country.

Health care and safe water and sanitation on the other hand are yet to become legislated fundamental rights. However, many court rulings have interpreted the fundamental right of protection of life and liberty (Article 21) to include right to health and access to medical treatment. The right to safe drinking water is in turn drawn from the right to food, the right to clean environment and the right to health. Time and again, several legal cases have concluded that the State, or its agencies, would be seen to violate the residents’ right to life if it fails to implement adequate measures to protect the environment or provide safe drinking water or ensure access to medical treatment. Thus, in all cases the role of the State becomes critical.

The Constitution has also made provisions for the State to meet these obligations. Responsibilities have been divided between the three levels of governments - Central, state and local government - and defined in the Union, the State and Concurrent lists of roles and responsibilities. Education is a Concurrent subject, wherein responsibilities are shared by the central and state governments (but central laws prevail in the event of conflicts) and both the centre and the state governments play a critical role in the planning and management of elementary schools. On the other
hand, both health and water are primarily placed in the State List. But here too the Central government plays a critical, and often a dominant, role because of its financial clout and because, within a central planning system that India follows, the National Planning Commission determines priorities through Five Year Plans, strategies and allocation of resources, though in consultation with the states.

Further the Panchayats and Municipalities have been assigned specific powers under the Constitution (11th and 12th Schedules) and subsequently, in 1992, they were given the responsibility for governance of basic services with the 73rd and 74th Amendments to the Constitution, providing a statutory base for decentralized planning and management of development activities. All States have since then enacted new Acts or incorporated changes in the existing ones in conformity with the Amendments and 29 development activities, including elementary education, health and water and sanitation, have been technically transferred to the Panchayat Raj Institutions (PRIs, or the rural local bodies). In addition, the State-Urban Local Bodies (ULBs) relationship has also been redefined with the Amendment putting the onus of service delivery on the ULBs. The recently floated National Urban Renewal Mission (JNNURM), an umbrella programme for infrastructure development and basic service delivery, has reiterated the central role of the ULBs and is pushing a reform agenda on the lines of the 74th Amendment. However, devolution of power and functions varies across states and barring a few states like Kerala, Karnataka, Sikkim and West Bengal, the PRIs continue to play a secondary role.

2.3.2. Service delivery mechanisms: infrastructure and resources

All the sectors under study operate within a pluralistic framework where, although the State is the principal provider of services, a range of other providers co-exists. In this section we look at the primacy of the State in service delivery.

Service delivery, until recently, was mainly a centralised top-down function. In many ways, this continues to be the case, framed around the fact that the sectors are largely dependent on central government funds, channelled through the states and its agencies for facilities and services. At the federal level the concerned Ministries coordinate the service delivery systems. Each state has a more or less similar structure in place and is the principal administrator, while the districts represent the level at which services are delivered. Each department at the state level in turn generally has multiple agencies with district and sub-district units. With the process of decentralization, the PRI, and to some extent the ULBs, have been brought within the scope of the service delivery system. Although the local bodies are meant to plan and implement local development plans, much of the planning and operation of the services continue to operate under the vertical structure of the central and state departments.

There are some sector specific features in service delivery mechanisms:

**Elementary Education** is on the concurrent list under which the Central Government and the state governments are expected to have a meaningful partnership for educational development in the country. The PRIs and municipalities have also been associated with school education. Elementary education is thus provided through a chain of over 664,000 primary schools, 296,000 upper primary schools and 133,000 secondary schools variously managed between the state government, local bodies and
private sector. Since 1976, primary education has been the joint responsibility of the Central and respective state governments. Subsequently, even before the constitutional process of decentralisation was affected, the National Policy on Education, 1986 (NPE) and its Programme of action (1992) brought about some changes in service delivery around the process of decentralisation. It not only advocated for the increased participation of communities but also the participation of local bodies in educational planning and management. Thus, according to data for 2001-2002 provided by the Ministry of Education, the government runs 47 percent of the Primary Schools while 43 percent belong to the local bodies. Similarly in the case of the Upper Primary Schools, while the state government runs 47 percent of the schools, the local bodies manage a little over 29 percent. On the other hand, at the High Secondary level both the government as well as the local bodies’ share is significantly less at 36 and 6 percent respectively. In 2000, the government created a separate Department Of Elementary Education and Literacy within the Ministry of Human Resource Development in view of the increased focus on universalisation of elementary education. Interestingly, although at the pre-primary stage i.e. education for children of six years and below is not compulsory, the State caters to this section through its early Childhood Care and Education Programme- primarily Integrated Childhood Development Scheme (ICDS) which aims to provide its services through functional Aganwadis (and Balwadis) in each settlement. Under the new umbrella programme - Sarva Shiksha Abhiyan (SSA) - the existing service delivery mechanism in the states and districts is not disturbed. Instead efforts have been made to bring about convergence of services and efforts. Functional decentralisation down to the school level is the key to participation and quality in delivery of services.

Health care in India is characterised by a government sector that provides publicly financed and managed curative and preventive health services from primary to tertiary level free of cost, and a fee-levying private sector that plays an important role in the provision of individual curative care across the country and accounts for 82 percent of the health care expenditure. Although the state government is effectively responsible for health care, the responsibilities are also shared by the Central and local governments. The Central government in addition provides supplementary funds for control of communicable and non-communicable disease through vertical programmes.

Health care services are delivered through a network of primary, secondary and tertiary facilities and with a range of professionals and para-professionals within the government, voluntary and private sectors. The state-run rural primary health care network includes over 160,000 sub-centres, 22975 Primary Health Centres (PHC) at the next level and 2935 Community Health Centres (CHC) at the highest level, formulated according to norms of population, density and terrain. The PHC is the first contact point between the village community and the medical officer and primarily provides primary out patient care, with minimal arrangements for in patient care and hospitalisation. The CHC on the other hand is supposed to be equipped with secondary facilities and specialist inpatient beds. In addition, there are 22,000

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4 The National Policy on Education (NPE1986) advocates a National System of Education, under which a common educational structure (10+2+3) has been envisaged. While the total number of general education remains 10 years, the way the 10 years are divided into primary, upper primary and secondary levels varies across states.
dispensaries and 2,800 hospitals providing services under the Indian System of Medicines and Health care (ISM&H) and 600,000 Aganwadis serve the nutrition needs of nearly 20 million children and 4 million mothers under an early child care programme. In terms of manpower there are over 500,000 trained doctors working under plural systems of medicine and a vast frontline force of over 700,000 female Auxiliary Nursing Midwife workers (ANM), Multi Purpose Workers (MPW) and Aganwadis workers in addition to community volunteers.

In urban areas, municipal hospitals exist in most cities, in addition to state government’s PHCs, hospitals set up as part of the Employees’ State Insurance Scheme (ESIS) and Urban Health and Family Welfare Centres run by the municipal corporations. The urban primary health care infrastructure has actually been established through specific schemes like the All India Hospital Post-partum Programme, the Urban Family Welfare Centres, the Urban Revamping Scheme (Health Posts in slums) and Sterilization Beds Schemes.

The extent of access to these services varies across states and social groups and there are ‘several facility gaps, supply gaps and staffing gaps’. The existing service delivery structure has come under severe criticism. Firstly, the division of health and family welfare and nutrition functions at all levels is seen as a hurdle to optimal performance with services largely focused on Reproductive Health Care (RHC) only. In addition, the referral system at the PHC and CHC is weak with no linkage between urban tertiary units and the primary health centres (PHCs), so that the urban and rural systems have developed as two separate structures: the hospital-based and tertiary care in urban areas, and low-level care at the village level. There is also a lack of engagement between allopathic and indigenous systems leading to far less than optimum use of services (Srinivisan; Planning Commission, 2002). The recently initiated National Rural Health Mission is expected to address a number of these issues and take measures to correct the anomalies. Apart from focusing on a decentralised process of planning and health delivery, some of the key components expected to bring about both efficiency and effectiveness in the health care delivery system are the placement of female health activist (ASHA) in each village, the development of village health plans prepared by a the sub-committee of the panchayat, strengthening of the rural hospital for effective curative, and integration of the vertical Health & Family Welfare Programmes for optimizing the use of infrastructure and strengthening delivery of primary healthcare.

Supply of drinking water is primarily the responsibility of the respective states. The state in turn delivers the water and sanitation services through public health engineering departments (PHED), city level water supply and sewerage boards and local governments and state level parastatal agencies. In addition, the state also often engages several private companies primarily, in construction and supply of materials. Between them these agencies are responsible for a range of activities including planning, designing, execution and management of water supply and sanitation projects. They are also responsible for levying and collection of taxes or user charges. However, the central government plays an influential role, as usual, through policies, guidelines and investments (Nair, 2004). The 73rd and 74th Amendments allowed for delegation of these function to the Panchayati Raj Institutions in the rural areas and ULBs in the urban. Subsequently, in the rural areas the Sector Reforms Program initiated in the late 1990s and its scaled up version- the SwajalDhara (2002-2003), has
specified that all planning, managing and operational responsibilities, including financial management should be vested with the PRIs, especially the Gram Panchayats. The PRIs on their part can take the support of the Public Health Engineering Departments (PHED), Water Boards or parastatal agencies, NGOs, Village Water and Sanitation Committees and even the private sector. Decentralisation process in the urban areas has been slow and in most cases the state level Water Boards or PHEDs/parastatal agencies continue to be primarily responsible for service delivery. Although, technically after execution of the scheme it is passed on to the local bodies or equivalent agencies for operation and maintenance, often the PHEDs/Boards take up the additional responsibilities as the former do not have neither resources nor capacities to do so. Only in a few metropolitan cities like Delhi, Chennai and Hyderabad are the Boards more equipped and functional. And in cities like Kolkata and Mumbai, separate departments of the ULB are responsible for service delivery. (World Bank, 2006)

The PRIs have been traditionally responsible for sanitation in the rural areas in most of the states in the country. After the initiation of the reforms process, sanitation has become the overall responsibility of the Rajiv Gandhi National Drinking Water and Sanitation Mission (RGNDWSM) at the national level and similar Missions are being set up at the State and district levels, while the PRIs have been given the responsibility of promoting and facilitating effective service delivery process

2.3.3 Policies and programmes

**Education (GoI, 2006)**

Universal Elementary Education has been a goal that India set for itself when a planned development process was initiated soon after the country gained independence. Until 1960 the policies and programmes focused on expanding the educational facilities. Given the size of the country and the gaps in facilities, it was a challenging task and one that could be achieved only to a limited extent within the given deadline (1960). The present programmes in elementary education have their base in the National Policy of Education (1986) and the subsequent revised Plan of Action, 1992 and the EFA framework. The NPE’s primary focus was on improvements in the quality of education and a more equitable expansion of educational facilities. More specifically (i) universal access and enrolment, (ii) universal retention of children up to 14 years of age, and (iii) substantial improvement in the quality of education to enable all children to achieve essential levels of learning were the key elements of the policy. In fact long before the international EFA declaration, the GoI had recognised the importance of quality in education and the need to make it relevant to the concerns of the disadvantaged and marginalised. The EFA only reaffirmed the policy orientation defined in the NPE.

The goals of the EFA and the NPE were incorporated into successive Five Year Plans. Several central and state supported programmes have been in operation since the mid 1980s, which, although greatly varying in design, addressed the overall objectives and strategies of the NPE and EFA. The programmes revolve within a framework that primarily focuses on universal enrolment, access, retention and collection of user charges or fees. At present there are 241310 GPs, 5564 Block Panchayats at the next level and 593 District Panchayats in the country.
quality of education, all with special focus on girls and the deprived social and economic groups. The following are some of the key elements of the framework that have emerged during the 1980s and 1990s and the programmes reflecting these elements:

- A holistic approach in planning and implementation has tried to establish linkages between programmes of early childhood care and education (ECCE), primary education, literacy and UEE., i.e. between pre-school, primary education, non-formal education and adult education. (ICDS).

- Improving facilities in schools, in addition to increasing the number of schools, has been a critical approach... The coverage has now also been extended to the upper primary schools. (Operation Blackboard). Nutritional support to schools primarily catering the poor communities has been another strategy to increasing enrolment, retention and attendance in primary schools. (School Meal Programme)

- Decentralisation of planning, supervision and management of education through district, block and village level bodies, has been one of the major strategies for designing different programmes. It meant an increased involvement of communities in project implementation and monitoring and the participation of the local bodies. The District Primary Education Programme (DPEP) was born out of the decentralisation strategies. (DPEP, Lok Jumbish)

- In order to not only improve access in terms of availability of schools but also to facilitate conditions for participation of the deprived sections, especially girls, disadvantaged groups and out of school children, several innovative strategies have been adopted, including alternative system of schooling and non-formal education programmes (NFE). Support has also been provided to community-based innovative and experimental projects by voluntary agencies. Although the focus of the programme is on educationally backward states, it also covers urban slums and hilly, tribal and desert areas in other states as well, and is being implemented in 20 states and union territories through the state governments and voluntary organisations. Almost all the major EFA projects have evolved different approaches and institutional arrangements for reaching primary education to the disadvantaged within the broad framework of NFE. Some of these are the Alternate School Programme under DPEP, and state specific initiatives like ‘Sahaj Shiksha programme’ under Lok Jumbish in Rajasthan, the Rajiv Gandhi Swarna Jayanti Pathshalas in Rajasthan, Shishu Shiksha Karmasuchi in West Bengal, Community/Maabadi Schools in Andhra Pradesh, and Education Guarantee Scheme in Madhya Pradesh. Under SSA, NFE was integrated with the Education Guarantee Scheme and Alternative and Innovative Education Programme and its linkages with the formal system strengthened.

- Advocacy, a campaign approach and adoption of a mission mode for mobilizing communities and reaching out to a large section of the people have become another strategy. (NLM, EGS)
• Community Participation has been considered necessary for bringing children into school and also as an essential prerequisite for ensuring long-term sustainability of initiatives. Hence, several projects have been implemented to encourage participation. (Lok Jombish, Shiksha Karmi)

• Minimum Levels of Learning’s (MLL) was introduced at elementary levels to improve achievements and school facilities were improved through specific schemes and connected to the MLL strategy. It is operational throughout the country with the help of voluntary agencies and research institutions.

Thus, in the wake of the NPE, the 1980s and 1990s saw initiatives like the Shiksha Karmi Project (Sida assisted 1987-1999, DFID 2000 onwards) and the Lok Jumbish Project (Sida assisted 1992-1999, DFID 2000 onwards) in Rajasthan, Bihar Education Project (UNICEF assisted, 1991), the Andhra Pradesh Primary Education Project (DFID, 1987), Mahila Samakhya (Dutch assisted, 1989) and, the indigenously designed Education Guarantee Scheme of the Madhya Pradesh government. Each of these interventions has underlined the importance of both context specific and multiple strategies to address the anomalies in the system.

The beginning of the current decade saw a process of consolidation and convergence. Thus, in 2001-02, based on the experience of DPEP and several state specific programmes, the Sarva Shiksha Abhiyan was launched as an umbrella programme for elementary education, with the objective of: (i) getting all children into formal schools, Education Guarantee Centres, Alternative Schools and Back-to-School camps by 2005; (ii) bridge all gender and social category gap at the elementary primary stage by 2010; (iii) achieve universal retention by 2010; (iv) and focus on elementary education of quality with focus on education for life. National Programme for Girls at Elementary Level (NPEGEL) and EGS&AIE are the two principal components. SSA is under implementation in 598 districts of 34 States of country.

Apart from SSA, DPEP continues to be operative as a centrally sponsored programme in 129 districts of 9 states; the centrally sponsored Mid- day Meal scheme was universalised in 2004 and currently covers over 900,000 primary schools and EGS&AIE centres; and the Kasturba Gandhi Balika Vidhyalay launched in August 2004, with the aim of setting up 750 residential schools at elementary level for girls belonging predominantly to SCs, STs, OBCs and minorities in educationally backward blocks (EBBs), where female literacy was below the national average and gender gap in literacy was more than the national average.

Thus, the State is the primary service provider in education sector and growth of the sector and literacy is dependent on budgetary allocations by the State. Financial allocation, especially in elementary education, has increased significantly during 8th, 9th and 10th Plans, although still short of the envisaged investment of 6 percent of GDP. In addition to government elementary schools, the central and state governments are also providing grant support to NGOs for providing elementary and non-formal education in rural and urban areas. (During 2003-04 grant in aid of Rs. 100,000 and above was provided to 647 NGOs under department of elementary education and literacy.)
**Health**

The major health policies and programmes in India have their genesis in the recommendations of the Health Planning and Development Committee Report of 1946 (Bhore Committee). The Report laid the foundation for comprehensive rural primary health care and the concept of primary health centres (Nanda and Ali, 2006). It envisaged a key role for the State and recommended that the focus should be on preventive health with a health services system based on the needs of the people, the majority of who were deprived and poor.

Accordingly, the first two Five Year Plans focused on development of infrastructure and a trained manpower together with several vertical programmes. During the Third Plan, family planning became a priority as an increase in population had become a worrisome reality and there was a shift in focus from preventive health to family planning. Subsequently, the 1978 Alma-Ata Declaration calling for a convergence of health, health care and development was endorsed by the Government of India together with equity in terms of equal access to health care, equal utilization of services and care according to need as the central principles. This, together with the ICMR/ICSSR report on Health for All by 2000, influenced the succeeding Plans and on the recommendations of the Report a comprehensive National Health Policy (NHP) was formulated in 1983.

The NHP was the first concrete policy direction on health care services from the central government to the state governments. The Policy was committed to providing health services to all by 2000. Thus, NHP and the subsequent Five Year Plans, from the mid 1980s to 2002, broadly focused on evolving a phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education; setting up an intermediary network of local health volunteers with appropriate skills and simple technologies; establishing a hierarchical referral system; a related integrated network of specialty and super-specialty services; and encouraging private initiatives in hospitals, clinics, etc., through tax and other incentives (NHP, 2002). The NHP had also identified nutrition as a problem needing urgent attention and in 1993 a National Nutrition Policy was formulated, followed by a Population Policy in 2002.

Several, national and state specific programmes have been developed and implemented from 1950 to date and major health services provided include:

- Health education and promotion as an integral component of all national health and family welfare programmes, using a community-based strategy. In addition, national vertical programmes (leprosy eradication, tuberculosis control, malaria eradication HIV/AIDS) also have a health education and promotion component. NGO participation is also encouraged.
- Since 1985 high priority has been given to the Maternal and Child Health programmes (MCH).
- Immunization programme as a result of which incidence of polio and neonatal Tetanus has declined significantly.
- Prevention and control of locally endemic diseases like malaria, Japanese encephalitis (JE), dengue is being provided through long and short term measures including selective treatment, vector control and IEC
- Treatment of common diseases and injuries are being addressed through several national programmes with well-defined goals. In addition, diarrhoeal
diseases are being addressed through the promotion of exclusive breastfeeding, good child feeding practices, etc.

However, inspite of policy statements for integrated services with a focus on overall socio-economic development, selective care and programme driven health interventions together with expansion of the infrastructure remained the focus of successive Plans. Thus, although the 1980s and early 1990s saw an expansion of infrastructure, the quality of services continued to remain poor. The NHP, amongst other issues has been criticized for failing to visualize a strategy to encourage the participation of the community and institutions of governance at the local level, the impact of which were obviously reflected in the less than desired level of performance of services across the states. Hence, a new National Health Policy was formulated in 2002, to address these shortcomings on one hand and to meet the challenges of a changed health and demographic profile on the other.

NHP, 2002, aims primarily to achieve an acceptable standard of good health amongst the general population of the country again in a time bound manner, by increasing access to the decentralized public health system. This was to be achieved by creating new infrastructure in deficient areas, and upgrading existing institutions, ensuring an equitable access to health services across the social and geographical stretch of the country. While the aggregate public health investment was to be enhanced through increased contributions by the central government, contribution of the private sector for health services was also to be actively promoted, focusing on those groups who can afford to pay for private services.

NHP2002 recognizes the potential role of NGO, s PRIs, civil society organisations and the private sector and points out that significant changes have been brought about in the mode of implementation of health services in the last two decades, primarily because widespread debate on various public health issues was initiated and sustained by NGOs and the civil society. In addition, the policy document acknowledges, that these institutions have been contributing in the delivery of certain components of public health services. The Policy therefore envisages that the disease control programmes should earmark at least 10% of the budget to these institutions and in principle recommends the handing over of public health service outlets at all level to NGOs and other institutions of civil society for management. Similarly it encourages the empowerment of PRIs at the primary level and the private sector in all areas of health activities – primary, secondary or tertiary.

In 2005 the GoI launched a major rural initiative - the NRHM - to provide healthcare to the rural population throughout the country with special focus on 18 states with weak public health indicators and infrastructure. It aims at the ‘architectural correction’ of the basic health care delivery system and bringing about synergetic linkages between the determinants of good health, i.e. nutrition, sanitation, hygiene and safe drinking water. The key components include provision of a female health activist in each village; a village health plan prepared through a local team headed by the health and sanitation committee of the panchayats; and integration of vertical Health and Family Welfare Programmes, amongst others. While decentralized planning and empowering the PRIs to own, control and manage public health services is the core strategy of NRHM, promoting non-profit sector particularly in under served areas, regulation of private sector including the informal rural practitioners to
ensure availability of quality service to citizens at reasonable cost and promotion of public private partnerships for achieving public health goals are some of the other critical elements of the strategy.

**Water and Sanitation**

Like in the case of the other two sectors under discussion, water and sanitation was included in the national agenda from the first Five Year Plan, although unlike these sectors there was no concrete policy providing guidelines and directions in the early years. In fact, the first water supply programme was launched as part of the state’s health programme, and sanitation was only a part of it. In 1972 GoI launched the Accelerated Rural Water Supply Programme (ARWSP) to assist the states with 100 percent grant-in-aid to implement water supply and sanitation schemes in problem villages. In 1986 the NDWM (renamed as the RGNDWSM in 1991) was set up and soon after, in 1987, the first National Water Policy was drafted to guide the management of water resource across the country, giving priority to drinking water. The Policy was revised in 2002 with drinking water continuing to be the key focus. However, it was only in the beginning of the 1990s (Eighth Plan), after the conclusion of the Water and Sanitation Decade and the Delhi Declaration of 1990, that both water and sanitation began to attract greater attention of the planners and policy makers and also external funding agencies.

In line with the commitments of the Water and Sanitation Decade, the policy focus of the sector has been on integrated management of water resources and waste management (solid and liquid) for safe guarding health and environment, initiating reforms for an integrated approach, behavioral and attitudinal changes as well as participation of women at all levels, community management of services, empowerment of local institutions to do so, and sustainable resource management through improved technology and optimum use of existing assets. The centrally-sponsored ARWSP, Accelerated Urban Water Supply Programme (AUWSP) and the Centrally Sponsored Rural Sanitation Programme (CRSP) were the key programmes initiated at that time for rural and urban water supply and rural sanitation. These programmes continued, with occasional revisions in norms, till almost the end of the 1990s. Community participation was also introduced as a component in some of the projects.

Towards the end of the 1990s there was a paradigm shift in policy and consequently, programme design, when a reform process was initiated to improve coverage and sustainability. A demand responsive approach with community participation and decentralisation became the key strategy where the State’s role was visualised as a facilitator rather than a provider. In addition, water has been visualized as an economic asset, and inter-sectoral convergence is emphasized and innovative partnerships are being forged for extended outreach. Initially the reform process was piloted under the Sector Reforms Programme (1999) in 64 selected districts and subsequently the reform agenda was reflected in the 10th Plan and operationalized in the SwajalDhar (2002), a programme for rural water supply. Similarly in the case of sanitation the Centrally Sponsored Rural Sanitation Programme was modified in 1999 and a Total Sanitation Campaign (TSC) approach was adopted based on the

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6 This section is primarily based on the GoI Assessment Report, 2002 and updated from recent reports of the GOI, WB and WaterAid
‘Midnapur model’ (West Bengal). The TSC, like SD, is supposed to be demand driven (using promotion strategies like IEC), promote low cost technologies and alternative delivery mechanisms. Both Swajaldhara and TSC have now been scaled up across the country and new institutional arrangements and linkages have also been forged.

The 10th Plan also places greater emphasis on urban water supply where, until recently, water to urban areas was being provided under the AUWSP (launched in 1993). However, a sector wide reform agenda under the Jawaharlal Nehru National Urban Renewal Mission (NURM) has been recently launched and the AUWSP has been merged with the programme of the Mission. The fact that NURM focuses on provision of infrastructure and services as well as basic services for the poor within the framework of a long term investment plan and the operationalisation of the 74th Amendment will have great implications on the profile of the sector in general and the nature of service provision in particular. Thus, at present under a sector wide reform process, SD for rural water supply, the merged AUWSP and the TSC are the key projects.

Although GoI has been the primary source of funding for the sector, both rural as well as urban water supply has additional funding support from external agencies, especially the WB, DFID, DANIDA, SIDA, and recently ADB (urban). In addition, international agencies like WaterAid and UNICEF have also been making valuable contributions in terms of innovative approaches. The ESAs have supported the reform agenda and have emphasized a demand driven approach, user participation, cost sharing and cost recovery as conditions for lending.

3. Non-state service providers: definitions, profile, role, organisation, and outreach

3.1 The voluntary and non-profit sector: NGOs, FBOs, CBOs and others

NGOs, FBOs and CBOs in India have originated from the voluntary sector, which in turn has its roots in religious obligations and philanthropy dating back to the pre-colonial era. Various terms are used to describe the voluntary sector in India, like ‘voluntary action’, ‘voluntary association’, and ‘voluntary initiatives’. The term NGO gained credence over the last 30 years and reflects a wide variety of initiatives and organisational structures. The term Non-Profit Organisations (NPO) is of an even more recent origin (late 1990s). It is necessary to capture the historical evolution of the non-profit or voluntary sector to understand the nature of its various forms like CBOs, NGOs and FBOs.

Sen, (1993, 1999), Khan, (1997) and Tandon (2002) have traced the development of voluntary organisations through the various phases of socio-political history:

- In the pre-colonial period the responsibility for the welfare of the community, especially the poor and downtrodden was largely shared between the state and religion, together with social organisations or voluntary institutions. Voluntarism was an integral part of the society and the functions of these institutions were influenced by social and religious values. Most of their activities were related to the field of education, medicine, cultural activities and also providing support in times of drought and famine. Thus, one finds
examples of residential *ashrams, pathshalas* and *mathas* or cloisters attached to a Hindu temple, all imparting education and religious teachings as the forerunners of today’s FBOs. Likewise, Buddhism and Jainism spawned its own brand of voluntary educational and medical services as far back as 600 BC. These traditional religion based forms of voluntary organisations flourished throughout these centuries, each reflecting the social and religious values of the time, which in turn were largely derived from the contemporary rulers (PRIA, 2001). Years later, the advent of the Mughul rule in India brought its own type of voluntarism, focusing around the concept of the better off supporting the needy in terms of food, education, hospitals and shelter. Christianity, with sanctions from the colonial rulers introduced the modern formal organisational form of voluntarism in India during 16th century (AD).

- The mid to late colonial period (1810s to 1947) was marked by the interventions of church-based organizations, on the one hand, and the process of social and religious reform initiated by educated Indians who were influenced by the freedom struggle and the need to defend indigenous culture on the other hand. While the Christian missionaries and their orders dedicated themselves to the field of education and health care, Indian reformers, also influenced by the work of the missionaries, started their own brand of social work. Several non-profit issue-based social reform institutions and initiatives originated during the 18th and 19th century with most of them focusing on mobilisation of the masses for self-rule and self-reliance on the one hand, and constructive grassroots work related to education, health care and social reforms on the other. The movement started off in West Bengal and gradually spread to Maharastra and subsequently to other parts of the country. Some examples of religion, caste and region-based organizations that came up as a result are the Ramakrishna Mission, the Brahma Samaj, Prarthna Samaj (Western India), Arya Samaj (Northern India), Kayast Sabha (North), Sarin Sabha (Punjab), Ahmediyas and Alighar movement, Singh Sabha (Sikhs), etc. These were the first indigenous and organized non-profit associations in the country. Moreover, inspite of being specific to a region or community, they shared a common content and manifested a common consciousness (PRIA, 2001). Some of these continue to exist and flourish even today, the Ramakrishna Mission being one of the most prominent one engaged in contemporary development issues.

- The promulgation of the Societies Registration Act of 1860 provided a legal status to many of these institutions. And the advent of Mahatma Gandhi with his concept of Swaraj, or self rule, in the 1920s was a significant milestone in voluntarism in India. It led to the creation and establishment of the Indian National Congress as a socio-political non-profit organisation. It was marked by mass participation of people from the rural and urban areas. In addition, linkages between political action and development-oriented social work were established during this time. Women’s leadership emerged as a critical force and, above all, a parallel dominant power (through the voluntary organisations) emerged with a value system that had overtones of nationalism. However, this legacy of voluntarism and mass participation was not carried over into independent India, primarily because those who worked in the non-
The early post-independence period (1950-1960) saw the emergence of a large number of Gandhian voluntary organisations, largely attributed to the initiative taken by the newly independent Indian state to promote non-profit organizations in development work. Since the priority of the new government was to put economic reconstruction on a fast track, social issues like health, literacy, sanitation and social welfare took a back seat. However, the State supported some Gandhian-based voluntary institutions through generous funds and in many cases it also took control through governing bodies. Because of these reasons, many of the organisations soon began to lose their autonomy and became parastatal agencies.

Since the beginning of the 1960s, when a general disillusionment with the prevailing approach to development and with the state’s failure to reduce poverty and inequality set in, the state system came under attack. A large number of movements, ranging from the leftist to youth groups opposing and challenging the government’s policies and plans emerged, but were quickly quietened when the government declared a state of emergency in the country.

The post-emergency period gave a new lease of life to the voluntary sector and laid the foundation for its present profile. Welfare and empowerment-oriented organisations emerged during this period and development, education, health, livelihood, environment, civil liberties all became the focus. While the flow of foreign funds to the sector started to increase in volume towards the end of the seventies, the state also initiated direct support to the sector during the 1980s, initially through PADI (People’s Action For Development in India) and CART (Council for Advancement of Rural Technology), which were subsequently merged to form CAPART (Council For Advancement of Peoples’ Action and Rural Technology).

From the mid 1980s the concept of NGO as a dominant sub-sector or synonym of voluntary organisations emerged. From the 1990s the sector has not only grown at a faster rate but has also taken a different shape. It is more closely linked to development issues, and activities are spread across a wide variety of areas - from development action to grassroots interventions, advocacy at various levels, and mobilising the marginalised to protect their rights. The primary reasons for this shift are the policies of liberalisation and globalisation and the growing influence of bilateral and multilateral aid in the development sector, which mostly comes with several conditionalities, including the increased participation of communities and NGOs.

Thus, the origins of the voluntary/NGO sector in India have been largely influenced by traditions and value systems on one hand and an interface between the Indian society and the western world (PRIA, 2001). A study (Comparative Non-profit Sector Study) by PRIA and John Hopkins University (2001) has attempted to analyse the evolution of the non-profit sector in India in terms of ‘social evolution theory’. The theory, based on two key dimensions - the extent of State spending on social welfare expenditure and the scale of the non-profit sector, defines the four routes of
development of the sector as the liberal, social democratic, corporatist and statist routes. The Liberal Model indicates low government spending on social welfare and a relatively large non-profit sector; the Social Democratic Model is represented as an extensive state-sponsored/state-delivered social welfare, leaving little room for non-profit sector; the Corporatist model is seen as situations where the State has a common cause with non-profit institutions to retain support of social elites; and the Statist model is where the state retains the upper hand in social policies and interventions but with a fair degree of autonomy. According to the study, the Indian case, from immediately after independence to the mid-seventies, fits into the social democratic model and thereafter there has been a gradual movement towards the liberal model. Although the movement towards the liberal model has accelerated in the 1990s, the State’s role is still predominant.

An interesting debate on the categorisation of the voluntary sector has been apparent in the country for some years. Votaries of the voluntary concept fiercely reject any attempts to broadly classify all initiatives as ‘voluntary’. In an attempt to define the voluntary sector and its several categories, the Centre for Civil Societies Studies, John Hopkins University (2000), has developed a ‘structural –operational’ definition, based on five specific characteristics, namely:

- **organised**, which meant that the organisation was legally registered or had an on going institutional identity;
- **private** in terms of being institutionally separate from government and governmental authority;
- **not profit-distributing** with the condition that even if profit was generated it was poured back into the work of the organisation;
- **self-governing** in terms of autonomous functioning and was independent of government and private business control; and
- **run on the basis of voluntary participation** of the people contributing time and effort without full compensation.

Using the definitional framework Sen (1993) and subsequently PRIA (2000) have attempted to analyse the applicability of the definition in the Indian context. Pointing out that the structural/operational definition not only allows for distinguishing borderline cases but also allows for the inclusion of a wider array of organizations in the sector, Sen (1993) states that the framework is useful in making cross-national comparisons, which neither the legal nor the conceptual definition permit. He thus, includes religio-political institutions, institutions that have emerged from social movements, NGOs, CBOs, welfare wings of religious organizations (FBOs), business associations, cultural associations, scientific associations, associations for promotion of sports or arts, caste associations, and traditional voluntary agencies within the non-profit sector. By implication he excludes social and political movements and political parties and includes cooperatives, trade unions, government-organized NGOs, and NGOs formed by the rich to get tax benefits as borderline cases. PRIA, on the other hand, concludes that although the structural-operational definition removes a lot of ambiguity in identifying organisations, and ‘purpose’ is inherent in the legal framework in India (relating to incorporation and tax exemptions), which views purpose to be central to the definition of organisational identity, yet the need and process of establishing the legitimacy and acceptance of ‘purpose’ as a public good remains unresolved.
A recent document of the Planning Commission has a simplistic but telling three-way classification of the voluntary sector: as traditional, community-based and government-sponsored (religious and charitable trusts dedicated to spread education, health care, orphanages and rehabilitation homes etc). Community-based organizations and the government-sponsored voluntary sector comprises agencies engaged in welfare programmes such as rural development, afforestation programmes, watershed management, health and education services as well as those engaged in research and evaluation.

Votaries of voluntary organisations in India are quick to point out that although the terms VOs & NGOs are often used interchangeably, they are different in terms of their objectives, methodology, and style of functioning, motives, legal status and socio-political orientation. While voluntary organisations are largely independent of the government and are controlled and administered by an association of citizens, NGOs is a term used for any organisation that is not established by the state. They are formalized organizations outside the market or the state and operate in the civil society. However, they may be at times influenced, controlled or sponsored by the government and private business houses. Therefore, the term NGO in India has been used to denote a wide spectrum of organisations, which may be non-governmental, quasi, or semi-governmental, voluntary or non-voluntary, partisan or non-partisan, formal or informal, non-profit or profit oriented bodies, with a legal status and registered under relevant Acts. (Mohanty, Manoranjan and Singh, 2001). They have also been variously classified according to the nature of their origin, size, functions and roles, type of activities, form of control and degree of autonomy, level of operations, etc. (Mohanty, Manoranjan and Anil K. Singh, 2001). Most of them support the poor and marginalized communities.

The profile of NGOs has been changing over the last two decades and the use of the term voluntarism in the context of the NGOs in their present context has been questioned. Kamat’s (2003) studies of NGOs in Western India suggests, like in other developing countries, ‘professionalization and depoliticization’ of NGO have occurred at the grassroots level leading to a shift in the organizational character and in the nature of their work. She found that a number of community-based NGOs in India have moved away from the task of organising the poor and the deprived to fight against marginalisation and inequality and have instead adopted a “skills training” approach. Although a ‘rights-based’ approach has been increasingly in focus in recent years, the spirit of voluntarism and the concept of a mass movement of the late 19th and early 20th century have been greatly diluted.

Today, while there are a large number of registered organisations in the country, there are also an equally large number of unregistered and hence unaccounted for organisations running in remote areas across the country. Although there is no complete survey or comprehensive study on the total number of VOs & NGOs working in India, according to some estimates their number is about 1,000,00 of which, only 25,000 to 30,000 are believed to be active. There were over 21,000 societies which were registered with the Ministry of Home Affairs, Government of India under the Foreign Contribution (Regulation) Act and their numbers are likely to

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7 Non-profit organisations can be incorporated by the following Acts: The Societies Registration Act, 1860; The Indian Trusts Act, 1882; The Co-operative Societies Act, 1904; The Trade Union Act. 1926; Section 25, of the Indian Companies Act, 1956.
have gone up in the last few years. The size of the voluntary and NGO sector also varies widely across the country. The largest number of agencies is in Maharashtra, West Bengal, Tamil Nadu followed by the other southern states. One estimate for example, claims 25,000 registered grass-roots organisations are in the state of Tamil Nadu alone.

A study undertaken by PRIA (2002), which looked at non-profit organizations as defined by the structural-operational framework reported above, shows that there were 1.2 million Non-Profit (NPOs)\(^8\) in the country in 2001, with more than half of them being based in rural areas and many others in urban areas but serving the rural settlements; almost 50 percent of these are unregistered; most of the NPOs are essentially small with about three-fourths of them having only volunteers or one paid staff. Over 26 percent of these NPOs are predominantly FBOs involved in social development activities. Out of the remaining NPOs, 21 percent are involved in community and social service, another 20 percent in education, 18 percent in sports or cultural activities and a little over 6 percent in health care. Nearly 20 million persons worked on a paid basis in the sector. Interestingly, the study found that education as a focus area for intervention was much more dominant in rural areas. The primary source of funding was self generated, loans, grants from government and international sources and donations from both Indian and foreign sources, mainly individuals and corporations. The study concluded that the identity of NPOs in India remains largely invisible. While there is a wide diversity in their profile, a pattern of sorts also exists and the sector is widespread.

**Community Based Organisations** or CBOs by comparison are very micro and local in interventions and scope. The terminology is thought to have received great impetus from the work of Mahatma Gandhi and his call for ‘constructive social work’, in the early part of the 20\(^{th}\) century. Since then a wide variety of CBOs have emerged reflecting the aspirations of local communities. There are also those CBOs that emerged as a result of the work of other development agencies, more specifically social development programmes of the government and other intermediary level voluntary agencies (PRIA, JHU, 2000). This trend was accelerated in the 1970s and grew through the 80s and 90s when many central and state specific programmes related to health, education, forestry, drinking water, women’s’ empowerment, were all specially designed with a focus the active participation of CBOs. Technically, these are village or neighbourhood homogeneous groups that come together with a common purpose. Most often they are informal in nature and do not have any formalised rules or procedures. When they grow beyond their immediate community or when local issues have wider ramifications they may sometimes change into people’s movement (NBA).

Within this broad category is a new entity - the **Government NGO** - in a way a special purpose vehicle, set up by the State, usually under donor funded programme and with relative flexibility in terms of structure, roles and functions. Interestingly, they are registered under the same Act as NGOs, but are more often than not headed by a senior government official.

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\(^8\) Schools, clinics, orphanages, sports clubs, cultural organisations, social service providers, research and training institutes and development organisations were included in the study.
3.2 Panchayati Raj Institutions and ULBs
In 1992-93, the 73rd and 74th Amendments to the Constitution technically ushered in the era of democratic decentralisation, where the rural (PRIs) and urban institutions (ULBs) of local governance have been given the responsibility of economic planning and social justice. All States have enacted new Acts or incorporated changes in their existing Acts in conformity with the 73rd and 74th Amendments. The Amendments allows the states to endow both the PRIs and ULBs with powers and authority ‘to enable them to function as institutions of self government’. The Amendments have also entrusted such development functions as preparation and implementation of plans for economic development and social justice as per the listen of activities defined in the Eleventh Schedules of the Constitution. However, in the case of the ULBs, the Twelfth Schedule is not mandated and it is up to the states to decide which functions to devolve to the ULBs. To facilitate this process of decentralization of development activities, in the case of PRIs a uniform three tier – at village, sub- district and district is in place. In the case of ULBs on the other hand provisions have been made for Ward Committees, District Planning Committees and Metropolitan Planning Committees. In addition financial resources are also to be devolved together with the establishment of a system of accountability and transparency. Interestingly, and of relevance to this study, in the case of PRIs, provisions have also been made to set up functional sub-committees, especially focusing on health care, education and water and sanitation. These sub-committees are being encouraged to evolve as active CBOs or even service providers at the local level.

However, the progress of decentralization has been very slow in rural areas and almost non-existent in urban areas, barring a few larger ULBs. Studies have shown that while a concrete and stable framework exists within the country for deepening the process of decentralization of governance, the process of devolution of power is still very week and varies in its depth and spread from state to state. In addition, political will and commitment shown by state governments to quicken the pace of decentralization has been marked by periodic fluctuations and uncertainties. Social factors, which inhibit the process of change and often obstructs the development of an effective system of grassroots democracy varies from state to state and even within a state. While the state on its own seems to be less capable of speeding up the process, civil society organisations (CSOs) have been able to create space for themselves and be accepted to play a vital role in this respect. It has also been observed that, from within the government, departmental efforts have been fragmented, as is evidenced by the catalytic role played on the one hand by the Panchayati Raj Departments to promote PRIs, and on the other hand by other departments to build their grassroots strategy around organizations promoted for the purpose (single-sector user committees as parallel bodies).

The situation is even of more concern in urban areas and has forced the central government to make the operationalistaion of the 74th Amendment mandatory in order for the states to access funds under the recently launched JNNURM. Studies have concluded that, over the years, the developmental terrain of the ULBs have been encroached by higher level institutions and parastatal agencies, which in a way are

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9 There are approximately 250,000 Gram Panchayats, 6500 Panchayat Samitis and 500 Zila Parishads elected and governed by State legislation.
parallel structures to local governance similar to issue-based CBOs being sponsored by government programmes.

4. State-NSP relationships in service delivery

4.1 Evolution and nature of the relationship: partnerships and collaboration, facilitation and dialogue, checks and controls.

As seen from the previous sections, non-state providers in India - originally purely voluntary organisations - have a long history dating back to ancient times, especially in the health and education sectors. Although in the early years there was no apparent formalised relationship with the State, the rulers and their policies (as well as the religious movements) greatly influenced the profile and activities of NSPs. A concrete relationship between the state and the NSPs, more specifically NGOs, began soon after independence when some of the Gandhian and other voluntary organisations that had emerged from the social and nationalist movement of the previous years were not only given funding support but were also controlled to a great extent through the presence of State nominated representatives on their management boards. A major reason attributed to this initial formalisation of relationship was the need to accommodate a number of nationalist leaders who could not be absorbed in the newly formed government (PRIA, 2002). Studies indicate that, in the process, these state-supported voluntary organisations lost a large part of their autonomy and consequently much of their voluntary characteristics.

With community participation being introduced as a defined component in a number of social sector projects during the early part of the 1970s, NGOs began to be formally recognised as a development partner of the State, with the private sector, the other predominant constituent of the NSP sector, being co-opted much later. Over the last decade, State processes to engage with NGOs in health care, education, water and sanitation has only rapidly increased for reasons, as studies indicate, related to the state’s own failure to improve the human development index on one hand and also because of the conditional funding support being provide by bilateral and international donor agencies, in which, NGO and of late public-private participation (PPP) are critical.

Tandon (2002) describes the various roles that the State has played since independence vis-à-vis its relationship to the voluntary sector:

- As a ‘regulator’ it has enacted a variety of mechanisms to regulate social, political and economic spaces. This it does through its organs, agencies and laws and legislations that include registration or incorporation, finance, etc. (Taxation Acts, FCRA).
- As a ‘funder’ it has set up several institutions as ways to promote funding of voluntary organisations. (KVIC, CSWB), National Wasteland Development Board, Peoples’ Action Development India and its revised version (CAPART). Tandon, notes however, that this relationship has not been without tensions. In addition, it has developed a relationship of dependency in that organization that is in a recipient-donor relationship, in which voluntary organisations have tended to become mere implementers of State projects and schemes. Increasing bureaucratization and control, he fears, has undermined the autonomy of such organisations.
As a ‘development actor’ the state is all pervasive and in all fields and regions, leaving little room for voluntary organisations. As such the State promotes its own brand of development models and expects the voluntary organisations to work within this framework. In the process it also attempts to monopolize all internal and external resources, thus increasing its’ hegemony. Interestingly, Kamat (2002), in her study on the ways in which grassroots NGOs have been brought into the realm of official development discourse in India, states that over the years the ‘non-party left activism’, which was earlier the hallmark of voluntarism in India, has been compromised by this relationship with the State. She adds that such NGOs (the recipient-donor type) have a corporatist identity and work within the existing political forms of the State. They no longer engage in a re-interpretation of a collective identity on a material basis. The State, as well as international donors, has not only found it convenient to support the growth of such NGOs but have also sought a collaborative relationship with them.

Tandon (2003) concludes that the multiple roles of the State in India impact its relationship with the voluntary sector. He defines these as:

- ‘Dependent-client’ in which dependency is in terms of ideas, money and resources and is most evident among organisations implementing social service and welfare work.
- ‘Adversarial’, where the State and VOs are locked in conflict. This is the case of organisations that challenge the policies of the State and its development paradigms, and take the form of movements or people’s organisations or NGO networks.
- ‘Cooperation’ where a healthy co-operation between the state and the VOs exist and where there is scope for discussing differences, identifying common areas of action on policies and programmes for collaboration. Tandon has identified issues of health, education, micro-finance, environment, drinking water, etc., as common areas for such cooperation, whereas rights and natural resource based issues are contentious ones. However, often in such cases the relationship may turn into one of contractor and sub-contractor. He therefore cautions that it is important to examine each case of co-operation and the extent to which co-operation with the State has reduced the role of the VOs to that of a mere commercial implementer of programmes. As a case in point he cites the health and family welfare programme. At the same time he adds that a number of voluntary organisations participate in such programmes with the laudable objective of ensuring that benefits reach the poor and also to influence policy directions in some way.

Another issue that has been the subject of research is the features of NGO-State partnerships. Ramnath (2005) describes the relationship within the broad framework of a dynamic ‘ecosystem’ and concludes that the evolution of the NGO–State relationship is a product of a broader political economy; that the NGO-State relations are not static but made up of complex and interdependent struggles and relations that change over time; and, NGO activities are likely to grow in complexity over the course of their lifetimes. Although Ramnath’s findings are specific to three NGOs working in the area of slum and squatter settlements in Mumbai, the study offers some conceptual contributions, which can be applied in the context of understanding how NGO-State interactions emerge and develop over time.
Contrary to the general belief, Ramanath (2005) suggests that each NGO uses different tactics in response to the same macro-level environment. This variation is a function of the internal institutional processes in each NGO and shapes its strategies for cooperation with the State. It is also dependent on the larger availability of resources with the NGO. Ramanath’s study also challenges the evolutionary model, which shows that NGOs travel through a series of set and normative stages— from the simple to the highly evolved, from service delivery to advocacy. Instead, the study found that NGO-State interactions are continually fashioned by the strategies and tactics of the NGO itself. “In efforts to gain and retain legitimacy and relevance, NGOs are found to shift strategies in succession.” In the process they also use multiple strategies sequentially and, often also simultaneously. It indicates that while broader policy thrusts are, without doubt, key factors in determining the nature of NGO-State interactions, they only account for the primary or dominant strategy (of confrontation or cooperation) prevailing between NGOs and the State. However, in an effort to respond to the State’s (client) requirements at the same time as being under pressure to establish and maintain relevance, even predominantly confrontational (or cooperative) NGOs deploy multiple strategies, many of which defy dominant NGO-State orientations. Thus, Ramanath concludes that NGO-State interactions are, first and foremost, the product of the space created by the State. Instead of presuming a withdrawal of the State, Ramnath echoes other studies when she states that the “the state has come to occupy a more decisive position in the ecosystem of NGO-GO interactions.” The state has not only provided the enabling environment in housing the market and the NGOs, it has also provided the environment for the emergence and the institutionalization of NGO strategies which has also helped legitimize the shifts in strategies.

Kudva (2005) draws a somewhat similar three stage evolutionary picture of the State-NGO relations in India: in the first phase, the State provided a limited safety net and the NGOs were their silent partners; in the next phase NGOs actively opposed the State and challenged them to initiate poverty alleviation through political and economic development strategies and subsequently engaged with the state to deliver services, enhance capacity, and empower the communities to fight for their rights. In the third and current phase, the diversification of the NGO sector continues as liberalization, globalization, structural reforms and decentralization together with apparent state withdrawal in service delivery and religious nationalism gain ground. Kudva (2005) observes that an “uneasy partnership” between NGOs and the state seems to be the norm. In this environment a number of NGOs follow the public service-contractor model (increased state and foreign donor funding being one of the incentives) while others work as intermediaries, with the specific aim of enhancing the bargaining power of their constituents vis-à-vis the State and other groups in society. Kudva argues that the impact of the NGOs can be best evaluated in the context of parameters set by the State: “the efficacy of NGO-driven, or state-driven but NGO-assisted policies turn on the question of the ability of a strong state to create openings that NGOs can then use to push for change. Strong states allow strong NGOs to flourish.” She also argues that the nature of the work and the issue focus also play a critical role in determining the relationship.

Similarly Sen (1999) examines the state-NGO relationships through the decades after independence using a specific analytical framework. He examines the applicability of
some of the propositions found in NGO literature on the State–NGO relationship in India, namely that: the Indian State is in search of a ‘shadow state’\textsuperscript{10}; the nature of NGO activities and programmes determine the NGO-State relationship; governments are distrustful of NGOs, especially if it adopts a confrontational attitude towards the ruling political regimes; the State is likely to be more stringent in scrutinizing NGOs when national security is at stake; and State-NGO relations vary with political regimes. Sen, also poses a set of fundamental questions: who were the primary actors in the NGO sector during each phase in history, what were their motivations in associating with NGOs and what were their attitudes towards the State; what was the nature of the State at a particular juncture in time, what was its attitude towards the NGOs; and what was the socio economic context under which these NGOs emerged. He examines the relationship at the level of the Central government as well as the local level in order to understand the diversities in the NGO sector.

Sen’s findings further emphasize the changing relationship between the State and the NGOs and the visible dilution of voluntary characteristics. He found that at the central level, three broad themes characterize the State–NGO relationship and these are linked to the country’s socio-political and historical phases. Thus, while the early post independence era was one of co-operation between the State and the NGOs, the 1960s and 70s were marked by a relationship of antagonism between the two, which graduated to increased State control in the 1980s and 90s. Sen attributes the increased control during this phase to the nature of the Indian State, wherein the power to restrict the development planning discourse to the State elites allowed it to enforce control over the NGOs. This was further strengthened by the fact that unlike, other countries in Asia and Africa, external donors did not take the stand of providing assistance primarily through the NGOs and set conditionalities. Given this, the State played a deciding role in development and also managed to not only define the role of the NGOs but also make them adhere to it. This meant that the NGOs follow the State’s development model and also take on the role of a ‘service delivery’ agent, to deliver services that the State itself had earlier provided. This tendency increased with the era of structural adjustment and donor conditionality in the 1990s, and is reflected in several policy initiatives, increasing inclusion in the successive Plan documents, increased funding support and procedural simplifications to engage NGOs in the State oriented development process. The increased attempts to control NGOs were also apparently fostered by the socio-political context of the period when a number of separatist, ethnic and fundamentalist movements not only increased their activities during the 1980s and early 90s, but also found easy accommodation in the NGO sector. Thus Sen concludes that many of the propositions were applicable to the Indian context: The States’ search for a ‘Shadow state’ increased as is reflected in the many interventions to define and increase the role of the NGOs in development and ‘service –delivery’; at the same time the proposition related to the government distrust of NGOs holds true as was observed by the stringent measures imposed on them, especially in relation to political activities; and the proposition that nature of NGO activities determine their relationship with the state became even more evident - the service provision roles have been encouraged because of the slow withdrawal of the State.

\textsuperscript{10} A term coined by J.R. Wolch in her study on the relationship between the non-profit and state sectors in UK and USA. (The Shadow State: Government and Voluntary sector in Transition. New York, The Foundation Center.)
On the other hand, Sen argues that the NGO sector is not homogeneous and at the local level there are differences in State-NGO relationships. It is generally characterized by hostility of local politicians, lower level officials, and local elites. He observes that the proposition that leftist governments may not welcome NGOs holds true at this level.

In understanding State-NSP relationships we also need to look at the State’s concept of Public-Private Partnership (PPP), which has gained credence in India since the early 1990s (Planning Commission, 2004). The GoI clearly defines it as a means of implementing government programmes in partnership with the private sector, wherein the term PPP encompasses all non-state agencies including the corporate sector, voluntary organizations, self-help groups, partnership firms, individuals and community based organizations. According to the Planning Commission, PPP does not compromise on the objectives of the service being provided earlier by the government. On the other hand essentially it is a shift in, “emphasis from delivering services directly, to service management and coordination” and the roles and responsibilities of the partners may vary from sector to sector. The Planning Commission’s sub-group on PPPs in the social sectors is quick to point out that PPP is different from privatization in terms of responsibilities, ownership, nature of service, risks and rewards. Benefits are seen in terms of cost-effectiveness, higher productivity, accelerated delivery, clear customer focus and enhanced social service and above all recovery of user charges. Collaboration by the government with the private developer/service provider may occur as (i) a funding agency wherein grant/capital or asset support is provided to the private sector on a contractual/non-contractual basis; (ii) a buyer, buying services on a long term basis; or (iii) a coordinator, specifying various sectors in which participation by the private sector would be sought. Funding patterns could be of various types, including (i) public funding with private service delivery and private management, (ii) public as well as private funding with private service delivery and private management, (iii) public as well as private funding with public/private service delivery and public/private/joint management, or (iv) private funding with private service delivery and private management. While the collaboration between the two may take various forms, the most stable partnership is considered to be that of a ‘contract’ binding on both the parties and which includes service contracts, operations and maintenance (management) contract and capital projects with operations and maintenance contract. The Sub-Group considered PPP as suitable method for delivering services commonly provided by local governments and is generally applicable to most components of service delivery. The types of services however, could vary from one local government to the other based on their needs and priorities. The different Ministries of Government of India in recent years have been implementing their various schemes through PPP.

Our earlier study on NSPs in basic services (Nair, 2004) illustrates how the State’s urgent need to engage NSPs has, seen the emergence of several policy and strategic measures:

- Specific policy documents that define the Central and in some cases, even the state governments’ intentions to support or enter into partnerships with NGOs and the private sector and even the traditional forms of service providers (health sector) have been drafted.
• Several sector specific reforms, to facilitate the process of participation and partnerships have been initiated.
• Special purpose vehicles and apex bodies to again facilitate the process of NGO and private sector participation have been set up.
• NGOs and members from the civil society have been co-opted into purely government planning and monitoring bodies at the apex level, even though at times only on an advisory capacity.
• Since the early 1990s, the concept of a ‘mission mode’ to plan and manage some of the social sector project, giving more scope for the involvement of the NGOs and other civil society organs has been adopted.

The level and nature of interventions across sectors, however, have been varied.
• While in the case of the health sector tax incentives and free or highly subsidised land has been the norm to encourage private participation, in the case of the water and sanitation sector the focus has been on the PRIs and CBOs, as also small local entrepreneurs to set up sanitary marts, or provide maintenance services. Services of large private companies on the other hand have been sought primarily for construction purposes or manage some parts of service delivery. In education on the other hand support to private schools has been minimal in most states and very often has been restrictive and counterproductive. In the case of the private sector, the study points out that, although the level and nature of the relationship varies across sectors, in many cases the interventions have not been encouraging.
• Moreover, the desire to involve other stakeholders has also led the State to recognise the spread and influence of traditional service providers, especially in the health sector.
• However, on the flip side, across sectors regulations and controls are minimal and the private sector, especially in health care and education, as well as with NGOs, have flourished both because and inspite of State interventions.

4.1.1 Elementary Education

Overview
Describing the evolution of the NSPs in the elementary education sector, Nair (2004) reports that, although statistics show that in most states a large percent of the funds come from the state government and over a majority (80%) of the children are enrolled in government schools, in reality India is considered to have a ‘pluralistic’ framework of education with a range of service providers. Within this framework NSPs have been slowly but surely growing since the 1980s, attributed partly to the failure of government systems to deliver, to differentiated market demand and to the emerging policies and programmes.

In fact, since the formulation of the NPE in 1986, the GoI and many of the states have shown increased receptivity to NGOs in education, especially in the area of community mobilisation, local level planning, and capacity building and development of innovative and cost effective curricula. The NPE spearheaded an extensive non-formal programme in which, while the overall responsibility for planning and managing the programme was vested in the central and state governments, the responsibility of running the NFE centres was given to the voluntary and non-profit sector and the PRIs. Eligible agencies were given grants to run NFE centres and to cover the costs involved in supervision and management. The NFE approach with
support to NGOs continued under different programmes until towards the end of the 1990s, when several large state-specific programmes under UEE and externally assisted programmes intensified NGO and private sector participation and finally formed the basis of DPEP (1994) and the Sarva Siksha Abhiyan (2002). As a result an estimated 20,000 education-focused NGOs around the country over the last 2 decades are reported to have emerged.

Inspite of these developments, the number of effective NGO-State partnerships are said to be limited in comparison to the size and needs of the country. Nair (2004) cites the PROBE survey (1999) which found that, although there was an increasing tendency for the State to look at NGOs as ‘crucial institutional resource’ or as ‘low-cost alternatives’ for achieving the goals of UEE, the NGO has largely restricted its contribution to improving classroom pedagogy, teacher training and school management, rather than to developing partnerships in the process of universalisation of elementary education. Nair also cites Nawani (2001), who has described the State–NGO partnership as one which constrains the latter’s activities within a limited framework of action towards a ‘pre-determined goal’ leading to under-utilisation of NGOs’ potential and fostering of a relationship of ‘control’ and ‘mistrust’.

The other main category of NSPs - private schools - have also been in existence since colonial times with support from government subsidies. However, in later years, only some states like Kerala and Maharastra are reported to have deliberately supported private primary schools as a policy for extending access to primary education. Many others states (MP,TN, Rajasthan) indirectly fostered the growth of these schools by removing regulations as they found the process of recognition of private schools to be cumbersome. UP on the other hand has seen an unprecedented growth of private schools because of the fall in quality of government schools. The PROBE survey states that in the 1990s a silent political decision was taken across the country to privatise the primary education sector. The liberalization process also fuelled the resulting process. Another study (Leclercq, 2002) found that in Madhya Pradesh, while the focus has been on expanding the public sector schools, privatisation has been cautiously introduced by allowing new private schools to open against payment of a deposit under the guise of doing away with corruption and to reduce the burden on the State. Leclercq also observes that the State’s arguments justifying privatisation appear to be both practical and political. The rules for State recognition of private schools have become ineffective and are illegally bypassed. Hence, the State in any case does not have any control over the growth of private schools, so has taken the practical decision to remove restrictions. The study also notes that the religious and caste-based schools in the private category are more prone to political ministrations.

The private-public partnership agenda has resulted in corporate interventions in education also gaining some strength, motivated on the one hand by the need to increase employee productivity and developing their skills to participate in an increasingly competitive global market and, on the other hand, by the political and lobbying edge that it provides. However, interventions have been limited to a few states with a relatively proactive public–private partnership approach and a progressive industrial base like Andhra Pradesh and Karnataka.

The Free and Compulsory Education Act, 2005, the latest in the line of government initiatives to universalise elementary education, has been severely criticized for giving
legal sanction to low quality educational streams for under-privileged sections of society. Our earlier study notes that educationists are of the opinion that the Act would undermine the role of the PRIs while promoting privatisation and “corporatisation” of school education, and parts or whole districts would be “franchised” to corporate or religious bodies to run elementary schools at the cost of the poor (Nair, 2004). The Bill has been accused of shifting the state’s constitutional obligation towards elementary education to parents and local communities.

**Policy dialogue**

Our earlier study points out two visibly distinct patterns which gives an indication of the scope and platform for dialogue that exists between the NSPs and the State in the education sector: one where the government policies and programmes have directly or indirectly provided space, although with limitations; and the other where large NGOs or NGO networks and private school federations or associations have carved out a space for themselves. For instance, community-focused programmes like Lok Jumbish, the Kerala SSP, and the District Primary Education Programme have provided platforms for dialogue and opportunities for NGOs and civil society organisations to influence policy, primarily through the relative autonomy provided by the special purpose vehicles set up for implementation. Being relatively free of bureaucratic tangles and working in a ‘mission’ mode, often with donor support, meant that it allowed them to integrate policy issues as a project component. However, the study notes that these government-sponsored forums have had limited effect, for the reason that ‘participation’ rather than ‘partnership’ with NGOs has largely been their mode of function. The study cites Jaganathan’s (2001) research on six NGOs in India which concluded that “while the NGOs are keen to ‘share their models’ with the government rather than create islands of excellence, government has still to recognise them as ‘full-fledged partners’”. The study underlines a need for putting strategic institutional linkages and mechanisms in place to facilitate State-NGO dialogue. The NSP study also cites Devi’s (2002) observation that in India, civil society initiatives led by NGOs, have actualised government policies on the ground by, on the one hand, playing the role of a catalyst and pressure group for framing and implementation of polices and, on the other hand, by executing policies on the ground, in collaboration and participation with the government. Devi concludes that “the alternative system of building parallel civil society structures – like the Bangladesh Rural Advancement Committee Informal School System – appears to have limited relevance in India, because in the Indian context, it has been demonstrated that a rights-based approach has made the government work better.”

Nair (2004) states that the 93rd Constitutional Amendment on the Right to Education is the most recent and significant example of how this process of ‘dialogue’ works and is the outcome of civil society movement led by NGOs, NGO networks and coalitions both at the national and state levels (NAFRE, FORCES and SACCS). Space for policy dialogue between the government and NGOs has of course also been provided by the opportunities that have opened with the initiation of the decentralisation process in general and its specific manifestations in the education sector. However, in reality the study states, apart from intervening for administrative restructuring and capacity building, both the Centre and most of the states have, deliberately or otherwise, been almost sluggish in sharing powers as well as resources between the various tiers of governments.
Regulations

Nair (2004) notes that the formal regulated structure under which ‘recognised’ private schools have to function, irrespective of the fact whether they are government aided or not, is the most prevalent system of government control of private schools in India. ‘Recognition’ requires the school to confirm to certain minimum norms and standards lay down by the respective state governments. It in turn entitles the school to hold examinations and issue results and transfer certificates, which enable students to move from one recognised school to another and access higher education and jobs, in addition to supposedly safeguarding the interests of teachers and staff. All states prescribe a stringent basic pattern with some variants and in the case of private aided schools the requirements become more stringent and involve cumbersome paper work, in return for which the schools have recourse to some aid. Various studies (Kingdon, 1996, Tooley and Dixon, 2003, World Bank 2003,) have all variously noted the counter productive nature of these measures to regulate private schools across the county and the introduction of a ‘licence raj’, in addition to impacting on issues of quality and equity. Nair (2004) found that apart from these ‘managerial and administrative’ regulations there is little that is done to ensure the quality of services provided by the private schools and NGOs. She cites Jagannathan (2001), on the role of NGOs in primary education who observed that monitoring and quality assurance are important when scaling up innovative interventions but these are as yet a weak areas in the Indian context. Jagannathan however, states that monitoring systems are better evolved within a project framework and recommends a stronger partnership between the government and the NGOs in order to internalise a system of monitoring. Another study (De et al, 2002) that looked into the issue of private schools for the poor in Haryana, UP and Rajasthan, observed that regulatory mechanism of ‘recognition norms’ had failed to ensure minimum acceptable standards of schooling. The study proposed that market forces dictate that if the government schools functioned to a reasonable standard, private schools would be forced to follow suit or would be forced out of business. Similar observations have also been made by Kingdon (2005) who notes that the main reason why private aided schools do not perform better than government schools is that they have become very like public schools. Like public schools, teachers who do not have incentives to perform and lack local level accountability, private school teachers are also not motivated to perform.

The NSP study notes that again the PRIs provide scope for client control of private schools and NGO interventions through parent-teacher associations and Village Education Committees (VEC). However, the experiments in ‘participatory governance’ have only been successful to a limited extent because of a lack of political will and bureaucratic commitment.

Collaborations and Contacting

The NSP study illustrates different types of collaborations in elementary education that have been studied by various researchers:

- The first kind of model is collaboration between a ‘high-profile’ NGO and government on the invitation of the latter. The established status of the NGO gives it relative autonomy and it is given the entire responsibility to plan and design the educational interventions (Jain et al, 2001), at times with financial support from the government within the framework of an agreement or a MoU. Often the NGO itself initiates the collaboration on the basis of its earlier performance. Such a collaboration may pass through stages- from an ‘informal
arrangement’ with local school authorities and district administration at the initial stage to a more official position in the system. It is observed that this is an effective collaboration and the NGO is able to have an impact both at the micro and macro level. Often, the individual officials at the district level also contribute actively. (Eklavya in MP, Bodh in Rajasthan, Pratham in Mumbai are some cases. Both Bodh and Paratham have now spread their interventions to other states)

- Corporate collaboration with the government also falls into this category, having its origin in personal initiatives of individuals (Azim Premji Foundation, initiated its activities in Karnataka and now has a presence). Usually such collaborations are tripartite in nature with funds coming from the corporate agency, while an NGO is responsible for actual implementation and the government for policy and administrative support. The objectives and responsibilities as well as deliverables are defined upfront. In almost all cases, while the NGO or the corporate agency (Pratham, MVF) provides the technical know-how and inputs in terms of curriculum development and improved pedagogy, etc., the state provides the project sites, allows the use of its infrastructure and human resources, utilises its legal and constitutional powers to make necessary modification to rules and systems, thus ensuring that existing government programmes are effectively implemented. Funding is often an incentive for NGOs and at times corporate agencies to collaborate.

- Another model that is emerging is one where NGOs and corporate agencies intervene in existing government schools rather than setting up parallel structures or systems. However, as the earlier study notes, often such a partnership is fragile and its sustainability depends on striking a balance between the political will of the government as well as the commitment of the bureaucracy and the ideology of the NGO (Eklavya, MV Foundation).

- Another type of collaboration is where the State sets up a state-sponsored NGO, registers it under the Societies Registration Act and supports it to operate in difficult areas. The NGO is in a way a ‘conceptual alternative to decentralisation’ (Jain, et al). (Baljyothi Project in AP)

- In another interesting model, diverse kinds of NGOs are coordinated through an autonomous body created within a government project. Within initiatives like the Jhanshala, District Primary Education Programme and now the SSA, two distinct kinds of government-NGO collaborations are visible: one where NGOs are hired to run non-formal or alternative centres within strict guidelines and funding schemes and the other where they are contracted to develop teaching learning materials and modules and undertake trainings of all kinds, while the State provides funds and monitors the contract CLPOA (City Level Plan of Action) a network of NGOs in Kolkata.

The NSP study concludes that non-state initiatives in elementary schools in India have generally evolved on its own in order to fill the gap in public education. The States’

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11 To provided resource support for Alternative Schooling and Shishu Shikshan Kendras in MP; and to run NFEs and ECE Centres in Maharashtra, Tamil Nadu)
response has been to usually restrain them or co-opt them into structured projects and organisations. However, there have been little efforts to provide a facilitative environment for NSPs to function. Nair (2004) cites a study of Kerala by Shah (2000) where he found that the state has actually allocated funds to private primary schools to facilitate them to function, in order to give parents a choice of schools. However, the study observes the persistence of a lack of political will together with the multi-layered, cumbersome and bureaucratic processes generally preclude effective facilitation by the State. In another study on the challenges faced by local actors in the primary education of the poor in Mumbai, Juneja (2001) examines the roles of the two major ‘supporting’ actors - NGOs and the Municipal Corporation. The study concludes that the State’s role in the primary education of the poor can only be supported, not ‘supplanted’. However, with experiments like the ones initiated by Pratham, an NGO which has been jointly initiated by the Municipal Corporation, corporate houses and individuals in Mumbai, a new kind of relationship may emerge.

While researching on the relationship between the State and NGO in a tribal area project in AP, MacKenzie (2003) noted that in general governments have been suspicious of NGO involvement in education. They question their motives, and also consider their work to be sub-standard and hence the State tended to control them through regulations. However, the State was happy to allow them to work in the non-formal mode in remote areas. But governments are now increasingly recognizing the need to link with NGOs, but a lack of mechanism for collaboration continues to be the obstacle.

Thus, the previous study on NSP concludes that the State does not have a clear and informed stand on private schools and, hence, has not been able to enact and implement measures to ensure that they maintain quality and equity in education and are not exploitative of the poor. In addition, as the State is not clear about its own role in elementary education, this has added to the confusion. What is more, as yet the State has not made effective use of the decentralisation process and the provisions of the 73rd and 74th Amendments giving an opportunity for local communities to participate, and to proactively regulate and monitor NSPs.

4.1.2 Primary Health
Overview
The private health sector is generally categorized as a broad group that includes for-profit and not-for-profit providers, nongovernmental organizations (NGOs), missionary hospitals, private pharmacies, and blood banks plus unqualified informal providers. Some of these are registered and others are not. Broadly the sector may be categorized as consisting of the rural medical providers (RMPs)\(^{12}\), not-for-profit (NFP) sector, including NGOs and religious-based facilities and the corporate, or for-profit, sector.

Data on non-state providers in health care is inadequate. However, in our previous report we have noted that about 80 percent of doctors in the allopathic practice are privately employed. In addition there are large number of practitioners in ISM, mostly in rural areas and unqualified medical practitioners, again largely in rural areas. A recent World Bank report (2005) notes that facility surveys in various states estimate

\(^{12}\) RMPs are unqualified medical practitioners, operating on a for-profit basis in the rural and semiurban areas. They primarily offer curative services
that the private sector includes as much as 93 percent of all hospitals and 64 percent of all beds nationwide. This remarkable growth, the study concludes, has occurred “largely by accident” as the private sector has stepped in to meet the needs that the public sector could not.

On the other hand in a case study of the private sector in Hyderabad, Baru (1998) puts forward an interesting hypothesis on the growth of the private sector in India. Baru states that within a framework of a mixed economy, the private sector is seen to use the public sector for its own growth and diversification. The public and private sector is seen as a composite unit, and the evolution of the private sector is examined in relation to changes in the public sector and the social roots of private growth. Baru concludes that dominant class interests shape the directions in public policy and as a consequence the contents of private health care, which is always seeking new avenues for investment. Thus, she states, not only is the private sector not independent of the public sector, but over the years it has used the later for its own growth.

The private voluntary or not for profit sector alone covers a range of health care activities, including implementation of government programmes, managing community based health programme, delivering care and rehabilitation services to disadvantaged groups, or simply advocating for health care. Some also sponsor health care, again for disadvantaged groups. Over 7000 NGOs are reported exclusively or as an integrated strategy, involved in health care activities.

Surveys also indicate that state variations exist in both the for profit and not-for-profit sector largely influenced by the political leaning of the state governments and other inherent development factors. Kerala, Maharashtra and Punjab have the largest numbers of private practitioners and Kerala also has the highest percentage of hospitals in the private sector. On the other hand Himachal Pradesh and Madhya Pradesh have a much lower share of private practitioners. In the case of the not-for-profit sector Uttar Pradesh has as little as 1.4 percent and Maharashtra as high as 35 percent of NGOs in the health care delivery system. NGO interventions in the health sector are limited in the less developed states like Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, as compared to the better-off states like Kerala or Maharashtra.

Policy development
Health policy never seriously addressed the issue of the non-state providers until well into the 1980s. The scenario began to change thereafter when the 1982 National Health Policy was formulated The Policy reported that the states should encourage private practitioners and NGOs, through logistical, technical and financial support, to establish curative centres in order to reduce the government’s burden. Thus, during the 1980s and 1990s the Centre as well as the states initiated a wide variety of public-private collaborations: apart from allowing Government doctors to undertake private practice, NGOs and the private sector have been increasingly invited to participate in vertical national programmes; private sector industries have been encouraged to provide health care to the population living in a defined area; and NGOs have been involved in promoting health insurance schemes (Janarogya).

The 2000 National Population Policy envisaged an increasing role for NGOs in building up awareness and improving community participation. Large and established NGOs like the Family Planning Association of India (FPAI) and Voluntary Health
Association of India (VHAI) were contracted to identify, train, support and monitor smaller, field-level NGOs for specific activities more related to awareness generations and community mobilization and thus, the concept of ‘Mother NGOs’ (lead NGOs) was introduced. In 2002 the Department of Family Welfare was funding 97 mother NGOs and over 800 smaller NGOs covering 412 districts.

These trends have been captured and articulated in the 2002 National Health Policy. It lays emphasis upon the implementation of public health programmes through local self-government institutions and urges the states to decentralise the implementation of the programmes to local bodies; it envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments; a social health insurance scheme, funded by the State and with service delivery through the private sector has been envisaged for the poor communities (pilot scheme in selected districts); disease control programmes are to earmark at least 10% of the budget of identified components, to be exclusively implemented through NGOs; public health service outlets may be handed over at any level for management to NGOs and other institutions of civil society, on an ‘as-is-where-is’ basis, along with the normative funds earmarked for such institutions. The policy also emphasizes the need to simplify procedures for government – civil society interfacing in order to enhance the involvement of civil society in public health programmes. The Tenth Plan thus proposed to allow NGOs with adequate expertise and experience to participate in RCH service delivery. In addition, efforts were to be made to improve networking between the NGOs, state and district administration as well as PRIs during the Plan period. The Plan also saw an effective role for the corporate sector, especially with regard to its skills in problem solving, which could improve the operational efficiency of health services.

In 2003-4 the GoI developed a concept paper outlining the proposed approach to PPP in the RCHII programmes, emphasizing its intentions to collaborate. It has included PPP as a planned and critical strategy, in which PPP has been defined as a “collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms.” The objectives of using the PPP model are primarily to improve access to essential RCH services and improve quality of RCH services available, monitoring the growth of private sector and directing it towards increasing its contribution towards the goal of improving RCH service delivery and ensuring optimal utilization of govt. investment and infrastructure. Franchising of different types, branded clinics, contracting out, contracting in, social marketing, BOT, joint ventures, voucher systems, donations from individuals, partnership with social clubs and groups, with corporate sector, professional institutions, autonomous institutions and CBOs and NGOs is the exhaustive list of partnerships envisaged. All state RCH II; PIPs have now incorporated PPPs into their time bound plan of action and a NHSRC has been conceived to facilitate overall planning and management of RCH II, including the PPP component. (GoI)

Policy dialogue
Our previous study has noted that research indicates that effective regulations require institutional arrangements for dialogue between the public and private sector and coordination mechanisms like public-private forums are one way of doing this. However, there are few such examples, the Karnataka Task Force comprising NGOs,
for-profit organizations and the State being one of them. Similar high-level committees of professional bodies, stakeholder associations and the government were constituted in Andhra Pradesh and in Maharashtra. In addition, the IMA (Indian Medical Association) and its state chapters are another group that has tried to influence government policies from time to time. However, the study points out that these groups only represent the interests of organized private health providers. The most promising possibilities for policy dialogue are however, presented by the PRIs with powers and structures that have devolved to them since the passing of the 73rd Amendment. The National Rural Health Mission has assigned a greater role to them and taking a lead from states like MP, District Health Societies have been constituted for the purposes. The study notes that the most effective tool so far has been the one generally adopted by NGOs and consumer forums - that of widespread campaigns through networks and research based advocacy.

Regulation and control
The health regulations existing in India fall under three categories: drug related which control the sale, price and quality of drugs; practice and consumer right related that define a professional code of conduct and a minimum standards; and facility related for controlling private clinics, hospitals and establishments. There is, however, hardly any effective regulatory framework for quality assurance in the health sector and regulation of private institutions is extremely varied across states.

Accreditation and self-regulation is one form of control mechanism promoted by the State and is extended through the state Medical Councils to help in maintaining high standards. However, our earlier study notes that usually attempts to set up accreditation bodies for private sector health facilities have failed because the processes did not involve key stakeholders. Hence, some voluntary efforts have also been initiated to develop standards for health care institutions (CEHAT). Some states like Madhya Pradesh and Himachal Pradesh have experimented with autonomous, registered societies with representatives of civil society, NGOs, etc., even in government run hospitals for quality assurance and efficient management, as well as to generate resources. This model has now been incorporated into the NRHM. Studies indicate that because regulations are often patchy and unenforceable, inadequate and outdated and because in most cases the state and central governments have failed to enforce them, persistent anomalies in the private provisions of health exist. The studies thus question the State’s capacity to regulate the private sector.

Partnerships and contracting
In the health sector in India, contracting takes different forms for different health services and the process of contracting varies. Contracting has been attempted in various national programmes. For instance in the AIDS programme the management of high-risk groups has been handed over to NGOs(AIDS control initiatives in AP and Kerala); franchising arrangements with private providers under the revised National Tuberculosis Control programme attempts to ensure services to under-served area or targeted group (TB treatment/control through a hospital in Hyderabad); essential health services like primary health care in remote slums and primary health care centres have been contracted out in some states (States like Karnataka and Andhra

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13 Set up in 1999 to address problems and make specific recommendations.)
14 CEHAT and Tata Institute of Social Sciences together influenced the drafting of the Maharashtra Clinical Establishment Act
Pradesh have shown that contracting out PHCs to NGOs can result in improved outcomes and reduced expenditure). Again this model has now been adopted under the NRHM. PHCs in an entire district in Gujarat has been handed over to SEWA; in Karnataka Karuna Trust manages over 25 PHCs under a contract with the state government; in AP, UP and several other states urban health posts were handed over to NGOs; non-clinical services have been contracted out in other states like in Maharashtra and West Bengal; public-private partnership contracts have been executed in Madhya Pradesh which has set up Patient Welfare Societies (Rogi Kalyan Samities), again incorporated in the NRHM); and social marketing of certain products, has also been initiated (Misra, 2003, Nadraj et al 2001).

The previous study on NSPs has summarized the findings from several other researchers (Misra, et al, 2003; Muraleedharan and Nadaraj, 2003; Ensor and Dey, 2003) wherein certain problems related to government contracting out health care services in India have been identified:

- Most governments are reluctant to enter into joint ventures because they fear that it will not meet the social equity mandate. Also since most joint ventures are supported under an externally assisted programme, sustainability is also suspect.
- Government capacity to assess needs, design contracts, manages negotiations and implementation is generally weak. Cases of corruption exist.
- The style of functioning of the bureaucracy affects contracting-out arrangements. There are few bidders for contracts because of low credibility of the government and because of opposition of public sector unions.
- While there is hardly any evidence on the impact of contracting out on savings, equity or quality, a government that fails to deliver quality health services due to a lack of ‘basic administrative’ capabilities is unlikely to plan and execute clinical or non-clinical contracts effectively.
- The cost of transfer of public facilities to the private sector in relation to the benefits that would be generated to the public and transparency issues are other difficult areas as vested interests may often creep in.

Our earlier study concludes that collaboration has had limited success and, although no exhaustive evaluations are available, evidence indicates that State-NGO collaborations have succeeded only where well-defined committed groups were involved and where clear-cut memorandums of understanding were executed. Studies have also shown that in spite of stated intentions to involve NGOs, their participation has been limited, primarily because of the inadequate capacity in the government to proactively manage the government-NGO relationship, amongst other reasons (World Bank, 1995).

Purohit (2001), on the other hand is of the opinion that now that the country is well into a reform track, the possibilities of the State increasing its share of expenditure on the health sector will get progressively reduced and private sector involvement is inevitable. However, he adds, that there are limits to market forces and the State should redefine and refine its role to avoid undesirable consequences of ‘rising costs, increasing inequity and consumer exploitation’. He recommends for instance, opening the health insurance market to multinational companies, the proper channeling of tax incentives to set up medical institutions in backward areas and reinforce appropriate regulatory mechanisms.
In 2004, POPTECH, undertook a detailed review of several cases (about 24 cases) of public–private partnerships in the health sector in India (RCH focused). The criteria adopted for describing the PPP model were: nature of service delivery, nature of the public partner, nature of the private partner, target group, nature of transaction, coverage, implementation procedures and type of partnership (social marketing, franchising, contracting out). They had another set of criteria for assessing the models, which included strengths, weaknesses, equity and quality elements, sustainability, scalability, coverage, health outcomes and constraints. Their key observations were that:

- Much of what is being termed as PPP is generally a contracting arrangement between a public and private entity. They state that true partnerships require shared objectives, investments risks and rewards. (In this sense Karuna Trust has been cited as a true PPP)
- Most of the PPP models were initiated because of a lack of facilities in a particular area. In all cases while the ‘public’ partner was a state department the private partners varied.
- Most of the models examined fell into the contracting out category, although some were also the franchising types.
- PPPs that have succeeded have done so in the face of numerous challenges and objectives, largely a result of management structures and conventions that have been designed for a large centralised public health authority which is generally not flexible to adapt to meet the needs of a specific partner, community or intervention.

In a study on donor-funded government partnerships for public service improvements, Brinkerhoff (2003) states that as the requirements advocated in partnership principles may not be possible to achieve because of organisational or political constraints, it may be appropriate to describe partnership on a relative scale, to explain the extent of interorganizational relationship. She states that partnership would depend on the will of the partners, particularly the government, to change, amongst other factors. She cites the example of IPP VIII in Hyderabad, to show that the donor took the lead in promoting a partnership approach and negotiating relationships, particularly with government bodies, to gain agreement on the approach and objectives. According to her findings the India Population Project VIII has been successful for several reasons, not least of all because “the willingness on the part of some government officials to view the partnership works not as a threat but as a means of bringing in more business and improvements in health care delivery”. She concludes that: “Looking exclusively at success stories can blur a realistic understanding of partnership work, leading development practitioners to underestimate its inherent challenges. Partnership actors often do not sufficiently reflect on what partnership means and how it differs from business as usual. While the rationale for a partnership approach may be readily agreed, too often actors engage and initiate “partners” without considering the changes necessary in their own behaviour to make partnerships effective.” This raises a pertinent question for our study: do we limit our research to apparently ‘successful’ partnerships or extend it to those that have not worked?
4.1.3 Water and Sanitation

Overview

The previous study on NSPs indicates that in the water and sanitation sector the primary non-state actors have been NGOs and the private sector. NGO involvement in water was first visible in the early 1960s during the famines in Bihar and Maharashtra, when the state governments contracted them for drilling purposes. However, after the Water and Sanitation Decade, and more specifically from the early 1990s, their involvement has been increasing, primarily as intermediaries between the government and the community. NGO involvement also got a boost with the initiation of several external funded programmes. Their major inputs have been in the form of community mobilizations, hygiene promotion and evolving community based structures for management. On the other hand private initiatives started relatively recently and are seen in the areas of construction and maintenance of traditional wells and household toilets and execution of larger water supply projects. In addition, poor maintenance system by designated government agencies has also led to the emergence of a network of rural private (untrained) handpump mechanics. The involvement of the private sector is more in the nature of supplier of goods and builder/contractor. In terms of large water and sanitation projects most of the private sector initiatives are restricted to a few cities.

Policy environment

The NSP study traces the evolution of non-state providers and the key policies that gave shape to its present status and profile:

- In 1986 when the first National Water Policy was drafted to address the growing water crisis and the ARWSP was given a ‘Mission’ status, in order to ensure inflow of technical and management inputs into the sector in a cost effective manner and the Technology Mission was set up NGOs emerged formally in relation to the State. The Mission was renamed the Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991 and its scope was subsequently expanded to also cover rural sanitation.

- At the same time, the Centrally Sponsored Rural Sanitation Programme was also launched (1986) with the primary objective of generating a felt need for toilets and better hygiene practices through awareness creation and health education. NGOs and the PRIs were to play a key role in the process. The Intensive Sanitation Programme (ISP) of the Ramakrishna Mission Lokashiksha Parishad in Mednipur, West Bengal (also supported by UNICEF) and the activities of the Safai Vidhyalay in Ahmedabad, were launched during this time with support from the government and went on to eventually influence the approach and strategy in the sector. They actually experimented with providing the community with low cost sanitation technology through accessible production and marketing centres set up by them.

- The International Water and Sanitation Decade, with its focus on the introduction of reforms promoting an integrated approach including changes in institutional structures, attitudes and behaviour and participation of the community, especially women, at all levels, community management of services, strengthening of local institutions in implementing and sustaining water and sanitation programme and sound financial practices for the better
management, sketched a large role for the community and hence the NGOs in the sector. Thus, throughout the 1980s and 1990s the government sought NGO participation in water supply primarily for community mobilization and better use and maintenance of facilities as well as to ensure equitable access to resource, in the case of sanitation increasing coverage was the goal.

- Unsuccessful attempts were also made by some states to transfer handpump maintenance to un-prepared PRIs. When the attempt failed, maintenance responsibilities were reverted back to state agencies that felt vindicated in their stand that they alone could do the job. NGOs again activated themselves to train and build capacities of local resource persons and PRIs.

- The PRIs, inturn received further recognition with the introduction of the decentralization process in the early 1990s and several experiments later – again spearheaded by NGOs within state specific donor funded programmes - village level water and sanitation committees have emerged as sub-committees of the PRIs. In addition, in some states the VWSCs have also donned the role of a service provider.

- The structural reforms and liberalization process of the 1990s slowly brought in the private for-profit sector into the drinking water sector. Private sector participation was advocated primarily to improve resource and systems management, and to address investment constraints and increasing demands for competition. However, because the Central government tried to promote changes without providing clear-cut guidelines or incentives to states and also because of vested interests, only a few large donor-funded private sector water supply projects made an appearance during this period. A new National Water Policy that was drafted in 2002, although putting into perspective the need for integrated development and increased community involvement, institutional reforms, private sector involvement for improving performance etc., failed to provide concrete guidelines for operationalising the approach.

- Realising these shortcomings and because of the urgency to cover the fiscal resource gap, the government initiated a process of reviewing and formulating guidelines for encouraging private participation in the urban areas focusing primarily on reforms in the institutional and policy framework to attract public and private investments. As it was thought that a clearly articulated state framework, backed by enabling laws, would pave the way for systematic reform, the central government adopted a consultative process to evolve guidelines and a wide range of stakeholders, including the private and voluntary sectors, were consulted.

- Together, the various NGO experiments and the desire to promote private investment (for profit sector), culminated in the evolution of the 3 programmes: Total Sanitation programme (TSC) in a campaign mode in the beginning of the current decade; a pilot Sector Reform Programme (SRP) which was scaled up to cover the entire country as Swajal Dhara in 2002; and lead to the inclusion of drinking water supply and waste management as a priority component in the reform oriented JNNURM. In the process, the State is increasingly trying to shift its own role from that of a provider and supplier
of services to a facilitator providing financial and technical assistance. These programmes embody within their framework elements of a demand driven strategy, wherein community mobilisations, empowerment and capacity building are critical. The reforms have thus, greatly enhanced the demand for both NGOs and private sector organisations as intermediaries as well as suppliers and managers of provisions.\(^\text{15}\)

- In order to move the reform process forward all states were expected to develop State (SD/TSC) and city (JNURRM) specific vision and policy documents. On the basis of the documents the Centre is to enter into a contract with the states for operationalising the reform process.\(^\text{16}\)

**Policy dialogue**

The NSP study (Nair,2004) notes that, until recently, there were relatively few NGOs active in the water and sanitation sector compared to education or health, and hence their influence on policy has been limited. Ramakrishna Lokshiksha Parishad, Safai Vidhayalya, and SPARC are the few exceptions that have been able to influence the Sector Reform and Total Sanitation Campaign strategies. Their approach has been to “demonstrate successful experiments in the field, to enter into dialogue and debate through workshops and seminars, and to lobby through the media. As a result the leaders of some of these NGOs have been co-opted into decision-making committees at the national and state levels and have forced the government to review or revise some of its policies.” Of late residents associations have started to emerge in larger metro cities to address the growing water crisis. However, generally these forums do not have a specific pro-poor focus, but cover citizens at large (Chennai: Citizens for Clean Waterways; Bangalore Agenda Task Force, Delhi: RWAs).

The private sector on the other hand is even less organized to negotiate on a common platform as firms operate on an individual basis and use contracts as a tool to negotiate. However, there are examples of water tanker service providers (Chennai) who have formed an association to negotiate collectively on shared interests.

**Regulations and control**

Our earlier study points out that as yet there are hardly any effective regulations for the planning and management of water supply and sanitation in the country. Considering that water is a state subject and responsibilities are distributed between different tiers of the government and agencies, regulation is necessary. But the complexity of the mechanism compounded by the multi-layered organizational structure and the different socio-political leanings of the various states makes this task difficult. The study observes that this gap however, limits the scope of effective participation of the non-state sector to contracting out ancillary services (Chennai Metropolitan Water Board), contracting out bill delivery and cash collection

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\(^{15}\) Some innovative ways of local production through self-help groups in Andhra Pradesh and Tamil Nadu and private sector supply chain initiatives in the rural areas of Tamil Nadu and Bihar are being tried out by WaterAid and UNICEF.

\(^{16}\) The signing of the MoUs under SD has been inordinately delayed in most cases and the SD programme has progressed very slowly. The central government is now making it mandatory for all states to completely switch over to the SD approach by the beginning of the 11th Plan. Under JNURM, City Development Plans are under preparation and will be followed by tripartite MoUs executed between the Central government, and the respective state government and the local ULBs.
(Hyderabad Metropolitan Water Supply and Sewerage Board) and management of operation and maintenance of water supply and sewerage treatment in the case of some Municipal Corporation.

The study notes that inadequate regulations have led to a number of problems:

- The rapid emergence of unregulated small scale operators (primarily water tankers and bottled water) in both cities and rural areas. The study cites Llorente and Zerah (2003), who found that two types of small scale private providers – bottled water and tankers – have emerged in cities like Delhi in the absence of any regulations. Moreover, most of them are not registered and there is no quality check.
- Conflicts between the provider and the user/client agencies, which either do not get resolved (Shianath River privatization in Chattisgarh, POABS Group of Companies in Kerala) or end up in a legal court battle.
- Ground water resources have become a private good defined by a de facto system of rights over land, leading to the rapid increase in private water suppliers (bottled and tankers).
- The sector has also been unable to attract much private investment primarily because of a lack of capacity for efficient development of projects and appropriate financial regulatory and legal frameworks.

However, states like Gujarat and Andhra Pradesh (AP) began to better organize private participation in the urban sector in the late 1990s by setting up Infrastructure Development Boards (Gujarat) and Acts (AP) which allows the government agencies to enter into concessions arrangements with the private sector, provide guidelines for co-coordinating with concerned departments and sector regulators, decide issues of setting, revising, collecting and regulating user levies, etc. Some states like Gujarat and Mahararashtra have also drafted regulation for the management of water resources. Both water supply and management of sewerage fall within the purview of the Gujarat Board and AP Act. Following this the Central government has also set up a special purpose vehicle for facilitating funding of infrastructural projects and obviously encouraging private sector participation. In 2004, the Government of India, with support from WSP, prepared draft guidelines for private sector participation in urban areas.

**Partnerships**

The NSP study concluded that the attempts to promote alternative models to the existing centralised supply driven one in the water supply and sanitation system in India, has lead to certain strategic trends in the sector: “Commercialization to improve cost recovery, privatisation to generate finance, improved technology and enhanced management capacities and community participation to ensure responsiveness and a sense of ownership.” This has led to the emergence of PPPs and partnerships between the state and NGOs and the state and the community. The study highlights following forms of partnerships:

- Noting that instances of private sector partnerships in water and sanitation are few, it says that only some large-scale attempts exist primarily in the form of
service or management contracts. Tirupur and Alandur projects in Tamil Nadu and an operation and maintenance contract in Chennai are some of examples of longer term complex contractual arrangements that appear to have succeeded so far.

- The ‘Apna Yojna’ in three districts of Western Rajasthan is another example of a large relatively successful project in partnership with a consortium of five NGOs partners, a Government department and the Village Water and Health Committees (VWHC). While the NGO consortium is designated as the Community Participation Unit and is a co-executing agency responsible for community outreach and participation activities, the VWHCs, through an agreement with the Project Management Committee, has assumed responsibility for local level planning, and operation and maintenance. The project, which is funded by KfW, has recently completed its first phase of activities and has been able to supply water to about 1000 villages and 11 towns. Capital cost sharing is on a 75-25 percent basis between KfW and the state.

- Sometimes, like in the case of Sulabh International, the government provides financial and other inputs like land, water, electricity, in return for which the NGO operates and maintains the toilet complex for a specified period as agreed. Revenue is raised through a nominal user fee. The model has been rated as a success, although its access by the poorest in the city has been questioned.

According to Nair (2004), several studies (for example, Reut et al, 2002) have identified the factors that have limited private sector participation in the water and sanitation sector, such as market uncertainties, fluctuating input prices, procedural hurdles largely related to inter-agency co-ordination, cost and time overruns, political interference and frequent policy changes, and judicial interventions largely due to a lack of adequate regulatory mechanisms. Thus, most partnerships have failed because of: a lack of clear guidelines and policy framework for private sector participation; lack of regulatory mechanisms, poor contract management capacities, lack of informed participation of a wide variety of stakeholders, misunderstanding about the objectives of the private sector, processes of awarding contracts and lack of transparency. In addition, existing low rates of tariff forbids cost effective increase, and the fact that the municipal authorities by and large are not vested with the powers to sign contracts without getting the endorsement of the state makes decision making cumbersome. Beside they also do not clarify the cost-sustainability as far as the poorest sections of society are concerned. Hence, Ruet et al (2002) point out that no city in India has considered adopting the ‘concession’ contract, where the risks are largely borne by the private sector. Between 1994-99 several BOT projects were initiated and abandoned.

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17 Alandur: A BOT for a sewerage treatment plant for 14 years; Chennai: an operation and maintenance contract for a pumping station and treatment plant; and Tirupur: Industrial and municipal water sewerage project with a 30 year concession, initiated in 1994.
The NSP study observes, however, that there have been several small-scale formal and informal private initiatives (by NGOs as well as for profit private companies) in partnership with the government, which appear to have been fairly successful and have been variously documented. Thus, small-scale providers, largely informal, have been increasingly making an appearance, as a result of the shortage of public water supply and the lack of regulations to control the functioning of such suppliers. Studies indicate that, with considerable regulation, these small suppliers can partner municipal governments:

- The PHED in Ajmere, Rajasthan has privatized the operation and maintenance of the filtration plant, pipelines and pumping stations of a new water supply scheme from the Bilaspur dam. A field study carried out by WSP notes that although labour unrest against privatisation and a fear of loss of jobs has been a problem, this private sector participation is generally considered to be a success. It underlines the need to design a well-defined contract with roles and responsibilities clearly laid out with a mutually agreed performance linked system of payments and penalties (WSP, 1999).

- The Songaon-Mekhali multi-village (4 villages) regional scheme in Maharashtra constructed by the Maharastar Jeevan Pradhikaran was handed over to the Zilla Parishad (ZP) for operation and maintenance. As the Kolhapur Zilla Parishad was not prepared to take over the project from the Maharastra Jeevan Pradhikaran (MJP), the community decided to directly take over the scheme from the government. A joint water committee or Mandal was formed which included the sarpanch for the three local gram panchayats, elected member from one of the villages, chairpersons from the three newly formed gram panchayats, and a technical officer from the Maharastra Water Supply and Sewerage Board as an advisor.

- Local NGOs together with international NGOs like WaterAid and international agencies like the World Bank and UNICEF have also been engaged in partnership with the state governments to provide local level water and sanitation services. Usually a tripartite agreement is arrived at, wherein the international NGO, World Bank or UNCEF provides the funds, technical expertise and oversight, the state facilitates with additional funds as well as policy and administrative support, and the NGO supports the actual construction. The WaterAid sanitation programme in Tiruchirapalli (Tamil Nadu) the hand pump maintenance programme in Andhra Pradesh, and the SWAJAL programme in Uttar Pradesh and Uttarakhand are some examples.

The NSP study (Nair, 2004) has identified key factors that contributed to the success of both the small-scale initiatives and those relatively larger ones supported by external donors and international NGOs:

- Because they were largely pilots, greater attention in terms of support and monitoring was provided to partners.

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18 WSP (South Asia) DFID series on Small Private Initiatives (SPI) In The Water And Sanitation Sector In India (1999-2000)
• As only a single agency was involved from the State’s side or a special purpose vehicle was set up, enormous amount of flexibility and effective inter-sectoral co-ordination was possible.

• Individual initiatives of certain key persons within the community and the State structure, helped in carrying the process forwards.

The study however, concludes that as these projects could achieve only limited changes within the larger institutional structure and policies related to roles and responsibilities of stakeholders could not be well defined there has been no long lasting change to encourage non-state participation. Further, as there is no regulatory mechanism to ensure quality of services provided and equity of access these partnership models could not be effectively scaled up. Moreover, by the very nature of the project, the NGOs themselves were only transitory service providers. SD, TSC and JNNURM, which presumably reflect lessons from these experiences may show better results in terms of long term impact.

5. Conclusions from the scoping analysis: Implications for case selection and methodology

The key factors which emerge from the above analysis of the NSP-State relationships in India and of relevance to the research framework and for locating the case studies are:

Locating the regions: Two factors dictating the need to look at NSP-State relations in the country on a regional basis are:

Firstly, socio-political variations in the country, as well as disparities in economic growth and human development are significant features. Although, broadly the services delivery mechanisms, constitutional and budgetary provisions for service delivery appear to be the same across states, the interpretation of these in terms of use and outcomes are different and may have been influenced by state specific factors, within which different forms of NSP- state collaborations may emerge.

Secondly, given that the NSPs in the country, specially the voluntary not for profit sector and the individual–oriented for profit sector, have a long history closely linked and influenced by the prevailing political regime, it may be necessary to construct a State-specific trajectory of the evolution of a range of NSPs and their relationship to the State over time. This will help in validating, or otherwise the observations of other researchers that State-NGO relationships vary with political regimes; and that evolution of NSP- State, more specifically NGO-State relationship is the product of a broader political economy (‘ecosystem’); and as such the relationship in this context is not static but made up of complex and interdependent struggles and changes over time.

On this basis the criteria for the selection of the states will include the trends in economic growth, the poverty level, the trends in HDI and the dominant political orientation over time and case studies will need to be located to cover a wide range of types of state.
A caution, however, is that selection of states would also be influenced by the presence of significant and apparently effective relationships (broad indicator being the overall impact of the programme). This in a sense would restrict the selection to the middle or higher income and the better performing states in terms of HDI, which in turn may not allow as understanding the dynamics of relationship in the relatively poor regions.

**Locating the types of NSPs:** NGOs and for-profit private providers have emerged as the two key players amongst NSPs, although there is a sector-wise variation in the extent of their presence and range of activities. Thus:

- While NGOs have been traditionally prominent in elementary education and less so in primary health care, they are a late entrant in water and sanitation.

- While individual, unorganised type of private sector is prevalent in health care and also in elementary education, the larger organised private sector players are few and largely found in the water and sanitation sector.

- Small NGOs are more predominant than large NGOs and together have made a significant presence across the non-state sector.

- So have NGO networks, in advocacy – more in the case of elementary education - influenced State policies.

- Community-based organisations and their constitutional forms - village level PRIs are becoming critical, especially in the water and sanitation sector. Though, not NSPs in the technical sense, the profile of the PRIs as community based organisations, as emerging alternative service providers and as being different from the government parastatal and departmental agencies creates the possibilities of another type of relationship, falling somewhere in between a pure NSP (for profit or not for profit) and a State institution.

Hence, the NSPs that may provide answers to our questions would primarily be the NGOs- both large and small, NGO networks, private for profit (formal and informal), CBOs (generally sponsored under government programmes) and village level PRIs.

**Locating types of partnerships:** Our analysis has thrown up two types of theories on the types of relationships: according to one school of thought within the framework of a mixed economy the private sector uses the public for its own growth; besides the internal functions of the private sector, the nature of activity (more so in the case of NGOs) and resource availability influences the relationship. The public and private is thus a composite unit. Dominant class interests shapes public policy as also the growth of the private sector. In the second, and in a way related theory, the State is the dominant partner and shapes the growth of the private sector by concessions, facilitations or partnerships. In addition, these relationships develop over time and may change in nature. Hence it would be pertinent to look at horizontal and vertical as well as formal and informal types of relationships.

**Locating cases to understand dynamics of relationship within an inter-sectoral framework** is a possibility, because in most cases the NGOs are multi-task oriented. In addition, programmes like ICDS, school sanitation are expected to engage in
convergence and co-ordinated planning and implementation. How this additional feature affects the State-NSP relationship is an area that has not been adequately researched.

**Locating cases both at the central and local level** would be critical because at the local level relationships are characterised by lack of understanding and hostility of the local politicians, government officials and elites. In fact, it would be worthwhile to trace relationships at all levels within a large programme.

**Locating the cases within a Programme** - national or state-specific - would allow for comparability of relationships and the influence of common parameters.

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